

THE BULLETIN

Our Mission:

To promote the science and art of medicine, the care and well being of patients, the protection of the public health, and the interests of the medical profession.

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Original tree art by Samuel P. Burre, M.D. (1957) and adorned by George Ingraham, M.D. (2002)

The Bulletin is published monthly by the **Humboldt-Del Norte County Medical Society**, 3100 Edgewood Road, P.O. Box 6457, Eureka, CA 95502. Telephone: (707) 442-2367/Crescent City (707) 465-0980; FAX: (707) 442-8134; E-Mail: hdnccms@sbcglobal.net Web page: www.hdnccms.org

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CMA HOD
EMILY DALTON, M.D.



The Annual House of Delegates convention was held in Anaheim at the Disneyland Hotel this October.

There were numerous discussions about all sorts of resolutions, ranging from matters of internal policy and procedure to far reaching public health issues like legalization of marijuana or the cost of end-of-life care. This is a very exciting time to be involved in medical politics because the impetus for badly needed reform is at an all time high. At our annual dinner on Thursday, December 3, you can hear more about what is going on at the State and National level.

Dustin Corcoran, Senior Vice President of the California Medical Association, is speaking to us. He is one of the people who voices your concerns to the legislature, and after you meet him I think you'll understand

how lucky we are to count him among our ranks. To give you a little preview: "To make matters worse the Governor continued his well worn pattern of veiled threats toward legislators for their failure to act on issues such as the budget, water and prisons. The Governor used a variety of methods to try to force legislators to act. At one point the Governor sent Senate President Pro Tem Darrell Steinberg (D-Sacramento) a bronzed sculpture of bull testicles insinuating that the legislature needed a pair. Not surprisingly Steinberg and other legislators were not amused." So come and listen, but also be prepared to let him know what is important to you.

Pull your heads out of the sand and understand that what happens in Sacramento and Washington affects us! We may feel isolated and disconnected, but the truth is

just the opposite. We need members interested in medical politics to volunteer to be delegates to the next annual meeting in October in Sacramento. We get allotted 3 voting seats, and embarrassingly, this year we only had 2 representatives there to vote. If you ran for student government, if you have ever chaired a meeting or if you read more that the sports section in the newspaper, you have the skills to represent your colleagues at CMA. Expenses are reimbursed, and the meetings are fascinating, exciting and a great place to network and meet other physicians struggling with similar issues. Fortunately, despite being light on delegates, our region was well represented at higher levels because of the hard work of Luther Cobb who is Vice-Speaker of the House of Delegates, and Mark Davis who is on the board of trustees. §

MARK YOUR CALENDARS...

ANNUAL GENERAL MEMBERSHIP / ELECTION MEETING

DATE: DECEMBER 3, 2009 (THURSDAY)

TIME: SOCIAL: 6:30 P.M.

DINNER: 7:15 P.M.

PROGRAM: 8:00 P.M.

PLACE: PLAZA GRILL, ARCATA

The POLST Paradigm: Upgrading Advanced Directives

SCOTT SATTLER, M.D.



An end stage cancer patient at a local board and care facility is found in bed unresponsive with agonal breathing. An ambulance is called. CPR is initiated, along with endotracheal intubation. The patient is quickly transported to the local emergency room, where the code continues until a chart is found which contains Advanced Directives for healthcare (ADs) indicating that the patient wanted comfort care only under such circumstances. The code is stopped.

An elderly woman with end-stage dementia has been able to live at home under the care of her equally elderly husband, with the help of Hospice. When he suddenly finds her unresponsive and “breathing funny” after her nap, despite instructions to the contrary from Hospice months ago, he panics and in his desperation he calls 911. On arrival the EMTs intubate her to stabilize her airway and then transport her to the ER. After further evaluation there, including lab, CXR and CT of the brain, the husband comes out of his shock and mentions that she is a Hospice patient. She is admitted for overnight observation and is discharged home in the morning under continued Hospice care.

