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Workforce – The Future For Family Medicine

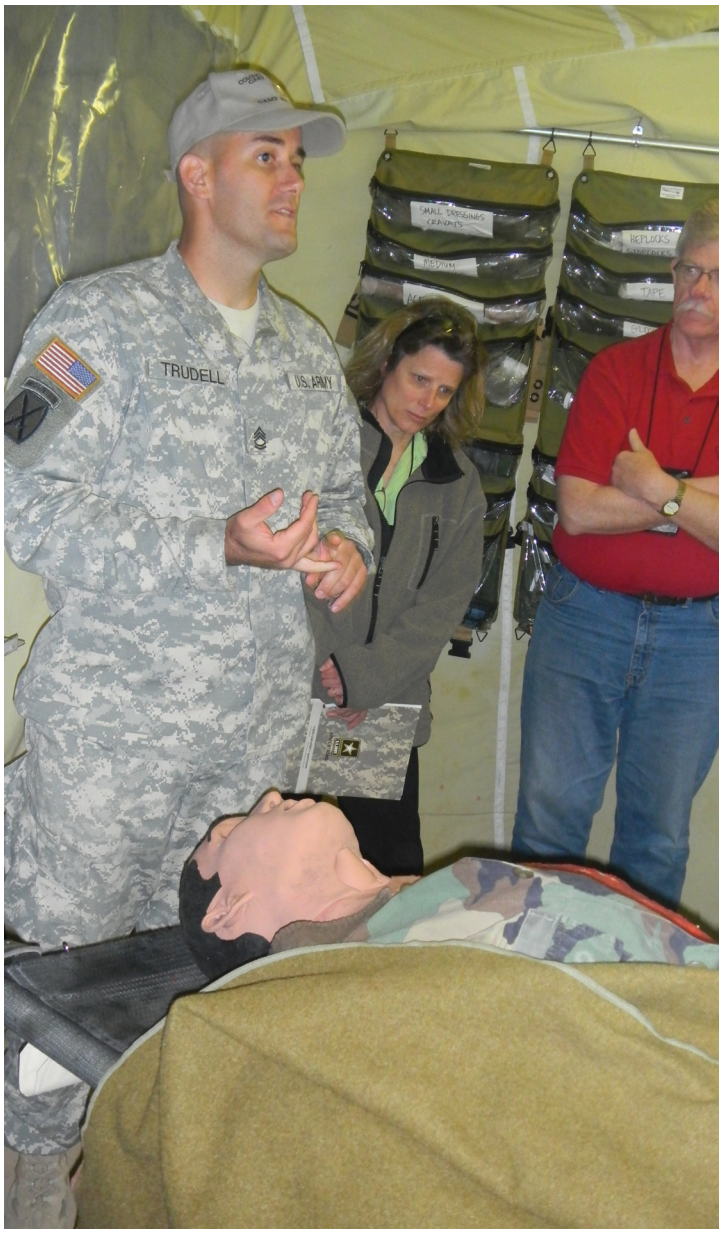
We know that family medicine is facing a future workforce shortfall. More than ever, the rest of the nation is coming to realize that fact that we've known since the AAFP 2006 Workforce Report. The federal health care reform laws and the funding that comes with it is supposed to help change the tide for family medicine and bring more family physicians to meet our nation's growing needs. But in reality, how quickly can we swing the pendulum back? Just how many future doctors will choose the joys, challenges and immense responsibility of being a primary care physician?

2011 marked the first Match since federal health care reform implementation began – and there was a measurable bump in the family medicine workforce for 2014. When today's medical school graduates finish residency training in three years, they will enter practice on the cusp of our nation's substantial expansion of government-funded access to health care coverage. Millions more Americans will be newly covered by Medicaid (estimated at 750,000 new Medicaid enrollees in Illinois) and additional patients who previously had no insurance options will be able to gain coverage through state-based or federally run insurance exchanges.

The mini-surge in U.S. seniors choosing family medicine residencies garnered significant media coverage in public and trade publications. To some degree, the increase in primary care matches (pediatrics and internal medicine also saw increases) was attributed to the positive focus on primary care in the 2010 enactment of the federal Patient Protection and Affordable Care Act (PPACA). Much of the discussion during the law's creation and debate focused on shifting our health care system towards primary care and preventive care, including incentives for payment and training of more primary care providers. Family medicine's public profile has never been higher than during President Obama's push for health care reform. Here in Illinois, family medicine was the face of the discussion among the Illinois Congressional delegation as well.

To bolster primary care, the federal government built in slight increases in Medicare payment rates for primary care services

(continued on page 4)



Have you ever thought about the physician workforce for the U.S. Armed Forces? Learn more about it inside this issue!

President's Message

David J. Hagan, MD

In many ways, it was the typical office visit on a typical day.

I reviewed her history and lab results, completed the physical exam and renewed her medications. The patient encounter was coming to an end, and then I asked that all-important question: "Is there anything else?"

"Well Dr. Hagan," began my patient, a lovely retiree whom I've known for over 20 years. "Charlie and I have been looking at our bills and we don't think you're being paid enough for what you do. Medicare is not treating you right!" I could have hugged her and for a moment I was worried she might even attempt to slip me some cash on her way out the door.

After thanking her for her comment and concern, we talked about the discouraging Medicare payment system and the impact it has on medical students looking at family medicine. Many of you know the numbers. We need about a 40 percent increase in primary care reimbursement to turn the tide towards family medicine and increase our workforce for the future.

Our Academy (state and national) is working hard to get payment reforms that will benefit primary care and improve family medicine's future. Surely you've seen the good news out there about family medicine and primary care. We have our supporters. Perhaps more importantly, have you seen anyone take punch at us? Have you read an editorial or seen a news story that criticized our role in providing quality health care or didn't support our call for a more equal payment system? I think overall, the media and public are well aware of the good we do and want to see our specialty succeed. Today's patients want the same compassionate and comprehensive care that we provide them readily available to their children and grandchildren tomorrow.

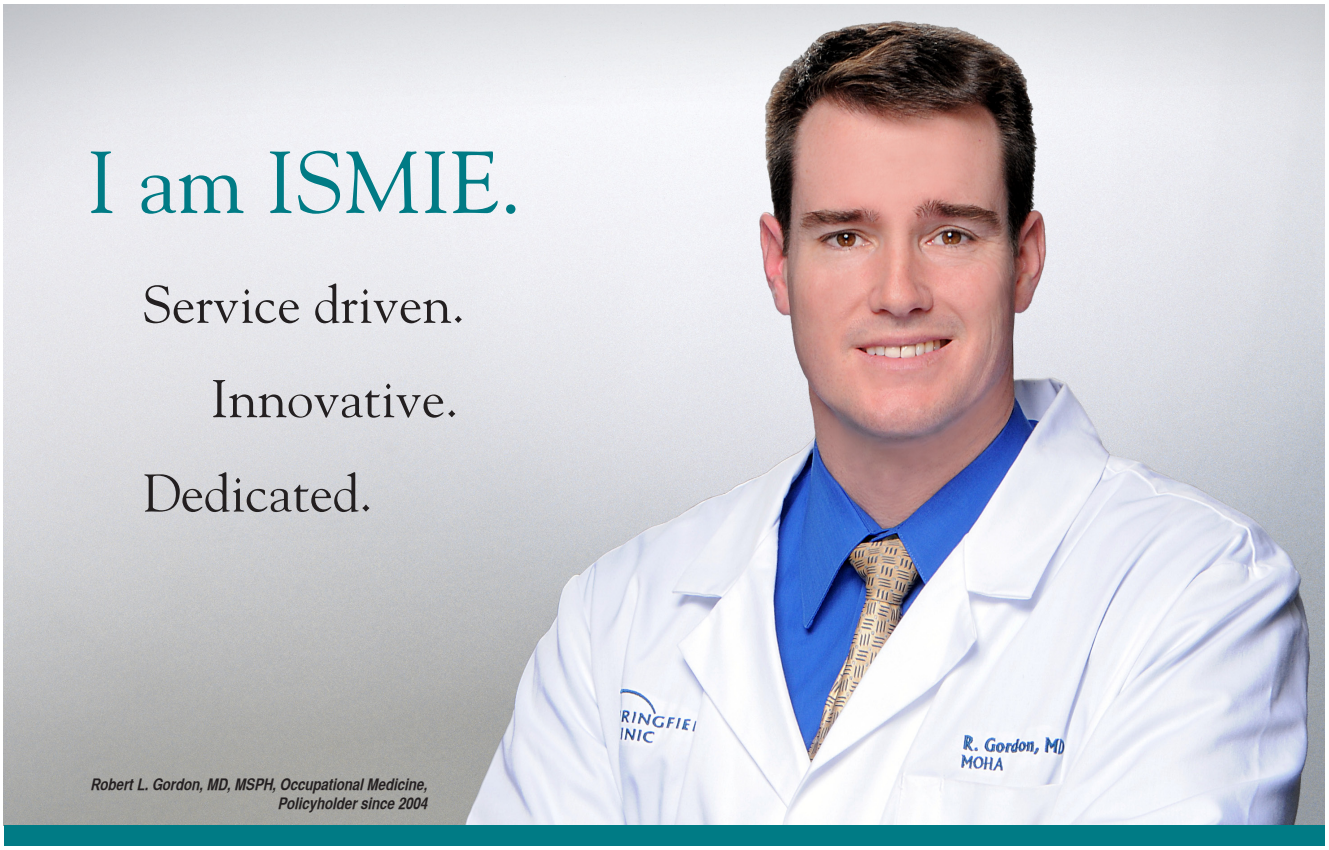
Despite the never-ending political battle over federal health care reform, we are starting to see some of the benefits for family physicians materialize. Medicare payments for primary care services are now reimbursed at a slightly higher rate. The disastrous cliff better known as the SGR formula has been shelved for now with the intention of finding a better system before Medicare simply falls apart. AAFP has set a bar for payment reform, where family physicians average at least 70 percent of subspecialty salaries. Currently we're under 60 percent.

