

THE BULLETIN

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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)

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Should I Trust the Government (Deference to Roger Waters) HAL GROTKE, M.D.



Statutory laws and regulations have been hard on us, to say nothing of case law. Thanks to Medicare, if we choose to provide medical care for people over 65 years old, or with permanent disability, we must submit bills electronically. Of course, most of us have people for that, but we still do it by extension. Thanks to HIPPA we can no longer tell a spouse, without specific permission from a patient, that a patient has herpes simplex virus infection. Thanks to new regulation from California Department of Managed Healthcare, if we cannot offer an appointment to a patient in a prescribed timeframe we may have civil liability. And thanks to MICRA if our doctor harms us with some egregious neglect we are severely limited in how much we can be compensated financially. (I include that last one a bit tongue in cheek.)

All of those laws and regulations, with the possible exception of electronic billing, exist because of large scale and repeated failure to do the right thing. None of those laws and regulations work entirely the way they were intended anyway. The greatest failure of those specific laws, to my knowledge, is the second P in HIPPA. Although there is now a federal mandate for COBRA coverage for people leaving a job at which they were lucky enough to have employer provided health insurance there is no regulation of premiums. Very few recently unemployed people can afford to buy such coverage. As for the new California regulation regarding timely access, the loophole for doctors is that we can simply document why we think the patient is unharmed by delay. The much bigger loophole for insurance companies is that they are not the ones being regulated. If there is an insured per-

son in the area who needs to be seen it doesn't matter that the insurance company pays so little that no doctor is willing to see a patient with that insurance. This regulation only applies to patients with insurance specifically regulated by DMHC and to physicians who contract with such health plans. As far as that regulation is concerned we can still delay indefinitely scheduling patients who are uninsured or have indemnity coverage such as Medicare without a managed care supplement.

I was just looking over CMA's table of recent and pending regulations on which they/we (we are CMA, right?) are taking a position. CMA supported the timely access regulation. CMA is opposing a regulation that would allow chiropractors to perform manipulation under anesthesia with a patient anesthetized by a physician or anesthesiologist. I really don't know what chiropractors do or whether it would be safe for them to do that with an anesthetized patient. I would like to think that individual anesthesiologists could decide whether to anesthetize a patient for the purpose of chiropractic manipulation. CMA is also opposing a regulation that would allow optometrists to treat glaucoma medically. There certainly are risks inherent in using medication for glaucoma, probably greater than the risk of using glasses or contacts. I would like to think that individual optometrists could use professional judgment about when or whether to treat. I certainly hope that they would make appropriate decisions in the care of their patients just as I hope that all physicians always make appropriate decisions. CMA is currently suing the governor for making an executive order allowing nurse anesthetists to practice with less phy-

sician supervision than is currently required. If that executive order is illegal it certainly should be repealed. Nurse anesthetists should choose to practice within their capabilities as well as within the law.

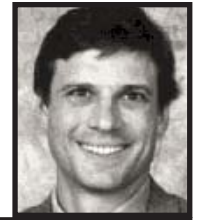
On a much broader scale SB 810 is probably going to come to a vote soon if not already by press time. If it passes and if it becomes law it will provide legal framework for creating single payer universal health care coverage plan for the state. It will not create such a plan primarily because it would require a second law to fund such a plan. CMA is opposed to this bill although apparently they/we are not actively campaigning against it. The reason active opposition is soft is that the governor has promised to veto it as he did with the very similar SB 610 twice in the past. Even if he changes his mind and signs the bill, should it reach his desk, it is still extremely unlikely to be funded since any funding in our state requires a two thirds majority vote in both houses. A few months ago CMA's chief lobbyist (since promoted) told us at our annual meeting that when we have a governor who likely would sign such a bill that it would not have votes to get out of the legislature. Currently, there apparently are conservative Democrats willing to vote for it knowing that it will be vetoed. They can tell their Democratic constituents that they supported health care reform when it was a dead issue. If it were to become a real issue they would vote their conservative beliefs rather than their party platform.

Just the other day US Senator Reid said he would fight for a public option in federal healthcare reform. That came weeks

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The Top Five List

LEE LEER, M.D.



Early in 2009, members of major health care–related industries such as insurance companies, pharmaceutical manufacturers, medical device makers, and hospitals all agreed to forgo some future profits to show support for the Obama administration’s healthcare reform efforts. Skeptics have questioned the value of these promises, regarding at least some of them as more cosmetic than substantive. Nonetheless, these industries made a gesture and scored some public relations points.

