

THE BULLETIN

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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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EMILY DALTON, M.D.

It is an honor and a pleasure to serve as president of HDNMS for the year 2008-2009. For those of who were not able to attend the June 10th dinner and presentation at the Sea Grill, I will recap some of the highlights of the evening. Everyone was sad to see Kate McCaffrey move on as she handed over the presidency. Her eager enthusiasm and endless patience will be missed, but she will be continuing on as mentor of the local Touro D.O. student training program. Cheers filled the room when she announced her plans to propose to her long time partner now that marriage is legal in California for same-sex couples.

A rousing vote to select the artwork for the cover of this year's directory took place, and the winner was *Steve Kamelgarn's "Trillium in the Redwood Forrest"*. Steve Kamelgarn, the new Director of Medical Education for the Humboldt-

Del Norte Clinical Rotations of Touro University, spoke about the Touro training program, Gregory Gibb talked about the million dollar grant the IPA will receive from the Robert Wood Johnson foundation (wow!) and Bill Carlson informed us about Organized Medical Staff issues. Of course there was the usual voting (the changing of the guard so to speak) and numerous door prizes were raffled off. Many thanks to Norcal for their generous support of the dinner and to Marsh Affinity for the door prizes!

Joe Dunn, the CEO of the CMA gave a fascinating talk intended to help us better understand how things work in world of politics. He is doing a fantastic job of educating and explaining a world with which most of us are unfamiliar, and leading us in a direction to truly effect change and effectively advocate for physicians and their patients. His ideas and strategic plan for our

organization are both inspiring and revitalizing.

I feel fortunate that my turn as president has come about at this time because I believe that this year will be momentous for health care in this country. We are on the brink of changes in delivery and reimbursement that will be unprecedented in the history of American medicine. Both presidential candidates are talking about "affordable, portable, quality health care for all Americans," even though the methods by which they would achieve these goals differ significantly. The House of Representatives and the Senate are working on bipartisan bills that would outline the details of how to accomplish these goals. It is exciting to see the political and popular will coming together to improve health care in this country. §



More Critical Thinking

SCOTT SATTLER, M.D.



When I read Dr. Lee Leer's editorial entitled "Critical Thinking" in the February 2008 issue of *The Bulletin* (1), it left me with mixed feelings. On the one hand, his reminder to physicians to hold dear to the processes of critical thinking was certainly laudable and consistent with the highest goals of our profession. On the other hand, something about the article deeply bothered me. Some of that feeling came from remembering randomized controlled studies from the days of yore. (I've been interested in the healing process in all of its manifestations for as long as I can remember. I studied acupuncture in China for 3 months in 1970, and still have an interest in the field.)

So I googled "Mayo Clinic on Acupuncture" just to see their current thoughts on the subject. After all, the Mayo is not an academically slouch organization. The first reference that popped up (2) was very interesting. It said that "...research shows acupuncture can help manage postoperative dental pain and alleviate chemotherapy-induced nausea and vomiting. It also appears to offer relief for chronic menstrual cramps and tennis elbow." Interesting. I skipped down to another reference (3) in this long list of articles. It documented a randomized controlled trial (RCT) done at the Mayo Clinic in 2005, which studied 50 patients with advanced fibromyalgia for whom other symptom-relief treatments were ineffective. Subjects were randomly divided into two groups. Each group received 6 sessions of either simulation or acupuncture over two to three weeks. The simulated acupuncture was of a type that had been documented to show that patients couldn't distinguish between simulated and real. Following the treatments, pain, anxiety and fatigue were significantly more improved in the acupuncture group than in the control.

Next I checked out homeopathy. There, too, I remembered in bygone days reading studies in reputable journals whose outcomes were quite disturbing to my allopathophilic sensitivities, as they supported the efficacy of homeopathy for certain conditions. So once again, I googled with most interesting results. As quoted from the American College of Chest Physician's journal *Chest* (4): "For alternative therapies to become accepted by the medical community and become integrated into a patient's treatment plan, it is essential that they be tested in an RCT...The benefit of homeopathy has been demonstrated for the treatment of asthma as well as allergic rhinitis and vertigo. (5)(6)(7)" I invite you to read the studies.

Here were established researchers reporting significant findings based on randomized controlled studies and published in respected journals. And they clearly supported the utilization of acupuncture and homeopathy for certain conditions. The authors, to my eye, were neither "intellectually lazy" nor "latter day snake oil salesmen..." And obviously they were not preoccupied with being politically correct. Publishing these articles in leading allopathic medical journals speaks quite to the contrary.

So, again, why did Dr. Leer's article bother me so? I think it is because it lumped together a host of modalities and indiscriminately painted them all with the same damning brush. The primary common denominator to these modalities, as far as I can see, is that they do not fall under the aegis of the current Western Medicine philosophy and world-view, and thus they cannot possibly contain anything remotely resembling valid, true, scientific healing benefit.

Well, that's what the leading physi-

cians of the time said about lemon juice curing scurvy. Do you remember that little episode in medical history? Bear with me a moment as I remind you.