Both of the above patients had Advanced Directives in place. In the first patient’s case, they were appropriately filed away in the chart at the board and care facility. In the second scenario they were sitting in a neat folder in a filing cabinet at the woman’s home. Unfortunately, as many of us have come to know, usually, despite completed Advanced Directives requesting comfort care only, once 911 is called, full intervention is the rule.

We also know that these same Advanced Directives have proven to be of great service to patients and staff in hospitals and

chronic care facilities. There they provide definitive guidance for a patient’s end-of-life care. But they clearly don’t work outside these institutions in emergency situations. Emergency Medical Service providers need to make urgent, split-second decisions. These response teams don’t have time to find and read a multi-page document when confronted with a critically ill patient. In addition, until recently, unless a special DMV form authorizing DNR status was present at the scene, these response teams were required to employ full resuscitative efforts even in the presence of a patient’s ADs requesting care to the contrary.

Emergency room physicians, too, are often caught in this dilemma. Without ready access to a patient’s ADs, they are compelled to maximize interventional medical care, often and unknowingly in direct contradiction to the unresponsive patient’s wishes. If the patient has a previous hospital record containing advanced directives, and if that document can be found, then these guiding principles will surface to help the attending physicians and staff. If not, maximal intensity of intervention is the rule.

In 1991, responding to complaints of seriously ill patients receiving medical treatment that was inconsistent with their wishes, Oregon physicians and ethicists, working with a host of involved agencies, began to develop a system to deal with this dilemma. They concluded that patients at risk needed to be provided with a portable set of medical orders prescribing implementation of the patient’s late-life wishes. These specific orders were identified as **Physician Orders for Life Sustaining Treatment**, and in 1995 the POLST paradigm was born. Today, with over one million forms distributed, the use of POLST in Oregon is now the accepted

medical standard of care. It is used by all hospices and over 95% of nursing homes in the state. Not surprisingly the idea has spread beyond Oregon. POLST is now operational in 26 states with another 4 states having programs under development. In 2006, Humboldt County was asked by the State of California to help develop California’s POLST program. After much work, we have now reached the point where the program is being activated.

The Key Components of POLST:

1. Patients wishing to benefit from this program must first meet with a trained service provider (nurse, social worker, MD, etc.) and discuss their end-of-life wishes, much like completing Advanced Directives. This may occur in a clinic, office, hospital, chronic care facility or patient’s home.
2. Based on medical indications and the patient’s preferences, the patient and their physician then review and complete the standardized bright pink POLST form, indicating those orders specific to the patient’s reasonable requests. Both the physician and the patient, or the patient’s legally designated decision-maker, must sign the form. Physician contact information is added. A copy of the form is kept for the medical record.
3. The original pink POLST form is sent with the patient and is to be prominently displayed at the patient’s place of residence either on the refrigerator or at the bedside. It will accompany the patient during all travel within the medical system (i.e. between home, long term care facility, ER or hospital). Upon discharge from all such facilities, the form shall go

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It Ain't Gonna Happen (at least not yet)

STEPHEN KAMELGARN, M.D.



The other night, when I came home from yet another day of getting beaten up by a monstrously dysfunctional health care system, I discovered a message on my home answering machine, from a local Single Payer Healthcare advocacy group. The message requested that I phone all of my federal representatives (Mike Thompson, Barbara Boxer, Dianne Feinstein, Nancy Pelosi, etc.) for their support for “Medicare for All.” Mind you, I’m as much a Single Payer Monomaniac as almost anybody could be—just read the recurring theme of many of the columns I’ve written over the years in *The Bulletin*, stating my feelings on the matter. But let’s get real here for a second.