The medical profession’s reaction has been quite different. Although major professional organizations have endorsed various reform measures, no promises have been made in terms of cutting any future medical costs. Indeed, in some cases, physician support has been made contingent on promises that physicians’ income would not be negatively affected by reform.

The above quotation comes from what I’ve found to be one of the most potentially important essays published in the *New England Journal of Medicine* since I began reading it in the 1980’s.

The title of said essay is: *Medicine’s Ethical Responsibility for Healthcare Reform – the Top Five List*, by Howard Brody, M.D., Ph.D (<http://healthcarereform.nejm.org/?p=2616&query=TOC>). Dr. Brody makes the argument that we physicians have not exactly lived up to our promise to put our

patients first. Rather than leading on healthcare reform, we appear to be more concerned about making sure that no Federal committee is ever in a position to comment on physician payment reform. We appear to be more interested in making sure that we get paid two and three hundred percent more than the Medicare allowed fee for our services (the “we’re special” argument?). Based upon what we now know about regional variations in healthcare provision, at least one-third of health-related costs could be eliminated simply by having physicians in high cost areas order tests and procedures at a rate ordered by physicians in low cost areas. Yet ALL of our professional organizations are mute on this subject. The AMA’s single suggestion to help with cost containment is tort reform!

While many physicians have shown themselves capable of carving out and expanding economic niches that contribute to said regional variation, I daresay history will be kindest to those visionary physicians who instead devote their energies to looking beyond their own interests. Dr. Brody proposes just such a model. And I believe we in Humboldt County are particularly positioned to be able to enact it.

Dr. Brody boldly suggests that each of our specialty societies convene a blue-ribbon panel that proposes five items, either tests ordered or procedures done, that we over-utilize, and that can be reduced in frequency if not eliminated without impairing health of our communities. Further, Dr. Brody is a primary care specialist. While he recognizes that primary care specialists have always gotten the short end of the financial stick, he suggests that we too can

and should generate such a list.

Imagine if we were to do such a thing in a big public fashion. Sure, it should raise the obvious question from the lay public: “If you can stop doing those things without hurting us, why are you doing them now?” This would be an entirely fair question. And somewhat embarrassing to us. But we’re good at explaining complex concepts in easily understood ways, and I’m sure we can get past that obvious hiccup.

To our disadvantage, we don’t locally have biostatisticians, epidemiologists, and experts in evidence based medicine with which to populate our panels. However, to our advantage, we do have a tight knit, sophisticated medical community that is uniquely positioned to make a difference for the population we serve. Thus, in the spirit of Dr. Brody’s recommendation, I’ve come up with far more than 5 tests and procedures that we primary care physicians are responsible for, and which we can order/do far fewer of. Of note, these are only to be taken as somewhat off the cuff examples and conversation-starters, and represent my opinion and experience only.

- 1) Vitamin D levels. All the rage currently. Essentially no long-term data on population effects of high replacement doses in otherwise healthy people. Yet testing for and treatment of “deficiency” has increased exponentially.
- 2) HbA1c’s in diabetics and every three month office visits: do we really need to see and monitor 85 year olds with HbA1c’s of 6.5% every 3 months? Of

“Opinion” Continued on page 17

The Editorial and Publications Committee encourages our member’s comments for publication. Please submit electronically prior to the 15th of the month preceding publication.

Insurance Death Spiral: What Comes Next?

STEPHEN KAMELGARN, M.D.



The latest brouhaha with Anthem and their “usurious” rate hikes illustrates, like nothing else possibly could, the “parlous” state of our health care in this country and just how seriously the entire system of health care delivery in the United States is broken. “Too many Americans are at the whim of private, for-profit insurance companies who are raking in billions in profits each year,” Kathleen Sebelius, Secretary of Health & Human Services, wrote on the White House blog. (*NY Times* 2/15/2010).

I’m seeing more and more patients who have no insurance at all, and consequently, are unable to have a lot of the tests, or purchase a lot of the medications they need to improve their health. A study released in early February by *Health Care for America*

Now (www.HealthCareforAmericaNow.org) found that the five largest health insurance companies collectively lost 2.7 million customers last year, including 1.4 million by WellPoint (the parent company of Anthem). Yet they reported record profits of \$12.2 billion. The people with insurance are paying higher and higher premiums, and this latest 39% increase (I know, delayed until May, but like the swallows returning to Capistrano, destined to happen), will probably force many of them to drop or significantly downgrade their current coverage. (That’s how the companies can lose customers and still show a profit.) Except for the insurance companies, the entire system seems to be on the brink of financial collapse. Uninsured patients can still go to the ER for episodic care, but if the ER’s see too many uninsured, they’ll go broke delivering non-reimbursed care. Physicians, for the most part, can’t afford to see uninsured pa-

tients, and the budgets of the clinics are being slashed so that their ability to handle the uninsured is becoming stretched. Yet, Health Insurers rake in record profits—something on the order of \$2.7 billion for Anthem alone, last year.

