

## Legislative Hearing on Health Care

Testimony of **Jay Erickson, MD** on behalf of

Glacier Medical Associates

January 8, 2011

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(Mr. Chairman/Madame Chair) and members of the Legislature, for the record my name is Dr. Jay Erickson. I am a physician owner and partner in a 12 provider primary care practice. Our practice employs 37 full- and part-time employees, and we have a \$2.7 million annual payroll with greater than ½ of the payroll paid directly to employees.

During the 2011 Legislative Session, I am asking that you assist me and many other physicians like myself in maintaining our ability to do business in Montana and serve the health care needs of Montana residents by:

1. Maintaining physician reimbursement in programs like Medicaid and Workers Compensation;
2. Maintaining the WWAMI program as it currently exists, including current funding;
3. Provide funding for additional WWAMI TRUST seats which selects students and educates them to return to the rural and underserved areas of Montana.

A recent study showed that each family physician creates a yearly economic impact of \$812,189. This legislative session, a number of bills have been requested that would cut health care provider rates in programs like Medicaid and in the Workers compensation system. These bills, if passed, will directly affect the bottom line of businesses like mine throughout the state of Montana.

Our clinic's cost of doing business increases every year, as it does for most businesses. Due to costs associated with providing medical care, some physician clinics face cost increases on a yearly basis that are more than the inflationary costs of other businesses. Due to our rising costs, each time physician provider rates are reduced in programs like Medicaid and Workers Compensation, we become less and less able to cover our own costs, pay our employees and, at the same time, treat patients in these programs. When provider rates are cut, clinics like mine are forced to either decrease access to patients in these systems or to discontinue seeing these patients. Because physicians as a whole feel a compelling interest to treat all patients, making the business decision to access for these patients is not easy. However, we are forced into deciding to limit access to care for

these patients. The economic realities force us into these decisions in order to keep our doors open. Some physician clinics that have a less flexible patient mix will have no choice but to terminate their employees and close their doors if provider rates are further reduced in these systems.

For these reasons the proposed cuts to physician reimbursement in Workers Compensation or Medicaid would necessarily decrease access to physicians for Montana's injured workers, families in need and the disabled. We hope you can help us continue to treat these patients by voting against any such proposed cuts and that you vote to maintain fair and adequate physician reimbursement in these systems.

As I ask for your help in maintaining physician reimbursement at adequate levels, I want to let you know that both I and my partners do our fair share of providing free services, as do many other physicians like me across the state of Montana. In 1994 I helped establish Shepherd's Hand Free Clinic and continue to be its medical director.

- ❖ Shepherd's Hand Free Clinic is the only free clinic in Montana
- ❖ 1600 patient visits yearly
- ❖ Over \$1/3 million of donated and free services yearly (physician, lab and imaging, medications).
- ❖ A new health system should provide **Quality, Value, and Access**

Finally, I want to talk to you a bit about the physician workforce shortage in the state of Montana and the effort that I am involved in to help reduce that shortage. For the past 7 years I have been the clinical dean of the Montana WWAM program- "Montana's Medical School." In that role I have gotten to know the physician workforce issue in Montana as we strive to create in WWAMI a medical education system that meets that need.

As you all have probably heard, we are experiencing a physician workforce shortage across Montana, in the northwest region and nationally – and therefore should continue on the path of "growing our own" physicians in the WWAMI partnership. Given the fact that Montana is surrounded by other states with acute health professions shortages, it is unlikely that we will be able effectively recruit doctors to work in Montana -we must train our own to assure adequate physician coverage in Montana.

The primary care statistics in Montana are staggering. In fact, *54/56 Montana counties are federally designated in part or total as primary care shortage areas. Currently we*

*are short a total of 53 primary care providers in those counties. There are 11 counties in Montana with no physicians.*

Increased utilization of services- currently 14% of our state population is 65 or older. By 2025 it is estimated that 25% of our population will be 65 or older, ranking Montana as third in the nation in the proportion of its state as elderly. This will put additional pressure on the health care delivery system in Montana since the elderly have significantly more clinical needs than the average citizen.

We have an aging physician population- 45% of Montana's physicians are 55 or older- one of the oldest physician workforces in the nation.

