THE BULLETIN

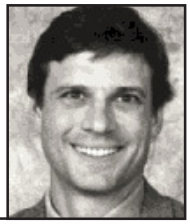
In This Issue:

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

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

THE NEXT BIG THING

LEE LEER, M.D.



"Like wildebeests thundering across the Serengeti in search of greener pastures, doctors have been fleeing their private practices for hospital employment."
Chen, P. New York Times; April 14, 2011

Whether we know it or not, we're in for a sea change in how medical care is financed and delivered. The Affordable Care Act (ACA) includes several provisions that are intended to inject improved value (i.e.,increased quality at reduced cost) intoAmerica' healthcare system. These include *The Patient-Centered Medical Home*; *Accountable Care Organizations* (ACO's); *Bundled Payments*; *Readmissions Reduction Programs*; and *Hospital-Acquired Conditions*. In sum, these provisions are intended to incentivize development of infrastructure necessary to improve efficiency, reduce cost, and provide better care – particularly for chronic diseases. The outpatient changes (*Patient-Centered Medical Home*, ACO's, and to a degree, *Bundled Payments*) will be reinforced by hospital readmission policies that are intended to improve care coordination (*Bundled Payments* and *Readmissions Reduction Programs*) and by initiatives intended to reduce hospital-acquired infections and "never events" (*Hospital-Acquired Conditions*).

ACO's are essentially integrated associations between hospitals, physicians, and allied health care providers. The ACO legislation is specifically written for Medicare beneficiaries. Each ACO must service at least 5,000 Medicare lives; however, they are encouraged to also cover commercial, non-Medicare populations. ACO's are intended to make care seamless, more efficient, safer, and ultimately less costly than the current non-system. We can look at Kaiser or the Mayo Clinic systems as already-existing ACO's, though in theory providers and hospitals participating in a particular ACO do not need to be part of similarly integrated businesses, but could rather be a private hospital (or hospitals) and private physicians (or more likely, physician groups) who jointly form the ACO and in some way jointly share control. No matter how they are structured, the intent of the legislation is that these ACO's be primary care focused, and that they be built around the concept of the Medical Home.

Nationwide, the response from hospital administrators to these aggregate changes is to begin buying up medical practices as if their survival depended upon it – because it very well may. In the 1990's, there was a wave of medical practice purchases by hospitals. Most of these were primary care practices, and most were unwound when the hospitals realized they lost money trying to manage medical practices. Indeed, the practice in which I work, Eureka Family Practice, was purchased by the St. Joseph Foundation more than a decade ago (different from the Foundation currently employing many non-PCP specialist physicians in Eureka today). Unfortunately, there were a couple of assumptions made at the time – by both parties – that were flat out wrong. We specifically declined a guaranteed salary and insisted on continuing to be paid strictly on productivity so that our motivation to work would not drop off once we were "employees," (a well documented problem that we wanted to avoid). So, having ensured a stable revenue stream, our first assumption was that the Foundation – what with all its layers of management expertise and economies of scale – could manage us more efficiently than we had managed ourselves (to be clear: we were not exactly brilliant managers ourselves). Instead, the Foundation managed *less* efficiently and lost money on us throughout the time we were affiliated. Second, both parties assumed that broad based integration of delivery systems was near at hand, and that by integrating vertically as we did, we would be able to tap into this industry-wide movement to improve infrastructure and improve quality and coordination of care. Sadly, we failed to take into account that(1) the ACA hadn't yet even been imagined, and (2) there was *no* industry-wide movement towards integration. Thus, there was no financial or legislative incentive to do anything differently, on a day-to-day basis, than we had been doing before our "merger." So, without much difficulty and with full agreement and support from both the EFP doctors and the St. Joe's administration, we unwound our relationship and went back to our independent ways. I believe the marriage lasted less than 3 years.