While I’m sitting here, writing this column, there are five health care plans getting diluted, de-fanged and made ever-less reformist as they wend their way thru Congress. The Baucus Bill barely made it out of the Senate Finance Committee, and even that totally watered down health plan was watered down even further before it made it out of committee. In not one of those five healthcare reform bills do the words “single” and “payer” appear in the same sentence, let alone together, as in the phrase, “Single Payer.” Even the highly touted “public option” (the option that was so roundly rejected by our fossilized, old fogey colleagues in the AMA) was pulled out of both of the bills in The Senate, and barely made it into The House plans, despite the reassurances of Mike Thompson (at the town hall meeting he had up here in Eureka last month) of how strong support for the Public Option was in both houses. The Republicans are playing revenge politics. (“Let’s do whatever it takes to sink the Obama Administration. Forget what it does to the country.”) The Democrats are too

spineless, debased and divided, to take on the insurance industry, and its hand-maiden, Big Pharma. Evil vs Venal. What a choice.

It is in this climate that I’m expected to campaign for the Holy Grail of Single Payer?! In this crazy, dithering, rancorous climate? It ain’t gonna happen.

As the insurance industry ramps up its campaign to maintain a stranglehold on the American People, it is also making the hoops we have to jump through for our patients ever more obstructive, labyrinthine and byzantine. We people in the front lines are having a more and more difficult time of negotiating the system, and we have little or no spare energy to devote to “the cause.” I love *Don Quixote* and its themes, but the “realist” in me says, “Uh-uh. Nope.” I’m way too mired down in the insanity of the present to put on my rusty armor and go tilting at windmills. When I’m caught in this position, torn between the real and the ideal, I think of what I was told many years ago by a “professional” environmental activist: real change can only come about from “constant pressure applied constantly.”

There are many ways that one can interpret that statement: Do we constantly “Swing for the Fences,” (as this single payer group is doing) or do we wait a bit, if only for an extended second, see what disaster (or combination of disasters) emerges from Congress, and then map out a short term strategy for effecting another minor change in the right direction? Constantly apply pressure for small, step-wise changes. Revolution vs evolution, if you will.

Although the actor in me wants to go for the Grand Futile Gesture, the ever more realistic burned out Family Practice doc, leans toward the latter gesture: Let’s take a breather here, regroup, recoup our strength

and energy, and then try to push for smaller, yet effective changes.

Why don’t we drop our sights, just a bit, and really put on the push for The Public Option. This will make healthcare affordable for millions of people, and, hopefully, force the insurance industry into cleaning up its act a bit. True, it isn’t ideal, but it is a giant step forward. More importantly, it’s a piece of the plan that is actually *enactable*. It’s an evolutionary and not revolutionary step. It’s how Nature has been operating for the past 600 million years. It builds upon itself, rather than creating new structures out of thin air. What fills we humans with such hubris that we think we can out perform nature? And, let’s face it, some form of government sponsored insurance, in competition with private insurance, is what’s used in most of the successful healthcare systems in Europe and The Far East. In Switzerland, there is no public option at all. But the private insurers are non-profit and are strongly regulated by the government, and their system works just fine, thank you. Whatever works, do it.

Should we bind ourselves to a political agenda that has absolutely, *no-way-in-Hell*, any chance of seeing the light of day? Shouldn’t we, rather, go after the possible, the do-able, step-by-step? When we talk about undertaking major changes, doesn’t it make more sense to take small steps, so that the tinkering required to correct and move on is much less complex. A healthcare system with a public/private option is a giant step, but also, one that would be relatively easy to tinker with, to improve it. And, almost immediately, it will extend healthcare benefits to millions of people. Perhaps not all of the 48 million uninsured,

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The Bulletin

My Word

LEE LEER, M.D.



Because of my job, I do not tend to take public positions on popularly debated topics. My patients cover the political spectrum, and I generally do not want my political opinions to interfere with the therapeutic encounter. However, the healthcare debate has changed that.

The need for reform seemed like such a no-brainer to me that I didn't imagine any opposition except from the insurance and pharmaceutical industries. Little did it occur to me that the minority party would twist this issue into somehow being about "God, country and taxes." Nor did it occur to me that a vocal proportion of the general public would be swayed by the opposition's lies and fear-mongering. But I was wrong, and so I must speak out – for whatever good my single voice may do.

First: the lies.