The Montana WWAMI program is working to help meet this current and looming physician workforce need. Established in 1973, the program has admitted 20 students yearly into a program that allowed access for Montana students to publically funded medical education. This unique 5 state partnership, partners with a top ten medical school to allow a world class medical education for Montana residents.

Our population since 1973 has increased by 36% with no concomitant increase in WWAMI class size. Montana funds about 1/3 of the national average for medical school seats per capita. This year we have 56 Montana students starting medical school. We shipped out 36 of Montana's best and brightest to attend medical school in other states.

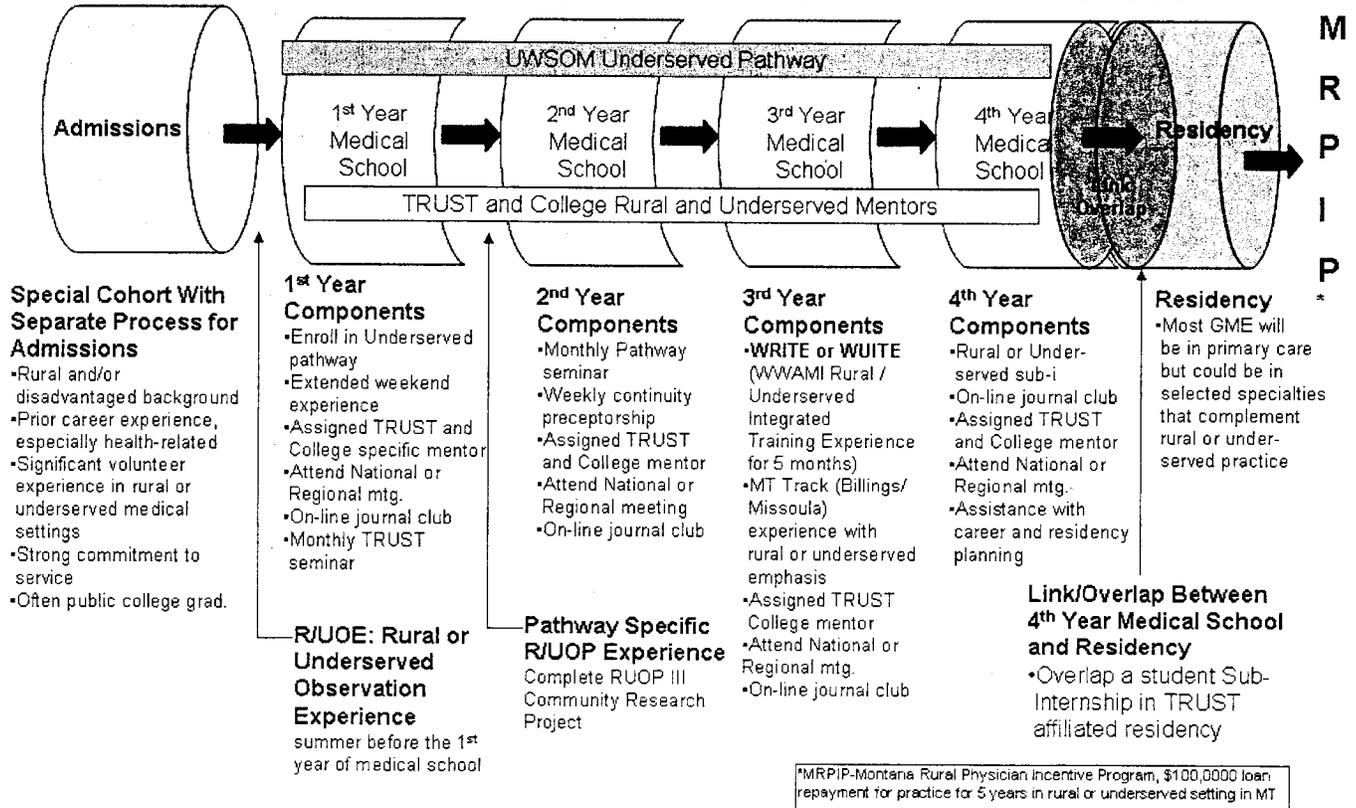
I'd like to leave you with 5 points in regards to WWAMI:

1. Montana WWAMI students do return to the state (~40%) and participation in the WWAMI program extends that investment by attracting WWAMI students from the other states that participate in this partnership (~55%). The national average for publically funded medical school return rates is 39%.
2. The state of Montana in 2010 supports the WWAMI program with an appropriation of \$3.6 million. 50% of that appropriation is spent back in the state of Montana.
3. The US average of state support per student based on the 80 WWAMI students that the state of Montana supports would be equal to an expenditure of \$9.3 million. The WWAMI partnership provides good value in that the state support per medical student is almost 1/3 the national average.
4. We rank dead last in medical residencies per capita. We need to support the expansion of the Montana Family Medicine Residency in Billings which is increasing from 6 to 9 residents over the next 3 years. Missoula is well along in plans to start a new Family Medicine residency of 6 residents per year in 2013.

5. The Montana WWAMI TRUST program, initiated in 2008, uses existing and new programs to create a continuum that selects qualified applicants, educates them with an enhanced rural and underserved curriculum, places these students into residencies and finally returns these graduates to the rural and underserved areas of Montana. (See the diagram pasted below for a description of the TRUST program.)

With the Chair's permission, I would like to submit for the record an additional handout which provides additional information on the WWAMI program. Thank you for this opportunity to present today, and I am available for any questions you or members of the Legislature might have.

# TRUST MONTANA - Targeted Rural and Underserved Track



# Montana WWAMI Fact Sheet

## Medical Student Education

1<sup>st</sup> Year – Montana State University-Bozeman for basic sciences/introduction to clinical medicine

2<sup>nd</sup> Year – University of Washington (Seattle) for integration of basic and clinical sciences/colleges

3<sup>rd</sup> Year- Approximately one hundred and ten students will have participated in required clerkships in MT in 2010-2011.

Number of clinical faculty in Montana is approximately 290. The Montana 3<sup>rd</sup> year required clerkships:

**Family Medicine**-Billings, Havre, Missoula, Whitefish **Internal Medicine**-Billings, Dillon, Missoula **Pediatrics**-Great Falls, Billings, Missoula **Surgery**-Billings, Missoula **Psychiatry**-Billings, Missoula **OB/GYN**-Billings, Bozeman, Havre, Libby, Missoula **WRITE** (WWAMI Rural Integrated Training Experience) - Lewistown, Libby, Helena

4<sup>th</sup> Year – Required and elective clinical rotations (Ability to do all 4<sup>th</sup> year rotations in Montana are under development):

- **Neurology**- Great Falls, Billings, **Chronic Care/Rehab**-Billings, Missoula **Anesthesia**-Missoula, Billings **Dermatology**-Billings
- **Family Medicine Subi**-Billings, **Nephrology**-Billings **Ophthalmology**-Missoula **Orthopedics**-Billings **Otolaryngology**-Missoula **Radiology**-Billings **Surgery**-Lewistown, Libby

Pre-Med The Montana Pre Medical Conference was held April 10, 2010 in Bozeman. Approximately eighty-five participants attended the event. The next conference will be fall 2011.

## Graduate Medical Education – Residencies

- Montana Family Medicine Residency- Billings-6 residents per year, 70% of grads remain within the state
- Additional GME offerings under consideration.

## WWAMI Results: 531 Montana WWAMI graduates in practice

- Return rate-212/531 (40%) practicing or have practiced in Montana
- Return on investment-293/531 (55%) graduates from all WWAMI states practicing or have practiced in Montana

## Financial Support of WWAMI

- FY 2010 state appropriations- \$3,585,602 (UW: \$2,966,045; MSU: \$619,557)
- FY 2010 amount of total expenditures spent in Montana - \$1,788,623 (50%)
- FY 2010 average state funding per student per year - \$44,820
- FY 2009 average Montana WWAMI medical school debt per student: \$128,928
- FY 2009 National Average: \$131,446 per student - publicly funded school; \$153,631 per student - private

## Research

- WWAMI is involved in the UW Institute of Translational Health Sciences and was awarded a supplemental grant to increase translational and clinical research capacity in Montana and throughout the WWAMI region.
- Faculty at Montana State University conducts biomedical research which is funded by the NIH, NSF, and NASA.
- WWAMI is engaged in healthcare workforce research.