Family medicine residency programs are using newly available federal funds to improve the training and capabilities of tomorrow's family physicians. Despite the challenges that we all grumble about every day, family medicine is on the first true "up-swing" that we've seen in over a decade.

This issue of *Family Physician* examines our workforce issues from many angles. National match results were certainly a positive, but small, step forward. The fact that family medicine's slight increase in 2011 generated a lot of press reinforces my belief that the public is rooting for our specialty. Our Illinois family medicine residency programs had a banner year and that bodes well for the Illinois family medicine workforce of 2014.

We do have some challenges ahead. As the 2010 New Physician Workforce Study (see page 5) tells us, we need to do a better job keeping the physicians that we train at our Illinois residency programs. The match data from our Illinois allopathic medical schools (see page 4) is another wake-up call that we need to ensure more of the students accepted into our medical schools have a future in primary care. As an Academy, we all need to connect with our medical students and nurture the same love for patients, families, wellness and progress that brought each of us into family medicine. Share your passion, share your story and share your success.

Your IAFP board members will be on Capitol Hill on May 10, talking to nearly every member of the Illinois Congressional Delegation during AAFP's Family Medicine Congressional Conference. We will share our stories, and yours. We will renew our relationships with veteran members of Congress and provide the family medicine perspective to those new lawmakers charged with representing you and your patients. Along with our colleagues from around the country, we'll ensure that family medicine remains a strong, separate and respected voice in shaping our nation's health care system.



As a policyholder, I value ISMIE Mutual Insurance Company's commitment to protecting Illinois physicians and our practices. ISMIE's comprehensive risk management program is a benefit to policyholders and our patients. Founded, owned and managed by physician policyholders, ISMIE is focused on being our Physician-First Service Insurer.®

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Protecting the practice of medicine in Illinois

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IAFP News

(Cover story, continued from page 1)

and increased funding for primary care training. Will their efforts be enough to close the gap and convince more of tomorrow's doctors that they can make it - and be happy – in a primary care profession?

According to the Council on Graduate Medical Education (COGME) recommendations to Congress, primary card physicians' income needs to reach about 70 percent of the average subspecialists to generate the workforce and the playing field that will shore up the future of primary care. Without that much of a payment increase, can we truly meet our workforce demands with the reforms currently in place under PPACA? Will all health care payers make the changes in their systems to make primary care an attractive option? The next two or three years will tell us if today's medical students are buying what federal health care reform and the primary care community are selling.

2011 Match results show great news for Illinois family medicine residency programs

After combining the NRMP and AOA matches, Illinois Family Medicine Residency Programs filled 99 percent (194/196) of available positions by Match Day, making a big jump from 2010, when Illinois programs filled 88.7 percent through the match process. Conversations with program directors showed enthusiasm for the family medicine future with the pendulum swinging in the right direction. However, all agreed that in order to meet our workforce goals for 2020 and beyond, we need to ramp up that increase even further.

UIC Family Medicine Residency program director Mark Potter, MD saw reasons to be optimistic this year. "The caliber of doctors that we interviewed this year was really great," he said. "My feeling is that things are definitely moving in the right direction." UIC filled all their slots by the Match, including the two additional slots they will have from 2011-2015 which were funded with new federal money available through PPACA.

Illinois Residency program results listed by program
http://www.iafp.com/residents/2011Match.pdf

U.S. medical school family medicine graduate numbers improve

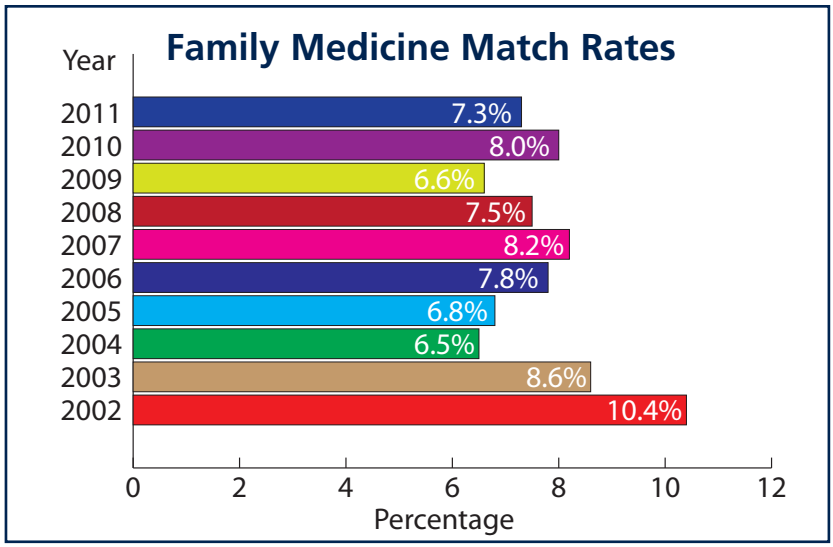
According to the NRMP, The percentage of U.S. medical school graduates chose family medicine in 2011 is up from 2010 (8.4% up from 7.9% in 2010). With more slots available and more US graduates matching into family medicine, the net result is that 1,317 US medical school graduates filled 48.2 percent of the 2,708 family medicine slots offered this year. Link to AAFP analysis at http://www.aafp.org/match.

However, the percentage of Illinois medical students matching into family medicine dipped slightly to 7.3 percent (83 out of 1,142 graduates), down from 2010's 8 percent. Of the 83 who matched family medicine, 31 will enter Illinois programs. The pay discrepancy between family medicine and subspecialties is still a possible concern. Also, with the federal health care reform law still in the earliest stages of implementation, some students remain skeptical about the law's impact on primary care training and payment.

"At this point, the financial concerns of repaying high student loans are still very much a reality," says Rahmat Na'Allah, MD, from the University of Illinois at Peoria Methodist Medical Center Family Medicine Residency program. She added that the medical school in Peoria is going to expand the family medicine rotation to six weeks, to give students a more in-depth experienced with all that family medicine offers.

Although the Illinois medical school data is disappointing for 2011, Deborah Edberg, MD, program director at Northwestern University-McGaw family medicine reports that Northwestern University - Feinberg School of Medicine recently held a panel discussion about family medicine careers for third year students, which attracted 35 students. "I see reasons for optimism in 2012."

You can see the 2011 match results by allopathic medical school at http://www.iafp.com/students/match11.pdf



Two Illinois FMRs land federal grant funds to boost community based training

A consortium including McGaw Medical Center of Northwestern University, Erie Family Health Center and Norwegian American Hospital will receive a new federal grant that could reach $16 million over five years to support an innovative new program to expand the primary care workforce.

The grant will fund family medicine outpatient residency training in a community-based setting that emphasizes preventive and chronic disease management. The program has begun training eight residents in primary care, will grow to 16 residents in July and will expand to 24 residents by July 2012.

Deborah Edberg, MD

"This is a new approach," said Deb Edberg, M.D, director of the Northwestern McGaw Family Medicine Residency Program. "We are creating a residency experience that emphasizes training at an out-patient primary care facility and isn't hospital dependent. One of the big problems with health care is physicians graduate and do a really good job of taking care of people when they are sick in the hospital, but don't do as good a job at primary care and prevention. This program is designed to help change that."

The Northwestern consortium is one of 11 designated teaching health centers around the country awarded a grant from the Health Resources and Service Administration.

UIC Family Medicine Residency program adds two slots with federal PPACA funds

The University of Illinois at Chicago College of Medicine has received a $1.92 million grant from the U.S. Department of Health and Human Services to expand its family medicine residency program.

The grant will fund two additional family medicine residents each year for five years beginning in July. The department currently has six residents in each of the three training years.

The grant, part of the Affordable Care Act Primary Care Residency Expansion Program, comes from the Health Resources and Services Administration. The grant was awarded to principal investigator Dr. Memoona Hasnain, director of research, and co-principal investigators Dr. Mark Potter, residency director, and Dr. Abbas Hyderi, assistant clinical professor and assistant dean of undergraduate medical education.

"This is not just a mechanical expansion of our program," Hasnain said. "We will be able to refine and improve our curriculum with a focus on training and developing more competent and caring providers with special skills for providing quality care to underserved populations." The grant will offer the opportunity to enhance teaching in health communication, health literacy, global health and women's health, as well as expand the resident scholarship program.