Lie #1. "There will be Death Panels." Good primary care physicians have been talking about end of life issues with their patients for years. No, we don't get paid for it, but it's part of the job. I think the proposal to pay physicians for counseling about end of life issues was silly (since we do it already), but it was extremely cynical of opposition pundits to then claim that this would lead to the mass extinction of senior citizens. And sad that some of the public actually fell for it.

Lie #2. "The government will make a mess of things, like they always do." Obviously the government does some things very well – think Fire, Police, the Armed Forces, The Coast Guard, National Parks; and, until we recently decided to stop paying for them: public universities. Also, the government does medical care very well. If you disagree with me on this, and you're over 65

or a veteran, then you darn well better disenroll from Medicare or the Veterans Administration before you dare tell me I'm wrong! Not that ALL medical coverage needs to be provided by the government: frankly, I'm of the opinion that the government needs competition in this area just as private insurers need competition. But to argue that the government can't do it? That's just silly talk.

Lie #3. "We can't afford it." Frankly, we can't afford not to enact comprehensive reform. The United States now spends more – in total dollars and per capita – on healthcare than does any other country in the world. And what does it get us? A healthcare ranking of somewhere near 40th in the world; medical debt as the leading cause of personal bankruptcy; medication costs that are orders of magnitude greater here than in countries that have a managed healthcare system. Unfortunately, just giving everyone insurance won't save any money. We also need system reform so that treatments and medications can be compared against one another. What works, will be covered. What doesn't work falls to the wayside. I see this as simple logic, not to mention good medical care. The opposition sees it somehow as limiting free choice. As if I should be free to recommend any therapy – proven or disproven – to my patients and have their insurance pay for it!

Lie #4. "The government will tell doctors what they can and can't do and care will be rationed." You think care isn't rationed now? That may be because you've never been sick, or it may be because you have no idea how much (uncompensated) work your provider and his/her employees do to advocate for you to get the care you need.

Those of you who don't believe your insurance company is rationing care right now should spend a day with my office staff as they argue on your behalf to get authorization for whatever treatment your doctor ordered. Then there are the people who self-ration: they don't go to the doctor because they can't afford the co-pay; they don't take their pills because they can't afford them; they pass on the physical therapy or counseling that could really help them because their insurance doesn't pay for that... the list could go on and on.

Now, the truth:

I see well-insured patients all day long, yet not a day goes by that I don't see a patient whose health has somehow or other been adversely influenced by the cost or (poor) quality of his/her insurance. They are insured, yes, but not for the pre-existing condition that really is their only health problem; they are insured, yes, but still can't afford their share of cost for the only procedure that can really help them; they're insured, yes, but can only afford major medical, which does not cover prescription costs; they're insured, yes, but their insurance company won't pay for any preventive testing, so they forgo the colonoscopy that could have prevented the colon cancer they are now battling. One of the ironies of this whole debate is that most of the insured people arguing against reform have no idea of the holes in their own health coverage and are using a lot of energy arguing against their own best interests. Never mind the interests of the millions without any insurance.

I applaud Representative Mike Thompson, his colleagues in the House and Senate, and the President for their efforts to

"My Word" Continued on page 10

Humboldt-Del Norte "Tattler"

CONGRATULATIONS to **Join Luh, M.D.** upon passing his boards for certification by the American Board of Radiology, Radiation Oncology!

HAPPY BIRTHDAY TO DRs: Anderson, Badgley, Dalton, W. Davis, Dickinson, Dorman, Ervin, Frank, Gans, Gerdes, Kajdos, Kelsey, Lock, Luh, K. Miller, Minor, Ploss, Polidore, Saunders, Scholz, Spencer, Stiver and Wakil

Coming, Going & Moving Around

WELCOME:

HARMANJEET DHALIWAL, M.D., Anesthesia, Redwood Anesthesia Group, Eureka

MOVING AROUND:

KATE MC CAFFREY, D.O.

New Practice: **Redwood Osteopathy**
1225 Central Avenue, #12, McKinleyville, CA 95519
(707) 601-8803
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with the patient.

