North Coast Physician

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"Driftwood Dragon 1 - 2011"
Stephen Kamelgarn, M.D.

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

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CMA LOOKS AHEAD

Agenda Set for 2013

For more than 150 years, the California Medical Association (CMA) has fought on the frontlines of nearly every major policy, political, budgetary, societal and legal campaign affecting the state's physicians. The shared challenges facing physicians are more formidable today than ever.

As California and the rest of the nation faces a time of unique budgetary challenges and monumental change in health care, it is more critical than ever before that physicians come together with a unified voice to advocate for the profession and for the health and well being of the patients we serve.

In January 2013 the CMA Board of Trustees adopted five distinct goals for the association this year. Below are details of each of those goals.

GROW MEMBERSHIP BY 5%

CMA member physicians are our most valuable asset. Without your dues dollars, CMA wouldn't be able to do its vital work protecting the practice of medicine and ensuring access to quality medical care for all Californians.

Over the past two decades, organized medicine nationwide has seen a gradual decline in membership, and CMA was no different. In 2011 and 2012, we reversed that trend, reaching a 20 year membership high of more than 37,000 members last year.

CMA made a significant investment in membership development in 2012, increasing data analysis and ramping up recruitment and retention efforts. These efforts, along with focused recruitment achievements in select counties, resulted in a net growth of over 2 percent for the year. It may not sound like a lot, but after years of slow decline, 2 percent growth is a significant and laudable achievement.

Our goal for 2013 is to continue the forward momentum and grow membership by 5 percent by year's end. Increased recruitment activities in 2013 will focus on "pilot projects" with select partner counties.

COMMITMENT TO PUBLIC HEALTH

CMA has a rich history and legacy of demonstrating its commitment to public health. CMA has incorporated key public health legislation in its legislative agenda every session and has maintained a high profile on public health issues. Advancing reforms in order to benefit our patients and the public has always been a priority for the association, and continues to be at the top of our list.

In 2013, CMA will be working proactively with public health leaders to track emerging trends and to strategize solutions for continuing challenges.

We will continue to include legislation focusing on public health in the legislative agenda this year. CMA is also exploring new ways of demonstrating its commitment to public health, including providing educational briefings to legislators on public health matters and participating in health fair-type events.

PROSPERITY FOR ALL PHYSICIANS

At no time perhaps since the creation of Medicare has the health care delivery system seen such dramatic and rapid changes. The transformation of health care in California is largely being driven by three major developments:

(1) The rise of large medical groups, integrated delivery systems and advanced analytics, health information technology and population health management.

(2) Health care reform-related policy changes at the federal and state levels that emphasize care coordination, accountability and paying for "value"—efficient, high quality care.

(3) Purchasers—private insurers in California and the nascent Covered California Health Benefit Exchange—are making it very clear that physicians and hospitals need to control costs or risk being isolated or frozen out of increasingly narrower network products.

These trends will likely accelerate as cost pressures grow, and health reform and other private sector initiatives continue to ramp up in 2013 and beyond.

These powerful forces pose particular challenges, and opportunities, for independent physicians and medical groups interested in maintaining a degree of autonomy while market and policy forces are driving the industry towards hospital-led systems. At the end of the day, the system benefits from a diverse set of providers competing to deliver high-quality, high-value care.

Over the next year, CMA will be working feverishly to help physicians in all modes of practice to not only thrive in the rapidly changing health care marketplace, but to lead the charge towards new patient-centric, physician-led models of care.

One of the biggest challenges for physicians now and in the future is access to capital to invest in their own practices so that they can expand into different markets, adopt new technologies and care models and maximize reimbursement. Without capital for necessary infrastructure, physicians are unable to implement systems to help them remain competitive and independent. In contrast, hospital systems and health plans are at a strategic advantage.

CMA staff are developing three distinct proposals that represent "game-changing" strategies in support of prosperity for all physicians; 1. Study and design

physician-led health care delivery models and create a CMA-sponsored backbone for independent physicians and medical groups; 2. Develop and implement a quality initiative for independent practices with the goal of reducing clinical variation; and 3. Increase physician access to financial capital.

Stay tuned for additional details as these proposed initiatives evolve over the coming months.

DEFEND MICRA

As we all know, the trial attorneys have sought to modify or eliminate California's Medical Injury Compensation Reform Act (MICRA) protections since the state's landmark medical malpractice insurance reforms were established in 1975.