It was the early 1400s, and the compass had found its way from China to the Mediterranean, where the Crusades had been the dominant phenomenon for the previous 400 years. The mixing of the sea-faring traditions during this period had brought about the development of ship construction such that a mariner could now sail far into the ocean and predictably return. For the first time in history prolonged sea voyages were undertaken (*en masse*), eventually leading to the great transoceanic British, Portuguese, Spanish and French fleets. They discovered the New World and trade routes to India, Africa and China. And they discovered scurvy. Vasco da Gama described its signs and symptoms in 1498, after six months at sea. Many of his sailors died from it. Magellan documented the similar death of a score of his men. Thirty Pilgrims landing at Plymouth Rock died of it their first winter. In 1744, a British fleet under Anson lost all but 145 of its original 1,000 men to scurvy over the four-year course of its journey in the Pacific. Between the years 1500 and 1800 it is estimated that over two million European sailors died from this disease. But the sad part is that da Gama's men realized in the early 1500s that fresh fruit was both preventative and curative. James Lind, a Scottish surgeon in the British Royal Navy, conducted experiments proving that scurvy could be immediately cured with citrus fruit, and published his results in 1753 in his book *A Treatise of the Scurvy*. Despite all the experiential data to the contrary, the physicians of western Europe were loathe to accept the fact that such a scourge could be

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No Room for Mandarins

STEPHEN KAMELGARN, M.D.



Just in case you haven't been listening to our patients and colleagues I thought that I'd clue you all in that there is tremendous dissatisfaction with the way our health insurance system works (or doesn't, as the case may be). The blizzard of pre-approvals, constantly changing formularies and other obstacles put in place by both public and private insurers to delay or deny care to their subscribers is maddening, frustrating, inefficient and, to coin a word, stupid.

If it's so bad, I hear you cry, why does it continue? Well, there's money to be made in making it difficult for physicians to do what's right for their patients, rather than what's cost-effective and profit making for the insurance companies.

However, there's one group of people for whom all this nonsense has no personal impact whatsoever: the members of Congress, that august group of 535 individuals who are supposed to represent our interests. People who were ostensibly elected by us to be for us. These paragons of the "public good" have a *completely free ride for their healthcare for life!* That's right. For the service of one measly two year term in the House of Representatives (the People's House) the Congressman, or former Congressman, has totally free healthcare at the public's expense for the rest of his/her life. This sort of privilege for every member of Congress divorces them from the day to day frustrations that their constituents go through to obtain even mediocre health care, let alone Class-A, state of the art care. Why should they push for insurance reform? They don't have to deal with reality, so why should they change things?

When Senator Kennedy had his seizure, before being diagnosed with his brain tumor, he had his choice of neurosurgeon;

he didn't have to sweat an "out-of-network" referral. He didn't have to come up with any sort of co-pay. Bethesda Naval Hospital just rolled out the red carpet for a VIP. He doesn't have to worry about making his deductible. His doctors didn't have to get a pre-approval for whatever testing was done before they made his diagnosis. Those physicians didn't have to go to the mat to obtain approval, or look up the right ICD-9 code for whatever meds he's on. They didn't have some petty middle-level bureaucrat tell them that the med wasn't on his insurance formulary. And that's exactly how it should be. Why can't the rest of us claim the same rights?

A little over a year ago I wrote of my experience of being an inpatient in a strange town, and what it felt like. It gave me a real appreciation of what our patients must suffer when they get caught in the clutches of the healthcare system, and I now find myself having a lot more empathy when they wind up in the hospital.

How can Congress really work for healthcare insurance reform when they don't have the same frustrating experience that the rest of us have to go through? To them, it's just an academic exercise, subject to the whimsy of the powerful insurance lobby greasing the wheels of their election campaigns.

If those dedicated members of Congress (and there are a few of them—Henry Waxman comes to mind) really wish to make a dent in how the health insurance companies do business they could make a start by passing a law that states: ". . . every member of Congress must be subject to, and abide by, the conditions of the laws that they pass." This should include having to pay parking tickets as well as having an off-the-shelf insurance plan. Imagine how quickly

things would change if, all of a sudden, Bethesda's doors were closed to Congress and the representative from the 3rd district in Nebraska (or wherever) had to come up with a co-pay to visit the ER for his chest pain. Think of how quickly things would change if the Chairman of the Senate Health Care Committee found out that he has to change statins every six months because his Blue-Cross plan keeps changing formularies.

Once Congress applied those rules to itself it could then mandate that the Boards of Directors of the various insurance companies live by the rules of those companies. How fast would Blue-Cross change its tune when the CEO finds out that his doctor isn't allowed to prescribe the ARB that he's been on for the previous 3 years?

Not only would there be some sort of cosmic justice in having people live by the rules they pass, it wouldn't increase costs very much. I'm sure even the CEO of Blue-Cross would be willing to put up with a few inconveniences to improve his company's bottom line, and I'd certainly be willing to live with the same insurance plan that he has.

In 1775, we launched a revolution that denied the Divine Right of Kings. Our Constitution in 1787 stated that all people were equal before the law, especially after the passage of the 14th amendment in 1868. Yet, over the course of the last 100 years or so (especially since the 1980's), the Mandarin Class has once again arisen—claiming a privilege far beyond that of the ordinary citizen—essentially re-instituting the English peerage system that we fought so hard to eliminate over 200 years ago.

Is it time for another American Revolution? §

Advocacy in Medicare Payment Problems

PENNY E. FIGAS
Executive Director



On May 23, 2008, National Heritage Insurance Company (NHIC) fully implemented the National Provider Number (NPI) claim submission requirements, which caused several problems affecting over 23 of our local offices (50+ physicians) in Humboldt-Del Norte county.

Humboldt-Del Norte County Medical Society and California Medical Association (CMA) are continuing to assist members in Northern California whose Medicare claims are being denied or suspended because Medicare's claims processing system does not recognize associations, or "linkages," between physicians and the medical groups that bill for their services. Several weeks ago Medicare promised that it would extend the deadline to August 1st before they would stop paying claims affected by these problems, but the CMA believes over a thousand physicians are currently not getting their claims paid. While Medicare is sending letters to physicians it identifies who are affected by this problem, not all are being identified and instead discover the problem when they realize their claims are no longer being paid.