Hasnain says the goal is to engage residents in educational experiences that enable them to acquire core attitudes, values and competencies related to providing high-quality, patient-centered, culturally appropriate care to all patients, particularly those who are underserved and vulnerable. According to Potter, half of the department's graduates in the last six years have practices located in federally designated medically underserved areas, and 90 percent continue to practice primary care.

"We'll be putting these new residents into specific areas we already work in," Potter said. "For example, a central element of the new residents' training will be the opportunity to work at Mile Square Health Center throughout the three years of their residency training."

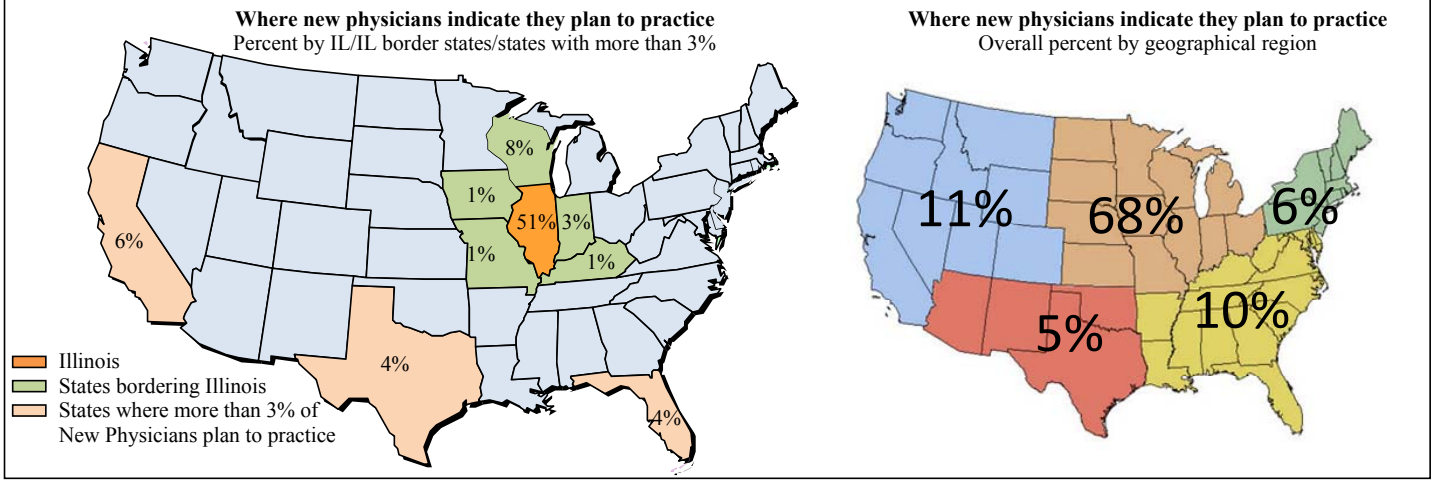
The next phase – from Illinois Resident to Illinois Family Physician

Given that only 31 Illinois medical school graduates will enter Illinois family medicine residency programs in 2011, out of the 196 interns starting this summer, how many new Illinois family physicians do you think we'll have in 2014? Even with 27 family medicine residency programs and an enormous academic medicine community, there is cause for concern about the future of our state's primary care physician workforce.

The 2010 Illinois New Physician Workforce Study was designed to examine and document the issues that affect new physicians' choices regarding practice decisions and to raise awareness of current physician workforce issues in Illinois. The study was a joint effort of Northwestern University – Feinberg School of Medicine, the Illinois Hospital Association and the Illinois State Medical Society. The first physician workforce study in Illinois in at least 25 years was conducted by IAFP member Russell Robertson, MD, then chair of the Department of Family Medicine at Northwestern University (now Dean of Chicago Medical School). Dr. Robertson and colleagues collected responses from 561 graduating Illinois residents

(continued on page 6)

Figure 1. New Physician Planned Practice Location



in the spring of 2010 - a statistically significant response rate of 32 percent. The study examined graduating residents' and fellows' plans for entering the workforce and the reasons for their choices.

Some key findings from that study:

Just under one-half of graduating Illinois residents and fellows are leaving the state to practice elsewhere. The primary reasons for leaving Illinois are overall practice opportunities and family, but the medical malpractice liability environment is a major consideration for those that plan to leave Illinois to practice. Fourteen percent of them will go to surrounding states (which have lower malpractice premiums than Illinois), and another 14 percent will leave for other large states - Texas, Florida and California. California and Texas have enacted liability reform.

Rural communities will remain undersupplied with physicians. Only 1.5 percent of graduating residents or fellows plan to practice in a rural setting. But 20 percent of Americans live in rural settings.

"I think medical schools will need to take a serious look at the geography of their applicants. The admissions process is still heavily weighted on MCAT scores and GPA," says Robertson. "As a consequence, schools are more likely to admit students that do not represent rural or underserved areas." In Robertson's study, nearly 75 percent of residents who graduated from Illinois high schools planned to practice in Illinois. Of the residents from other states, less than 40 percent planned to stay in Illinois and only 37 percent of survey respondents are Illinois high school graduates. As a result, Illinois exports nearly half of their newly trained physicians.

Of those planning to practice in Illinois, the majority commented that either family or a spouse's employment were the main factors in their decision to stay in Illinois. Several others indicated that they intend to work in Chicago, specifically, because of its research environment, opportunities to work in an academic setting, or their desire to practice and live in a major city, which further reduces supply in underserved areas, especially Illinois rural communities. A few respondents even noted that they are looking for options to move to Indiana or Wisconsin, so as to remain in somewhat close proximity to Illinois but allowing them to escape the medical liability environment.

Currently Illinois ranks 25th in active patient care doctors per 100,000 residents and 22nd in primary care physicians per 100,000. When asked to put those rankings in perspective, Robertson says that Illinois should be seriously worried about the crisis we face as a state. "As a nation, we are facing an insurmountable shortage of primary care physicians. That fact that Illinois ranks in the middle of the pack should not be interpreted in any way, shape, or form as a good thing."

The study calls for legislators to:

1. Create an Illinois Physician Workforce Institute at Rosalind Franklin University/Chicago Medical School
2. Fight for medical malpractice tort reform.
3. Develop strategies to retain Illinois medical residents and fellows; investigate medical school and residency admission policies to align recruiting efforts to be more favorable to those who are likely to practice in Illinois.
4. Centralize the Illinois physician job search and recruitment process.
5. Promote physician opportunities in rural communities and provide more incentives to attract physicians to practice in those communities.

Robertson cites some of the reasons we are exporting so many of our trained physicians to other large states - we don't have a coordinated recruitment effort or incentive programs to keep them here. Texas has a significant loan repayment

program funded by the state. Unfortunately, Illinois is currently not in a fiscal position to offer state-funded loan repayment programs to attract or keep our physicians.

One final suggestion for our current physicians: "We can't project blame onto everyone else," Robertson says. "As a specialty, we are not moving into the team-based approach as fast as we could or should. We're not embracing some of the transformative options and technology that is available." Robertson encourages family physicians to utilize medical assistants more effective and to add physician assistants and advanced practice nurses as true extenders delegating care appropriate to their level of expertise. Physicians should make every effort to implement the available technology (EHRs) to facilitate practice growth and the ability to extract data per the NCQA recommendation to increase the quality of service to patients and to enhance practice income.

Link to the full study at http://www.isms.org/NewsRoom/Documents/2010_1111_workforce_study.pdf

Another sector of the primary care workforce

The U.S. Armed Forces Medical Corps

Everyone is (finally) talking about the primary care physician shortage facing our country. The projections for shortages in rural HPSAs as well as Chicago's south side and other urban areas are well-known and on the forefront of discussion. Have you thought about the primary care workforce serving our country's military personnel and their families? Primary care physicians are needed in this vital sector caring for patients of all ages and both sexes around the world.

Recently Illinois *Family Physician* spent two days learning about military education at one of the nation's largest hubs for health care education and training – Ft. Sam Houston, Texas - home of the Medical Education & Training Campus (METC), Brooke Army Medical Center and Combat Training at Camp Bullis. At these facilities, physicians, nurses, physician assistants, dentists, X-ray techs, therapists and combat medics are trained to provide the highest quality care under the most extreme and dangerous circumstances. METC will graduate an average of 47,000 students a year. Beginning in fall 2012, the enormous Medical Education Training Campus will serve three major branches of the service: Army, Air Force and Navy – training all three forces side-by-side.

These medical professionals are ready to serve in war zones and also to care for those personnel and their families

anywhere in the world at U.S. military medical centers. Although the people and the places change frequently throughout a military career, they are committed to the same medical home principles as civilian primary care. A new state-of-the-art primary care clinic opened last fall with a staff of 300.

Camp Bullis features a fully-assembled Combat Support Hospital (CSH) where physicians and other providers train using high-tech- and very realistic - casualty mannequins. Physicians from many specialties serve in deployments at these "tent hospitals" in Iraq and Afghanistan. Each one has an ICU with twelve beds and a patient ward with 20 beds, as well as X-ray, lab, pharmacy, and surgical suites. There is actually a great need for primary care physicians to help with the primary and acute needs of our troops in deployment.