Today's buying frenzy is different. First, the vast majority of the practices thus far purchased are specialist practices, which ensure the hospital a steady base of providers to perform costly, well remunerated procedures. With the advent of the ACA legislation, however, hospitals are increasing their purchases of primary care practices. Second, it is not going to be as easy in the future as it was in the past to unwindthese relationships. Why? Because of the ACA: new payment structures and care models will

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OPEN FORUM

Community Health Alliance Update: Patient Engagement

M. ELLEN MAHONEY, M.D.

Medical Society Representative to CHA

On May 15th, the San Francisco Chronicle featured the story of Austin Whitely, a 22 year old graduate who walked across the stage to receive his diploma from UC Berkeley. This event is remarkably similar to others experienced by thousands of undergraduates across the country this time of year, until one learns that Whitley is paralyzed, and has been since a 2007 car accident that severed his spine above his hips. Whitley's "surreal moment" of standing and accepting his diploma happened with the help of a computerized body brace called an "exoskeleton."

A team of four doctoral students in Professor Homayoon Kazerooni's Robotic and Human Engineering Lab at UC Berkeley worked with Whitley for nine months to solicit his insights and feedback in the development of the exoskeleton. His involvement in the project became significant. Whitley's input led to design modifications such as flatter "feet" for stability, telescoping legs to accommodate for changes in height when moving from a standing to seated position, and most importantly, locks for the hand held controls to help eliminate the risk of falls from unintended movements. Customer and consumer insight like Whitley provided in the development of the exoskeleton has long been valued in the creation of goods, services, and materials in a variety of markets. Yet this practice is still only emerging in health care.

The many definitions of patient and consumer engagement in healthcare make this subject a challenge to meaningfully address. The Robert Wood Johnson Foundation defines consumer engagement as "the situation in which consumers take an active role in their own health care, from understanding their own conditions and available treatments, to seeking out and making decisions based on information about the performance of health care providers."[1] A recent Institute for Healthcare Improvement (IHI) webinar defined patient engagement in individual and collective frameworks in which individual patient engagement is "strategies for involving patients in their own health care, including techniques for personalizing care and offering patients more choice," and collective patient engagement is "giving voice to the public and involving them in shaping health care delivery."[2] The Center for Advancing Health definition is broad, simply stating that engagement is "actions individuals must take to obtain the greatest benefit from the health care services available to them."[3] With such a myriad of definitions, it is difficult to forge best practices that prove truly meaningful and have a legacy beyond a specific patient to reform the way care is delivered. Approaches such as share decision making, motivational interviewing, and self-management support help patients to engage in their personal experience of care, but reconciling the role of the patient in system redesign and care delivery can be a bit of a conundrum. Nationally, several health organizations have had success engaging patients in this type of work. At the Kimbrough Community Clinic in Fort Meade, Maryland patient advisors were instrumental in developing community outreach about precautions with swine flu treatment. Members of the Pediatric Intensive Care Unit (PICU) Family Advocacy Board at Stony Brook University Hospital in New York participated in developing processes such as including patients in nurse bedside change of shift reports, improving transitions from the Emergency Department to the PICU, and creating an education module on communicating with families for hospital staff.[4]

Locally, similar work has been initiated through the development of the Patient Partner role as part of the Primary Care Renewal Collaborative. This brings patients to the table with a team from their primary care providers' office to address quality improvement and preparation for Patient Centered Medical Home certification. Patient Partners have also provided feedback and valuable consumer insight in design of materials, marketing, and enrollment for a health care services program.

The benefits of patient engagement for patients are many. The Picker Institute lists improved experience of care, quality of care, health literacy, fit of "medical plan" and patient situation, quality of life, and self management as benefits to the patient. Health care systems experience increased responsiveness to patients, increased accountability to people served, and increased patient confidence as benefits of patient engagement.[5] *Seven Leadership Leverage Points for Organization-Level Improvement in Health Care,* a white paper issued by IHI,

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Attn. Members:

You have an option of receiving The Bulletin electronically. If you're interested, please contact the Medical Society, 442-2367 or hdncms@sbcglobal.net.

Disaster Healthcare Volunteer (DHV) Program

ANN LINDSAY, M.D.