To resolve these "linkage" problems, Medicare usually requires physicians and their medical groups to file new enrollment forms, known as CMS 855I, 855R and/or 855B forms. While Medicare has dedicated additional staff to processing applications, it is taking up to over two months. The HDNCMS and CMA are monitoring National Heritage Insurance Company's (NHIC - the Medicare contractor in California) processing of these forms to ensure that re-enrollment is occurring as quickly as possible. To address these problems, physicians should do the following:

- 1.) Check with your billing staff, or

outside vendor if applicable, to find out if claims payments are being delayed or if any error messages are appearing on Explanation of Benefit (EOB) forms or in electronic claims processing reports.

- 2.) Contact the NHIC hotline at 1-877-527-6613 to inquire if NHIC sees any problems with claims processing and to verify that the physicians in the medical group are properly linked to the group in Medicare's claims processing system. When making this inquiry, NHIC will need the individual NPI (type 1) for each physician in the practice and the group NPI (type 2).

- 3.) NHIC should instruct physicians on what steps to take if there are problems, which may include submitting new 855I, 855R and/or 855B Medicare enrollment forms. If NHIC does not provide this information, contact the ACCMA for assistance. Enrollment forms can be downloaded at http://www.medicarenhic.com/cal_prov/enroll_forms.shtml.

- 4.) Complete enrollment forms as instructed. Medicare is very precise in its requirements for information and supporting documentation, so read the instructions carefully to avoid processing delays. Call NHIC if there are questions about the forms at 1-877-527-6613. Physicians who are unable to get satisfactory answers should contact the HDNCMS.

- 5.) Send completed enrollment forms via priority mail, return receipt requested, to NHIC Provider Enrollment, P.O. Box

2812, Chico, CA 95927-2812. After you receive the postcard confirming delivery of the application(s), send a fax to the HDNCMS (707/442-8134) with the following information: names of impacted physicians, NPI numbers of impacted physicians, group name, group NPI number and return receipt tracking number. Upon receipt of your fax, the HDNCMS will forward this information to the CMA, which will follow-up with NHIC to ensure that enrollment forms are processed expeditiously. CMA can also provide assistance completing the enrollment forms by calling 916/551-2046.

Some Claims Rejections May Be Corrected By the Following Actions:

1. Error messages M402, M417 and M419: MED LEGACY ID SUBMITTED

Beginning on May 23rd claims containing legacy PTAN numbers along with appropriate qualifiers are no longer accepted. If the above error messages appear on electronic claims, remove the REF*1C Segments that contain the Legacy numbers from Loops 2010AA, 2310A, 2310B and 2310D. For paper claims, do not place legacy numbers anywhere on the claim form (Items 17a, 24J, 32b, or 33b).

2. Error message M381: EIN/SSN NOT TIED TO NPI

This error message appears when the EIN or SSN in the rendering physician Loop 2310B does not match the billing provider EIN. The EIN or SSN in this loop is *not required*. This problem may be corrected in electronic claims by removing the REF*EI (for EIN) or REF*SY

From the Med Student Front

STEPHEN KAMELGARN, M.D.

Director of Medical Education—Humboldt-Del Norte Clinical Rotations



On June 23, ten Touro University Medical Students started the first of their year-long rotations up here in Humboldt and Del Norte Counties. Two other students also came up to do a single six week rotation in OB/GYN.

This explains the several students you may have seen running around the hospitals and various offices wearing white coats, Touro name badges, and an enthusiastic eager attitude. So far, the feedback I've been receiving from the students has been extremely positive, and the several attending physicians I've spoken with over the past week have also been happy, if somewhat confused about their role, with the students.

I know it's a stretch for most of us to remember the fears and craziness that permeated our third year clinical clerkships, but it is important if we wish to pass on our experiences to the next generation of physicians; several of whom may wish to eventually settle up here.

Here's the last installment of their nano-biographies, all of which have also been posted in the various local hospitals. When you see the students in the hallways or offices, introduce yourselves and make them feel welcome. They may, after all, be taking care of we old guys some day.



Ethan Breen - I grew up in a great little progressive neighborhood in Brooklyn, New York. Eight years after graduating college I decided to acknowledge my lifelong interest in health science and my desire to help others. While working in construction and home repair I returned to school to gain the necessary premed requirements. My decision to attend Touro was part happenstance, desire for geographic change and the vicinity to a close lifelong family friend. So Barlo, my dog, and I packed the car and made the journey to Vallejo CA. We have both enjoyed this coast very much. In my free time I enjoy cooking, and the subsequent eating of the aforementioned cooked food. I also enjoy spending time outdoors, and traveling. I have lived overseas and during my first summer of medical school, I traveled to Ethiopia to work in a hospital. I am enthusiastic about starting my clinical training and moving to Humboldt county



My name is **Dustin Lopes**. I am a 26 year old medical student. I grew up in the town of Orland, California and have been around Northern California all of my life. I graduated in 2005 from California State University, Chico with a bachelor's degree in Biology and a minor in Chemistry. Before coming to medical school, I spent four years working for the BloodSource organization, which draws, processes, and delivers the blood supply of most of the Sacramento Valley.

When I started college at age 18, becoming a physician was always a far-off possibility for me; one of those unlikely dreams that you can only imagine happening to other people. The idea of making a difference in the world and being able to help people everyday was what encouraged me to begin pre-med coursework and to work hard at it. After spending a few years volunteering in healthcare settings I was sure I was ready to commit myself to entering medical school and becoming a good physician.

I've enjoyed the last two years of attending school and living in the bay area. My wife Candace and I were married last summer and are looking forward to our first anniversary. When I have spare time I enjoy hiking, snowboarding, and visiting with friends and family. Right now I'm not committed to pursuing any medical specialty so for the time being I plan to work hard in all of my clinical rotations and learn as much as I can. I'm excited to begin clinical rotations and am looking forward to my summer in Eureka.



