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Fall 08 - Medicine in Oregon

Fall 2008 Issue

The Road Ahead: With the Workforce in Crisis, a National Proposal Comes from Oregon

In the Summer issue of Medicine in Oregon, Oregon Senator Ron Wyden contributed a column discussing his Healthy Americans Act. When Senator Wyden reached out to Oregon physicians for input on the bill, they told him it did not do enough to solve the country's growing health care workforce crisis.

Hearing that, Wyden asked OMA to convene a workgroup to address the issues as part of the legislation. Since March, representatives from OMA, Senator Wyden's staff, the Health Care Workforce Institute, OHSU, the Oregon Centers for Nursing, the Oregon Office of Health Policy and Research, the Office of Rural Health, and the Oregon Area Health Education Centers have been working to craft a proposal that will be incorporated into the legislation.

The key provisions include federal support for workforce and workplace demographic data, and additional funding for medical education and incentive programs to address the needs of underserved populations.

Roots of the Workforce Shortage

"For the last 30 years, proposed health care delivery system changes anticipated a stable demand for physicians" says John Moorhead, MD. "With this assumption, in the U.S., funding for medical education has remained flat. Now, according to the AAMC, we need a 30% increase in physician supply across all medical specialties to meet increased demand for medical services." Moorhead should know. He has been serving as the head of this Workgroup, and as Chair of the OMA's Workforce and Access Committee; he's a board member of the Oregon Health Care Work Force Institute, and he has been involved at the national level with the workforce efforts of the American College of Emergency Physicians.

During the past 30 years, innovations in health care, changing levels of access, and an aging population increasingly affected by chronic disease have contributed to the crisis.

A Shortage of Data

In order to determine appropriate funding for physician education, policy makers and educators need a more accurate picture of the workforce currently in practice.

According to Jo Isgrigg, Executive Director of the Oregon Health Care Workforce Institute, the number of physicians working in Oregon varies depending on whose

data you look at. “In 2006, the Oregon Medical Board had records for 9,538 physicians with an active license. The Oregon Employment Division identified just 6751, and the OHPR/OMA study (referenced on page 17) identified 8151. That’s quite a range, and that represents a lot of patients when you think about the number each physician can care for.”

Across the country, Isgrigg says, the lack of data is an increasing problem recognized by the Federation of State Licensing Boards, though a handful of states have systems in place. North Carolina, for example, has data going back to the 1970s. “They can trend out their data over 30 years, report it every year by occupation and county, and tie it together with other economic data on the population. This paints a good picture for policymakers and educators engaged in workforce and economic development, because it makes it easier to identify where they need to make their investments.” Isgrigg also sits on the Wyden workforce workgroup.

Specific policy improvements can be supported by data. In Massachusetts, policymakers have demonstrated the need for creative solutions to attract and support physicians to the state. According to Isgrigg, “Reform efforts identified shortages in primary care providers, so the state enacted legislation that pays more attention to their workforce building capacity at state medical institutions, and incorporates incentives like loan repayment and housing assistance to get to underserved areas.”

Most states lack ongoing, accurate data for practicing physicians, and Oregon is no exception. State data for nurses is much better, because the Board of Nursing has been collecting workforce and demographics data through the licensing process since 2001. “That’s the model we would like to see replicated for other health professions here in Oregon,” said Isgrigg. Federal support through the Healthy Americans Act would make that easier.

A Multi-Part Prescription

“We need a significant health care workforce investment at the state and federal level if we’re going to provide access for both insured AND uninsured people,” says Moorhead. “A 30% increase in the number of physicians is estimated to require a $3 billion investment for graduate medical education; capacity can’t expand without resources.”

Physician extenders are important, but they are not an adequate solution. The real urgency now is getting more physicians in the training pipeline. “We can invest in other needed personnel and get results in one to three years; however, with doctors it will take as long as 15 years to see an impact on the supply of practicing physicians. Within five years, 20% of the doctors in this state will have decided that they will retire. There is no one to replace them.”

We need to recognize that the training pipeline for physicians is 12–15 years. Moorhead asserts that in addition to expanding education, we need robust efforts to retain physicians in practice in our state, and we need to develop re-entry programs for physicians who leave the profession by choice for a time (see sidebar).

“We need a variety of solutions to create incentives and make it attractive to work in underserved areas. Loan repayment and loan forgiveness programs are important, and one of the best ways to attract physicians to rural areas is to train them in an environment similar to that in which they will practice.” Decentralizing medical education training may help increase access in rural areas.

Short- and Medium-Term Fixes

Perhaps reflecting that the Baby Boomer generation expects to be professionally active in some capacity for longer than previous generations, we need to look at those older physicians who want to remain active as a potential resource. We

need to look at retired physicians as a volunteer resource and make it possible for them to contribute. “It’s not reasonable for doctors to take a liability risk when they volunteer. We must protect doctors who want to volunteer. One step OMA has taken is to work with CNA to create an insurance product for OMA members who volunteer their time for just $100/year. At press time, details on this policy were still being finalized.