A separate training center simulates actual combat, where medics train in rescuing injured soldiers under fire. Once those medics are able to move the injured to the Level 2 aid station physicians take over the care until that soldier can be evacuated to a CSH and then transported to Europe and back to the U.S.

Wherever you are in your medical career, the Army has career options and incentives for those who want to serve their nation while pursuing their calling to medicine.

Residents can choose to follow an ACTIVE DUTY route, or a RESERVE DUTY route.
The active component resident would receive a yearly grant of $45,000 plus a $2,060 monthly stipend with loan repayment beginning after one year in working market – possible maximum benefit of up to $250,000. Your commitment to the Army is one year for each year receiving benefits plus one.
The RESERVE component physician can receive a $2,060 monthly stipend with loan repayment up to $250,000 max. The reservist's payback time is

(continued on page 8)

2008 Summer Extern Success Stories

Most of the 41 students who participated in the IAFP summer externship program are graduating this year, with the exception of three who deferred graduation for a year or are doing MD/PhD programs. IAFP combed match lists and contacted 2008 externs to find out where they chose to continue their medical training.

Of the 40 we have been able to establish residency results:
- 13 (32.5 percent) matched into a family medicine residency program.
- 27 (67.5 percent) chose primary care specialties.

We caught up with three externs who will be fantastic family physicians!

Bethany Cohen –
Loyola University– Stritch School of Medicine and IAFP Student President
2008 Preceptor: Leslie Sleuwen, MD – Hinsdale Family Medicine Residency
Residency program: Saint Joseph Regional Medical Center, Indiana

Why did you choose this program?
I chose Saint Joseph Regional Medical Center because it was where I felt at home. The faculty and staff are kind and approachable, and I really clicked with the residents. After all of the interviews, this is where I could envision myself working and growing.

Do you remember an experience that ultimately led you to choose family medicine?
I fell in love with family medicine during my IAFP summer externship at Hinsdale Hospital! I worked with Dr. Leslie Sleuwen and the residents there, and I was convinced by the continuity of care I saw in even four weeks that family medicine was the specialty for me.

Where do you hope to be in 2016?
I am actually hoping to learn more about myself as I go through residency. I still need to explore if I enjoy global mission trips, high-risk OB, or teaching because I am certain those experiences will shape my career. I think I would like to continue my participation in IAFP/AAFP because as a student I have really enjoyed learning how family physicians advocate for their patients.

Advice for the class of 2012
Your interviews are a time to learn about the programs and to learn about yourself. Don't be surprised if you aren't entirely sure of what it is that you want until you find it. I would recommend attending all of the interview dinners that you can and just a couple second looks for the programs you want to rank highly so that you can ask the residents plenty of questions and get to know them better.

(continued from page 7)

calculated two years repayment per one full year of support. Both programs will receive the monthly Troop Program Unit Pay of $448.00 per month.

Active physicians who would like to start their career as an Army or Army Reserves family physician can join the service. It's not too late to serve your country! Current family physicians that join the Army Reserves will work only 38 days each year and are entitled to $75,000 bonus, plus salary and loan repayment. Family physicians who select the Active Component are can earn a bonus of up to $252,000 in addition to salary and loan repayment.

For upcoming medical students who are in the Health Professions Scholarship Program, the Army provides full tuition for each year in exchange for a year of service. Most are four year scholarships that require four years of active service as an Army physician post-residency. For those already in medical school who are interested in pursuing a military medical program, the Medical and Dental School Stipend Program offers financial assistance of around $2,000 per month for living expenses in exchange for a commitment to the Army Reserves after residency.

What does an Army commitment mean? First, you'll need to pass the Basic Officer Leadership Course, spending seven weeks over the summer at Ft. Sam Houston in San Antonio learning how to be an officer in the U.S. Army, which includes two weeks of track training as a physician officer. Once you complete officer training, you go back to being a medical student or a resident (you are not required to be in a U.S. military residency program) and if you're out of residency, you'll be ready for your assignment to a medical facility.

If you would like more information about the Army's physician programs, Northern Illinois is served by a Chicago area recruiting office: Contact Sergeant First Class Donald Wagman at 877.655.2749 or donald.wagman@usarec.army.mil
Find them on Facebook at http://www.facebook.com/pages/US-Army-Westchester-MRS/114553611949527

Southern Illinois is served by the St. Louis recruiting office Staff Sergeant Adam Robb is the primary care recruiter for Illinois. His e-mail address is adam.robb@usarec.army.mil and cell phone number is 877-571-2236.

Carl Lambert – Rush Medical College
2008 Preceptor: Forrest Robinson, MD – Westchester
Residency Program: West Suburban

Why did you choose the program?
I chose West Suburban because I found the program to be academically and clinically rigorous but also with a very strong underserved medicine component. You really can't beat the location, it allows for quite a diverse patient population mix as it's between the communities of Oak Park and Austin. I was especially attracted to the unopposed aspect of the program which would allow me more opportunities to do procedures and get interesting cases and gain clinical independence. I honestly felt like I could be a part of the West Suburban team and family and am so glad to know that soon I actually will be just that!

Do you remember an experience that ultimately led you to choose family medicine?
Honestly, it was the time I spent with Dr. Forrest Robinson that ultimately led me to choose family medicine. I had always had a desire to work with the underserved, Dr. Robinson taught me about the heart and the different touch that family physicians have with their patients. I was so impressed with how he could effortlessly deal with such a wide array of patients and problems and never lose his composure or compassion at difficult moments. He's become a true role model and even greater friend to me with whom I keep frequently contact with to this very day!

Where do you hope to be in 2016?
I see myself in Chicago involved with my family, church, and community, perhaps still as faculty at West Suburban or practicing back on the south side. I can also see myself working more with adolescents at a school-based health center or maybe even the Cook County Juvenile Detention Center.

Any advice to offer the class of 2012?
I know that this whole process of applying to residency seems like such a daunting task, but I want to urge you to enjoy the ride! And, if any questions should arise (which they will), I strongly recommend getting your hands on both the AAFP's "Strolling Through the Match" booklet and Kenneth Iserson's fantastic book Iserson's *Getting Into a Residency: A Guide for Medical Students.* Good luck and best wishes!

Nora Glasspool – Rush Medical College
2008 Preceptor: Fred Richardson, MD
Oak Park
Residency Program: Advocate Christ in Hometown

Why did you choose this program?
Ultimately, I plan to practice rural medicine, so I sought a program that would give me maximum exposure to a full spectrum of diagnoses and patient types. I would like to be as well-rounded as possible, in anticipation of a time when there is little or no specialist support in the immediate area. Advocate Christ Hospital represents the best of both worlds, as a community-based tertiary care center with a Level I perinatal center, a Level III trauma center, and Hope Children's Hospital adjoining. I was also impressed with the sincerity and dedication of the residents I met and with the approachability and professionalism of the faculty. And finally, I already have a purple stethoscope to match the Advocate logo!

Do you remember an experience or a person who ultimately led you to choose family medicine?
By the time I began medical school, I had already set my heart on primary care, either family medicine or med-peds, and my IAFP summer externship with Dr. Fred Richardson reaffirmed this conviction.

Where do you hope to be in 2016?
I would like to practice rural medicine, both to fill a need in underserved communities and to fill my family's need for extensive outdoor play-space, hiking and camping. My husband and I have discussed moving to the Pacific Northwest after residency.

Any advice for the class of 2012?
1. If at the end of most clinical rotations (Internal Medicine, Pediatrics, Obstetrics/Gynecology, Psychiatry), you could envision yourself spending the rest of your career in that particular field, then family medicine is probably the right choice for you!
2. When the time comes, just relax and enjoy your interviews.
3. Don't be afraid to show some personality; if you're going to spend the next three years of your life with these people, they deserve a glimpse of the real you. They interview so many applicants that it probably helps to be a bit memorable.

Media coverage!! Northwestern-Feinberg School of Medicine students **Rebecca Cantone** and **Emma Daisy** were featured in a March 21 American Medical News article about the 2011 Match and the encouraging increase in U.S. seniors choosing primary care specialties. Both Cantone and Daisy matched into family medicine. Learn more about them and two other family medicine bound Northwestern students on the school's Dept. of Family and Community Medicine website http://www.familymedicine.northwestern.edu/northwestern_scholars_fam_med.

The 2011 IAFP Annual Meeting is set: November 11-12 Marriott Oak Brook Hotel

The IAFP leaders and staff will transform the format of our annual meeting, which returns to Oak Brook in 2011. We plan to have something to offer all IAFP members, along with some new ideas!

What you should do now: Save the date – put it on your calendar, iPad, BlackBerry, whatever gadget you use!