As I’ve written many times over the years, for the insurance system to work a whole lot of healthy people have to subsidize the minority of us who through bad luck, bad genes or bad choices (or natural aging) consume the bulk of the insurance dollars. As more and more people (Californians especially) are losing their jobs, and employer supplied health insurance, fewer and fewer people are able to afford the premiums. This forces the insurance companies to raise their premiums on their remaining customers, thereby forcing more people out of the insurance pool, entering what Paul Krugman has dubbed “The Death Spiral” (*NY Times* Feb 19, 2010). As he states: “Bear in mind that private health insurance only works if insurers can sell policies to both sick and healthy customers. If too many healthy people decide that they’d rather take their chances and remain uninsured, the risk pool deteriorates, forcing insurers to raise premiums. This, in turn, leads more healthy people to drop coverage, worsening the risk pool even further, and so on.”

This shouldn’t be a problem according to the Free Market boosters: more insurance companies will enter the market, driving the premiums down. However, California already has the most competitive insurance market in the US, and our health insurance premiums are climbing out of sight along with everyone else’s, and all of the insurance programs are entering into some phase of the Death Spiral. For private health insurance to survive in its current

form, they’re either going to have to have government subsidies or raise their premiums to the point where no one can afford them. (For my own part, I’d love to see all the companies go broke, and their CEO’s do jail time as felons for practicing medicine without a license, but I think a lot of the powers that be consider that an unacceptable alternative.)

Although this may not be what the Congressional Republicans envisaged when they unanimously decided to give a large resounding “NO” to any health care reform plan that was put on the table by the Congressional Democrats, and since the Democrats are too spineless to campaign for what is right, this is the situation we are left with. Congress is unwilling, or unable, to sit down and work out *something*—even a bad compromise is better than nothing—and the states are too broke to do any experimenting.

Since it seems as if our health care delivery system is imploding, and Nature abhors a vacuum, I dread to see what awaits us should this entire house of cards come crashing down without some plan in place to replace what we’ve got. It’s been reported that President Obama would release a comprehensive health bill before the bipartisan summit scheduled for Feb 25, 2010 (long before this issue of *The Bulletin* has gone to press). But, if it goes as well as the previous proposals over the past year, nothing will change; the Republicans will still obstruct with a unified voice, the Democrats will still take their majority and hide and cower, and the system will continue its inexorable decline into bankruptcy and chaos.§

Insurance Companies Steal Health Care from Babies

EMILY DALTON, M.D.



Eureka Pediatrics, the oldest and largest pediatric practice in the Humboldt and Del Norte counties, is planning to stop accepting Anthem Healthy Families insurance next month, and this will impact about 1800 local children. Healthy Families is a government funded program that is supposed to provide medical insurance to low income children, and the Anthem product is the largest in our area. Recently Anthem split off the healthy families population into a separate group that does not have access to the same network of providers as the prudent buyer clients. The new panel of providers is expected to accept a drastically reduced fee schedule that is insufficient. Why should those of us who do the work of providing the care take a huge financial hit while Wellpoint (Anthem's parent company) rakes in record profits? The recent congressional hearings highlighted the large profits that insurance companies are making at the expense of the patients they insure.

Consider these points:

1. Tax dollars go to fund this program
 2. That money is given to Anthem Blue Cross, who " shipped \$4.5 billion in profit to its parent company WellPoint Inc. since 2004"-(CMA In the News 2/23/10)
 3. Anthem collects premiums from the patients as well
 4. Patients don't get medical treatment because they can't find a doctor.
 5. Government agencies do little to hold Anthem accountable.
 6. Anthem spends too little on medical expenses, and keeps more as profit.
- Is this how we want to deliver medical care to low income children? Who speaks

for the kids? Where is the Department of Managed Health Care? Anthem Healthy Families was entrusted by our lawmakers to deliver health care to the low income children in California, and they are not doing so. These children are vulnerable, and denying them services is as easy as stealing candy from a baby.