Hi, my name is **Anne Neumann**. I graduated from UC Davis with a degree in Evolution and Ecology along with a minor in Psychology. I also rowed for three years at Davis so I am hoping to have some time to spend down at the boathouse with the Humboldt Bay Rowing Association. I am excited to begin my rotations in Humboldt County in June. I am originally from Crescent City so it will be nice to return to the redwoods.



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

**NEW RECOMMENDATIONS FOR
VARICELLA VACCINE**

Two varicella virus-containing vaccines are currently licensed for use in the United States. VARIVAX® is the single-antigen varicella vaccine and ProQuad®, or MMRV, is a combination vaccine of measles, mumps, rubella, and varicella. (At this time MMRV is not available.) Both vaccines contain live, attenuated virus. Children 12 months through 12 years of age should receive **TWO** 0.5ml doses of varicella-containing vaccine administered subcutaneously, separated by at least 3 months. However, if

the second dose is administered after at least 28 days following the first dose, the second dose is considered valid and does not need to be repeated. Persons 13 years of age and older should receive two 0.5ml doses of the single-antigen varicella vaccine subcutaneously 4-8 weeks apart. The combination MMRV is approved for use only among healthy children 12 months through 12 years of age. MMRV is not approved for use in persons 13 years of age and older. All live virus vaccines should be administered on the same day or four weeks apart. For example if a child receives MMR vaccine and

then a week later receives a varicella vaccine the vaccine given second would be invalid, to recalculate the date count four weeks from the last live virus vaccine given. The recommended schedule for varicella vaccine is the same as MMR first dose at age 12-15 months, second dose age 4-6 years. Vaccine efficacy is approximately 90%. Varicella vaccine is fragile and must be stored properly to retain potency. Freezers must be able to maintain a temperature below +5F. Please contact Susan Wardrip R.N. Immunization Coordinator At 707-268-2155 for any other questions regarding vaccines. §

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As Goes the IPA, so Goes the Nation...(Part 1)

ALAN GLASEROFF MD,



One year ago, it appeared as if health care reform was coming to California. Looking back, the competing interests involved in the attempt to make it work were an unlikely group to remain cohesive (Governor Schwarzenegger’s plan was purported to distribute the “pain” equally amongst all groups) and all deserve some of the blame for the reform efforts’ demise. Each constituency (politicians on both sides of the aisle, hospitals, clinicians, pharmaceutical companies, device manufacturers, health plans, etc) may desire universal coverage at some level (it’s good for business to have clients who can actually pay for services rendered), but no group was eager to share in contributing to the political and funding maneuvers required to make reform a reality. A game of “chicken” ensued – “You go first” was the mantra heard from each group. And we are left with a lost opportunity that may not come back anytime soon. Where were the adults when we needed them?

Now we are left with a huge budget shortfall, proposed cuts of 10% across the board for all state programs, and a steadily rising rate of un- and underinsured patients seeking care in private practices, safety net clinics and emergency rooms, while our primary care base is shrinking due to antiquated, dysfunctional reimbursement schemes and practice environments. What does this mean for the IPA, and healthcare in Humboldt County? There are two ways to “spin it”, one based on the optimism derived from the record of innovation and success that is ongoing at the IPA, and the other based on the pessimism that is derived from the “Woe is us” mood that has become entrenched in the medical community over the past several years. While there is solid justification for both views, *only the former is useful in building towards the future*, and in being able to recruit and retain clinicians

to the area. This is the path the IPA has chosen. I would like to describe several areas of work where such optimism is justified in an ongoing effort to keep our membership informed and activated, and to provide hope for the future. I also intend to make the case for your participation in the efforts to save health care in Humboldt County, and to serve as an example for the rest of the state and nation. Now is the time to get involved if you want to have a decent healthcare system to access after retirement or to pass on to your kids. If we don’t do it, who will?

Comparing the US Health Care System to the Rest of the Developed World

The discussion in regards to health reform in California over the past year focused solely on universal insurance coverage at the expense of true system reform. It is well known that the US is alone in the developed world in not viewing health care as a social good to be extended to all its citizens. Yet we also know that we are already spending twice as much per capita as a nation as the next most expensive country in the world. What do we get for all we are spending? See ‘Six Nation Comparison Chart’ from an article from the Commonwealth Fund May 2007¹

As you can see, **overall we come in 6th out of 6**. The one area where we shine in is called “Right Care”, which is a category that combines prevention and prompt access to specialists and to surgical services. We perform well in these areas only for those who can afford insurance, as “Access, Efficiency, Equity, Healthy Lives, as

well as Safety, Care Coordination, and Patient Centered Care” were all considered weaknesses of our system as compared to the other 5 nations (we came in last or next-to-last in all these categories).²

Is more money the answer? With healthcare already consuming 17% of the GDP, and 27% of people living in Humboldt County already uninsured, it is very unlikely that more money will be forthcoming, or that prices can go any higher. The insurance premiums already cost more than many can afford, and Medicare is poised to go “belly up” in 2017. **Remember, we already cost twice as much as any country on earth!** More likely, there will be attempts to cut reimbursements by payers rather than increase them, and while one can make a good argument about insurance and drug company profits and CEO salaries and bonuses, some of the responsibility also belongs to those who set the whole process in motion – *we clinicians*. The only solution that can work in the long run is to *lower the total per capita cost of care while simultaneously improving quality, equity, coordination, safety and patient-centeredness*. Accomplishing these goals is the long range busi-

“IPA” Continued on page 17

Six Nation Comparison Chart⁶

	Australia	Canada	Germany	New Zealand	United Kingdom	United States
Overall Ranking 2007	3.5	5	2	3.5	1	6
Quality care	4	6	2.5	2.5	1	6
Right care	5	6	3	4	2	1
Safe care	4	5	1	3	2	6
Coordinated care	3	6	4	2	1	5
Patient centered care	3	6	2	1	4	5
Access	3	5	1	2	2	6
Efficiency	4	5	3	2	1	6
Equity	2	5	4	3	1	6
Healthy lives	1	3	2	4.5	4.5	6

“Opinion” Continued from page 3

caused by a simple dietary deficiency. Scientists of the day, eager to sustain their personal pet theories of disease, consistently distorted and suppressed the information.