Some early details about the 2011 IAFP annual meeting:

- The annual meeting will have a SAM workshop (topic to be determined), along with CME on clinical and practice improvement topics and an update on the Practice Improvement Network (aka the "PIN Project"). You'll hear from some of the small practice pilots – with their real world experiences so that YOU can benefit from hearing their stories.
- **Put the MEMBER in the IAFP All-Member Assembly** - Committees will meet and the All-Member Assembly will convene to set the Academy's agenda for the following year. If you have an idea for a resolution to consider, submit it to IAFP executive vice president Vincent D. Keenan, CAE by September 29th at vkeenan@iafp.com.
- We will honor AAFP Fellows who elect to have their convocation at our annual meeting. If you are eligible for convocation you will receive an invitation directly from IAFP this summer.
- We'll celebrate family medicine's finest at our awards luncheon to honor the Family Physician of the Year, Family Medicine Teachers of the Year and President's Award honorees. There is still time to submit your nominations for the awards – go to www.iafp.com/pr for nomination forms.
- We'll host a fellowship fair and job fair for the resident members. Second and third year residents won't want to miss this incredible networking opportunity to investigate fellowship and employment possibilities from around the state. Any member looking for a new job is welcome to stop by the job fair and talk!
- New this year: Members-only showcase area! Do you have a side business or a product that you've created? This is your opportunity to share it with your family medicine friends. Bring your samples, information and enthusiasm and we'll have a special section of the IAFP exhibit hall for members to showcase their entrepreneurial side!
- Bring your running shoes and cold weather gear; because we'll have a "beat the president 5K-ish" run bright and early on Saturday morning. IAFP president David Hagan, MD is an avid runner, so bring you're "A" game. We have some fun planned for members and their families in between all the CME and business events.

Look for more details in future issues of this newsletter, in IAFP e-News and in your email inbox as details are available.

Call for nominations: IAFP Board of Directors
IAFP members in good standing are invited to self-nominate for the IAFP Board of Directors. The Academy will hold elections via electronic voting, with contested elections for open positions. Only president, president elect, board chair and the AAFP delegate and alternate delegate positions are not open to contested elections. Members interested in any of the following positions should submit a letter stating their desired position and a current CV to Vince Keenan at vkeenan@iafp.com by August 5, 2011.

The following positions have the possibility of contested elections:

- First Vice President (up to 2 candidates)
- Second Vice President (up to 2 candidates)
- Board Directors, class of 2013 (up to 5 candidates)
- New Physician, class of 2012 (up to 2 candidates)

The IAFP Leadership Development Committee, chaired by Steven D. Knight, MD of Harrisburg will review all candidates and present a final ballot in mid-August. Independent Voting Services of Wilmington, Del. will create the IAFP electronic voting web site and voting will be open from early September until mid-October. More details to come in the July/August issue.

What does it take to serve on the IAFP board of directors?

- Willingness to serve the Academy and its 3,500 members.
- Ability to meet projected time commitment (including board orientation, board meetings, continuing education, committee/task force/interest group participation, etc.)
- Ability to participate in group decision-making and support board decisions, leaving any personal agenda out of the discussions.
- Objectivity.
- Integrity and absence of serious conflicts of interest.
- Openness to strategic planning and visioning.

IAFP Task Force on AAFP Resolutions seeks input

Have an idea for the AAFP Congress of Delegates? The IAFP Task Force on AAFP Resolutions seeks your resolutions. The annual IAFP All-Member Assembly often results in the Illinois Chapter resolutions for the AAFP Congress of Delegates. If you weren't in St. Louis for the 2010 All-Member Assembly, but have a great idea for a policy that you feel AAFP should consider, formulate a resolution for the IAFP Task Force on Resolutions. The Task Force will consider your idea and formulate into an acceptable resolution for the IAFP executive committee to approve.
Current plans for IAFP resolutions include asking for a postponement of the ICD-10 code implementation deadline. What ideas do you have? Deadline for resolutions is May 30, 2011. Please email your resolution to Gordana Krkic, IAFP deputy executive vice president for external affairs at gkrkic@iafp.com.

Are you in the Network? The Practice Improvement Network

PIN

Check out the PIN section of the IAFP web site at www.iafp.com/PCMH

Find more information and links to current resources to help you make your practice the medical home you want it to be! Or just learn more about the medical home movement.

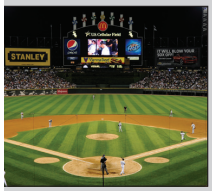
Coming soon: CME, including webinars, self study and live programs. Bookmark the PIN website and look for upcoming opportunities in your email inbox.

IAFP congratulates our members who have received NCQA's Physician Practice Connections®-Patient-Centered Medical Home™ (PPC-PCMH) recognition

This program reflects the input of the American College of Physicians, American Academy of Family Physicians, American Academy of Pediatrics and American Osteopathic Association and others in the revision of Physician Practice Connections® to assess whether physician practices are functioning as medical homes. Building on the joint principles developed by the primary care specialty societies, the PPC-PCMH standards emphasize the use of systematic, patient-centered, coordinated care management processes.

The following members and family medicine practices have received recognition as of 4/4/11

Cesar S. Arguelles, MD – Decatur
John A. Benages, MD – Elmhurst
Shamir Bhatt, MD - Westmont
Paul D. Bicek, MD - Westmont
Tanja Boskov, MD – Elmhurst
Laura B. Boyd, MD – Wood Dale
John G. Bradley, MD – Decatur
Carlos M. Cespedes, DO – Lombard
David B. Cespedes, DO – Lombard
Natalie J. Choi, MD – Aurora
DuPage Medical Group – Westmont Family Practice
Charles R. Ellington, MD – Decatur
Brenda K. Fann, MD – Aurora
Stephen C. Hung, MD - Westmont
Mary C. Hutton, MD – Oak Park
Robert A. Janowitz, MD – Westmont
Jessie A. Junker, MD - Decatur
Zeina Kalache, MD - Westmont
Susan M. Klein, MD – Decatur
Maria Lasher, DO - Aurora
Jonathan W. Littman, MD – Elmhurst
Indrid Y. Liu, DO – Oak Park
Anthony T. McCormack, MD - Decatur
Marci L. Moore-Connelley, MD – Carbondale
Kyaw T. Naing, MD – Carbondale
Nathaniel Pae, MD – Elmhurst
Rush Copley Family Medicine Center and Residency Program – Aurora
Scott K. Schoenwolf, DO – Carbondale
Quincy O. Scott, DO – Carbondale
Mark Scott, MD – Decatur
Vineet Singla, DO – Addison
SIU Family & Community Residency Program – Carbondale
SIU Family & Community Residency Program – Decatur
Sharon A. Smaga, MD – Carbondale
Matthew Spiewak, DO – Elmhurst



Family Health Foundation of Illinois

WHITE SOX VS. TWINS

Thursday, July 7, 2011 - 7:10 PM
U.S. Cellular Field

HOME RUNS FOR HEALTHY FAMILIES:

Every ticket you purchase from the IAFP Foundation for that game will mean a tax-deductible donation to the Family Health Foundation of Illinois to support our programs.

Tickets are only $35 each (less than face value!) for our LOWER BOX seats!

Orders will NOT be redeemed at the U.S. Cellular Field ticket windows or the White Sox administrative offices.

ALL ORDERS MUST BE RECEIVED BY FRIDAY, JUNE 3RD

MAIL OR FAX THIS FORM WITH PAYMENT TO:

Illinois Academy of Family Physicians
ATTN: FOUNDATION
4756 Main Street
Lisle, IL 60532

Fax: 630-435-0433

FAMILY HEALTH FOUNDATION OF ILLINOIS
THURSDAY, JULY 7TH, 2011- MINNESOTA TWINS

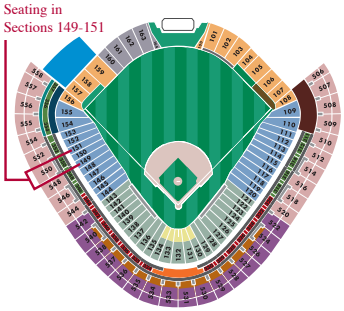
QUANTITY	DESCRIPTION AND PRICE	TOTAL
	Lower Box @ $35 each	
	Hot Dog Value Meal (hot dog, chips, soda – $5.75)	
	Parking @ $23	
	Total Enclosed	

All orders must be received by FRIDAY, JUNE 3RD! Tickets will be mailed to the address you provide below. All game times and promotions are subject to change.

Questions? Contact: Ginnie Flynn – e-mail:gflynn@iafp.com or phone: 630-427-8004

NO REFUNDS OR EXCHANGES.

Seating in Sections 149-151



Name _____

Address _____

City, State, Zip _____

Cell Phone _____ Work Phone _____

E-mail _____

Please charge my: ☐ Visa ☐ Mastercard ☐ Amex ☐ Discover

Account # _____ Expiration Date _____

Signature _____

OR: Enclosed is a check or money order payable to the IAFP Foundation.

Check # _____

GRAND SLAM GROUPS whitesox.com

This is Morgan. Morgan is a pregnant 17 year old and a recent high school drop-out. Two years ago she was a 15 year old girl doing well in school but became depressed. If Morgan's symptoms had been diagnosed as Depression early on and treated, Morgan could have received the care she needed and stopped the Depression in its tracks—before leading to devastating consequences which research has linked to untreated Depression.