I went on the Anthem website called provider finder: (Go to: Anthem Blue Cross @ <http://www.anthem.com/ca/> to "Find a Doctor" to Local California Providers to New Member/Visitor Search to search the physician list) and under the state sponsored Healthy Families EPO this is what I found:

Of "155" providers near the 95503 zip code, one is dead, 17 moved away, 4 are retired, and 7 are locum tenens. There are numerous duplicate and even triplicate entries, and each one is counted separately. The count is also falsely increased by listing both the name of the doctor, and the name of the practice, and counting each as a separate entity. For example, Dr Cody is listed 4 times and counted as 4 providers. (Actually, if you know him this could be accurate!) There were so many mistaken addresses that I lost count. I tried to find an Ear, Nose, and Throat specialist, and it lists a doctor who has been retired for over two years! And this website claims to be updated as of 2/4/10.

I then did a search to see what the pediatric resources for the Eureka area. The list includes "26" doctors doing pediatrics in a 20 mile radius around the 95501 area, but when you remove the duplicate, bogus and inaccurate entries there are really only 14 listings that are legitimate. Even then, three of the doctors listed do not accept

Anthem HF and they have asked Anthem to remove them from the website without success. So, strike that total down to 11, and if Eureka Pediatrics drops, down to 6. I doubt the 6 physicians who are left will be in a position to take on this flood of children, and I worry that they will lose access to medical care.

The final problem for these families is that even if these "insured patients" wanted to see a doctor who does not accept healthy families and just pay for it, they cannot. Any billing, balanced or otherwise, of these patients is illegal under state law. The need for Anthem to provide an adequate network is critical precisely because it is *not* legal for patients to pay for care outside the network. And if there is no network, they are really stuck. It seems absurd to offer these vulnerable children a insurance product that hinders their ability to access care, and only covers emergency services. The point of good health coverage should be to provide a medical home, access to preventative services, and and be able to access care before the illness escalates into an emergency.


Who speaks for the kids? §

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Osteopathic Survey of Somatic Dysfunction and Zink Compensatory Patterns in Sololá, Guatemala

KATE McCaffrey, D.O.



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Background: There is a paucity of research done in developing countries on J. Gordon Zink, DO's model of compensatory patterns of fascial restriction and ease. The Compensatory Pattern is assessed in a supine patient by noting ease of rotation at the following four junctions: craniocervical, cervicothoracic, thoracolumbar, and lumbosacral. The Common Compensatory Pattern has been Left/Right/Left/Right (LRLR). Is the "common" compensatory pattern truly common to all humans or is it an artifact of the lifestyle in industrialized countries? In Sololá, Guatemala, the pre-existing cultural category for a group of healers known as *sobadores* (bone-setters) made Sololá an ideal place for this study, where osteopathic manipulative medicine (OMM) was culturally well received by the community.

Objective: To survey Zink Compensatory Patterns among the Maya men and women in Sololá, Guatemala.

Materials and Methods: Patients were screened for musculoskeletal and visceral problems and referred to the OMM clinic by the physician at a local primary care clinic. Forty patients (30 female, 10 male) participated in the study. Verbal and/or written consent was obtained from all participants. Translation was provided as needed. Four TUCOM students, who had completed

their first year of osteopathic medical education and had received additional training in Zink screening by faculty, performed an osteopathic structural exam using standard OMM tables. Results were noted on a Zink Fascial Screening Exam form developed by John C. Glover, DO, FAAO.

Results: Zink fascial screening data demonstrated a wide range of fascial strain patterns. Of our 40 patients, 26% had an LRLR compensatory pattern (the "common" pattern seen in prior research) and 6% had a RLRL compensatory pattern. Furthermore, 69% of all patients showed right rotational fascial preference at the cervicothoracic junction, 46% of whom had a left rotated compensatory pattern at their occipitoatlantal and thoracolumbar junctions.

tions.

Conclusion: The Common Compensatory Pattern of LRLR was the most consistently noted pattern among the Maya in Sololá, Guatemala. The wide variation noted in Zink patterns may actually represent the population studied, or be an artifact related to small n and intra-examiner reliability. Documentation of examiner reliability during the study, as well as prior to, should be included in future research. This study has been approved in its entirety by the TUCOM IRB Committee. §

*Published in the Journal of the American Osteopathic Association, January 2010.
Http://www.jaoa.org/cgi/content/full/110/1/24. Abstract number S18.*

OFFICE MANAGER NETWORKING MEETINGS

EUREKA: Professional Healthcare Managers Group
(an independent networking Group)

3rd Wednesday each month @ 8:30 A.M.
Foundation Conference Room
Contact: Reggi, 443-9577

Meetings: 3/17 * 4/21 * 5/19

HDN Foundation for Medical Care is hosting the following Office Manager networking meetings:

Contact: Rose Gale, 443-4563 rgale@hdnfm.com

ARCATA: 1st Thursday of each month 12:15 - 1:15 pm
Quality Inn meeting room,
3535 Janes Rd, Arcata

FORTUNA: 3rd Thursday of each month 12:15 - 1:15 pm
Redwood Memorial Hosp., Marion Room



ANN LINDSAY, M.D.
Humboldt County Public Health Officer

CDC reports that obesity rate has held steady for the past five years

According to data from the Centers for Disease Control and Prevention the national obesity rate has held steady for the past five years. The new data are based on health surveys involving height and weight measurements of 5,700 adults and 4,000 children. The results show 68 percent of adults are overweight, with African American having the highest rates of obesity, followed by Hispanics and Whites. About one-third of children aged 2 to 19 were overweight, with the percentage of extremely obese children steadily increasing. For more information please visit: <http://jama.ama-assn.org/cgi/content/abstract/303/3/235> (adult rates) and <http://jama.ama-assn.org/cgi/content/abstract/303/3/242> (children and adolescents). We have yet to see the leveling off trend in Humboldt County.

Please keep offering H1N1 vaccine to all patients over 6 months of age, and don't forget Pneumococcal vaccine!

Incidence of H1N1 influenza is waning in Humboldt County and across the county. The possibility of a "third wave" of infection remains, although it could be this spring or next fall. Although it is hard to tell for sure, it seems like 1/3 of Humboldt's population may have gotten H1N1 vaccine in recent months. Good job, and thank you! CDC estimates that 20% of the population nation-wide has been vaccinated against H1N1. High vaccination rates could significantly lessen the impact of subsequent H1N1 activity, improving "herd immunity". Therefore, **I urge clinicians to bring up the subject of H1N1 vaccine with every patient, encouraging it, or ask your intake staff to do so.** Surveys have shown

that there are still people out there who would accept vaccination, particularly if encouraged by their medical practitioner. Seniors, especially, have shown high rates of acceptance of H1N1 vaccine, and may be under the impression that they are not eligible because we had previously restricted vaccination to high risk groups. Those over 65 are less likely to succumb to H1N1, but are more likely to get seriously ill. We are offering H1N1 vaccine free at the public health clinic, 529 I St in Eureka, although people should call ahead for times (445 6200). Public Health will send a team of vaccinators to any community setting (i.e.

workplace, church, etc) with 20 or more people interested in vaccine. We also have more vaccine for providers. (Call Earleen Bean-Sasser 268 2198) Don't forget to immunize patients against invasive pneumococcal disease, a significant contributor to influenza-related deaths. Pneumococcal Polysaccharide Vaccine should be given to all adults 65 years of age or older and persons 2 years of age or older with chronic illness (including diabetes and alcoholism), anatomic or functional asplenia, immunocompromise, HIV infection, cochlear implant. §

BLOOD BANK AUDIO CONFERENCE

The Northern California Community Blood Bank is again pleased to announce its participation the education programs offered through the AABB Audio-Conference program. The programs are available free to the medical community and offer continuing education credit for physicians (1.5 CME contact hours), nurses (1.8 CE contact hours), and medical technologists (1.5 CE contact hours). Certificates of attendance are also available for others in attendance. Audio-conferences that would be of interest to the medical community are listed below.

All audio-conferences are scheduled from 11:00 a.m. - 12:30 p.m. in NCCBB conference room. Please call at least a day ahead to reserve a space for any audio-conference you wish to attend. *Hope to see you there!*

- **Wed. April 28, 2010 Update on Platelet Transfusions**
- **Wed. July 14, 2010 Hot Topics in Transfusion Medicine**

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Dr. Hunter: 441-1624 * Dr. T. Dennis: 725-6101

Dr. Frugoni: 825-5000 * Dr. Fratkin: 496-6846 * Dr. Rehwaltd: 464-3513

Or contact a physician through CMA at **650/756-7787**

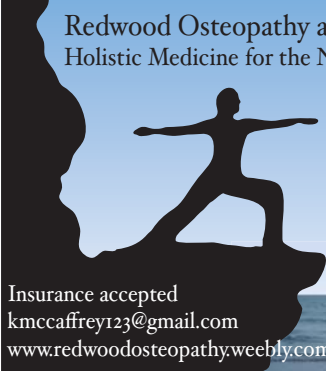
"President" Continued from page 2

after the bill from his house of Congress did not contain a public option. I don't know if he can get a more robust bill now than he could a few weeks ago just because a new bill would come out of conference committee. Last month I wrote that I thought federal healthcare reform was dead because of the loss of the Democratic supermajority. The emails I get from MoveOn and Physicians for a National Health Program indicate that those organizations also think that federal reform is dead. By the way, CMA supported the bill from the House of Representatives that included a public option but separated out the repeal of the Medicare Sustainable Growth Rate. CMA did not support the Senate bill that did not include a public option but did include the SGR fix. Go figure. My personal belief is that the problem with the public option is the option part, but I think the public option would

be a small step in the right direction. I think that if we had a single payer system that was truly singular that SGR would be moot. If the government was the only entity that paid us and if the government were going to pay us an unsustainable rate we would all have to find another way to make a living.