How does this differ from the difficulty Barry Marshall and J. Robin Warren experienced convincing the medical establishment that the bacterium we now call *H. pylori* (which Marshall discovered in 1979) and not stress, was the primary cause of gastric ulceration? Despite their definitive paper published in 1983, it was not until 1994 that the NIH officially recognized this connection and recommended antibiotics for the treatment of these ulcers.

My point is that as allopathic physicians practicing in the USA we appear to have acquired a distinct chauvinism: our current way is the best way, the only “true” way, and if you’re not with us, you’re against us. In fact, this allopathic xenophobia seems to have transcended the principles of the scientific method.

Being a human is hard work. Staying healthy takes a lot of effort, especially as we age, and all of us humans are in this together. So let us in the healing professions rise above the distinctions and differences that divide us and take the high road together. Snake oil salesmen did and do exist. Let us shine light on such fraud, but let us thoroughly check it out first using unbiased scientific method. And let us not be afraid to use evidence-based therapies even though we don’t understand exactly how they work. Trying to understand the entirety of this phenomenal world is like trying to understand the nature of an incredibly long parade that we get to watch through a very narrow crack in a very tall fence for a very short period of time. So let us not hesitate to go with what works, and let us test it to make sure it works, but let us test everything, no matter how odd it may seem, with equal diligence. §

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Aches, Pains, & Achoos Welcome!

The Urgent Care Clinic (formerly the Urgent Care Center at General Hospital) is now open at St. Joseph Hospital!

This brand-new clinic features all new equipment, 10 modern exam rooms (double the space of our old Urgent Care), close proximity to the Emergency Department and other hospital services, parking just for Urgent Care patients, and more.

The Urgent Care Clinic is designed to meet your needs when you have a minor illness or injury. Services provided are similar to those normally provided in your doctor’s office or a clinic. Urgent Care is available to everyone from mom and dad to grandma and grandpa, and even little ones. No appointment is needed! We’re here for you seven days a week, 8:00 am to 8:00 pm at the south end of St. Joseph Hospital.

*For more information, visit our website at
www.stjosepheureka.org.*

A Ministry of the
Sisters of St. Joseph
of Orange



The procedure room at the Urgent Care Clinic.

Urgent Care Clinic

St. Joseph Hospital
ST. JOSEPH
HEALTH SYSTEM



APRIA HEALTHCARE

**APRIA HEALTHCARE
OFFERS YOUR PATIENTS
COMPREHENSIVE HOME CARE
PRODUCTS AND SERVICES**

- **Oxygen & Respiratory Care Services**
- **Respiratory Medications**
- **Obstructive Sleep Apnea Treatment**
- **Enteral Nutrition**
- **Specialty Beds**



**1735 Second Street
Eureka, CA 95501
(707) 444-8022**

“Exec Desk” Continued from page 5

(for SSN) segments from Loop 2310B. The *required* information is: NMI*82*1*DOE*JANE****XX*1234567891 = 24J (NPI). For paper claims, do not put an EIN or SSN in Item 24J.

3. Error Message M379: EIN/SSN NOT TIED TO NPI

This error message appears when the billing EIN/SSN in loop 2010AA of an electronic claim does not match what NHIC has as the EIN or SSN for the NPI number in our records. To correct this error, verify on the NPI database (<https://nppes.cms.hhs.gov>) that you have the correct tax or SS number. Verify that this is the SSN or tax number you have on the Medicare Provider Enrollment file. To do this, call NHIC Customer Service at 877-527-6613, provide the tax number, and ask them to verify if this is what is listed. They can tell you yes or no, but for security reasons cannot tell you what they do have. If you need that information, request it in writing from the Written Inquiry Department. If the tax number on NHIC’s records does not match what you have in NPPES, you must correct either the NPPES record, or submit the appropriate enrollment application to correct your Medi-

care enrollment record. For paper claims, the information entered in Item 25 must match the tax information NHIC has on file for the provider. If it does not, the claim will be rejected. You must take the same steps outlined above to make the necessary corrections.

CMS Says it Will Offer Some Financial Relief

The Centers for Medicare and Medicaid Services (CMS) says it will consider providing, in limited circumstances, advance or accelerated payments to physicians experiencing financial difficulties as a result of these claims denials. Please let us know if you need information for this option.

We are working very closely with the CMA Economic Services, Center for Medicare Services and Congressman Mike Thompson to help our members who have let us know they are having problems.

One of the many outstanding benefits of membership are the advocacy efforts that are available to you to assist you in the hassles of getting paid. Documentation of problems are very important to monitor that the insurance carriers are following the rules and “take it to the top” when there are problems.

Thank you for your membership support which enables us to advocate on your behalf! §

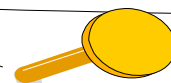
Mark Your Calendars

3rd Annual Medical Society

Family Picnic

September 20, 2008

Freshwater Park



“IPA” Continued from page 11

ness plan for the IPA; we will need your help in bringing it about. In the following section I will discuss several current efforts that seek to find and implement solutions to the areas of weakness outlined in the research by the Commonwealth Fund.

