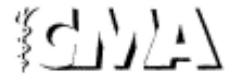




THE BULLETIN



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Who benefits? HAL GROTKE, M.D.

I'm writing this relatively early in the month. Penny wants to take some time off over the holidays and we are trying to get the January edition of *The Bulletin* ready for publication early. I don't know if there will be important news that will come to pass between now and the time that I usually write my monthly article. In the December *Bulletin* I made one prediction about which I am happy to say I was wrong. We will not need a retroactive SGR fix from the new Congress in January. We got a one year reprieve from cuts, albeit with no increase unlike the 6 month adjustment we got earlier in 2010. We don't have to fight that battle actively for another 11 months. That said, 2010 has been a monumental year in health care law at the federal level. I know you are all aware of that and I will not belabor it further.

A few years ago I attended some doctors' meeting in Eureka. I don't remember what the meeting was about but I remember that the conversation of the relatively large group turned to control of diabetes on the population level. A couple of ophthalmologists in the room commented enthusiastically about how they remembered a time that they would diagnose diabetes based on eye exams but that in recent years they had been seeing fewer patients with diabetic retinopathy. These were spontaneous remarks and the thankfulness that this serious disease was less common was obviously sincere. I assume that ophthalmologists could increase their income by treating more patients with this significant eye problem but to those in the room that was more than offset by seeing fewer sick patients. Some time later I attended the annual medical staff meeting

at St. Joe's. CEO Joe Mark delivered prepared comments about the financial health of the institution. He exclaimed how "productivity" at the hospital and its affiliated facilities was on the rise and how this was good for all. He appreciated that the doctors were delivering sick people to his doors.

Of course there will never be a shortage of sick people. The doctors will continue to admit patients to whatever hospital exists. Still, it seems most tragic to me that what is good for the hospital is in direct opposition to what is good for the patients. The physicians' goal remains to keep people relatively healthy. Sure, most of us still enjoy the intellectual stimulation of the "interesting" patient. That enjoyment is almost always tempered by our observation that interesting cases tend to have bad outcomes. The CEO doesn't have to look the patient and family in the eyes and let them know that the odds aren't good. The CEO never even has to meet the patient that we know is going to suffer and die.

The obvious converse argument is that many of the people who do get sick will benefit from having access to a hospital that is financially sound, humanely run and technologically appropriate. As such, I do think the physicians in the community have an obligation to act to make the local hospitals the best they can be.

On a recent evening I attended a fund raising dinner for State Assemblyperson Wes Chesbro. Mr. Chesbro's chief of staff asked me my opinion of the bill introduced by Mr. Chesbro that would allow some rural hospitals to employ physicians directly. The idea is that hospitals are large organizations that

are able to absorb the cost of starting a practice and allow for lifestyle options for the physicians. I was not prepared for the question and I gave a simple answer in opposition. I really want to find an opportunity to meet with Mr. Chesbro and describe to him the observations I describe above as illustration of why I think hospital employment of physicians runs a very high risk of doctors being encouraged and perhaps coerced to provide care that would – um – push the bounds of ethics. I did not have an opportunity to talk with the Assemblyperson directly.

At that same dinner I happened to sit next to County Supervisor Mark Lovelace. He and others at the table suggested that there should be a coordinated effort to recruit physicians to the area. I told them about the video (<http://www.youtube.com/watch?v=wFlz7yco02s>) and other existing efforts. I also mentioned to the people present the current financial issues facing the Medical Society. It is conceivable that we may be able to get county government involved in funding physician recruitment. With newly elected Supervisor Bass' recent tangential relationship with the medical community I think we may just be able to make this fly. I can't help but think that any money the county would spend on physician recruitment would be more than offset by tax revenue within the county, but I certainly am no accountant. I have not had opportunity to talk with anyone in detail about this yet but I will keep you posted.

The Medical Society's annual meeting and dinner at Baywood Country Club

Benefits, Cont. on Pg. 19

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

Are You Ready For Change?