Besides the insight into the future of SB 810, the other big lesson for me from the then chief CMA lobbyist at our December meeting was the prediction that there

will have to be complete collapse of the health care "system" before there will be meaningful reform. In the meantime I will continue to provide the best possible care for whatever patient happens to be sitting in front of me in my exam room at any given moment. Taking care of patients would be much easier without money and regulation. How did we get into this mess in the first place? §



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Saturday 9-12

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“Opinion” Continued from page 3

course not. I hope I’m not the only one who has found himself doing this!

3) Nephropathy testing in diabetics without evidence of renal disease who are on maximum doses of ACE/ARB treatment. Ditto above.

4) DEXA scans. Remember: except for special cases, not indicated until age 65 for women and there’s no proven benefit to repeating DEXA’s after initiating bisphosphonate treatment.

5) Liquid nitrogen to actinic keratoses – certainly one of the areas where I personally help to drive up costs, but it’s so easy to give in to patient concerns (and improve remuneration!) than to explain that the increased risk from most AK’s is truly immeasurable.

6) MRI’s for back/knee/shoulder pain. So much easier than explaining the natural history of sciatica/osteoarthritis/frozen shoulder syndrome.

7) Ordering abdominal CT’s following every “probable” hepatic or renal cyst

found on ultrasound. So much easier than using good clinical judgment, not to mention common sense.

8) Annual PSA’s.

9) Annual pap smears.

10) Pap smears in women who have had total hysterectomies (I don’t make this stuff up, I’ve seen it too often to count).

11) Use of brand name pharmaceuticals when equivalent generics are available.

12) Head CT’s/MRI’s for benign headache without neurologic deficit.

13) Signing off on EVERYTHING that home health agencies tell us they’re doing/have done/want to do. I’m as big an offender here as anyone reading this. However, as I read the order sheets that come from the home health agencies, and which include costly items that Medicare won’t pay for until I put my license on the line (original signature only, please!) many things I’m requested to order sound dubious at best.

I’ll stop the list here not because I can’t think of anything else, but because this is too much fun, and I’d like to leave some options out there for you all to think of.

If we Humboldt and Del Norte county physicians really care about reform and really care about helping to cut down on costs, then I challenge us to do the following:

Through the IPA (which comes closest to being the local organization that (1) almost all of us belong to, (2) is motivated by quality and science, and (3) has some potential to motivate behavior change) each specialty convene a committee of 5-7 individuals. Over the next 4-6 months, these committees each come up with a *Top 5 (or more) List* specific to their specialty. These lists would then be voted on by the membership – an up or down vote, no micro-management. If passed, we could then devote our energies over the next year to educating our membership on alternative effective practice strategies and making these suggestions a reality.

No, it’s not going to solve the nation’s healthcare problems, but would indeed be meaningful on a local level. I’m optimistic that we can do this, but somewhat pessimistic that we will. Should things play out in the optimistic direction, I stand ready to serve on the primary care specialty committee, and look forward to seeing the recommendations from committees representing all the other major specialties.§



SUBJECTS NEEDED

Intraductal Therapy of DCIS: A PreSurgery Trial

We are seeking 30 women newly diagnosed with DCIS on core biopsy (stereotactic, Mammotome, or ultrasound-guided vacuum-assisted techniques).

For details, please call 707-476-0690.

Sponsored by: Dr. Susan Love Research Foundation and the CA Breast Cancer Research Program

February 22, 2010

The meeting was called to order by President, Hal Grotke, M.D. at 7:10 P.M.

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

-Minutes of the January 18, 2010 Executive Board Meeting, as presented.

- Physician Coming/Going Grid, to file.
- Budget Committee Meeting (1/22/10), as presented.
- Editorial and Publications Committee (12/9/09), as presented.
- Medical Quality Review Committee (1/20/10), as presented.
- Annual Membership Meeting Minutes (12/09), as presented.
- Practice Management Seminar Flyer
- Physician Well Being Committee (2/9/10), as presented.
- Regulation Quick List (CMA), to file.
- Info. Candidates for Senate Seat, to file.
- AMA Joint Letter with AARP re: SGR, to file.
- Letter to CMA RE: Timely Access Press Rel., to file.

