



From Your Governor

Dear fellow Idaho internists,

This will be my final newsletter as Governor for the Idaho Chapter of the ACP. **Dr. Duane Jeffers**, a general internist and geriatrician from Burley, will assume the governorship at the national ACP meeting in May. I hope that Duane can continue efforts at improving our ability to provide adult medical care in this great state. I want to thank **Cheryl Orr**, who has provided me with administrative support over the past four years. I have learned much over my term as Governor, and I am aware that my work as a concerned internist cannot end now if we are to see any improvements in the dysfunctional health care system that is heading towards collapse, especially with regard to primary care for our seniors. Perhaps, it is the total collapse that is needed before any meaningful changes can occur. We need more involvement from Idaho's internists to improve the care of our citizens. I know that everyone has limitations on their time, but just choose one of the following **NOW** in order to help your patients and your practice:

- become involved locally through your medical society
- contact me or **Dr. Jeffers** to voice any concerns or ideas
- join the chapter leadership by offering to help with the chapter meeting or as an advocate for public policy
- plan to attend the next Idaho chapter meeting
- become a Key Contact at http://www.acponline.org/advocacy/key_contacts/
- plan to attend Leadership Day in Washington, DC next May

The main point is not to become discouraged but rather to help visualize solutions that can eventually be implemented when the current forces move in the direction of sustainable reforms. It has been an honor and a privilege to serve as your Governor. Let's keep up the good fight.

Dr. Montamat's testimony given to Idaho's Select Committee on Health Care on February 20, 2008:

Honorable Members of the Select Committee on Health Care,

I appreciate the time and effort that each one of you is giving in this vitally important issue for our state. My name is **Dr. Stephen Montamat**. I have been a practicing physician in Idaho for almost 20 years. I am a board certified general internist, geriatrician, and clinical pharmacologist. I am currently the Medical Director for St. Luke's Internal Medicine in Boise. I have also held the position of Governor for the Idaho chapter of the American College of Physicians for the past four years. I am also a proud member of the Idaho Medical Society and the Ada County Medical Society.

I will focus my presentation on an issue that impacts several of the recommendations from the Governor's Health Care Summit that I wholeheartedly support, specifically the recommendations that address physician

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workforce needs and the principle of ensuring that all Idahoans have access to a "medical home." The issue that threatens these goals is the collapse of primary care medicine. I feel that I am witnessing a train wreck in slow motion, but I sense that many others do not see it.

Primary care mainly consists of the practices of internal medicine, family medicine, and pediatrics. As an internal medicine physician, an internist, in this community, I can truly tell you that the practice of general internal medicine is dying as we speak. It is dying nationally and it is dying in our state. We are becoming extinct. And the extinction of these respected and valued practitioners is occurring at a time when our communities, now more than ever, need primary care physicians. Internists are especially well suited to partner with complex medical patients and the elderly to help them and their loved ones navigate the passages of illness and health with expertise and efficiency. There are many causes for this collapse in primary care medicine, and they are germane to any solutions that are proposed. Skyrocketing student loan debt, increasing bureaucratic demands such as insurance pre-authorizations, declining reimbursement of cognitive services, and decreased respect for the practice of general internal medicine are just a few of the causes. According to the Association of American Medical Colleges, the average educational debt of medical school graduates in 2006 was between \$120,000 and \$160,000, and this debt load is increasing at a rate of 6% or higher. Make no mistake, physicians in our country are able to make a comfortable living through sacrifice and hard work. But the striking discrepancy in salaries between the procedural and cognitive specialties of medicine is helping drive many excellent candidates away from primary care. Even if a graduating medical student is drawn to the intellectual and emotional satisfaction of providing comprehensive, longitudinal care to patients in need, they must sustain a tremendous amount of debt with a substantial discount in reimbursement for their services.

This brings me to a specific proposal to address a growing need that requires a short-term solution. A bill was introduced in the General Assembly of Pennsylvania in 2007 to establish a physician retention loan forgiveness program. The purpose of the bill is to improve recruitment and retention of physicians and therefore improve patient access. The bill was initially intended for all physicians, but it has been amended to include only specific primary care specialties. It prioritizes the needs of Pennsylvania by giving preference to those who agree to practice medicine in an area that is reported by the Department of Health as medically underserved or in a primary care health professional shortage area. The 100% loan repayment plan covers ten years of practice in the state in a graded fashion. The bill has currently been referred to an Education committee, and I have included a copy with my written testimony. Idaho should take heed of this idea or similar ideas before other states begin to offer inducements specifically targeting recruitment and retention of primary care physicians.