4. All local fire and ambulance first responders have agreed to abide by these orders. In addition, on January 1, 2009, California State POLST Legislation (AB 3000) went into effect requiring that all health care providers honor POLST orders even when signed by a physician not on staff at the treating health care facility. The POLST form is thus portable statewide and across all levels of care.
5. POLST does not replace the need for

Advanced Directives, but rather complements it. Each has their place. ADs are not physician orders, while POLST paradigms are. POLST does not authorize a legal surrogate decision maker, while Advanced Directives have that capability. Everyone over the age of 18 is advised to complete a set of Advanced Directives, but only those who are seriously ill are advised to complete POLST forms.

6. The presence of the POLST paradigm stimulates conversation about late-life care and provides a platform for periodic

review of a patient's circumstances. Because it is a dynamic document, POLST can easily be modified or revoked based on new information or changes in a patient's condition or preferences. One simply voids the obsolete form and creates a new one.

Who Should Complete a POLST form?

1. Anyone who has a progressive, chronic medical condition such as advanced COPD, CAD or AIDS.
2. The medically frail elderly.
3. All those in long term care facilities.
4. Anyone having a terminal illness or for whom you, as a physician, would not be surprised were they to die within a year. This would include all those in hospice programs.
5. Anyone who carries the designation of DNAR (Do Not Attempt Resuscitation) at the time of hospital discharge.
6. Anyone wishing to further define his or her late-life preferences of care.

In short, POLST has proven itself nationwide to be an effective tool both for preventing unwarranted treatment at the end of life and for ensuring that we provide desired and appropriate medical treatment in a timely fashion. It is a good idea whose time has come. Let us, as physicians, greet it whole-heartedly.

For more POLST related information see: www.POLST.org (national) and www.caPOLST.org (California) §

PUBLIC HEALTH NEWS

ANN LINDSAY, M.D.

Humboldt County Public Health Officer



H1N1 Update

Humboldt County Public Health has put together a monitoring system for H1N1 activity in the county. We receive school absence reports, aggregate data from Eureka Family Practice's EHF regarding total visits and visits for influenza like illness, reports from HSU Student Health Center, Eureka Community Health Center and Eureka Pediatrics about flu visits, data on outpatient sales of anti-virals, and reports of total visits at the emergency rooms and urgent care with percentage for influenza-like illness (delayed). As of October 20, 2009, there has been a modest rise apparent in H1N1 activity locally. Our monitoring sys-

tem is pretty basic. We are working on improvements, particularly electronically mining hospital and clinic aggregate encounter data. Hospitalizations and deaths from influenza are reportable to public health.

As of October 16, there have been 20 hospitalizations and 1 death in Humboldt since April, 2009, when the epidemic began. About half the specimens submitted state wide to the California Department of Public Health laboratory are flu A, presumed H1N1. Therefore we can assume not everyone with a fever, sore throat, and cough has H1N1.§

*For current updates, visit:
humboldtthealthalert.org.*

"Thoughts" Continued from page 4

but many millions of them. Isn't our goal, after all, to provide affordable, quality healthcare to all of our citizens? Who cares what shape it takes, just so long as, ultimately, those three basic qualities are met.

And, who knows? We just may find that we've achieved our goals without achieving true Single Payer Health care. That would be just fine. §

"My Word" Continued from page 5

fix what is a terribly broken system. I am not naïve enough to think that any fix will be perfect, yet I am experienced enough to know that the status quo is an abject failure. Embracing change, and accepting a need to maximize the common good, are truly the only ways forward. Let's hope we the people have the collective wisdom to proceed in this direction.

Ed Note: this article was published as a My Word article in the Times Standard

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The meeting was called to order by President, Emily Dalton, M.D. at 7:05 P.M.

M/S/C to approve the following items on the "Consent Calendar":

-Reading of the minutes (8/17/09), approve as presented.

-Physician Well Being Committee Minutes (8/25/09), approve as presented.

-Public Health Advisory Cmt Minutes (8/18), approve as presented

-Medical Quality Review Committee Minutes (9/30/09), approve as presented.

-Society Balance Sheet/ Budget Report, approve as presented.

