North Coast Physician

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

In This Issue:

Cover Photo
"Pilings"
Stephen Kamelgarn, M.D.

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In My Opinion

How We Got Here

George W. Ingraham, M.D.

Health care in Humboldt in the 1960s wasn't very different from the 1890s. Most doctors practiced solo. They rented an office, hired a receptionist and perhaps an office assistant or a nurse, and took out a loan to buy some equipment. Patients, after home remedies and pills from the drugstore hadn't worked, made appointments or dropped in. Sometimes the doctor came to your house. The receptionist took a check or some cash at the counter. or sent a bill at the end of the month. At the end of the day, one of the office ladies took the day's cash receipts to the bank. There was no medical insurance as we know it today. Medical care was not very expensive, and compared to today, it wasn't very effective. All of that changed in the last quarter of the Twentieth Century.

In the 1970s, I was at a meeting at St. Joseph Hospital with some local doctors and insurance folks from San Francisco. We knew they were big city business types: they had flared trousers and wall to wall neckties, and said "prioritizing our options" instead of "deciding what to do first". They represented a new invention called a PPO: "preferred provider organization". This was a medical insurance company which would reduce premiums by contracting with doctors to provide services at reduced fees. The policy holders would have only an annual premium to pay for all their health problems: no more budget busters from unexpected emergencies, as long as they had seen a "preferred" provider. Doctors, as long as they had signed up to be discount…oops: "preferred" providers, would get paid: no more "no pays or slow pays". It sounded pretty good. The other shoe dropped when some of the docs at the meetings asked how it would work if all the local doctors declined to be preferred providers; the insurance folks said they'd recruit their own doctors and set them up in the community; or limit enrollment of doctors so that those who did not sign up would find themselves frozen out. An empty threat, but an early indication of how the insurance industry was poised to earn a profit from health care; which was then disorganized, independent, and mainly solo practices which set their own scope of practice, office hours, and of course fees.

Preferred Provider Organizations were followed by Health Maintenance Organizations ("HMOs") in the 1990s, who promised the same benefits: single monthly premium for the public, and guaranteed payment of the negotiated fee to the doctor. "Negotiated" meant that the doctor either signed a fee agreement, or lost patients to those who had. This, added to some other Medicare and Medi Cal regulations, many of which made pretty good sense, led to the closing of many single doctor practices. The introduction of required computerized billing and record keeping by the government and the insurance companies, requiring heavy investment in equipment, made solo practice too burdensome for most doctors. In the 1990s, physicians formerly solo began forming group practices, former groups acquired more doctors, and the insurance companies found themselves holding less powerful hands at the bargaining table. Some of the older solo docs turned off the lights and rode off into the sunset. Some younger solo docs turned out the lights, went to business or law school, and for one friend of mine: divinity school (not much chance of insurance companies taking an interest in that).

Those are a few of the reasons why we are where we are today. The solo doctor

"How", Continued on Pg 10

PHYSICIAN EDUCATION & EVENT CALENDAR

Physician Education & Event Calendar has been posted on the Medical Society's Website - *www.hdncms.org* under "Events/Calendar" drop down menu. We will be posting community educational programs for physicians with details regarding date, time, location, target audience *(including if closed meeting)*, agency providing CME Credit, RSVP and contact information. With the proposed increase in educational opportunities, we hope this real-time calendar will help avoid overlap of CME meetings. For more information contact: Terri Rincon-Taylor, CME Coordinator, *ttaylor_hdncms@sbcglobal.net,* (707) 442-2353.

Planning for Blood Safety and Availability in Emergencies

Elie Richa, M.D. MBA
Medical Director
Northern California Community Blood Bank

Providing critical health services in our geographically isolated area is vital during emergencies. At the Northern California Community Blood Bank (NCCBB), we find that a difficult part of the emergency preparedness process is raising the priority status of the local blood supply with emergency management agencies and ensuring that we are not overlooked in the larger plans and conversations occurring in the health system at county, state, and national levels.

Blood donation is in decline, here and across the nation. We are looking at ways to increase collections in order to meet the needs of the patients we serve.