It has been well documented that communities with a higher percentage of primary care physicians not only have higher measures of quality care, but that the care was provided at less cost as well. Currently, patients are entering the health care system through the emergency room, specialists, nurse-staffed clinics in retail stores, and even internet or telephone consultations. The internet has rapidly increased the amount of information and misinformation that is available to healthy consumers and those with illness. The primary care physician must be recast not as a "gatekeeper," but as a trusted advisor, assisting patients in their quest for optimal health in an evidence-based and cost-effective manner. Primary care physicians, especially internists, already perform many of the duties that are defined in proposals for a patient-centered medical home model. The problem is that primary care physicians are retiring, limiting practice, or leaving practice with a scarcity of trainees to assume the increased demand for such care. The utilization of nurse practitioners and physician assistants will undoubtedly increase, but in my experience with complex medical patients and the elderly, the availability of consultation with a well-trained physician is necessary for the care of these patients. So while the use of these providers is paramount for care of the increasing load of complex and elderly patients, it is not sufficient without physician involvement. As I alluded to, many of us already perform the duties inherent in a medical home, we just don't get reimbursed for them. Much of what we do that is beneficial for patients and their families does not come from a face-to-face encounter, yet our health care system is still mired in an acute care model that refuses to recognize and respect care of patients with chronic conditions. Quality of care does not begin and end with the patient entering and leaving the office visit. In addition, the financial incentive to manage patients mainly through office appointments results in hurried visits and hence, the greater likelihood for the ordering of expensive tests instead of spending more time with patients. For all of these reasons, I firmly support the concept of a

patient-centered MEDICAL home as a prominent feature in any reforms of our state's health system.

I would also like to support the notion of expanding internal medicine residencies in our state. We currently have second year internal medicine residents from the University of Washington who rotate for an entire year in Boise, primarily at the VA hospital. They spend their third year back in Seattle. We have several alumni from that program in my group practice. Allowing all three years, or at least adding the third year of residency to the existing program would help entice more of these residents to continue their medical careers here in Idaho. It has been well documented that most residents will ultimately practice in the state in which they trained, many times in the very same community as their residency. I would therefore focus more on developing residencies in the near future as opposed to dedicating tremendous resources to a brick & mortar medical school.

Again, I would like to thank each of you for the time and energy that you are giving toward this monumental effort. Change will likely happen incrementally, and that is why I have focused on a very specific short-term solution - loan forgiveness. But I promise that I along with other internists in Idaho will provide whatever support is needed to advance any proposals in the short-term or the long-term that ensure value-driven health care for all Idahoans.

College Launches Leadership Program

The College has launched a new leadership development program that will unroll over the next three years. The Leadership Enhancement and Development (LEAD) program is designed to help young Fellows in particular cultivate leadership skills they can use in any setting.

The first elements of the program are now in place. The CME portion will be available at IM 2008. A pre-course entitled Essential Competencies for the Emerging Leader will be offered on Wednesday, May 14, 2008. You can register online at http://www.acponline.org/meetings/internal_medicine/2008/attendees/course_listings/emer_lead.htm, or by calling 800-532-1546, ext. 2600. Several other courses will also focus on leadership skills such as negotiating, managing change, making presentations, and serving in the government. Watch for these in the IM 2008 Final Program.

A second component, online mentoring, is also underway. Experienced leaders are available in the LEAD discussion group to explore a variety of leadership challenges with members. The "*challenges*" will be announced every two weeks in the ACP Internist Weekly. Go to http://www.acponline.org/education_recertification/resources/leadership_development/challenges/ to join the discussion now.

Another component of the program is chapter involvement. Find out how you can take an active roll in local chapter activities by calling your Governor to discuss the Five Pathways to Leadership Development at the Chapter Level, available at http://www.acponline.org/education_recertification/resources/leadership_development/chapter_activities/.

Those who meet five out of seven criteria within any three-year time period will be eligible for a LEAD Certificate of Completion (http://www.acponline.org/education_recertification/resources/leadership_development/certificate/).

An overview of the whole program can be found at http://www.acponline.org/education_recertification/resources/leadership_development/.