EMILY DALTON, M.D.



Obama rode to victory on the platform of “Change”, which is a strange theme to win on because any sort of change, even change for the better, causes stress, which is uncomfortable and generally disliked. However, for Obama’s purposes, change was a winner. In the world of medicine we are experiencing dramatic change. The structure around us is in the midst of a metamorphosis. In addition to the Health Care Reform Act, the role of insurance companies has expanded, a shortage of primary care providers has developed, there has been a movement away from solo practice towards large physicians groups, and new performance measurement programs such as Pay for Performance have been instituted. Locally we have seen the merging of two hospitals, the aging of our physician population, a shortage of both primary care and specialists, and a recurring cycle of practices/physicians affiliating with hospitals, breaking away, and coming together again. On top of all this, electronic medical records and the Internet are changing the way we practice.

Physicians are using and relying on electronic medical records more than ever, and the incentive to use them has never been greater. In our office we have had electronic records for over year. We carry laptops into the rooms as we see patients, and enter

notes and data electronically. Some of the best features of our software include an up to date vaccine forecast, graphic printouts of growth charts with body mass indices, and the computer-generated routine forms. The hard parts are the little glitches that crop up, or working in a power outage or when the Internet is down. The arrival of a back-up Internet cable to our area will be a big plus for everyone online.

A wonderful feature of having your computer in the room, online, is that you have instant access to an entire encyclopedia of knowledge. My ability to give good, accurate, current information to my patients is greatly improved. Many physicians like Up To Date (<http://www.uptodate.com/home/index.html>) for current good quality information on diagnostics and treatment. I have been using e-textbooks from Skyscape (<http://www.skyscape.com/index/home.aspx>), which I highly recommend. Their e-books are easy to download, easy to navigate, and they have excellent quality medical titles. They also work with multiple formats, so no matter your mobile device, they are likely to work on it. I have over 12 medical tomes on my iPhone, from which I can access information quickly, on the spot. The Harriet Lane Handbook, the Red Book, Essential Psychopharmacology, Labs 360; Nelson’s Pediatric Antimicrobial therapy,

Thomas Hale’s Mother’s Milk and Medications, 5 Minute Pediatric Consult are just a few. The information in these is invaluable for going over drug doses, side effects, and other minutia that no one with a normal memory can recollect. My nurse practitioner swears by Epocrates (<http://www.epocrates.com/>) for prescribing, and it’s amazing what Google can locate. Google is great for finding ICD-9 codes or information on rare topics. I can often get more and better medical information from a Google search than I do from specialty or physician-specific websites

Voice recognition software has come a long way in recent years. Dragon Medical Dictating is great for complicated and lengthy notes, and it takes dictation much more quickly than any typist. The longer and more complicated the word, the better it works. I think the quality and the originality of my record keeping has gone way up because it is easy to spew off a few unique sentences using Dragon, and originality is what we need to protect most of all in this digital revolution. How drab to have medical records look like a bank statement!

According to this wanna be techie—

Change can be good. §

PHYSICIAN TALENT SHOW?

The Medical Society is in the early stages of planning a Physician Talent Show. It's been several years since we've had one and we've got a lot of new talent!

PLEASE contact the Medical Society office if your interested in working on a Planning Committee for the Talent Show.

PLEASE contact the Medical Society office and let us know you'd be interested in performing and what your talent is.

We look forward to hearing from you!

Colorectal Cancer Screening in Humboldt County

ALAN GLASEROFF M.D.