The U.S. Preventive Services Task Force recommends that primary care providers screen adolescents between the ages of 12-18 for Major Depressive Disorder when systems are in place to ensure accurate diagnosis, treatment and follow-up.

Call us at Illinois **DocAssist**; we can help you help your patients!

"If the Illinois DocAssist program could be described in a few words, I would have to say that it is a 'lifesaver' for primary care providers at community health care settings and for patients who are uninsured and underinsured with limited resources. A job well done by the team at Illinois DocAssist. Thank you for being there for our patients and physicians."

Physician and Medical Director
Community-based health center in Chicago

Illinois **DocAssist**

866-986-ASST (2778)

www.psych.uic.edu/docassist

Answering your child and adolescent behavioral health questions

Government Relations

IAFP members gather in front of the Statehouse on the first Spring into Action Lobby Day on May 3. From L to R: Abrar Husain, MD; Brin Schuler, MD; student member Theodora Sakata, Stephanie Place, MD; Gary Wainer, DO; Meredith Hirschfield, MD; Adianez Abelo, MD; Patrick Tranmer, MD; Carrie Nelson, MD; David Hagan, MD and Daniel Novella, MD.

State Legislative Halftime Update

During the first half of the 2011 Spring Session of the 97th Illinois General Assembly, more than 2,400 bills were introduced in the Senate and a staggering 3,700 in the House to mark this first year of a two-year cycle. As of April 16th, only those bills voted out of their respective chamber are still alive and moving through the process towards final passage. For the remaining bills, this marks their "hibernation" until next year. Since there are always exceptions to the rule, some bills received extended deadlines for consideration and others may have their content amended onto "live" bills. Now that only a fraction of the bills remain viable, legislators will mainly focus on passing a budget and re-districting map. Other issues may have to wait until Veto session before they're addressed.

As IAFP leaders headed to Springfield for three days of "Spring Into Action" lobbying on May 3rd, 4th and 5th, here are some issues that they addressed with their senators or representatives. You can find fact sheets about many of the bills on the Government Relations Page of http://www.iafp.com/legislative/.

Rush Copley residents Abrar Husain, MD and Daniel Novella, MD meet with House Republican Leader Tom Cross in his Statehouse office.

Gary Wainer, DO (left) and IAFP board chair Patrick Tranmer, MD, both from Oak Park, introduce new state representative Camille Lilly to IAFP at the May 3rd Spring into Action.

- HB1338 – the immunization registry bill passed out of the Senate Public Health committee on May 4. IAFP supported this bill through the House with written testimony.

- HB 1965 – Unfortunately, a bill that would create an exemption to Smoke-free Illinois for casinos in border communities has passed the House and is alive in the Senate. Two other bills that threatened the SFI Act (HB 171 and HB 1310) were held in the House Rules committee and are inactive for now.

- HB 1577 - the creation of a state health insurance exchange is poorly defined in this bill, which ignores an opportunity to draw down federal funding and develop this implementation correctly. This bill has passed the House, so providers and health advocates are asking for substantive amendments to the bill that would incorporate all the benefits of SB 1729 in the final solution. The AAFP has provided chapters with a wealth of new information including principles for state health insurance exchanges, which are posted on the IAFP government relations page.

- HB 1530 – this bill provides mental health parity and compliance with the implementation of federal reforms. Having passed the House, it will continue on its journey through the Senate. Our efforts to pass this will help insure the treatment of mental health or substance use disorders.

- HB3236 – this bill is another opportunity for Illinois to implement a federal health care reform with the creation of Consumer Operated and Oriented Plans, or "Co-Ops." A cooperative allows small employers, such as farmers and agribusinesses, to purchase health care as a large group, thereby increasing buying power and stabilizing or lowering premium rates.

Many scope of practice and licensure issues were left in committee. Should any of these be amended to "live" bills, we'll alert you. Also, the workers compensation reform remains unresolved and both chambers continue to seek an agreed upon solution. As always, please visit www.ilga.gov for detailed information on any legislation, legislator look-up, and chamber schedules.

Medical Malpractice Insurance Rates in Illinois – Why Are They So High, Especially Compared to Surrounding States?

By Kevin J. Ryan

It is a common refrain among doctors throughout Illinois: "Why are our medical malpractice insurance rates so high?" After all, every physician knows colleagues who practice in other parts of the country—in some cases just over the state line—and pay less for medical malpractice insurance. So exactly what makes the rates in Illinois so high?

Any physician who has practiced in Illinois for longer than 10 years will know that there is a long history of concern about the state's high medical malpractice rates. Although the debate has fueled numerous attempts at legislative reform, these efforts have ultimately suffered setbacks by the Illinois Supreme Court.

Medical malpractice insurance rates are based on multiple factors. For starters, insurance carriers have their rates set by actuaries who evaluate diverse risks (e.g., the number of physicians to be insured, medical specialty, location of practice, claims experience and previous judgments) and then set the premiums based on that analysis. There are certain specialties—obstetrics/gynecology, orthopedics and neurosurgery, to name a few—that have a higher number of claims and higher judgments. Also, certain courts within the state have higher awards for medical malpractice than other court systems. In fact, Cook, Madison, St. Clair and McLean counties have all been cited by the American Tort Reform Foundation as "judicial hellholes" for various reasons, including the length of time it takes to move a case through the court system, the plaintiff-friendly rulings by the judges and the extremely high judgments often awarded by the juries.

To address these persistent problems, the Illinois legislature passed tort reform in 2005 that placed caps on noneconomic damages (e.g., pain and suffering, emotional distress, loss of consortium or companionship, and other intangible injuries) in medical liability lawsuits. The cap was $500,000 for physicians and $1 million for hospitals, with the stipulation that the caps would not be adjusted for inflation. Other aspects of the reform included higher standards for expert testimony and additional provisions relating to the certificate of merit clause required when filing medical malpractice lawsuits. At the time, physician groups, medical malpractice insurance carriers and tort reform advocates applauded the legislation. *(continued on page 16)*

(continued from page 15)

The tort reform, however, was challenged and ultimately struck down. In *Lebron v. Gottlieb Memorial Hospital*, decided in 2010, the Illinois Supreme Court concluded that the limitation on noneconomic damages violated the separation of powers principle, which states that one branch of state government cannot exercise powers properly belonging to another branch. Because the courts—not the legislature—have historically determined damages and there was no severability clause allowing the caps to be "severed" from the other elements of the tort reform, the Illinois Supreme Court declared the entire legislation invalid. As a result, the state is now in the same position it was in before the tort reform legislation was passed in 2005.

Even though the Illinois Supreme Court ruled the caps unconstitutional, several neighboring states have successfully enacted their own medical malpractice reform legislation. In 1975, , Indiana imposed caps on total damages, today set at a hefty $1.25 million. However, physicians are only responsible for the first $250,000 in damages to any patient for one act of malpractice, and no more than $750,000 in damages in the annual aggregate. Indiana maintains a Patient Compensation Fund that pays any excess in damages, up to $1 million, towards the maximum of $1.25 million. The Indiana system also limits plaintiff's attorneys' fees. In addition to these economic caps, Indiana's medical malpractice reform requires that patients have cases reviewed by a panel of three physicians (two of whom must be from the defendant's specialty) prior to filing the case in court.

Wisconsin has also passed medical malpractice reform legislation. Similar to Indiana, Wisconsin has placed a cap of $750,000 on noneconomic damages in medical malpractice lawsuits and requires a panel review before a case can be heard by the court. The panel—made up of a lawyer, a health care provider and a layperson—is charged with identifying claims without merit and assisting in the timely resolution of claims that do have merit.

Nearby Michigan has placed its own cap of $280,000 (currently adjusted for inflation to $411,300) on noneconomic damages awards in medical malpractice cases. However, that limit is raised to $500,000 (currently adjusted for inflation to $734,500) in certain cases, including when the plaintiff has become a hemiplegic, paraplegic or quadriplegic due to a brain or spine injury.

These reform measures taken by Indiana, Wisconsin and Michigan, have resulted in lower medical malpractice insurance premiums—especially compared to Illinois. But the disparity extends to other parts of the United States. According to the Tort Reform Record, published by the American Tort Reform Association, 21 states have adopted legislation to limit noneconomic damages and an additional 32 have passed legislation limiting punitive damages.

There has even been discussion of tort reform at the national level. In an October 2, 2009 report to the Senate, the Congressional Budget Office (CBO) cited recent research showing that lowering the cost of medical malpractice tends to reduce the use of health care services. The CBO estimated that the adoption of certain federal tort reforms—including a cap of $250,000 on awards for noneconomic damages, a cap of $500,000 on awards for punitive damages and a one-year statute of limitations for adults—would reduce national health care spending by 0.5 percent annually, or an estimated $11 billion at the time of the report. The CBO further estimated that Medicare would save $41 billion over the next 10 years, as federal tort reform would allow physicians to practice medicine less defensively. More recently, during his State of the Union address on January 25, 2011, President Obama said that he was willing to consider medical malpractice reform as a way to "rein in frivolous lawsuits."