Under MICRA, injured patients are fairly compensated, medical liability rates are kept in check and physicians and clinics can remain in practice treating patients. MICRA has no limits on the economic damages that can be recovered by injured patients (medical costs and lost wages). Injured patients also can sue for unlimited punitive damages and recover up to $250,000 in non-economic damages (pain and suffering). In addition, MICRA includes a sliding pay scale, which ensures that more money goes to patients, not lawyers. The $250,000 cap on non-economic damages has proven to be an effective way of limiting meritless lawsuits, but has been targeted by the trial lawyers because it restricts the amount of money they can collect in damage awards.

For more than 40 years, CMA has defended this important law in the legislature, in the courts and in the court of public opinion. We have been successful primarily due to vigilance and allocation of sufficient resources on all fronts. This year will be no different.

Several factors make 2013 a decisive year for defending MICRA. Both houses of the legislature contain Democratic supermajorities, traditional allies of the trial attorneys. Also, nearly half of the members of the Assembly are newly elected without a voting history. Attorneys are utilizing new and creative arguments to challenge long-standing constitutional approval of MICRA and to move public opinion. They are attempting to use heart-wrenching horror stories placed with compliant media outlets in order to defeat MICRA.

CMA in 2013 will focus on educating new members of the legislature on the importance of MICRA for their constituents and the role MICRA plays in patient protection and access to care. CMA's government relations team will also be ready to jump into action at a moment's notice should the trial attorneys try and utilize a late "gut and amend" to push an anti-MIRCRA bill through the legislature, as they did at the end of last session.

As always, CMA's political action committee (CALPAC) will remain involved in the fight, amassing the financial resources that will be needed should a costly MICRA challenge emerge this session.

CMA's legal team also continues to aggressively monitor court activity and seek out opportunities to provide guidance to courts when they are asked by plaintiff attorneys to weaken or eliminate MICRA.

LEAD CHANGE IN HEALTH CARE REFORM

In 2010, Congress passed historic sweeping health care legislation, the Patient Protection and Affordable Care Act (ACA), which reformed the for-profit health insurance industry and beginning in 2014 will provide health insurance to most of the nation's uninsured. The ACA also formed the CMS Innovation Center to fund myriad pilot programs to test new health care delivery and payment models.

Under the ACA, two thirds of California's uninsured will be covered by private insurance through a health insurance exchange purchasing pool. The remaining uninsured will be covered through a massive expansion of the Medicaid program.

CMA in 2013 will continue to monitor implementation of the ACA in California, ensuring that health care reform works for physicians and their patients. Specifically, CMA will remain engaged as Covered California, the state's health benefit exchange, prepares to open for business. The exchange's goal is to start pre-enrollment in October 2013. Critical federal regulations and guidance, however, still must be finalized and released.

Among the critical issues still needing to be hammered out before the exchange opens for business are: the state's plan for monitoring and enforcing network adequacy requirements; the reconciliation of major discrepancies between state and federal grace period guidelines for premium nonpayment; and how exchange plans will handle the subject of out-of-network benefits.

While the pre-enrollment date is only months away, exchange leadership has yet to select which plans will offer products on the new marketplace, meaning that benefit design, contracting and enrollment policies will need to be developed at a breakneck pace.

CMA will also be working to make sure that physicians understand the implication of contracting with exchange plans and to ensure that doing so places minimal administrative burdens on physicians.

TOGETHER WE ARE STRONGER

The shared challenges facing those who practice medicine may never have been more formidable than today. In this uniquely turbulent political and fiscal environment, we have redoubled our efforts to provide the support and services physicians need to be able to focus on their jobs and bring good health and happiness to the lives of millions of Californians.

Changes are coming – and CMA is poised and ready to meet the demands of the future.

Medical Fragmentation

STEPHEN KAMELGARN, M.D.

Medical practice, over the past 35 years, has undergone changes that have been little short of revolutionary. We, who trained in the 1970's and 80's wouldn't recognize the training of today's physicians. When we were in training we had a panel of hospitalized patients that we saw for their entire illness. Our attendings rotated with us for a month, and, at least from our viewpoint, there was a lot of stability in the composition of our medical teams. And while we worked long, inhuman hours we were able to keep on top of what was going on, and what needed to be done.