IPA CMO



Colon cancer is a “sad way to go”. On April 22, 2008, Sue Parks, a pediatric nurse practitioner who worked for many years with Ted Humphry, died of colon cancer after a valiant struggle at age 62. She had undergone colon cancer screening at age 55 and was diagnosed with an apparently resectable adenocarcinoma, which recurred 4 years later (with liver metastases) and eventually led to her death. She initially delayed screening until age 55 despite a positive family history (her mother). Her delay was a result of aversion to colonoscopy, and her assumption that her healthy lifestyle protected her. Those of you who knew Sue understand what a loss her death was to our community. *Sue’s death was tragic in all the senses of the word, made even more so as it was preventable.*

Unfortunately, Sue’s death may not be an isolated occurrence. The California Department of Health and Human Services sponsors the California Cancer Registry www.ccrca.org. One of the categories reported in the registry is “Age-Adjusted Invasive Cancer Incidence Rates”. They have data on invasive cancers overall, and also on several types of cancer. For colorectal cancer (CRC), Humboldt and Del Norte Counties combined are the *worst* county in the state in regards to invasive cancer rates – we are the 53.09 per 100,000 that brings up the rear of the dataset based on 2009 data (*see chart on this page*):

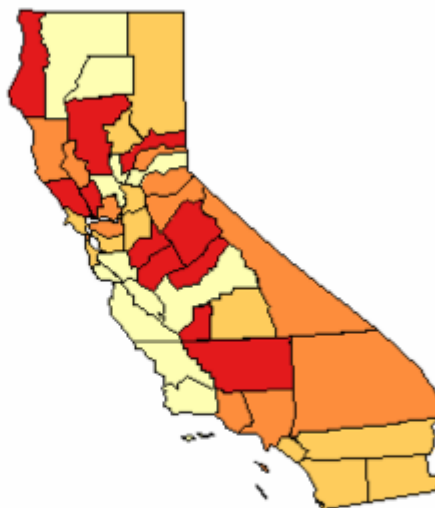
I was surprised by this data, as the IPA rate for CRC screening was 68% for HMO patients, a number above the 90th percentile for HMO patients nationally. National benchmarks generally show a ~15% gap at the 90th percentile of performance between HMO and PPO, with HMO outperforming

**Age-Adjusted Invasive Cancer Incidence Rates in California
Colon and Rectum, 2003-2007
By County**

Age-Adjusted to the 2000 U.S. Standard Million Population

California Rate: 44.36

Rate per 100,000	
36.34 - 42.36	Lightest Yellow
42.50 - 44.55	Yellow
45.39 - 46.99	Orange
47.00 - 53.09	Red



Rates generated on Aug 13, 2010

Based on October 2009 Quarterly Extract (Released October 08, 2009)

Copyright (C) 2010 California Cancer Registry

Veterans Health Administration hospitals did not report cancer cases to the California Cancer Registry (CCR) in 2005, 2006 and 2007. Therefore, case counts and incidence rates for adult males in 2005, 2006 and 2007 are underestimated and should be interpreted with caution (see www.ccrca.org/publications/V/technotes).

PPO for most measures. Let’s assume therefore that the screening rate for non-IPA patients is roughly 15% below the 68% achieved for HMO patients: ~53%. This analysis implies that we are appropriately screening patients > 50 and < 75 years old for colon cancer approximately half of the time. The cost, discomfort from the prep, and the invasive nature of colonoscopy may have something to do with this.

Realizing that the US Preventive Services Task Force (USPSTF) recommends several acceptable approaches for screening eligible patients for CRC (colonoscopy every 10 years, *or* flex sig every 5 years, *or* FOBT yearly, *or* double-contrast barium enemas every 5 years), we looked at the total IPA and Anthem PPO patient populations to see what is occurring locally. Remember, we send reminders to practices about these patients, who are being screened at rates

above the national benchmark. Here is what we found in 2009 for the 6820 patients (52%) who were screened:

- Colonoscopy – 85%
- FOBT – 12%
- Flex sig – 3%

Our apparent community standard suggests that only colonoscopy is worthwhile to pursue, and the nearly half of the patients who decline to be scoped for either financial reasons or simple dread of the procedure perhaps are *not being offered the far less costly or invasive FOBT alternative*. Rather, patients who refuse to schedule colonoscopy are frequently marked down as “declines screening.” Additionally, almost no one is offering flexible sigmoidoscopy locally. *The result of this implied community standard is the highest rate of invasive cancers in CA, although there could be environmen-*

tal factors involved as well. Smoking rates are higher in Humboldt than for the state as a whole (17.9% vs. 14.3% - 2005 data¹); this disparity could be a factor in the invasive CRC rate, as well as others that we are not aware of. However, I suspect that low overall screening rates are part of the explanation as well.