The health care system will have to use other providers to their maximum until physician supply is substantially increased, and Moorhead noted that we may need more PAs and CNPs to take part in a team approach to medicine. There will be more DOs coming in Oregon because of the osteopathic medical school in development by Samaritan Health Services in Lebanon, slated to open in 2011. In January of this year, Larry Mullins, president and chief executive of Samaritan, announced that they expect to enroll 50 students in the first year, gradually building to a capacity of 100 per class.

The starting point, however, is gathering data. “The key part to know if its working is to have good data collection—our proposal for the Healthy Americans Act is attempting to get to that data up front. Having the data that shows what our workforce looks like, where they are practicing and for how many hours they provide direct patient care will help us up front make better investments in using finite resources in building our workforce supply,” says Isgrigg.

Our health care workforce crisis is too big to solve alone, and the collaboration represented by the Wyden Workforce Workgroup is only the beginning. As the fate of the Healthy Americans Act plays out with the new administration, OMA will continue to contribute to sustainable workforce solutions.

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To Negotiate or Not To Negotiate a Physician Employment Agreement: That Is the Question
by Mark A. Bonanno, Esq.

Abstract: *This article discusses the issue of entering into physician employment agreements. Typically, a physician joining a medical practice will wonder if it is worth negotiating over the terms of the agreement. Before negotiating or dismissing the idea of any negotiation, both the employer and employee should understand the terms of their agreement. This article provides a basic list of provisions found in an employment agreement, and provides some practical information regarding the meaning of those terms.*

Introduction

“I need you to pick apart this employment agreement and help me hammer out a way better deal,” demanded the young physician of his newly hired attorney.

“Okay, but do you have a copy of the agreement?” asked the attorney.

“Right here,” said the physician handing one over.

The attorney flipped through the document, came to the last page, and asked: “It looks like you and your new employer have signed this agreement, is that right?”

“Yeh, but I needed the relocation money they offered so I signed that and thought once I got here, I could just get a real contract negotiated.”

The attorney paused and simply said: “But, this is a real contract.”

The Nature of Physician Contracts

Physician employment agreements are commonplace in health care today. Physicians entering practice or those relocating to a new practice should be aware of the meaning behind the legal terms in their contracts and try to work out changes before signing off on the paper versions of the agreement. In the above scenario, the young physician did lose the ability to negotiate any changes in the business relationship because he signed the document prematurely. His only option would be to exercise any right to terminate the agreement, and try to renegotiate a new one. Feasible? Sure, but is he likely to be rehired?

In general, you do not need a contract in place to work as a physician. But, common sense should dictate that you probably do not want to rely on just memories of verbal promises a year or even just months after starting work. The employment agreement or written contract documents those promises.

In other words, a contract basically is just the paper version of a verbal agreement. The reason it exists is to memorialize the business relationship and to try and clarify that relationship as much as possible. Most physician contracts start off as a template in some attorney’s computer that is refined and reworded over time. There are some nuts and bolts provisions such as salary and duties, and there may be unique items such as relocation expenses. No matter what is in a contract, the language should be understood by the parties and drafted to clearly explain the intent of the parties. This concept is known as coming to a meeting of the minds. If there is no meeting of the minds, there is no agreement.

Should the parties negotiate every provision of an agreement? Yes, but … the parties should be reasonable. If a young physician fires back a ten page letter ghost written by his lawyer that demands changes to every provision of the contract, will that physician get hired? Unlikely. As they say about parenting, you have to pick your battles. Any attorney can tell someone what each provision of a contract means and whether the provision makes sense, but the decision to negotiate the best possible language for a provision should be weighed carefully against the big picture of the business relationship. Perhaps the minor points could be let go, in favor of focusing on larger issues. Hence, this is the art of negotiation.

Before getting to that point, both parties (i.e., the employer and employee) should understand the terms of the proposed agreement. Armed with a solid understanding of how the agreement is intended to work as is, the employer will know what to give in on or not, and the employee will know what to push back on or not.

Above all else, the parties should work out their differences reasonably and professionally. After all, the last thing anyone should want is to start a new job that is adversarial before the first day on the clock.

Employment Agreement Basics

The following discussion highlights basic provisions that may be found in a typical employment agreement between a medical group (employer) and a physician (employee). This list is not exhaustive. If there are specific legal questions about an agreement, those should be directed to legal counsel *before* the agreement is signed. So let us get started.

Who are the parties? This fact often is overlooked in contracts, but a physician should understand who is the employer. Is it a professional corporation or a limited liability company? If so, who owns those companies and is ownership something the young physician should be thinking about too?