Clearly, progress has been made towards reform in other states, and the high cost of medical malpractice lawsuits has attracted the federal government's attention. Back home in Illinois, physicians should continue to work with their state and national medical associations and their insurance carriers to push for tort reform. Until these efforts are successful, physicians in Illinois will continue to pay much more for medical malpractice insurance than their counterparts in neighboring states.

Kevin J. Ryan, Chair of the Health Care Law group at Chicago-based Much Shelist, concentrates his practice on legal and regulatory issues facing the health care industry. Kevin can be reached at 312-521-2429, or kryan@muchshelist.com.

EDITOR'S NOTE: The AAFP supports the federal HEALTH Act (H.R. 5) for federal liability reform. At the state level, SB 1888 introduced by Senator Kirk Dillard (R-Hinsdale) would re-enact and repeal various statutory provisions to eliminate changes that were made by Public Act 89-7. This bill remains stuck in the Assignments Committee in the Senate. There is no indication that this bill will be addressed during the current legislative session.

Continuing Medical Education

IAFP ACCME Accreditation extended to 2016

IAFP received re-accreditation through the ACCME for four years in March 2010. In November 2010, IAFP submitted a required progress report indicating what improvements we were making in the area of evaluation. As a result of those efforts, IAFP's progress report was accepted and the ACCME has changed our accreditation status from Accreditation to Accreditation with Commendation, which extends our accreditation term by two more years until March 2016.

Accreditation with Commendation is awarded to providers that demonstrate compliance in all 22 Criteria and is the highest level of accreditation that can be achieved through the ACCME. Congratulations to the CME Committee and Kate Valentine, Education Manager.

"The IAFP has a well organized, highly effective CME programming committee responsive to the needs of physicians," said IAFP board member Janet Albers, MD of Springfield. Members can be sure that IAFP CME modules meet the highest standards. "The IAFP has consistently provided high-quality services to its members including sponsorship and development of cutting edge CME programs. This serves as additional evidence of the quality of their work," added CME committee member Lee Washington, MD of Homewood.

IAFP Online CME Update: Three NEW Behavioral Health modules and updates of current CME

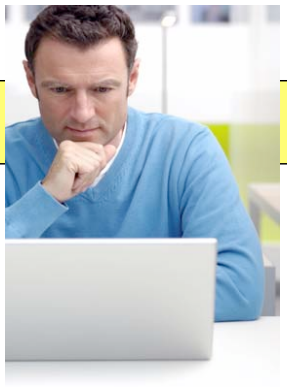
The IAFP has updated all eight education activities on www.Yhplus.com and has added three more topics.

New:

- Managing Bipolar Disorder in Primary Care
- Pain Management with Opioid Drugs in Primary Care Practice
- Medical Management of Patients with Schizophrenia and other Psychotic Disorders in Primary Care

Updated:

- Managing Childhood Asthma in Primary Care: A Quality Improvement Program
- Managing Adult Depression in Primary Care: A Quality Improvement Program
- Managing Type 2 Diabetes in Primary Care: A Quality Improvement Program
- Managing Chronic Obstructive Pulmonary Disease (COPD) in Primary Care: A Quality Improvement Program
- Managing Coronary Artery Disease in Primary Care: a Quality Improvement Program
- How to Conduct a Quality Improvement Program in Primary Care Practice
- Managing Heart Failure (HF) in Primary Care: a Quality Improvement Program
- Managing Substance-Use Disorders in Primary Care: a Quality Improvement Program



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Earning CME credit could not be any easier - you don't even need to leave the house – thanks to Your Healthcare Plus (YHP), Illinois' disease management program.

Earn credit with easy-to-use, FREE CME. Topics include:

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IAFP

IHFS Illinois Department of Healthcare and Family Services

Bernard Ewigman, MD

What's the greatest thing about being a family physician?
What we are trained to do as family physicians is so fundamentally important we can work literally anywhere in the world filling a wide variety of roles. I have practiced in rural and urban areas in the US as well as doing volunteer clinical work in West Africa and Central America. I have also been a university professor training medical students, residents and fellows; a medical editor and funded researcher; medical director of a county health department and of a federally qualified health center; and I am currently a department chair. There is always something new to learn and do as a family physician.

What advice do you offer medical students about family medicine?
My advice is always the same, regardless of career choice. I tell students that they should learn what their natural strengths, talents and passions are and choose that path. Students who tell me that they are good at problem solving, easily learn new things, love variety and are passionate about establishing personal relationships with patients, are the students that I steer toward family medicine.

Resurgence of family medicine at University of Chicago
I started the family medicine department at U of C eight years ago. Last year (2010 Match) we had 11 go family medicine and other years with 9 or 7. Traditionally it had been more like one to three chose family medicine. I think it's safe to say there have been more students from University of Chicago going into family medicine over the past eight years than we've had in the history of the school. It's been wonderful.

What is the Academy's best resource or service?
At the annual meeting I really enjoyed doing the SAM (Self Assessment Module), it was a really efficient way to get that done. And to just interact with other family physicians from different parts of the state and different expertise was excellent.

Biggest health concern on the North Shore
I would say it's the whole obesity and diabetes problem, especially in the Hispanic population, but really in all populations. For the first time in our history, researchers are predicting the life expectancy to decrease as a result of the obesity epidemic.

How do you balance career and your own well-being?
I take my vacations. And I try to take as much time off on weekends as I can. I try to be good about exercising and I eat vegetarian about 90 percent of the time.

A story from childhood that influenced your desire to be a doctor?
I had watched an episode of Superman, and I thought it would be cool to fly. So I wrapped a red towel around my neck and climbed up on the chicken house (he grew up on a farm), ran as fast as I could and jumped. I landed on my arm and fractured it. So I went to my family doctor who fixed it up for me. I grew up on a farm outside of a town of 2,000 in rural Missouri. My family doctor delivered me and most of my 35 first cousins, treated my poison ivy, set my fracture when I jumped off the chicken house and supervised me on my family medicine preceptorship as a third year medical student. I never really considered any other specialty besides family medicine and have never regretted my choice.

If you weren't a doctor, what do you think you'd be doing?
I would likely be an architect, an engineer or a physicist.

Members in the News

IAFP President-elect **Michael Temporal, MD** of Belleville authored a Letter to the Editor criticizing the Illinois House of Representatives for passing HB 1965 to allow smoking at border casinos. The letter ran in the March 31 *Chicago Tribune*, the Sauk Valley Newspapers April 1, The *Quad Cities Dispatch* and *Rock Island Argus* April 3 and the *St. Louis Post-Dispatch* on April 4.

IAFP board member **Dennon Davis, MD** of West Frankfort was featured in an April 4th *American Medical News* story about the positive economic impact physician practices have on communities with jobs and related business generated by the practice.

U of I at Rockford student **Rocio DeLa Torre** was featured in the April 6th *Rockford Register-Star* for her research project examining the lack of effective Spanish language patient education information available. Hers was one of 30 posters presented at the annual Research Day. She found there is a shortage based on her research at Crusader Clinic. DeLa Torre will enter the MacNeal Family Medicine Residency Program this summer.

IAFP member and entrepreneur **Paul Kinsinger, MD** was featured in the April 7th *Illinois Times* with an update on his Piggy Paste, which has sold more than 12,000 tubes.

Past president **Tim Vega, MD** of Peoria espoused the benefits of the patient centered medical home model in the April 10th edition of the *Peoria Journal-Star*. Vega stressed the benefits to patient outcomes and the potential to contain unnecessary costs when care is coordinated by a primary care medical home.

IAFP member **Robert Sawicki, MD** was interviewed by WEEK-TV in Peoria about National Health Care Decisions Day on April 11. Sawicki emphasized the benefits of having family and physician discussions about advance directives now, so that family members and physicians have clear guidance to make the right decisions when the patient is not able to.

IAFP Practice Transformation committee member **Stephen Sproul, MD** of Mount Prospect was quoted in an April 11 *Chicago Tribune* article about electronic health records and the progress among Chicago health providers in this new age of federal incentive payments for meaningful use. Sproul stressed the challenges, both fiscal and workflow, for smaller practices in the transition to an EHR.

Lawrence Lerner, MD of Chicago offered patient education perspective on fasting in the April 13th issue of the *Medill Reports*. He advises against fasting, saying the practice hurts more than it helps and recommends putting nutrients into your body every day.

IAFP past president and life member **Robert Heerens, MD** was honored by the University of Illinois College of Medicine at Rockford for his 40th anniversary with the school's Service Award. The awards ceremony was covered by the March 30 *Rockford Register-Star*.

James Lang, MD of Chicago, a past recipient of the IAFP Distinguished Service Award was honored by Resurrection Health Care with their Best Physician Servant Leader Award for his community-service focus. He is well known for his volunteerism and his dedication to access for the underserved.

Gregg Stoner, MD of Peoria is featured in the March issue of IPHCA (Illinois Primary Health Care Association) *Health Source* newsletter for his Primary Health Care Clinician Devotion Award for his 23 year commitment to providing quality care and reducing disparities. His work at Heartland Community Clinic and his work in Haiti the past six years lead to his selection for this honor.