The potential explanations for this “colonoscopy or bust” approach are several. Most likely, there is a strongly held belief that colonoscopy is the “gold-standard”. The general public (and apparently the medical community as well) views the term “colonoscopy” as synonymous with “colon-cancer screening” in much the same way “Xerox” is seen as synonymous with “copier”. Katie Couric underwent colonoscopy on morning television after losing her husband to colon cancer. The 10-year interval is attractive to some patients – “I’ll get it over with now and won’t have to think about it for a long time”. So why does the US Preventive Services Task Force view colonoscopy as but one of several equivalent choices? It is true that a single traditional guaiac FOBT is not nearly as sensitive as colonoscopy, but doing one yearly for 10 years increases the yield to the point that they are roughly equal in sensitivity: Traditional FOBT (rehydrated guaiac) is ~30% sensitive for carcinomas in a given year, but 92% sensitive if done yearly over a decade, while colonoscopy is 90-95% sensitive at best² though recent studies from Canada suggest that in reality the sensitivity is closer to 60-70% due to the difficulty identifying right-sided lesions³. There is also the difficulty in getting the FOBT test kits returned by patients, as proper ad-

ministration of the test is done at home and returned to the office via mail or hand-carried, which requires tracking systems to follow-up with patients who haven’t returned their kits.

There are newer *immunologic* FOBT (iFOBT) test kits that only recognize *human* DNA, and don’t necessitate avoiding meat during the period of collection. A recent study of iFOBT found “[iFOBT] had an 81.8 percent sensitivity for detecting colorectal **carcinoma**, and a 29.5 percent sensitivity for detecting advanced colorectal **adenomas** (noncancerous tumors). Specificity was 96.9 percent for carcinomas and 97.3 percent for adenomas”⁴ These results reflect a single year’s screening. Repeating the test yearly over 10 years may well surpass a single colonoscopy over the same time frame. Additionally, performing the iFOBT at the time of the physical via a digital rectal exam (DRE) appears to be acceptable, as opposed the traditional guaiac test. The CPT code for iFOBT is 82270. Medicare has 2 codes for iFOBT: screening FOBT is G03328QW; diagnostic is: 82274QW, and Medicare pays about \$23, while it costs approximately \$20 per test.

So what should we do as a community to decrease our rate of invasive colon cancer? Obviously, if we could increase our screening rate to above 90%, we can save lives. To achieve a 90% screening rate, we will need to develop systems to deliver colon cancer screening to our patients in a reliable and cost-effective manner. We will need to offer patients choices beyond colonoscopy; in order to accomplish this, we will need to

rethink our current misconception that only colonoscopy is worthwhile. What is the proper ratio for different screening methods? We should let our patients decide this. Our current “85% colonoscopy ratio” does not indicate that we are giving patients the choice with any regularity. In my own practice, I am committed to offering every eligible patient the choice of yearly iFOBT as an alternative to colonoscopy, and let them decide. I bet that I can reach 90% using this strategy.

What are you going to do to lower the local rate of invasive colon cancer? I look forward to hearing of your plans. Remember, these are our patients, friends and colleagues whose lives are in the balance, not just statistics.