If you are a health care professional who would be willing to volunteer in a disaster situation, read on. The Public Health Branch is reaching out to register Disaster Healthcare Volunteers in conjunction with the California Emergency Medical Services Authority (CAEMSA), California Department of Public Health (CDPH), and Humboldt County Department of Health and Human Services. This outreach is undertaken within the scope of the County's Hospital Preparedness Program.

The Disaster Healthcare Volunteer (DHV) program is a statewide system used to manage and mobilize licensed healthcare providers in response to large-scale public health emergencies. Registered volunteers may be called to assist the community in the event of an emergency. Volunteer categories include nurses, physicians, pharmacists, dentists, medical technicians, psychologists, social workers, family therapists, psychiatric technicians and other allied professionals.

When a volunteer registers on the secure web-based registry, they will indicate volunteer preferences and enter information about their skills. The registry will notify volunteers in the case of a disaster and track deployment.

During a disaster, state or county officials will determine what kind of health professionals are needed, search the database for available volunteers, and contact members via e-mail, telephone, and pager. If you receive an alert you will have a chance to accept or decline the volunteer request. If you accept, you will receive instructions on where and when to report, and what is needed for the incident. There is no obligation to participate during activation.

SOME KEY POINTS TO REMEMBER

- DHV volunteers are pre-registered and pre-credentialed
- Volunteers may select where and when they choose to serve
- Information about volunteers is secure and confidential
- THE DHV database will only be used during declared disasters and emergencies

It's Easy to Register:

GO TO: **www.healthcarevolunteers.ca.gov**

Contact **DVolunteer@co.humboldt.ca.us** with questions.

What Physicians Can Do To Preserve MICRA

To counter the personal injury lawyers' strategy, organized medicine will once again educate legislators and the public about how MICRA serves the public's and patients' interests. Members can support this effort by doing the following:

1. **Support CALPAC - CALPAC supports the candidacy of elected officials who support organized medicine's views on MICRA and other health care issues. In the 2010 election individual personal injury lawyers and their political action committees contributed almost $1.6 million to promote candidates who have the opposite viewpoint.**

2. **Encourage nonmember colleagues to join the HDNCMS/CMA and support CALPAC** – If MICRA is weakened the increased cost of professional liability insurance will far outstrip the cost of membership in organized medicine. Add in all the other benefits and advocacy that CMA and HDNCMS offer and membership is a great bargain. Call the HDNCMS with names of any physicians you talk to who are responsive. We'll follow-up.

3. **Be prepared to support HDNCMS/CMA legislative advocacy to preserve MICRA** – As of this writing, the personal injury lawyers have not yet introduced legislation to modify MICRA. If they do so, it will be essential for state legislators to hear physicians' personal perspectives on the adverse impact that increased professional liability rates and litigation would have on your ability to care for patients and remain in practice.

4. **When the legislative battle ensues, consider talking to your patients about MICRA –** Physicians' greatest asset is the esteem in which they are held by their patients. If you are comfortable doing so, share your thoughts about MICRA with your patients, and encourage them to convey these concerns to their legislators.

MICRA's public policy attributes are numerous, but the personal injury lawyers have an economic interest in seeing it weakened and have devoted considerable financial resources toward that end. For MICRA to survive this onslaught, physicians must speak with one voice to keep legislators' and the public's focus on what is most important in this debate: MICRA is fair and preserves access to care.

Additional Resources on MICRA and Tort Reform:
American Medical Association – www.ama-assn.org
American Tort Reform Association - http://www.atra.org/
California Medical Association – www.cmanet.org
Californians Allied for Patient Protection – www.micra.org (a coalition of health care organizations, including the CMA)
Civil Justice Association of California - http://www.cjac.org/
Health Coalition on Liability and Access - http://www.hcla.org/content/about-hcla

Patients Looking for Referrals & Background Info?