When does the agreement start? An agreement may be signed as of a specific

date (i.e., the effective date), but work may not actually commence until a later time (i.e., the starting date). The parties should spell out these dates because the timing may trigger responsibilities on either side of the table such as obtaining proper licensure or certifications (for the employee) or the promise to pay or provide benefits (for the employer).

Is the physician an employee or independent contractor? Most employment agreements state the physician is an employee. Unfortunately, some agreements are not clear or the employer attempts to treat the physician as an independent contractor. There are pros and cons associated with independent contractor versus employee status, and those should be reviewed by legal counsel and a tax advisor.

What are the duties of the physician (and employer) and how will the physician be compensated? Basically, these terms are the consideration for the employment agreement. The duties of a physician usually include providing medical services to patients of the employer. As for compensation there may be two general options. The first option would be a fixed guaranteed salary such as $150,000 per year. There, all of the business risk is held by the employer, in that, they are guaranteeing payment to the physician likely at a time when he or she is just learning how to be productive. The second option would be some sort of base salary (less than a full time fixed salary) and a bonus or productivity payment based upon a combination of factors. Here, the business risk is spread between the parties because the new physician would need to meet specific benchmarks before obtaining greater payment under the contract. Any promises of bonus or productivity compensation should be drafted clearly and an example calculation is a good idea for more complex formulas.

What benefits are provided under the agreement? The benefits offered by employers these days range from none to many. If benefits are offered, they should be written into the agreement and clarify which party is responsible for some or all of the cost. Benefits may include items such as health insurance, pension or profit sharing plans, vacation time, holidays, continuing medical education, moving expenses, and professional dues.

What are the term and termination provisions? The term provision sets forth the time period of the agreement. Be aware of "evergreen" clauses that automatically renew the agreement unless someone affirmatively objects. With respect to termination provisions, the basic question is how does either party get out of the agreement if things go bad? If the termination provisions are unclear they should be amended.

Are there fraud and abuse issues? The main concerns here are compliance with the federal Anti-Kickback Statute and the federal Physician Self-Referral Provisions (a.k.a. the Stark Law). Bone fide employment relationships generally fit under a safe harbor or exception to the fraud and abuse laws. An understanding of the laws, however, is a good idea because improper compensation for physician services or referrals can result in serious legal problems.

Are there privacy issues? The federal Health Insurance Portability and Accountability Act (HIPAA) resulted in some fairly complex regulations governing the use and disclosure of a patient's protected health information as well as the standardized and secure use of electronic information. Some of the regulations make sense, and some do not. A decent rule of thumb would be to treat patient information as you would your own, and ask questions if there is a concern about a HIPAA policy.

Are there any restrictions regarding confidentiality or an ability to engage in business outside the employment relationship? These provisions are sometimes called restrictive covenants or noncompete provisions. The first issue is to make sure they are legal in the state where the agreement is made. Where they are legal, as in Oregon, they generally have to be reasonable in time and geographic proximity or they have some other restriction imposed such as prior

notice or a threshold test (i.e., the restrictions only are valid if salaries are above a certain amount). Another form of a restriction that is becoming more common is a nonsolicitation provision that prevents an employee from soliciting patients of the employer after the agreement is terminated. Restrictive covenants should be reviewed carefully because they could require a physician to relocate after the agreement is terminated.

What about professional liability coverage and indemnification provisions? Physicians generally cannot practice without malpractice insurance. Find out what levels of coverage are required in the agreement and if the employer covers the cost of premiums. Also, some agreements require a departing physician to obtain tail coverage to provide insurance for acts that occurred while employed but have not been complained about yet. Again, the issue is who pays for potentially costly premiums. Watch out for other hidden costs of insurance requirements (e.g., disability, general liability) and indemnification. Do you need more than just professional liability coverage? Are the coverage limits required in the agreement the same as in the insurance policy? With indemnification, who are you agreeing to indemnify and what are you indemnifying them for? In general, any type of indemnification provision (or "contracted for" liability) should be run by the physician's insurance company to see if there will be coverage.

How is the contract amended? The rule of thumb here is to not allow the agreement to be amended without prior written approval by both parties.

Are there arbitration and attorney fee provisions? Look out for provisions regarding how disputes are resolved. If there is an arbitration clause, it should be "binding" arbitration. If it is not, you could end up going through the time and expense of arbitration, only to have the losing party jump over to court for a second try at winning. Also, when considering arbitration versus litigation in court, remember that both parties give up significant legal rights by agreeing to arbitration. With binding arbitration, nobody gets their day in court, yet there can be very similar costs as compared with litigation. Finally, check for attorney fee provisions. Who pays for legal fees and costs? The prevailing party? Are the fees and/or costs split evenly, or does each party bear their own fees and/or costs?