(Footnotes)

1 *California Tobacco Survey, CA Department of Public Health, March 2009*
 2 *Frazier, et al, “Cost-effectiveness of screening for colorectal cancer in the general population,” JAMA 2000 Oct 18;284(15):1954-61*
 3 *Association of Colonoscopy and Death From Colorectal Cancer Nancy N. Baxter, Meredith Goldwasser, Lawrence F. Paszat, Refik Saskin, David Urbach, and Linda Rabeneck, Ann Intern Med January 6, 2009 150:1-8; doi:10.1059/0003-4819-150-1-200901060-00306*
 4 *Allison JE, Sakoda LC, Levin TR, Tucker JP, Tekawa IS, Cuff T, Pauly MP, Shlager L, Palitz AM, Zhao WK, Schwartz JS, Ransohoff DF, Selby JV, Screening for colorectal neoplasms with new fecal occult blood tests: update on performance characteristics, J Natl Cancer Inst. 2007 Oct 3;99(19):1462-70. Epub 2007 Sep 25* §



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

Health Reform: A Vision for Community Transformation

The federal health care reform bill includes funding for communities to move “from a focus on sickness and disease to one based on wellness and prevention.” CDC has announced strategic directions for the nation’s health:

- Active lifestyles
- Tobacco-free living
- A healthy physical and social environment
- Injury-free living
- Mental and emotional well-being
- Health eating
- Countering alcohol and substance misuse.

Promotion of these six areas would certainly help address the most critical social determinants of health in Humboldt County. The hope is that the federal government will award funds to public health departments and community partners for “community transformation” to promote health.

The Community Health Alliance (CHA) hosted a meeting November 4 with the theme of realizing “Community Transformation.” Speakers presented the successes of the Robert Wood Johnson funding for Aligning Forces for Quality in Humboldt

County. The grant focuses on improving the experience of patients and those with chronic diseases. For example, the Pathways to Health Program run by CHA engages people with chronic diseases in a six week program aimed at empowering them to improve their health and satisfaction with their medical care experiences. St Joseph’s is conducting a program in conjunction with HSU nursing students to ensure patients with chronic disease have a smooth transition to outpatient care and wellness.

As a follow up to the November 4 meeting, the DHHS Public Health Branch and CHA are holding a meeting February 14 from 10-2 at the Humboldt Area Foundation to highlight prevention efforts in Humboldt that are more “upstream” with the idea of fleshing out the continuum of care and prevention in the county. We are inviting people to make 5 minute presentations of their work. Presentation may include: Safe Routes to School, the Trail Master Plan, the Food Policy Council; or the Community Garden Project. We aim to strengthen partnerships and map out prevention efforts along the full spectrum in preparation for applying for a community transformation grant. People interested in attending can contact me at 268 2181 or alindsay@co.humboldt.ca.us.

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Benefits, Cont. from page 2

was very nice. CMA president-elect Jim Hay came to talk to us about big issues we will be facing in the coming year; that was after he introduced himself as “the only Republican in the room.” (I happen to know of at least 2 other Republicans present that evening.) Anyway, the biggest new issue coming up on the state level is really quite an old issue. **THERE IS GOING TO BE A LEGISLATIVE CHALLENGE TO MICRA IN THE COMING YEAR.** The trial lawyers see a Democratic majority in both houses AND a Democratic governor. I am sure that they

are aware that MICRA originally became law the last time Jerry Brown was governor. They undoubtedly also are aware that he has a long and colorful history of being politically unpredictable. We CANNOT rest on our laurels and assume the status quo. We will ALL need to contact Assemblyperson Chesbro (<http://democrats.assembly.ca.gov/members/a01/>) and State Senator Noreen Evans (<http://sd02.senate.ca.gov/>) in coming weeks and months to encourage them to keep MICRA intact. I am almost certain that the vast majority of us, Democrat, Re-

publican and *etcetera*, agree that we can ill afford to lose this one! I really don't know whether either of them are predisposed one way or the other but their (my) party traditionally has been on what I see as the wrong side of this question. Penny and I, along with the folks at CMA, will let you know when the timing is imminent. If you have existing relationships with either of these representatives you may want to start the conversation soon (hint, hint; wink, wink; nudge, nudge).§

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4/2

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*Please contact Terri Taylor, CME Coordinator at (707) 442-2353 or
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