-Consortium Balance Sheet/Budget Report , approve as presented.

-Annual CMA-CEO Report, Joe Dunn, review as presented.

REPORTED on CMA is partnering with the California Primary Care Association and the California Association of Public Hospitals in an application to be a HIT Regional Extension Center (REC) for Health Information Technology (HIT) and work with the local component medical societies to help our members. CMA also encourages us to help identify and coordinate activities with those interested in applying to be Local Service Providers. The local HDN IPA (in conjunction with the North Coast Clinics Network) have applied to be a Local Service Provider.

SUGGESTED that some of the local offices might want to work with other offices and share some of the costs of keeping the systems up-to-date. Agreed that we need to have commonality amongst the systems locally so information can be shared.

UPDATE was presented on a grant received through the Community Health Alliance to develop a local Primary Care Electronic Referral System (IRIS). The HDN IPA has contracted with CHA for development of the project. Offices in Fortuna are being brought into the program first as they build the specialists into the system and hope to have everyone on board by the end of the year. They are getting positive feedback from the offices working with the program.

REPORTED that the HDN IPA has received recognition by the Integrated Healthcare Association for overall performance in the top 20 percent for 2008, based on Pay for Performance measures of clinical quality, patient experience, IT-Enabled Systemness and Coordinated Diabetes Care.

REPORTED that due to several member complaints, we have been working with our CMA Economic Advocacy division in filing a formal complaint with the Department of Managed Care on the Blue Cross/ Healthy Families program and the lack of adequate access to care issues in Humboldt and Del Norte counties.

REPORTED that the final reports of the CMA House of Delegates Reference Committees have been made available to the Executive Board for review. Representatives attending the meeting will be highlighting specific resolutions for publication in the December Bulletin. Noted that these reports are also posted on CMA's website. Mentioned that all members were encouraged to review and comment on these resolutions prior to the annual meeting.

MENTIONED that the outstanding Plessner Award Video on Dr. Jutila was viewed at the House of Delegates. CMA is considering posting of the video on the website for review as well. Suggested viewing the video at the Annual Meeting if possible.

REPORTED that Luther Cobb, M.D. will take over as Speaker of the 2010 CMA House of Delegates.

ACKNOWLEDGED and thanked the following representatives that attended the 2009 CMA House of Delegates: Drs. Dalton, McCaffrey, Cobb, M. Davis, Jutila and Carlson. Mentioned that Dr. Rangel was present for the Organized Medical Staff Section (OMSS) on Friday.

Health Department Update was presented by Dr. Lindsay on H1N1. Reported on local activities relating to education and distribution of H1N1 vaccines. Public Health will start vaccination in local schools early November. Updates continue to be posted on the www.humboldtthealthalert.org website. Practices are encouraged to make a plan so their offices are safe. Respiratory Hygiene packs (including hand cleaner, kleenex, masks, laminated signs, etc) are being distributed to local offices. Testing for H1N1 is only being done for inpatients. Dr. Lindsay thanked the Medical Society for assistance in coordinating meetings of the Public Health Advisory Committee and assistance with distribution of important public health information.

MENTIONED the goal to get "Health" into every policy that is adopted within the county. Officials are finally realizing that their decisions may have health implications.

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EXECUTIVE DIRECTOR Update was presented as follows:

-Reported that the 2010 Nominating Committee meeting is scheduled for October 28th. Nominations are now being accepted for Officers, Directors and Committees.

-Report was presented on the Medical Society Family Picnic held September 26th; the NORCAL Risk Management Seminar "Anatomy of a Lawsuit" held October 1st and plans regarding scheduling a CMA "Best Practices Seminar early next year. Mentioned that the Best Practices Toolkit was sent to all members' Office Managers for review.

-Reported that statements for 2010 have been mailed. Mentioned that statements were sent to non-members as well and so far 4 new members have joined as a result.

-Annual Membership Election Meeting has been scheduled for Thursday, December 3rd at Plaza Grill in Arcata. Speaker will be Dustin Corcoran, CMA VP Government Relations on "Legislative Advocacy".