Brenda K. Fann, MD of Aurora is featured in the Elmhurst College Prospect Spring 2011 newsletter article "Seeing Patients Whole" about the opportunities ahead for family medicine to rescue our chaotic health care system and her role as program director at Rush-Copley to produce those family physicians. Fann is a 1988 graduate of Elmhurst College.

Sharon Smaga, MD of Carbondale has a letter to the editor in the *Randolph Co. Tribune* and *Chester Sun-Times* with patient education about March as Colorectal Cancer Awareness Month. Dr. Smaga is a medical ambassador for the American Cancer Society.

Sam Grief, MD of Chicago provided insight in a very messy *Medill News* article on March 11 about a study of major metropolitan area grocery stores and the levels of fecal bacteria found on shopping cart handles. Things that make you go "eeeww!"

Benjamin Montgomery, MD of Jacksonville penned a patient education column for GateHouse News Service about urinary tract infections. The column ran in about two dozen newspapers across the state.

Life member **Mary Pohlmann, MD** who is also a member of the Carbondale City Council, moderated a panel discussion on end-of-life care for 75 attendees. The event was reported in the April 14 *Southern Illinoisan*.

Susan Buchanan, MD of UIC has a new blog called "Green Kids Doc" with information for providers and patients. Check it out at https://greenkidsdoc.wordpress.com/. And don't forget IAFP first vice president **Carrie Nelson, MD** has "Dr. Carrie's Better Living Blog" at http://www.doctorcarriesbetterliving.com/.

Family Medicine Educators committee member **Rahmat Na'Allah, MD** of UICOM-Peoria was featured in an April 18 *Peoria Journal Star* story about a community forum hosted by the Peoria City/County health department on reproductive health that addressed the high rates of teen pregnancy and STDs in the region. Dr. Na'Allah was a presenter at the meeting.

Public Health committee member **Arvind Goyal, MD** of South Barrington authored a letter to the editor in the April 27th *Chicago Tribune* outlining some of the challenges of electronic health record adoption and implementation.

In Memoriam:
Former member **Alvaro Hernandez, MD** of Kankakee passed away April 9th at his home. The Mexican immigrant completed his residency training at Holy Cross Hospital in Chicago and had a family practice in Kankakee for 20 years.

News You Can Use

The Worst Doctor at the Worst Clinic

John J. Frey, III, MD
Medical Editor, Wisconsin Medical Journal
Wisconsin Medical Journal • 2010 • Volume 109, No. 3

A double distortion lies at the heart of paying for primary care: Clinicians are paid for throughput, charges and piecework—sometimes called efficiency— and are increasingly being "paid" for quality. The piecework creates a process—high volume, high cost, and high charges—that is antithetical to the proper role of primary care in the process of care.

Primary care providers need to spend adequate time and effort on the management of multiple complex problems of individual patients using clinical judgment that is both cost effective and evidence based. They also should target higher risk groups within a practice population that need more attention and creative strategies for care. Doing less pays less under the current system, even if less, in many cases, is better for patients. The term "production" used by health systems to pay primary care doctors is a wonderful metaphor for what medicine feels like.

Charlie Chaplin in the factory scene in Modern Times captures the feeling better than anyone could describe it. The term quality is the second distortion—at least how it is used in US health care as determined by insurance companies and the National Committee for Health Care Quality (NCQA), the self-appointed guardian of quality. The current term used is "pay-for-performance"and conjures images of dogs being rewarded with treats for jumping through hoops in the circus. No one, of course, argues against quality, but a lot of clinicians argue about what quality means and how it should be measured.

Linking quality measures to payment raises a whole raft of issues for primary care when those payments are also linked to reimbursement for billable services and don't take a practice population into consideration. A study of pay-for-performance comparing physician attitudes between family doctors in California and general practitioners (GPs) in Britain showed that the British GPs felt better about the process and its subsequent effect on their income compared to the California family doctors who felt overburdened and under resourced.1

This should come as no surprise. In England, GPs have a base average salary of 100,000 pounds (roughly $180,000) upon which pays for quality can be added but not subtracted. The results are a much better achievement of quality improvement and an increase in compensation of the British GPs compared to the US doctors who, depending on meeting quality grades, put up to one-third of their basic income at risk. In addition, British GPs use quality measures derived from their own practices while California physicians were judged by external criteria, mostly from the NCQA.

I have been in practice at a residency teaching clinic for almost 17 years, a clinic whose population, in contrast to other practices in our health system, is ethnically diverse with disproportionately lower incomes, with a high percentage of Medicaid, permanently disabled and uninsured patients. Every month I get an individual report on how patients of mine meet NCQA measures of "control" of diabetes and most months since this started, I have ranked dead last and our clinic ranks last of all the clinics in the system. So, by externally derived quality measures, after 40 years of being a doctor—at least for diabetes—I have been deemed the worst doctor in the worst clinic.

As I go through my list, I recognize names of patients who are uninsured or, because of high deductibles or co-pays, are effectively uninsured who have enormous economic and social burdens, who struggle with paying to come to our clinic, spreading their medications over longer periods of time than they should because they need to buy food and pay rent. My clinic colleagues and I have looked at our diabetes patients and found that, despite these challenges, we are improving their HgbA1c levels but not making the magic "7.0 or less" benchmark. If we were British GPs, we would be rewarded for progress, but because we are in the United States, we are punished for not meeting externally driven "standards." The quality system in the US is pass-fail, not improvement.

Higher risk practices, just like higher risk school systems, need more and different resources than those at lower risk. Research repeatedly supports the view that more resources improve care in higher need primary care. In the British National Health Service (NHS), community nurses, paid by the NHS, work with each practice to broaden care by doing home visits to patients who are missing care and do care management in the community, not simply in the office. Higher need communities get more nurses than those with less need. In our practice, we get supported for office-based staff at the same rate or less than practices with less demanding populations. But the current production driven reward system assures that practices with patients who have socioeconomic as well as medically complex problems will have less to invest in care.

Disparities in health outcomes in society often mirror the disparities in practice support for clinics trying to care for socioeconomically burdened communities, a concept first identified almost 40 years ago,2 which stated that "the availability of good medical care tends to vary inversely with the need for it in the population served."

I realize I am not the worst doctor and I know my clinic is not the worst practice—we have been providing consistently high quality care for over 35 years to our community. We are all—whether an "A" doctor or "F" doctor—locked into narrow definitions of quality that are often poorly tested. For example, a recent study demonstrated the risk of increased mortality for type 2 diabetic patients whose HgbA1C is driven below the NCQA goal of "less than 7.0." This study was interrupted before it was completed because of the danger to patients who were treated aggressively.3 But the "standards" for the diabetes report card hasn't changed. Even if loosening the standards of quality might actually save patients lives', it doesn't seem to matter. Pushing primary care clinicians to put our patients at risk to achieve increased pay-for-performance goals presents an intolerable conflict of interest.

Any attempt to improve the morale and quality in primary care requires changing not only how much primary care providers are paid but, more importantly, how they are paid. Large groups or collaborative and insurance companies can find ways to experiment in primary care by paying for populations, which would let the practices concentrate more on innovation than on throughput. An experiment at Group Health in Seattle, Washington, showed that investment in primary care that is not production driven can lower costs, free up more time for patients, and increases both provider and patient satisfaction.4

Why not try giving primary care doctors a dependable base income and reward improvement? Ask them to improve the health of their overall practice population rather than meet arbitrary and evidence-poor "benchmarks." Push collaboration with many different health professionals who can divide both the work and the reward for doing better. Discovering new ways of delivering care that would not pit the "high producers" against the rest, and concentrate on health not billings. It would be a better world for doctors and patients alike. It is not too late to try.

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Home care practices in Illinois get a boost

Illinois home care physician practices continue to advance in the new era of health care reform. Illinois and Maryland- based Home Physicians benefitted from an $11.5 million investment from Triangle Capital Corporation in North Carolina. IAFP Board member Michael Fessenden, MD is the medical director of the Chicago branch. *American Medical News* covered the Triangle investment announcement in their April 25th issue.

On Sunday, May 2 the American Medical Student Association chapter at Benedictine University in Lisle held their second annual Run to Fun 5K race which benefits HomeCare Physicians, based at Central Du Page Hospital and founded by IAFP member Thomas Cornwell, MD of Carol Stream.

The economic feasibility of house call medicine has long been challenging. But analysts say that has changed slowly over the past decade as Medicare increased payment rates and an aging population raised demand. The program paid for more than 2.3 million house calls in 2009, up from 1.5 million in 1995, according to an analysis of Medicare data by the American Academy of Home Care Physicians.

IAFP member Tom Cornwell, MD of Carol Stream (far left) with the AMSA members who organized the second annual AMSA Run to Fun 5K which raises funds for his HomeCare Physicians practice.

Experts expect the number of home visits to increase because of several aspects of the Patient Protection and Affordable Care Act, including the Independence at Home program, which will provide incentives for primary care teams to provide house calls. The American Academy of Home Care Physicians and Dr. Cornwell had a role in the development and advancement of the legislation.

Some hospitals and large health systems may incorporate house calls into accountable care organizations, and others may use them to avoid penalties for high readmission rates.

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