Seeking Solutions

Imagine the following scenario:

It is 2015. Healthcare in Humboldt County has come a long way from the low-point of the failed reform plan of 2008. Everyone living in the county has insurance coverage, and a “medical home”. Clinicians in the county are united by a common information system that allows all relevant patient information to be accessed rapidly when and where it is needed. Primary care has been stabilized by national and local payment reform that rewards primary care for population-based health results (paying for planned care, group visits, e-mail, telephone calls, and registry management in addition to results) rather than just for 15-minute face-to-face individual visits. Loan forgiveness for those entering primary care residencies also helped increase the supply.

Physicians enjoy their role as “team captains” working side-by-side with behavioral health coaches, nurses and medical assistants to provide the best care possible. Each patient has an individual shared care plan that reinforces the productive relationship necessary for the patient and care team to best understand and implement their separate roles and responsibilities for healthy outcomes. Access to visits is virtually immediate- patients come in when they choose to via the “Open Access” scheduling process. They also arrive prepared, having met with their health coach prior to the visit to go over potential questions and issues that need to be addressed, and to assure that their medications are understood and are being taken as directed. Follow-up calls are arranged by the coaches to help keep patients on track with their self-care.

Likewise, local specialty care has evolved into a more consultative and less procedural profession. Again the driver was payment reform, paying handsomely for e-mail and telemedicine visits, and no longer incentivizing procedures over prevention. Payment for non-elective surgeries and evidence-based procedures has risen dramatically, solving the “on-call” crisis of the early 21st century, while elective “lifestyle” surgeries and procedures that allow baby boomers to continue their active recreational lives are no longer covered by basic insurance packages, but can be purchased on a competitive market basis both locally and overseas (Thailand has become a popular medical tourist destination). Procedures that are untested or have been shown to provide little or no benefit occur rarely, which has reduced overall costs significantly. Likewise, futile end-of-life care has been reduced through a public education campaign along with implementation of end-of-life protocols and helping clinicians discuss these issues with their patients. While there has been a modest decline in income for a few specialists, overall we have seen an increase in satisfaction with the ‘new ways’ and graduates of specialty training programs view us as a great location in which to settle their families. The new payment structure actually increased income for many specialists, much to their initial surprise. Having a stronger system of primary care referral also allowed specialists to do what they most enjoyed – deliver services that they are well-trained to provide to appropriately selected patients without first having to do the initial work-up.

Hospitals were able to down-size as a result of fewer severely ill patients, which saved millions during the seismic retrofit. Savings from improved community health are shared amongst clinicians, hospitals, payers, and patients alike. A portion of the savings is now continually re-invested in new technologies that meet the standard of “truly making a difference”. Patient safety has become the guiding principle, and hos-

pital-acquired infections have become a thing of the past via checklists and a “culture of trust rather than blame” that rewards rather than punishes the employees who bring problems and especially solutions forward. Public disclosure of errors and solutions that were developed by multidisciplinary teams including patient representatives also helped rebuild public trust, virtually eliminating hospital malpractice suits in just a few years. Defensive medicine was largely replaced by evidence-based practice - what better defense than following an accepted guideline?

Public health, having spent the previous 4 years successfully guiding the county general plan towards a healthy configuration that included improved public transit, safe walking and biking trails for recreation and commuting, and access to healthy, fresh local foods, has finally succeeded in stemming the obesity epidemic, and life expectancy is again on the rise. Inequalities in life expectancy between rich and poor, or people of different ethnicities, have also been narrowed due to these measures. Better paying local jobs in health care and information technology also helped reduce disparities. The societal re-investment in public education played a role as well.

All of these efforts combined saved the community 30% on its overall per capita health care costs in just over 7 years, which in turn created the pool that brought in universal coverage for Humboldt residents and made us a model for the whole state. Recruitment is no longer a problem - in fact, we now get to choose from amongst the best graduates in the whole country (our rejects go to Kaiser). That’s why our campaign slogan “Humboldt: A Great Place to Practice, A Great Place to Live” has become a reality!

While the above-described scenario may seem outlandish, each element discussed already exists in some form in the

“Laws” Continued from page 13

cian has: (1) a license in good standing; and (2) a permit for general anesthesia from the Dental Board of California (Business & Professions Code §1646.9.) To get a permit, the physician must have completed a post-graduate residency-training program in anesthesiology recognized by the American Council on Graduate Medical Education. The physician must also (1) document that all equipment and drugs required by the Dental Board of California are possessed by the physician and will be available for use in any dental office in which the physician administers general anesthesia; and (2) must document hospital staff membership. The prior requirement that the dentist have a permit has been repealed. The physician also has to submit a copy of the application to the Medical Board of California that verifies license status and specialty training. (Business & Professions Code §2079.) For more information, see CMA ON-CALL document #0202, “Surgicenters and Other Outpatient Facilities.”

(S.B. 620, Ch. 210, Stats. 2007.)

As noted above, the law allows a “Tarasoff” warning to be disclosed without violating the Confidentiality of Medical Information Act, consistent with applicable law and standards of ethical conduct, by a psychotherapist who in good faith believes the disclosure is necessary to prevent or lessen a serious and imminent threat to the health and safety of a reasonably foreseeable victim or victims, and the disclosure is made to a person or persons reasonably able to prevent or lessen the threat, including the target of the threat. (Civil Code §56.10(c)(19).) For more information, see CMA ON-CALL document #0815, “Physician’s Duty to Warn.”

(A.B. 1727, Ch. 553, Stats. 2007.)

WORKERS’ COMPENSATION

The 24-visit cap on chiropractic, physical therapy, and occupational therapy

treatments in the workers’ compensation system no longer applies to visits for post-surgical physical medicine and postsurgical rehabilitation services provided in compliance with a postsurgical treatment utilization schedule established by the Administrative Director of the Division of Workers’ Compensation. (Labor Code §4604.5.) For more information, see CMA ON-CALL document #1950, “Utilization Review.”