Send them to the Medical Society's website @ www.hdmcms.org to the physician locator "Find A Physician" (Linked to the CMA site). Members are encouraged to check their individual profile to be sure that all information is accurate. Eventually you'll be able to upload a personal photo and expand on the information posted - including the insurance carriers you're contracted with!

Contact the Medical Society office if questions, 442-2367.

MAY 18, 2011

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

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

-Reading of the Minutes (4/20/11), *approve as presented.*

-Coming, Going and Moving Around, *reviewed/filed.*

-Society Balance Sheet, *approved as presented*.

-CME Budget Report/ Balance Sheet, *approved as presented*.

-Membership Committee Minutes (5/2/11), *approved as presented*.

-Letter of Support EMS Grant, *approved to file.*

-EMCC Annual Report, *review and file.*

-AMA Communication SGR, *review and file.*

-AF4Q Press Release, *review and file*.

-Corporate Medicine Article, *review and file*.

-HPSA Designation Willow Creek, *review and file.*

-Legislative Hot List, *review and file*.

REVIEWED Coming, Going and Moving Around report and encouraged increasing outreach efforts in our membership recruitment and retention activities. Shared report of Membership statistics in prior years. Shared a copy of the Non-Member Contact Grid for feedback re: contacts.

DISCUSSION was held regarding the Governor's Proposed Budget Revision. Also discussed the impact of the changes with the Healthy Families program which will affect 3,580 enrollees in Humboldt and Del Norte.

REPORTED that the District X Delegation Caucus meeting is scheduled for June 25th in Santa Rosa. Suggested "draft" resolutions be circulated for discussion at our June 18th Executive Board meeting for presentation/discussion at the caucus meeting. Dr. Mastroni suggested that a resolution be crafted regarding utilizing local proctoring sites, such as H.S.U. for Specialty Board Re-Certification whenever possible.

DISCUSSION was held regarding difficulties with access to mental health services through County Mental Health and the problems with communications. Stressed the need for increased communication with local physicians. M/S/C to send a letter from the Medical Society calling attention to the problems with access and communications.

TREASURER REPORT. Reported meeting with the Medical Society accountant regarding changes to the financial reports to increase clarification and comparisons from year to year. We will be working on these revisions over the next couple months.

EXEC. DIR. UPDATE.

-reported that the V.I.P. program has officially started. All members need to encourage local businesses to participate in the program.

-reported that CMA has hired a company to help with follow up calls to physicians who did not renew their membership for 2011. Mentioned that this will also help in identifying their reasons for not renewing, which is something that we will be tracking closer.

-reported that we have signed the contract with DocBooksMD. NORCAL will be sponsoring an fees for 2011 (reassessing at end of year). DocBooksMD will assist in finding future sponsorship if needed. Data will be sent soon so we can begin offering this new benefit to the membership.

-reported broadcasting Memorial announcements for Drs. Frank and Corbett. Articles will also be published in *The Bulletin* and posted onto the website.

-reported that the CalHIPSO Outreach Grant has been extended into September.

-reported meeting with the Dean from Western University regarding student rotations.

-reported current surveys to Office Managers regarding salaries and interest in a local Certifying Biller Course.

-reported working with local consultant regarding updates for applications for re-designation of local Health Manpower Shortages. Discussions regarding the renewal for the Mental Health HPSA as well.

-reported sharing information regarding CMA's new "EHR Desk Reference" tool kit and assessing whether there is interest in a local meeting to review the toolkit.

-shared information regarding communications that have gone out to the membership and/or the Office Managers over the past few weeks.

-reported on plans to try to coordinate a local Physician Community Calendar - similar to the Grand Rounds Calendar to post on our website to try and avoid overlap of some of the big meetings/events. Mentioned the need to reschedule the Medical Society Talent Show due to conflicting meetings.

-report was presented on the recent Spring Social held at the Ingomar Club. Mentioned that several asked that these events be scheduled more frequently.

COMMITTEE UPDATES were presented as follows:

CONSORTIUM FOR C.M.E.

-recently completed the extensive application

Briefs, Continued Next Page

BRIEFS, Continued

for re-accreditation. Re-accreditation Site Visit is being scheduled in June. Encouraged Executive Board participation as well.