DISCUSSION followed regarding the CMA and California Primary Care Association being the recipients of two Cal Rec Grants (Northern and Southern California) to work with physicians on Electronic Health Record systems and work towards "meaningful use". Shared copy of powerpoint presentation and the draft LEC and Service Provider Criteria. Mentioned that the local HDN IPA and the North Coast Clinics Network both indicated interest in working with CalRec. Agreed that once a decision is made on who the LEC/Service Providers will be for Humboldt and Del Norte Counties that we assess the interest in helping to coordinate a local meeting for our members.

REVIEW, DISCUSSION AND APPROVAL of the Membership Policies and Editorial and Publication Committee Policies followed. The following sections were added as follows:

NEW: 11. MEMBER PUBLIC SERVICE ANNOUNCEMENTS (PSA'S)

Members wishing to publish an announcement that they feel may provide interest to our target audience (ie: other physicians), are welcome to submit a ½ page or less for publication. It will be published at the discretion of the Editorial and Publications Committee. Examples include: announcements for physician and/or public lectures. If possible, the PSA will run in the month preceding the event date. Announcements will be limited to one month at no charge. Subsequent months, standard advertising rates will apply.

12. MEMBER USE OF MEDICAL SOCIETY COMMUNICATION TOOLS

ADD: 4. Anything other than practice-related announcements will be reviewed by our Legislative Chairperson and/or local CMA representatives.

The following revision was made to the Policy on Acceptance of Materials for Publication:

ADD: The Editorial and Publications Committee reserves the right to withhold any submission if they deem the submission to be inappropriate.

WEBSITE:

NEW: LOCAL BUSINESS LINKS TO WEBSITE.

Business that regularly support our publications with advertising revenue (with minimum of \$250.00/year in advertising) can request that their business websites be linked to the Medical Society website at no additional charge.

EXECUTIVE DIRECTOR UPDATE followed:

-reported 2010 Physician Membership Resource Directories should be available any day and will be delivered asap. Residence Directories will go out this week.

-brief update re: attending the recent Annual Medical Executive Retreat in Sacramento.

-shared a copy of the new CMA Membership Sticker.

-reported working with the CMA Taskforce on PECOS and coordinating member communications.

-forwarded communication from physician interested in relocating to area.

-reported forwarding of information to Members and Office Managers re:

-proposed Rules on Meaningful Use for EHR Technology.

-Medicare Update re: Medicare Participating and Non-Participating Options.

-Recruitment Video and Website now complete! Shared Recruitment Postcard directing potential recruits to website.

-Survey and information re: Medical Waste Disposal options for our area. Shared results with Office Managers for office follow-up.

-Welcome notice for Dr. Rubio forwarded.

-"Everything Physicians Need To Know About Their Practice" Seminar scheduled for March 24th. Seminar will go over Best Practices Toolkit as well.

-reported scheduling appt with candidates for Senate seats. Once scheduled the Exec Board will be notified.

-NORCAL Community Involvement Fund Grant applications are solicited for the 2010 grant cycle. Requests to send

Continued on next page

application information have come in for: Humboldt Breast Health Project; Planned Parenthood; Needle Exchange (Mobile Medical) Applications will be reviewed for decision at the March meeting.

-reported that the annual CME Reports, Letters and Statements have been sent for 2009/2010.

-reported on calls received requesting information re: Attorney consults on Workers Comp; Answering Service options; Terminating Patient-Physician Relationship; Billing for Missed Appointments; etc.

-shared the CMA Charter Certificate that is now posted in the Board Room.

-reported getting a lot of calls from local offices regarding the Blue Cross Healthy Families and the revisions to their contract. Information has been forwarded to CMA. Also reviewed the inaccuracies of the provider list that is posted on the Blue Cross website and forwarded to CMA for their discussion with Blue Cross.

COMMITTEE UPDATES were presented.

HEALTH DEPARTMENT UPDATE was presented in writing, as follows:

1. Although H1N1 activity is low, we are requesting that medical practices actively encourage all patients over 6 months of age to be vaccinated to protect the community and themselves against a possible upsurge in activity. PH can send out immunization teams to any business or other group that can gather 10 or more people to be vaccinated for free. PH Clinic is offering free H1N1 vaccination: 529 I St Eureka 445-6200 call ahead for info. Interestingly, there is virtually no other flu circulating this season so far.