(A.B. 1073, Ch. 621, Stats. 2007.)

MEDI-CAL PROVIDER ENROLLMENT

and CMA sponsored Assembly Bill 1226 establishes that, as of July 1, 2008, a physician and surgeon who is enrolled and in good standing in the Medi-Cal program, and is changing the location of his or her individual physician practice (as defined) within the same county, will be eligible to continue enrollment at the new location by filing a change of location form in lieu of resubmitting a complete enrollment application. The new law also provides, as of July 1, 2008, for the expedited enrollment in the Medi-Cal program of any physician and surgeon licensed by the Medical Board of California or the Osteopathic Medical Board of California who meets specified conditions and submits a short form application to be developed by the Department of Health Care Services (the “Department”). Commencing July 1, 2008, Assembly Bill 1226 grants an applicant provisional provider status for twelve months. It also establishes various deadlines regarding notice from the Department of the status of an enrollment application granting of provisional status. The legislation also precludes reapplication for three years following the denial of an application for enrollment, and specifies that the three-year bar against reapplication commences on the date the application was denied. Under prior law, the three-year bar did not commence until the date of final administrative action. (Amends Welfare & Institutions Code Sections 14043.1, 14043.26, and 14043.65.) For more information, see CMA

ON-CALL document #0610, “Fraud and Abuse.”

MEDICAL BOARD OF CALIFORNIA

Assembly Bill 253 reduces the number of members of the Medical Board of California (“MBC”) from twenty-one to fifteen. It abolishes the MBC’s Division of Licensing and Division of Medical Quality and provides that the MBC, as a whole, shall perform the functions previously undertaken by the two former divisions. Also requires the MBC to delegate to its executive director the authority to adopt default decisions and certain stipulations in disciplinary proceedings. (Amends and repeals Sections of the Health and Safety Code, and repeals and adds Business and Professions Code Section 2008.) §

“IPA” Continued from page 17

US. What is unique to our county is the ability to address all elements in a comprehensive manner, resulting from our “island mentality” and our strong relationships with all significant players in health care. The job over the next 7 years is to collaborate with other community partners to help bring the vision about in an incremental fashion. We have built a solid foundation for system improvement work through support from the California Health Care Foundation (starting with the Humboldt Diabetes Project in 2003), and now have secured ongoing funding for innovation efforts from the Robert Wood Johnson Foundation’s “Aligning Forces 4 Quality (AF4Q)”, which will be discussed in detail next month. §

¹ K. Davis et al, Mirror, Mirror on the Wall: An International Update on the Comparative Performance of American Health Care (Commonwealth Fund, May 2007)

² L. Wulfsin, International Health Effectiveness Systems: How Does the US Stack Up? (Insuring the Uninsured Project, April 29, 2008)

May 22, 2008

The meeting was called to order by President, Kate McCaffrey, D.O. at 6:40 P.M.

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

- Minutes of the April 22, 2008 Executive Board Meeting, as presented;
- Executive Director Update, as presented.
- Membership Committee Report, to file.
- Society & CME Cmt Budget Reports and Balance Sheets, as presented.
- Legislative Hotlist, information/file.

EXECUTIVE DIRECTOR UPDATE was presented including the following:

- Reported on "call log": April: 120 calls for referrals, 3 complaints, 212 other calls for assistance. Special g-mail e-mail has been set up for referrals: doctor.referral@gmail.com
- Reported on the impact of the Medicare NPI mess in Northern California and the impact on several local offices.
- Reported that the final vote was to submit application of the Humboldt Bay Regional Simulation Center for consideration of the 2008 NORCAL Community Involvement Fund Grant.
- Reported on push for advertising sales for 2008-09 Physician Membership Directory. New solicitation card has been developed featuring photos of some of our members.
- Reported on attendance at the recent CMA Back To Basics Billing Seminar and Medicare Seminars.
- Shared a copy of the "We're Sorry" card that has been developed to send out to non-members when patient complaints are received, requests for information, etc.

Committee Updates:

CONSORTIUM FOR CME:

- Working on areas identified in recent accreditation site visit for update/revision.
- Working on identifying programming needs for 2008.
- 2007 reports were mailed. 2008 statements and questionnaires were mailed.

DISASTER -Meeting held 4/10/08, minutes and notes in Bulletin to follow.

EDITORIAL COMMITTEE:

- Working on preparation for 2008-09 Physician Membership Resource Directory and Residence Directory.
- Shared copy of the advertising solicitation card that has been printed using local physician photos.

PUBLIC SERVICE AND MEDICAL ETHICS COMMITTEE

- 2 reviews in process

HEALTH DEPARTMENT UPDATE was presented as follows:

Big news is the impact of the state budget. -Could impact TB control, immunizations, PH laboratory response at the state

July 2008

level, and disaster preparedness funding.

- The state health officers association, CCLHO, has joined the Alliance for Patient Care, a statewide advocacy group to maintain core clinical services for underserved.

-I presented to Grand Rounds the Health Impact Assessment we did of the three density options being considered in the county general plan update process.

There was more positive health impact from meeting housing needs in areas already served by infrastructure (e.g cities) and considerable negative impact by expanded development into areas outside of the existing infrastructure.

The HIA proposed extensive mitigations the county might take if it decides on options that negatively impact health. Summary available at www.nrsrcaa.org/humpal/resources.htm.

M/S/C to send a letter to the Planning Commission and Board of Supervisors endorsing the HIA process and encourage them to consider health impacts of the general plan alternatives, mitigating where necessary.

NOMINATING COMMITTEE REPORT was presented as follows. Nominations also will be accepted from the floor at the Annual Membership Meeting, June 10th.