Today's physicians in training have a completely different work environment. Because of new safety regulations, no one works more than 18 hours, there are more hand-offs from physician to physician, attendings are present for only a week or so, rather than the full month. Because of EMR, we're all being drawn toward the computer, and answering to its demands, rather than that of the patient. (See "Deal with the Patient, not The Computer" NCP April 2011). The available number of medications, diagnostic tests, imaging technologies, and other interventions have increased astronomically. While this enables us to "do more" for the patient, it also increases the number of people involved in the patient's care. With the addition of each new team member, the patient's complexity of care increases exponentially.

The changes that have occurred during medical training have also been replicated in "the real world." Very few, if any of us, now take care of hospitalized patients. Inpatient care has now been delegated to hospitalist physicians, who like today's residents, rotate in 12 to 24 hour shifts. As the number of people involved in patient care increases, the likelihood of medical error increases proportionately.

The increased number of new communications technologies threatens to drown us all in a sea of information overload. Cell phoning, texting, tweeting, face-booking, e-mailing, and faxing hammer us with a constant data stream. Ironically, as we all become more "interconnected" we become more atomized. We become less able to actually communicate and talk to someone. When a patient now enters the hospital, he is going into a big black box. It is seemingly hard, if not almost impossible, for the inpatient doc and the patient's outside physician to talk to one another. In other words, medical care is becoming increasingly fragmented. This is no one's fault. It's an unintended consequence of the increased volume of communications stemming from all the new technologies. Who has the time to wade thru phone menu systems, or check their tweets on their cell phone in the middle of meeting with a patient? Either the patient or the caller gets shortchanged. Vital information ofttimes does not get transmitted.

These changes are not unique to medical practice. It's happening in all spheres. But since medicine is so intensely personal, these changes are especially acute. As automation increases, we interact less with one another. Now this may not be that big a deal if one deals with an ATM rather than a bank teller, but it is a huge deal if one is communicating critical information.

While it is possible for the hospitalist physician to have "Read Only" access to a patient's outpatient medical record, it still isn't common, and I wonder how often physicians actually take advantage of that availability. Having access to a medical record, while important, cannot take the place of the two involved physicians actually talking to one another.

With inpatient docs changing every 12 hours it's difficult, if not impossible for the patient's personal physician to actually speak with the hospitalist. People are proposing centralized "Health Information Exchanges" (HIE), but so far results are quite discouraging. As it is now, just in the interchange between St Joseph's or Mad River's EHR's and what we have in our files are often in disagreement, and sometimes just flat out wrong. It may take me weeks to figure out just what transpired when one of my patients was admitted. For many of my complex patients there have been major changes in medications and therapies, and it takes quite a while to "get up to speed," once the patient comes back to my care. This could potentially result in something extremely important not getting done in a timely or appropriate manner.

In our office we are in the process of adopting a "pod" structure of the workspaces of providers and other members of the team. This allows us to informally talk to one another, share tips and generally brainstorm. This is also mirrored in private industry as Google and other IT giants are designing there office spaces around open "bullpens," that allow employees to interact informally. Obviously, we can't "bullpen" with hospitalist docs, but I see no reason that it couldn't be done electronically: a secure patient oriented chat room. It isn't as good as a conversation, but it's better than nothing.

We went into medicine to deal with people, not communications systems and

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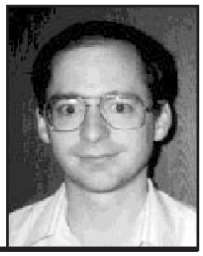
Open Forum

Latest News on Sutter Health's Regionalization and Critical Access Efforts

Gregory Duncan, M.D.



You may be wondering what prompted the resignation of our CEO. Based on the timing, I doubt the resignation had anything to do with physician input. Local doctors, including those employed by Sutter Health and Sutter Coast, asked Mr. Cohill to bring in a new CEO for our hospital last year, but Mr. Cohill took no action. I believe it is all of us in the community standing together that makes Sutter Health nervous. Our local elected leadership deserves credit for relaying your concerns to statewide agencies. The local response has been universally positive, but in particular, Kathryn Murray and Kelly Schellong have been working with the City Council, Roger Gitlin and Martha McClure with the County Supervisors, and Dwayne Reichlin and Kevin Caldwell with the Healthcare District. Sheriff Dean Wilson and District Attorney Jon Alexander have both written strong letters of support, and Richard Enea and Mike Sullivan each submitted recent letters on behalf of city and county leadership. The Director of the United Indian Health Services, representing seven local Native American tribes, wrote an excellent Declaration in support of the litigation opposing Sutter Health. Most of all, the more than 2500 local residents who signed our petition to oppose Sutter Health should know your voices are being heard. Next week, I will send a copy of the petition to state and federal representatives.