2. Support is requested for AB1701 (Chesbro) that would extend the sunset on prior legislation that authorized Counties to permit pharmacies to sell 10 syringes at a time to intravenous drug users. Since needle exchange was severely limited with closure of programs 7,2009, Humboldt County PH is working actively with local pharmacies, with 7 participating and more interested.

3. I am going to the National Association of Counties meeting in Washington DC March 7 with Supervisor Mark Lovelace to present the Health Impact Assessment that was done on the General Plan Update.

DISTRICT X TRUSTEE UPDATE was submitted by Trustees, Mark Davis, M.D. and James Bronk, M.D. and will be republished in *The Bulletin*.

DEL NORTE DISTRICT UPDATE was submitted by Mark Davis, M.D., as follows:

-will be presenting the Recruitment Website, videos and postcard at the upcoming meeting of the Del Norte Physician Recruitment and Retention Committee.

TREASURER REPORT followed. Dr. Mastroni reported that he will be meeting with Penny next week to review the 2009 year end and proposed budget for 2010. 2009 Non-Profit Tax Return was available for review.

LEGISLATIVE UPDATE.

-shared a copy of the recent CMA Federal Update that came in earlier today. Agreed to forward onto Executive Board distribution list.

-communication received from CMA Government Relations encouraging component medical societies to help monitor City and County Agendas for discussions of Legislative bills affecting the practice of medicine.

MEMBERSHIP COMMITTEE REPORT was presented.

-shared a list of members who have not yet renewed for 2010. Strongly encouraged peer-to-peer contact with these members to encourage them to renew their membership.

TOURO UNIVERSITY UPDATE. Reported that Touro University will no longer have a local Director of Medical Education. All contacts will go directly through Dr. Pera at the University. Mentioned that there will still be students rotating through this next year.

REPORTED Drs. Ellis and Kinsley attended the NORCAN "Introduction to Board Service" Workshop recently. Although most of the meeting was directed to 501 C 3 non-profit organizations, both felt that the workshop was beneficial. Drs. Ellis and Mastroni agreed to check into options for grant funding to help support some of our activities, i.e. our website and the possibility of adding a Doctor Finder, etc.

REPORTED that the meeting date for the 2010 Annual Meeting has been changed to December 2, 2010 due to conflicts on December 9th.

SHARED information from CMA on the CMA Testimony given on Discount Health Plans. Information will be forwarded to the Executive Board for information.

REPORTED on the following CMA Meetings and inquired regarding plans for attendance:

-CMA Leadership Academy, San Diego, April 9 - 11, 2010.

-CMA Legislative Day in Sacramento, April 27, 2010.

M/S/C to welcome and approve applicant for membership:

-Cherrie Andersen, M.D., OBG - Center Women's Health

The meeting was adjourned at 8:30 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 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 Terri Clark at (707) 443-4666x22 or tclark@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 Angela Curran, Office Manager for North Coast Emergency Physicians at (707) 269-4250 if you are interested. (RC)

FOR SALE

FOR SALE. Used Ritter 307 Exam Table. Good working condition. Custom mounted on wheels. Contact Sarah Kerr by e-mail at sarahk@srpp.org. \$1,000. OBO.

FIREWOOD FOR SALE. Deliveries between McKinleyville and Fortuna. Call Lee @ (707) 499-2805.

PROPERTY FOR SALE / RENT /LEASE

FOR LEASE: Henderson Center Office Space for Lease. Waiting room, reception area, office, lab, three exam rooms. Beautiful, peaceful location with good parking. 1200 square feet. Lovely garden. Available August. 677-0490. (MB 03-10)

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 LEASE: Join our new professional medical facilities near Mad River Hospital. Build to suit in new Planned Unit Development. 1200 - 4000 sq. ft. spaces. Contact Mark , 707-616-4416 or e-mail: Jones202@suddenlink.net.

FOR LEASE OR SALE: 1551 Nursery Way, McKinleyville. 1,596 or 1,920 sq. foot unit(s), adjustable finishes and floor plan. Ample parking next to Dialysis Center and Timber Ridge at McKinleyville. Pictures at www.danco-group.com or call 707-822-0826 for showing.

MEDICAL OFFICE SPACE AVAILABLE in Fortuna. 3-4,000 square feet. Contact Nina Escobar, (707) 725-8770. (JG 02-10)

<p>Display Advertising Rate Schedule</p>	<u>SIZE</u>	<u>MONTHLY</u>	<u>SIZE</u>	<p><u>DEADLINE:</u> <u>15th day of the</u> <u>preceding month to be</u> <u>published</u></p>
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	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"	
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