-working on annual letter to Hospitals regarding financial assistance.

-working on welcome letter to new physicians with invitation to speak at Grand Rounds.

-Planning Committees continue to work on coordinating 2011 Pain Conference (hopefully in October). The Infectious Disease Symposium being planned for 2012.

Next meeting scheduled May 18th @ 12:15 p.m. Members interested in participating are encouraged to attend.

EDITORIAL AND PUBLICATIONS CMT Next meeting scheduled for June 8th @ 12:15 p.m. Discussing re-design of local website - cross linking with CMA's website. Physician Locator linked from our home page.

MEDICAL QUALITY REVIEW CMT. Meeting scheduled for May has been canceled - no cases for review. Next meeting to be held in September.

Election of Committee Chair and nominations to fill two open slots for Orthopaedic representation on the committee at the September meeting.

Risk Management Seminar scheduled September 7, 2011. *" L e s s o n s Learned in Litigation: EHR Best Practices"*

MEMBERSHIP COMMITTEE -. Next Meeting scheduled: July 11th @ 6:00 p.m. Focus of committee has been Membership Retention. 21 members did not renew for 2011 prior to the cut-off date of 4/1/11. Working on identifying reasons for non-renewals and/or not joining. All members are encouraged to help with recruitment and retention activities.

PHYSICIAN WELL BEING COMMITTEE - Next meeting scheduled June14, 2011. Working on design of poster for medical staff lounge and libraries. Working on outreach efforts for committee.

PUBLIC SERVICE AND MEDICAL ETHICS COMMITTEE - Working on outreach article AND communication to send out to Office Managers re: referring patients to committee when needed.

WOMEN IN MEDICINE GATHERING scheduled for Sunday June 5, 2011, 1-3 p.m. @ Dr. Marshall's.

REPORTED regarding the need for two additional "Host" Homes for medical students that are rotating through later this month.

HEALTH DEPARTMENT UPDATE.

-reported recently giving Grand Rounds presentation on "Humboldt County Health Statistics", which will be posted to the Medical Society's web site for member's reference.

-reported on case of human rabies in Willow Creek. Suspected source may be unvaccinated cats at a local school. CDC and California Department of Public Health are on site to assist with the investigation. Public Health is advertising for upcoming low cost pet vaccination clinics. Noted that more community education about vaccinating domestic animals, avoiding contact with wild mammals and trapping the animal - seeking medical care if bitten.

LEGISLATIVE UPDATE.

-reported going to Sacramento to testify regarding AB824 (Chesbro), which would erode the ban on Corporate Practice of Medicine by allowing rural hospitals to hire physicians. The bill was pulled by the author.

-encouraged the Exec Board to review the Legislative Hot Sheets and the CMA Press Clips.

REPORTED on the recent Spring Social and requests to have these more frequently. Suggested referring to the Membership Committee for further discussion.

REPORTED that the California Public Protection and Physician Health, Inc. has posted copies of the new policy statements and guidelines from two organizations central to CPPPH's mission (the Federation of State Medical Boards and the American Society of Addiction Medicine. These have been forwarded to the Physician Well Being Committee for review.

The meeting was adjourned at 7:50 P.M. Next meeting will be held on June 15, 2011, to discuss resolutions prior to the District X Caucus Meeting.

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states that: "In a growing number of instances where truly stunning levels of improvement have been achieved… Leaders of these organizations often cite putting patients and their families in a position of real power and influence, using their wisdom and experience to redesign and improve care systems as being the single most powerful transformational change in their history."[6]

If you would like assistance building patient engagement opportunities within your practice, please contact Jessica at the Community Health Alliance: 707-445-2806.

References:

[1]. Robert Wood Johnson Foundation, Quality/Equality Website: Glossary of Related Terms http://www.rwjf.org/qualityequality/glossary.jsp

[2].Institute for Healthcare Improvement, *Self Management and Patient Engagement: An Opportunity to Optimize Outcomes*, 16. Feb. 2011.