- PRESIDENT..... Emily Dalton, M.D.
- PRESIDENT-ELECT..... Vacancy
- SECRETARY/TREASURER.. Mark Ellis, M.D.
- DIRECTOR..... Willard Hunter, M.D.
- DIRECTOR..... John Nelson, M.D.
- DIRECTOR..... Ronald Cordova, M.D.
- DEL NORTE DISTRICT CHAIR... Mark Davis, M.D.
- EASTERN DISTRICT CHAIR..... Norman Bensky, M.D.
- CMA DELEGATE..2nd year of term..Kate McCaffrey, D.O.
- CMA DELEGATE..... Joan Hoffman, M.D.
- CMA DELEGATE..... Emily Dalton, M.D.
- CMA ALTERNATE..... Vacancy

PUBLIC SERVICE AND MEDICAL ETHICS COMMITTEE:

Elect: M. Ellen Mahoney, M.D.
Committee: Drs. Jutila, Lesch, Mahoney, Mahan and Schunk

MEDICAL QUALITY REVIEW COMMITTEE:

Elect: Drs. Montgomery, VanSpeybroeck, Miller, Kessler, R. Jones, Pardoe and Holland.
Committee also includes: Drs. Feuerman, Bensky, Olsgard, DK Stokes, Lau, Hino, M. Davis and Mizoguchi.

2009-2010 NOMINATING COMMITTEE:

Elect: Drs. Abels, Clark, Copeland, Grossman, Mahoney,

Marshall and Mastroni;

DISCUSSION followed regarding the Press Conference scheduled for June 10th. Suggested that Mark Davis, M.D. meet with the media separately in Del Norte county. Agreed that the following topics should be discussed with the media:

- Shortage of physicians (statistics)
- Medicare problems means less access to care
- Medi-Cal cuts means less access to care

CMA TRUSTEE UPDATE was presented as follows:

-reported that the main discussion items at the CMA Board of Trustees meetings include Medicare and Medi-Cal cuts. Mentioned that the CMA is joining forces with the Nurses, Hospitals and several other organizations in filing a suit to stop the Medi-Cal cuts.

-Reported CMA is facing a financial crisis. Dr. Davis is currently a member of the CMA Finance Committee. Business must be done differently as we're operating with 1/3 less staff.

-Reported that he is running for the seat of Vice-Chair of the CMA Board of Trustees.

-Reported that CMA is in the process of implementing the new IT system that will be linked to share data with the counties.

M/S/C to change membership status from "Active" to "Retired" Membership:

David Davis, M.D.

Kenneth Miller, M.D.

TOURO UNIVERSITY Student Clinical Rotation program update was presented.

-15 students will be starting their Humboldt-Del Norte rotations on June 23rd! So far we have 58 local physicians that have agreed to be preceptors and/or lecture with the students. We are currently working on housing needs for Del Norte county rotations. Announced Steve Kamelgarn, M.D. has been named the Director of Medical Education for the program. Reported that 20% of Rebekah Harmon's time will be dedicated to the program, which will be reimbursed by Touro.

M/S/C to approve the proposed MOU between the Medical Society and Touro University for the Humboldt-Del Norte Clinical Rotation Program. A monthly fee will be paid to the Medical Society for helping to support the program and for staffing. Agreement is as follows:

Responsibilities of Touro University:

- a. Letter of good academic standing
- b. Immunization records
- c. Proof of malpractice insurance coverage
- d. Proof of health insurance

Humboldt-Del Norte County Medical Society will provide:

- a. Assist local Director of Medical Education (DME) in coordinating clinical rotations for 16 students who will each require 8 weeks Internal Medicine; 8 weeks Surgery, 8 weeks Family Medicine; 6 weeks OB-GYN; 6 weeks Pediatrics; and 4 weeks Psychiatry.
- b. Office Space
- c. Staffing
- d. Access to office equipment/supplies as necessary.

BRIEF discussion was held regarding the Cancer Detection Program, aka Every Woman Counts, paying for breast exams, mammograms and breast biopsies for women under 200% of poverty level. The program doesn't pay for digital mammography and since St. Joseph Hospital and Mad River Community Hospital have switched to this method, women from Eureka and Arcata who rely on this program must now travel to Fortuna for a mammogram. Redwood will be changing over to digital soon, so even that option is only temporary. Mentioned that Assemblymember Patty Berg has legislation pending to fix the problem, but that wouldn't be effective until January. Suggested crafting a letter to the CDP requesting that they immediately change their policy. **M/S/C** to draft a letter for circulation and approval of the Executive Board prior to sending.

DEL NORTE UPDATE was presented. Huge recruitment and retention issues still major problem in Del Norte. Mentioned that we will soon be losing our only ENT in Del Norte, the Hospitalist program is having difficulties, etc. Dr. Davis mentioned that they are looking forward to working with Touro University on the student program.

REPORTED on the California Medical Association Foundation's Obesity Prevention Project and the new provider toolkits addressing Adult and Child Obesity, as well as Pre/Post Bariatric Surgery. Copies were available for review.

SHARED copy of the California Cancer Registry Report, 2008.

MENTIONED receiving notification regarding the renewal notices for the Eureka/Arcata Health Professional Shortage Designation (HPSA) and the Facility HPSA for Pelican Bay Prison. Reported that we will be working with the consultant on the local physician data for the Eureka/Arcata re-designation.

DISCUSSION regarding the need for appointment of ByLaws AdHoc committee. Dr. Dalton agreed to work with Ms. Figas on the bylaws revisions in preparation for membership vote.

The meeting was adjourned at 8:05 P.M. Next meeting is scheduled for June 17, 2008 at 12:15 p.m.