In the event of a catastrophic storm, will our Blood Bank be appropriately prioritized for access to fuel and early restoration of utilities? When a landslide or tsunami closes highway 101, will our hospital deliveries be prioritized for transportation? How rapidly will we be notified of mass casualty events? When flights are grounded, will we find assistance in moving critical supplies?

For this reason, the NCCBB and the blood bank industry have long recognized and advocated that the availability of blood is a crucial element of emergency preparedness.

I am pleased to announce a recent advocacy win on the national level: Congress has passed the Pandemic and All-Hazards Preparedness and Advancing Innovation Act (PAHPA) following approval in the House of Representatives. The bill (S.1379) is now headed to the president's desk to be signed into law. This marks the first time that this nationwide disaster preparedness legislation specifically addresses the role of blood collectors, calling for action in support of a safe and adequate blood supply through three important provisions:

- A requirement that the US Department of Health and Human Services (DHHS) Assistant Secretary for Preparedness and Response consult with leaders from blood centers when developing emergency response plans
- A requirement that DHHS recognize and consider financial implications to blood centers
- A requirement that DHHS submit a report to Congress within one year of the bill's enactment regarding recommendations for maintaining an adequate national blood supply

Locally, our focus has been and continues to be on maintaining a blood inventory capable of meeting demand surges, and encouraging local agencies and hospital partners to integrate the Blood Bank into their emergency management planning efforts, including the addition of blood-related scenarios in emergency drills and tabletop exercises. Our Quality Assurance Director Ms. Laura Williston and Laboratory Technician Mr. Luis Castellon both serve on the California Blood Bank Society Emergency Preparedness Committee.

Please consider how your organization can collaborate with the NCCBB in your disaster planning efforts, and feel free to contact Ms. Kate Witthaus, CEO of NCCBB, at (707) 443-8004 or myself at erichamd@nccbb.org with your thoughts.

Blood donation is in decline, here and across the nation. We are looking at ways to increase collections in order to meet the needs of the patients we serve.

How can you help?

- Be an advocate for blood donation in your community.
- Share your stories. How, as physicians, family members, or individuals, has blood donation or transfusion impacted you?
- Host a blood drive or bloodmobile.
- Be a blood donor!

Read Any Good Books Lately that you would recommend to your colleagues?

Send us the title, author and brief description and we'll highlight in NCP

hdncms@sbcglobal.net

FAQ: When Am I Required To Offer Naloxone To Patients?

A new law took effect on January 1, 2019, that requires opioid prescribers to also offer a prescription for an opioid-overdose reversal drug such as naloxone.

Under the new law, physicians must offer a prescription for naloxone or another drug approved by the U.S. Food and Drug Administration (FDA) for the complete or partial reversal of opioid depression when one or more of the following conditions are present:

- The patient's opioid prescription dosage is 90 or more morphine milligram equivalents per day.
- An opioid medication is prescribed concurrently with a prescription for benzodiazepine.
- The patient presents with an increased risk for overdose, including a patient with a history of overdose, a patient with a history of substance use disorder, or a patient at risk for returning to a high dose of opioid medication to which the patient is no longer tolerant.

Physicians must then provide patients who are prescribed naloxone with education regarding overdose prevention and use of naloxone or other similar drug approved by the FDA.

The California Medical Association (CMA) has received calls from physicians regarding the ambiguity of these new requirements. Specifically, there have been questions regarding exactly when co-prescribing is required. Concerns have also been expressed about the applicability of this law to patients receiving hospice care or to patients in inpatient settings whereimmediate medical attention is readily available.

Presently, there is an active bill, AB 714 (Wood) that seeks to address these concerns. CMA continues to work with legislators and other stakeholders to clarify a physician's obligations under the law and will update members as soon as we know more.

To learn more about prescribing controlled substances, including this new requirement, see CMA health law library document#3201, "Controlled Substances: Prescribing."

This document, as well as the rest of CMA's online health law library, is available free to members at cmadocs.org/health-law-library. Nonmembers can purchase documents for $2 per page.

Contact: CMA Legal Information Line, (800) 786-4262 or legalinfo@cmadocs.org.