[3].Center for Advancing Health, *A New Definition of Patient Engagement: What is Engagement and Why is it Important?* RLINK"http://www.cfah.org/pdfs/CFAH_Engagement_Behavior_Framework_2010.pdf"http://www.cfah.org/pdfs/

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make it progressively more difficult if not downright impossible to return to private practice.

> "Right now you may know how to make money in a fee-for-service world; but you'll have no experience in the payment system five years from now."
> Robert Kocher, M.D., Quoted in the New York Times; April 14, 2011

As of now, there are more hospital-owned medical practices in America than there are physician-owned practices. And this ratio is guaranteed to continue to rise, driven as much by changing physician work habits (younger physicians are much more willing to trade their autonomy for defined work hours and guaranteed salaries than were their predecessors) as it is by regulatory and structural change. However, the struggle to determine who – physicians or hospitals – dominates the future healthcare landscape is hardly settled. Unfortunately, I doubt most local physicians even know this struggle is going on. It behooves us, though, to pay attention. Ideally, we will ultimately decide where to throw our allegiance based upon reason, logic, and the best interests of American healthcare and the future of medical practice. Alternatively, we physicians will repeat past behaviors: remain relatively oblivious and be swallowed up by whatever powerful entity ends up being in control when the dust settles.

If physicians should come to control Accountable Care Organizations (ACO's), the implications for hospitals, communities, indeed, the entire medical industrial complex will be immense and far-reaching. Hospitals' census will decline as more care shifts out of the hospital sphere.Hospital revenue will fall.Hospital bond ratings will fall, and hospitals and hospital systems will have more difficulty borrowing money and expanding services. Their influence in their local communities will fade, and their market dominance will cease.

If, instead, hospitals come to control ACO's, most of the savings from the new delivery system will go to the hospitals. Both physician income and physician status as independent professionals will decline. Once this happens, it will be difficult if not impossible for physicians to ever regain the lost income and status, let alone the ability to raise the capital necessary to try to control health care institutions.

To a great degree, what happens in each community is going to depend upon local variables, such as how dominant, well organized and forward thinking a local hospital is currently; how well organized and cohesive the independent physicians are; and whetherthere are already in existence powerful integrated medical groups. It will be interesting to see how this all plays out in Humboldt County. Right now, we have a robust, well-organized IPA that has the management and IT infrastructure to do whatever its members get behind. However, its members are hardly ever of one mind about much of anything – let alone something as big as forming an ACO. Indeed, many of its members – and more all the time – are also employed by the hospital through its Foundation, thus creating a potentially fatal conflict of interest. On the other hand, we have a hospital that clearly has the resources and the will to take control, but that is encumbered by far-away corporate control and even farther-away religious constraints that are not always in alignment with Humboldt County's needs. These realities can make moving intelligently, strategically, and efficiently quite difficult if not impossible.

> ...the next few years will be a period of what economists call "creative destruction": our fragmented, fee-for-servicehealth care delivery system will be transformed into a higher quality, higher-productivity system with strong incentives for efficient, coordinated care. Consequently, the actions of physicians and hospitals during this period will determine the structureof the delivery system for many years.
> Kocher, R., and Sahni, N.
> N Engl J Med 363;27; nejm.org; December 30, 2010

Who knows? It is possible that the conflict inherent in this jumble of allegiances, coupled with our geographic isolation from many competitive factors that could drive a wedge between entities (e.g., multiple powerful competing hospital systems, multiple competing medical groups) will lead to something not heretofore envisioned. We may choose to develop a uniquely symbiotic ACO that is good for hospitals, good for doctors and very good for patients.

But I'm not holding my breath.