-Reported that the 2010 Physician Membership Resource Directory is now in the development stages with data verifications, ad solicitation, etc. with a January completion date. Noted that there are a lot of changes from the 2008-09 issue. The Residence Directories will be published soon after the main directory is completed. Assistance with advertising solicitation is encouraged.

-reported consulting with CMA Legal re: crafting a letter to Hagadone Directories that publishes the "Black Book" regarding several inaccuracies that are published in their 2009-2010 Phonebook in the Physicians and Surgeons Guide.

-reported sending a letter in support of the commitment to collaborate with CMA's proposed Regional Extension Center Application in California to support Northern California's priority primary care providers in achieving "meaningful use" of certified electronic medical record technology.

-California Physician Performance Initiative (CPPI) communication to physicians notifying them of preliminary scores on a series of quality measures. (Contracts with Anthem, BX, BS or UnitedHealth PPOs or with Anthem BX or BS HMOs from 2007-08) Several physicians tossed the information without reviewing the accuracy of the data. Several members called for assistance in getting their BQID Number to check the accuracy of the information prior to the deadline to make any request for corrections.

-Congratulatory letter and Re-Invitation to membership sent to local physician who is a recipient of the Steven Thompson Loan Repayment Program.

-Update was presented on the Physician Recruitment Video along with the links to preview the rough cuts.

-Updates on Committee activities was presented, highlighting the following:

Consortium for CME - Dr. Cobb is now the CMA rep-

resentative on the IMQ-CME Committee.

Editorial and Publications Committee - encourage review and vote on the cover for the 2010 Physician Membership Resource Directory. Feedback will also be requested from members attending the Annual Membership Meeting in December.

Physician Well Being Committee - updated brochures for the Physician Well Being Committee have been reproduced and distributed to all physicians and Hospital Medical Staffs. The brochure is also posted to the Medical Society's website in the Members Only section.

Public Service and Medical Ethics Committee - reported 2 current reviews in process and 2 complaint forms mailed out.

TREASURER REPORT was presented. Reported that 2010 dues are coming in. Mentioned that a budget committee meeting is in the process of being scheduled. Strongly encouraged peer-to-peer recruitment of non-members!

LEGISLATIVE UPDATE - Dr. Cobb reported on Dustin Corcoran's 2009 Legislative Wrap-Up that was distributed to the Executive Board. The overview will be republished in the November Bulletin.

MEMBERSHIP COMMITTEE REPORT was presented by Dr. McCaffrey. Coming, Going and Moving Around report was included in the Consent Calendar. Member communications were provided to the Executive Board for review.

REPORTED working with CMA Legal on a letter to the Medical Board of California and the Chiropractic Licensing Board on inappropriate advertising that is being published in our local newspapers by one of the local Chiropractors along with misleading patient handout materials.

M/S/C to approve the following applicants for membership:

- Ellen Dar, M.D., EM, Fortuna
- Ali Gamini, M.D., IM, Eureka (EIM)
- Sandra Hare, M.D., IM, Eureka (EIM)
- Cassandra Kennedy, M.D., GS, Fortuna
- Gurudarshan Khalsa, M.D., FM, UIHS, Arcata (*Gov. Empl.*)
- Antoinette Martinez, M.D., OBG, UIHS, Arcata (*Gov. Empl.*)
- Gita Meshri, D.O., OB-GYN, Eureka
- Paul Stauffer, M.D., GS, Fortuna

There being no further business, the meeting was adjourned at 9:30 P.M. §

CLASSIFIED ADVERTISEMENTS

JOB OPPORTUNITIES

Also refer to Practice Opportunities on our website
www.hdncms.org

PRACTICE EXPANSION. Accepting psychiatric referrals for adults - as well as children and adolescents. Additional hours for inpatient consultations. Contact Dr. Soper's office (707) 445-4705, fax: (707) 445-0581 or e-mail to: sopermd@humboldt1.com

FAMILY PHYSICIAN - will work for medical coverage. Due to retired status and malpractice restrictions for tail coverage, an administrative position is desired. 1 month's employment will allow reactivation of COBRA until I hit 65. Work need not be medically related. Contact Scott Sattler, M.D. 443-8183

PSYCHIATRIST NEEDED For County of Humboldt.