Here is the update on the litigation between the Healthcare District and Sutter Health: You may recall that during the most recent hospital Board meeting, the Board voted to "postpone" their efforts to transfer hospital ownership to Sutter Health.

But the Board did not rescind their three prior votes in favor of Regionalization, nor did they agree to set aside litigation in the Court of Appeals, where Sutter Health is trying to lower the Injunction that is blocking them from taking hospital ownership or implementing Critical Access designation.

Next, some good news: Based on letters of concern from community members, I was contacted by the offices of State Senator Jim Nielsen, and U.S Congressman Jared Huffman, who offered their support. If you want to have a say in the future of healthcare in our region, please consider writing to Sen. Nielsen and Congressman Huffman. If you need help putting your thoughts on paper, send me an email at drgjduncan@yahoo.com or call me at 707-465-1126.

Finally, the best news of all: If we keep working together, something good will come out of this struggle. If we can expand and improve healthcare in our region, every resident and visitor to our beautiful North Coast will benefit.

Thank you all again for your advice, support, and prayers,

Actual Size 4"x 5"

Emergency Situation Driving Emblem

CMA, in cooperation with the California Highway Patrol (CHP), has put life back into a state law that allows physicians to exceed speed limits when driving to emergencies. The law (Vehicle Code 21058)—passed in 1959, but implemented for only a short period—provides a waiver of most speeding laws when the physician's vehicle displays the CHP-approved emblem.

Please be aware that:

1. the exemption applies only when traveling to emergencies;
2. the exemption is intended for use on freeways, and doesn't allow a physician to exceed the state maximum speed, which varies by locale between 65 mph and 70 mph;
3. the exemption does not apply to other traffic laws, such as stop lights, stop signs, HOV lanes, yield signs, etc.; and
4. the exemption does not apply if the vehicle is operated in a reckless manner or without regard for the safety of others.

The emblem is now available from CMA in sticker form.

CMA members receive one free emblem. Member can order additional emblems for $10 each. The nonmember price is $50 each. *http://www.cmanet.org/resource-library*

Millennial Times: Women in Osteopathic Medicine

KATE MCCAFFREY, D.O.

Dr. Still commented, "I opened wide the doors of my first school for ladies…Why not elevate our sisters' mentality, qualify her to fill all places of trust and honor, place her hand and head with the skilled arts?"

A.T. Still, D.O. believed in equality. In fact, the first class of osteopathic medicine at the American School of Osteopathy accepted women. Jeanette Bolles, D.O., was the first woman to be granted the D.O. degree. Louisa M. Burns, D.O., was a prominent researcher in the osteopathic profession. Barbara Ross-Lee, D.O., became the first African-American woman to be appointed the dean of a United States medical school.I was recently asked by one of my students to participate in a Woman in Medicine Panel at COMP Northwest in Lebanon, Oregon. I felt honored and immediately started thinking about what I might share. The student expressed interest in inviting local women physicians who represented all walks of life and specialties to gather informally for wine, cheese and conversation.

I started thinking about my experiences as a "female" physician. Had I experienced acceptance in medicine? Where had I encountered resistance or sexism? What makes my experience of practicing medicine different from my male colleagues? And most importantly, what could I pass on to the next generation to inspire hope, courage and fulfillment?

A couple of thoughts came to mind immediately. A few scenarios were not pleasant at the time but thankfully, benign. I recall being passed over for invitations to go play golf with my male classmate on my cardiology rotation in the third year of medical school. He received a higher grade than me, and, in this case, I was pretty sure I was smarter than he was. This was probably the harshest overt gesture I experienced during medical training. Again, I count myself lucky. I remember my surgical rotations, and the strong women residents who ran the surgical service at Emmanuel Hospital in Portland, Oregon. I remember wanting to be like them, to talk like them and to cut my hair like them. I guess we all want to feel like we belong. I remember assisting a female orthopedic attending, who was a hundred pounds soaking wet, perform a surgical procedure with confidence and finesse. I have yet to see anyone handle a saw like she did!