Articles reviewed for and discussed in this essay:

1. **Kocher R, Sahni NR. Physicians versus hospitals as leaders of accountable care organizations.** ***N Engl J Med*** **2011;363:2579-82.**
2. **Kocher, R, Sahni NR. Hospitals' Race to Employ Physicians – the Logic behind a Money-Losing Proposition.** ***N Engl J Med*** **Online; March 30, 2011 (10.1056/NEJMp1101959).**
3. **Chen, P. What 'Big Medicine' means for Doctors and Patients.** ***New York Times*** **April 14, 2011.**
4. **Iglehart, J.K. The ACO Regulations – Some Answers, More Questions.** ***N Engl J Med*** **2011; 364:e35.**

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CFAH_Engagement_Behavior_Framework_2010.pdf 2010

[4].Johnson, B. *Hospitals and Communities Moving Forward with Patient and Family Centered Care.* May 2011

[5].Picker Institute Europe, www.investinengagement.info

[6].Reinertsen JL, Bisognano M, Pugh MD. *Seven Leadership Leverage Points for Organization-Level Improvement in Health Care (Second Edition).* IHI Innovation Series white paper. Cambridge, MA: Institute for Healthcare Improvement; 2008. (Available on www.IHI.org)

CLASSIFIED ADVERTISEMENTS

JOB OPPORTUNITIES

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

BOARD CERTIFIED PRIMARY CARE PHYSICIAN needed at the Eureka Veterans Clinic. Part-time and full-time hours available. Please contact Nancy Craig at 442-5335 if interested. *(BC511)*

BUSY PSYCHIATRIC PRACTICE with Psychiatrist and P.A.-C looking for mid-level practitioner to join practice (part time at first) Pleasant office environment and staff. Practice focuses heavily on psychopharmacology and brief supportive counseling. Psychiatric experience a big plus but will train and supervise the right person. Please Fax Resume to 707-826-2481 *(IT311)*

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)*

FAMILY MEDICINE physician needed at United Indian Health Services (UIHS). We are seeking a California Board Certified/ Board Eligible Family Practice Physician to join our Del Norte County team at the Smith River Clinic to provide outpatient care; preferably with obstetric skills. Physician will work closely with a fellow physician and two other physician's assistants in providing culturally sensitive, family practice care, to achieve wellness for the American Indian community served. Contact: Trudy Adams Human Resources Recruitment Technician at (707) 825-4036 **trudy.adams@crihb.net**

FAMILY NURSE PRACTITIONER OR PHYSICIAN ASSISTANT. (Smith River UIHS)- Current California FNP or PA license & ACLS cert. req'd. Individual will work closely w/ team of professionals to provide culturally sensitive, high quality, comprehensive health services to the Indian Community. Must have ability to work independently. Contact: Trudy Adams **trudy.adams@crihb.net**, Phone (707) 825-5000 ext. 4036.

TRANSCRIPTONIST AVAIL 4+ yrs exp. in GP, OB-GYN ultsnds, IM, ortho, cardiac, ltrs & C notes. Local/Reliable. (707) 725-6517 or (707) 845-6181.

PROPERTY FOR SALE/ RENT/ LEASE

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.

MEDICAL OFFICE SPACE AVAILABLE in Fortuna. New clinic -- 2,500-5,000 sq ft. Equipt for lab; has comfortable waiting room, eight treatment rooms and 4 private offices for providers and/or office/ nurse managers. Please contact Arlene Guccione for more information , (707) 725-8770 . *(JG7-10)*

MISCELLANEOUS

SMALL BACKPACKING TENT, excellent condition, room for one tall person or two small persons, being offered for a medical person to live in while volunteering in Haiti and leaving behind to shelter a Haitian. Call Gena Pennington at 822-4948.

* * * *

FOR SALE:

Welch wall mounted Blood Pressure Monitor
Metal xray storage shelves –(2) 5 tier (1) 6 tier
Blood draw chair
Ambco Audiometer model 650
Large Dry Erase Board
2 bullet proof reception desk widows with metal mounting hardware

Contact Nancy Craig at 707-442-5335 x 338 *(BC611)*

EXAM TABLE FOR SALE. LIKE NEW. $50. OBO
Contact: Elesha @ Eureka Pediatrics, 445-8416
(ME611)