"Look", Continued From Pg 8

to exploring in a new land without chart or compass. This most ancient of fears has always been with humankind since the beginning, and many that have confronted it have asked: "where can I get the light to traverse this encompassing and unforgiving darkness?"

And, as I ask the same question, the words of King George VI come to mind. He ruled a nation that was facing war and uncertainty. Yet, stood adamant, gazing at the same dark horizon of anticipation as the one I now stand against.

"And I said to the man who stood at the gate of the year:

"Give me a light that I may tread safely into the unknown."

And he replied:

"Go out into the darkness and put your hand into the Hand of God.

That shall be to you better than light and safer than a known way." (3)

1. H.P Lovecraft, Supernatural Horror in Literature
2. Bible, Ecclesiastes 4:12
3. Minnie Lousie Haskin, The Gate of the Year

"How", Continued From Pg 5

is gone, but so is the rare doctor who set fees which amounted to gouging, and did unnecessary surgery. Inexpensive lab tests are gone, but today's labs reveal problems nobody knew existed. X-ray equipment has been joined by computerized scans which yield information unobtainable a few years ago; information which saves lives, but at great expense. Senior News will be exploring some of these issues in future. As they used to say back in the days of network radio: "stay tuned"

Originally published in the June Issue of Senior News.

2019 Humboldt County Public Health Reportable Communicable Diseases 2019

	Diseases	January	February	March	April	May	June	July	August	September	October	November	December	2019 Total Cases
Sexually Transmitted & Bloodborne	Chlamydia	53	58	51	77	56								295
	Gonorrhea	17	24	22	17	20								100
	Hepatitis B, *acute*	0	0	0	1	0								1
	Hepatitis B, *chronic*	2	2	3	0	3								10
	Hepatitis B, *perinatal*	0	0	0	0	0								0
	Hepatitis C, *acute*	0	0	0	0	0								0
	Hepatitis C, *chronic*	47	44	33	54	32								210
	Hepatitis D, *acute*	0	0	0	0	0								0
	Hepatitis D, *chronic*	0	0	0	0	0								0
	Hepatitis E, *acute*	0	0	0	0	0								0
	HIV, *stage Three (AIDS)*	0	0	0	0	0								0
	HIV, *acute infection*	0	0	0	0	0								0
	Syphilis	5	3	5	7	4								24
Enterics, Food and Waterborne	Amebiasis	0	0	0	0	0								0
	Botulism	0	0	0	0	0								0
	Campylobacter	3	2	4	3	1								13
	Cholera	0	0	0	0	0								0
	Ciguatera Fish Poisoning	0	0	0	0	0								0
	Cryptosporidosis	1	0	1	0	1								3
	Cyclosporiasis	0	0	0	0	0								0
	Cysticercosis or taeniasis	0	0	0	0	0								0
	Domoic Acid Poisoning	0	0	0	0	0								0
	E. coli, Shiga toxin-producing	0	0	0	0	0								0
	Giardiasis	0	1	1	1	0								3
	Hepatitis A	0	0	1	0	1								2
	Legionellosis	0	0	0	0	1								1
	Leptospirosis	0	0	0	0	0								0
	Listeriosis	0	0	0	0	0								0
	Paralytic Shellfish Poisoning	0	0	0	0	0								0
	Salmonellosis	0	0	1	1	0								2
	Scombroid Fish Poisoning	0	0	0	0	0								0
	Shiga toxin	0	0	0	0	0								0
	Shigellosis	1	0	0	0	0								1
	Trichinosis	0	0	0	0	0								0
	Typhoid Fever	0	0	0	0	0								0
	Vibrio Infections	0	0	0	0	0								0
Direct Contact & Respiratory	Coccidiodomycosis	0	0	1	0	0								1
	Influenza, deaths (lab confirm.)	0	0	0	0	0								0
	Smallpox (Variola)	0	0	0	0	0								0
	Tuberculosis	4	1	2	2	1								10

The information on this report is accurate to the date it was run. Information may be added or changed

CLASSIFIED ADVERTISEMENTS & BULLETIN BOARD

PRACTICE OPPORTUNITIES

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www.hdncms.org

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