I remember my emergency room attending at Lutheran Hospital in Cleveland Ohio. She taught me about kindness and humanity. She taught me to feel empathy and show respect toward patients that a normal person might pull away from in disgust. She taught me to write about my medical experiences. She taught me about a world out there without borders; that people all over the world need our help to build sustainable health care systems. She taught me that most of the world's health care is linked to public health, politics and religious beliefs. I encourage my students to visit third world countries and to start ambulance services and hospitals in countries that have none.

Years ago I recall seeing one of my mentors stand up in front of 500 people at a national conference and speak to a resolution. I remember bursting with pride that she was from our delegation and that she was my friend. I have since become a physician capable of expressing my thoughts succinctly to hundreds of physicians. Somewhere along the way I lost my shell and my shyness thanks to this woman and women and men like her. Because of her example I advocate for justice and equality for all physicians and in doing so, indirectly our patients.

I recall being coached by a colleague as I made one rookie mistake after another with my first medical student class at Touro University in Vallejo, California. I now dress the part and practice "restraint of pen and tongue". I strive to act appropriately around students, staff and faculty. It is serious business educating and training the next generation of osteopathic physicians. There may be a few students in my audience who are looking to me to teach them about respect and professionalism in medicine. We rarely glimpse our impact upon others. As physicians we are always "on" and we are held to a higher standard by society.

I would like to take a moment to recognize a few of my women mentors who have helped to make my journey more comfortable; who illuminated the path when it was dark; who unknowingly showed me how to be a caring physician, teacher, advocate and person.

It is these women and many others to whom I say, "L'chaim!" Dr.'s Karen J. Nichols, Paula M. Crone, Susan Macintosh, A. Kay Kalousek, Lorane M. Dick, Stephanie White, Robyn L. Dreibelbis, Alissa Craft, Wendy Neal, Michelle "Micha" Veneziano, Rachel Brooks, Maud H. Nerman, Bonnie Gintis, Sandra L. Sleszynski, Ann L. Habenecht, Judith O'Connel, Janet M. Burns "Burnsy", Rebecca E. Guisti, Janice U. Blumer "Nettie", Geraldine T. O'Shea, Jane E. Carreiro and to all the osteopathic physicians of the future!

CLASSIFIED ADVERTISEMENTS

JOB OPPORTUNITIES

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

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)*

BUSY MEDICAL PRACTICE LOOKING FOR PA OR FNP. Part time or time negotiable. Please call Dee @ 707 444-3885

FNP WANTED: Experienced FNP wanted for busy Family Practice, 20 to 30 hours per week, to include Saturdays. Small office with excellent staff, high tech internet based EHR and great physician support. Send resume to Teresa Marshall, at drmarshall-soffice@att.net

FNP NEEDED. Full Time. Busy Family Practice.
Contact: Lorraine (707) 443-8335

TEMPORARY BACK OFFICE person. Part Time. Experienced with EMR. Fill in for illness. Contact Melvin Selinger, M.D., (707) 822-8395

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.

LODGING FOR YOUR LOCUM TENENS' AND TRAVELING NURSES' NEEDS: Third Street Suites at 1228 3rd Street offers fully furnished luxury one-bedroom apartments in Old Town Eureka. The monthly rate of $1800 includes all utilities, CableTV, and Internet, a private garage, and weekly maid service. Please visit www.ThirdStreetSuites.com for additional info & pictures, or call Regina at 707-443-3001.

MISCELLANEOUS

FIREWOOD FOR SALE. Call (707) 499-2805

PARTNERSHIP HEALTHPLAN OF CALIFORNIA (PHC) is looking to hire local staff in Humboldt and Del Norte counties.

-Provider Representative -Facility Site Nurses

more information and to apply on line @: www.partnershiphp.org

E-Mail Address Updates? Allied Health Practitioner Updates? Find information published in the Directory that needs to be updated? Please let the Medical Society know so we can keep records as up-to-date as possible.

23RD ANNUAL CRITICAL CARE CONFERENCE

Friday, April 19, 2013

8:30 - 4:00 p.m.

River Lodge Conference Center

Information/Registration: (707) 834-4289

Display Advertising Rate Schedule

SIZE	MONTHLY	SIZE
1/4 Page	$140.00	7.45" x 2.61"
1/2 Page	$160.00	7.45" x 5.23"
1/3 Page Vertical	$150.00	2.37" x 9.95"
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Inside Cover/Full Page	$275.00	7.90" x 10.40"
Business Card Ad	$65.00	Copy Ready 2" x 3.5"
Classified Ads	$5.25 per line	

DEADLINE: 15th day of the preceding month to be published