## Community Outreach

- Montana AHEC (Area Health Education Center)

*To improve access to quality healthcare by addressing the primary workforce needs, in rural and underserved areas, through medical, community and academic partnerships.*

In the past year Montana AHEC has:

- Continued development of the regional AHEC centers, in Dillon, Billings (opened 2007), Missoula (2008), and the Northcentral region (2009)
- Continued affiliation with the UWSOM
- Provided financial support to health careers students engaging in extended rural rotations
- Collaborated on three major conferences on rural health, health and prevention, and increasing the number of American Indians/Native Alaskans in health professions
- Prepared a study of Montana's Primary Care Workforce and allied health workforce, with presentations to the Montana Legislature
- Developed a partnership with Health Occupations Students of America to expand health careers education and greatly expanded K-12 outreach programs
- Supported R/UOP (Rural/Underserved Opportunities Program), a one-month opportunity for students to spend in a rural or medically underserved community.
- Placed 15 Montana WWAMI Students and 9 WWAMI students from other states in Montana rural and underserved rotations.
- Established a Montana Recruitment Collaborative
- Created the Montana Rural Health Initiative, a social networking project for community wellness initiatives
- Provided extensive technical support to develop Montana's health information exchange
- Created a student internship program for medical, health science, and engineering students
- Conducted Community Health Service Development assessments with 17 critical access hospitals over the past 3 years

Rev 11/2010

Pioneer Medical Center (PMC) is a 25 bed critical access hospital and a 35 bed nursing home. The PMC also includes a rural health clinic, hospice, ambulance service, public health and assisted living facility. The medical center has over 15,000 patient visits annually.

Pioneer Medical Center is owned by Sweet Grass County and is the only medical facility in the county. The viability of Sweet Grass County's health infrastructure and services largely depends on the success of Pioneer Medical Center.

The facility's success is also of utmost importance to the economic stability of the county. Although Sweet Grass County is full of diverse employment opportunities from government, mining, agricultural, retail, service, construction and manufacturing jobs; it is sensitive to employment changes from its larger employers such as the Stillwater Mining Company and Pioneer Medical Center.

The total economic impact attributable to PMC operations is estimated at more than \$8.5 million dollars. PMC is the second largest employer in Sweet Grass County. It is also estimated that local spending by the PMC accounts for an additional 25-30 jobs in the local economy.

A recent report from the Montana Department of Labor and Industry stated that health services employment in Sweet Grass County "is about one and a half times as high as one would expect given statewide employment patterns" and 1.79 times as one would expect given national statewide employment trends. Given the small population of Sweet Grass County, the county's economy is very sensitive to changes in Pioneer Medical Center employment.

This was confirmed in a 2009 survey by the Montana Office of Rural Health which found that nearly 95% of Sweet Grass County residents surveyed felt that local health care services are very important or important to the economic well-being of the area.

Like all frontier hospitals, we are financially very vulnerable. Both private and public funding streams are extremely important for the continued operations of the medical center, but Medicaid, which covers nearly 70 percent of PMC's long-term care patients, is especially critical.

Any wholesale reductions to the Medicaid program would compromise the viability of the medical center and the employment of 150 people.

A second financial challenge is access to capital. Like many rural facilities, our facility operates on such a tight margin that we cannot save the money we need to make needed repairs. And we are such a small player in the financial markets that typical sources of capital are not available to us.

I encourage the Legislature to consider creating a revolving fund that could provide low-interest loans for critical access hospitals for just this purpose. One way to achieve this would be to set aside the interest from a portion of the coal tax trust fund.

The Pioneer Medical Center, like many other rural healthcare organizations, is already fragile. Due to the economic recession and decreased volumes in early 2009 the PMC reduced its workforce by nearly 10 FTEs in order to decrease its expenses. During the same year, county residents supported the medical center with double the tax support to help maintain operations. Maintaining Medicaid funding levels is necessary to support rural healthcare organizations and their economic contributions.

Rural healthcare organizations are also major suppliers of local workforce development programs. The PMC offers a Certified Nursing Assistant Training Program to provide local residents the necessary training to qualify for CNA employment. Likewise, the PMC holds courses to become an Emergency Medical Technician and provides opportunities for existing employees to move up in positions or salary through training and education.

Adequate Medicaid funding and access to capital financing are essential to maintain rural healthcare infrastructure and support economic stability in rural areas.