The incumbent will provide psychiatric diagnostic and therapeutic services in a variety of inpatient and outpatient settings. The Psychiatrist will perform psychiatric evaluations, develop treatment plans, monitor medications, provide consultations, perform conservatorship and forensic evaluations and provide expert witness court testimony and consultation to various child and adult service programs and agencies.

Must possess a valid license to practice medicine in the State of California.

Must possess Board eligibility or certification as a Psychiatrist as defined by the American Board of Psychiatry and Neurology or the American Osteopathic Board of Neurology and Psychiatry. Must possess a valid California driver's license.

Initial salary is between \$206,050 - \$227,656 annually

Apply online at www.co.humboldt.ca.us/jobs and view complete description with benefits.

FAMILY MEDICINE PHYSICIAN NEEDED to join established practice in Fortuna, CA. Would consider some locum work while considering relocation to our area. If interested please contact: Mary Moriarty, Office Manager, e-mail: Loletamary1@aol.com, (707) 725-3318. (PO)

OB-GYN NEEDED for very busy established practice. Total Women's Health including IVF. 4-D OB Ultrasound Machine, Dexa Scanner, Advanced GYN Surgery, High Risk OB, etc. Potential for expanding practice and services. Contact Kim Pfanensteil, Office Manager, (707) 445-3443. (www.stokesmd.com) (DS)

FULL OR PART TIME PHYSICIAN OR MIDLEVEL OPPORTUNITY. Mobile Medical Office is looking for a full or part-time. physician or Nurse Practitioner to join our staff. We are a non-profit mobile clinic which brings healthcare to the underserved in Humboldt County. Contact Wendy Ring, M.D. at (707) 498-6183 or wring@mobilemed.org for details. (WR)

WANTED - FAMILY PRACTICE PHYSICIAN Full or part time. Aviation Medical Examiner preferred. Contact George Jutila, M.D., 725-3334 or home.md@suddenlink.net (GJ)

URGENT CARE CLINIC: North Coast Emergency Physicians Group is looking for Family Practice Physicians interested in part time work in the new St. Joseph Hospital Urgent Care Clinic. Malpractice insurance is paid through the Group. Please contact Ronald Cordova, MD, Managing Partner for North Coast Emergency Physicians at (707) 616-7435 if you are interested. (RC)

PROPERTY FOR SALE / RENT /LEASE

EXECUTIVE / VACATION RENTAL 2 Bedroom, 2 Bath newly remodeled home on quiet street in Henderson Center. See Details at www.vrbo.com/208351 Contact Jim at 707-845-3908

2 MEDICAL OFFICES FOR LEASE. 2504 Harrison Avenue, Eureka, CA. 1688 sq. ft. & 1326 sq. ft. Can be seen by appointment. Phone 530-755-1354 / 916-261-8088.

FOR SALE Prime Central Ave. McKinleyville Location Currently Lima's Pharmacy. Real estate only for sale (Lima's Is expanding to new site) 2 separate legal parcels under 1 roof. Lots of parking, ideal medical or professional office use. Only \$345,000 Northbay Realty 707-599-7962

FOR LEASE: Professional / medical office space near Mad River Hospital. Build to suit in new Planned Unit Development. 850 sq. ft. available now. Contact Mark Jones, 707-616-4416 or e-mail: Jones202@suddenlink.net .

Display Advertising Rate Schedule

SIZE	MONTHLY	SIZE
1/4 Page	\$120.00	7.45" x 2.61"
1/2 Page	\$140.00	7.45" x 5.23"
1/3 Page Vertical	\$130.00	2.37" x 9.95"
Full Page	\$170.00	7.45" x 9.95"
Inside Cover/Full Page	\$240.00	7.90" x 10.40"
Business Card Ad	\$60.00	Copy Ready 2" x 3.5"

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