What is the governing law and venue for disputes? Because most of the services being provided under an employment agreement will be local, the state law governing the contract should be where the services are provided. Also, watch for location provisions for dispute resolution (these are called venue provisions). The venue should be the state and more specifically the county where the medical group is located.

Are there references to exhibits, attachments, or other documents? Be careful with references to external documents (such as policies and procedures), especially when those documents are "incorporated by reference." The general rule is to avoid being bound by external documents unless you have a chance to review those as well (and have some ability to approve or at least be forewarned of changes to the documents). On the other hand, a common practice is to put benefit items in a cover letter and not in the agreement. Where that is done, make sure the cover letter is incorporated by reference into the agreement.

What about signatures and execution of the contract? Remember to have an employment agreement reviewed before signing it, and keep a signed copy.

Conclusion

In sum, both parties to a physician employment agreement, the employer and the employee, need to understand the terms of the contract. Where language is vague, it should be made clear. Spending some time understanding and clarifying the business relationship before signing the contract document should avoid more time consuming and costly disputes down the road.

Mark is an Oregon-based attorney in private practice. He provides business and compliance legal services to clients in the health care industry, and may be reached on the web at healthlawoffice.com. This article is for informational purposes only and is not intended to be legal advice. Copyright 2008 Mark A. Bonanno.

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From the Desk of Jo Bryson
Joanne K. Bryson, CAE

Where We Stand: OMA's Workforce Principles

The goal of health care workforce planning is to match the supply with the current and anticipated future need for health care services.

The physician workforce shortage is an issue that has been building for years. The OMA commissioned a report on workforce in 2004, which led directly to the adoption of Workforce Principles in 2007. Those principles are as follows:

OMA Policy Statement Regarding Physician Workforce

Access to primary and specialty health care services for all Oregonians requires an adequate number of health care workers to achieve universal coverage. The goal of health care workforce planning is to match the supply with the current and anticipated future need for health care services. Oregon suffers from a health care workforce shortage affecting all areas of the state. The Oregon Medical Association advocates for an increase in physician supply. Realizing that the "marketplace" for physicians is national in scope, continued advocacy efforts will be necessary to improve the practice environment essential to attract and retain adequate numbers of physicians in the state. (A-07)

The following principles will guide OMA's advocacy efforts in health care workforce planning:

• The OMA is committed to supporting the development and retention of an adequate number of well-educated physicians in all specialties to meet anticipated health and health care needs of all Oregonians.

• To enhance access to care, workforce planning should utilize data on all aspects of the health care system, including projected demographics of physicians and the population, as well as the number and roles of other health professionals.

• OMA encourages and supports collaborative efforts with the Oregon Board of Medical Examiners and other organizations in the collection of physician workforce data in sufficient detail to describe current physicians' practice activities.

• OMA will be integrally involved in any health care workforce planning efforts sponsored by federal or state governments, or by the private sector.

• OMA will support improvement in the practice environment and work actively to influence government policy to attract and retain adequate numbers of physicians and an appropriate specialty mix to meet the needs of the entire state.

• OMA will promote the distribution of physicians of all specialties to rural Oregon, work to reduce barriers that inhibit physicians from

establishing rural medical practices and create incentives to make practice in rural and underserved areas more attractive.

• OMA supports efforts to further diversify the physician population to reflect the diversity of Oregon's citizenry.

Our 2004 survey showed that there were access problems in the rural areas of Oregon, and in this magazine you'll hear from some voices in those areas (page 18). We're hearing stories at OMA headquarters that there are no longer physicians accepting Medicare patients in Bend. That in Sisters, one couple trying to buy a home wrote a contingency into their offer that they would only buy the house if they could secure a physician to treat them.

In 2006, we conducted another workforce study we conducted in conjunction with the Oregon Office of Health Policy and Research and the Division of Medical Assistance Programs (excerpted in this issue on pages 17–18); the complete report is available online at *www.theOMA.org/workforce*). It showed that workforce shortages are becoming a problem in the Willamette Valley corridor, as well.

The economic consequences to Oregon, and the consequences for the health of Oregonians, could be dire indeed if we do not work to expand our workforce. With that in mind, the OMA is working with many groups in Oregon on several fronts to address the workforce shortage for physicians and other health care professionals. On page 12, you'll hear from John Moorhead and Jo Isgrigg, who have been prominently involved in creating a workforce component for Senator Wyden's Healthy Americans Act (S 334).

We've also included coverage of one effort to fill the access gap in the metropolitan Portland area (page 20), and a couple of practical pieces related to the work of being a physician: contract negotiation tips (page 26), and discussion of how to get better results from the claims collection process (page 25).

The workforce problem in Oregon is not a short-term issue, and its solution will not be achieved quickly—that's a refrain repeated throughout this issue. But by bringing the issue to light here, we hope our members will gain a better understanding of the scope of the problem, and a better sense of how they can help.

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