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What is a disaster?

HAL GROTKE, M.D.

On March 11th I was awakened by my NOAA weather alert radio with a tsunami warning. About a minute later a high school friend on the east coast called to tell me to evacuate. Another moment later the district manager of Samoa Peninsula Fire District called to ask me if I could take the day off work to help with evacuations. I serve on the board of directors of the fire district. I decided I really should go to work. I awakened the medical student who had been staying with us for the previous couple of weeks and had planned to head home to Marin County that morning anyway. She was a bit incredulous but she decided to get on the road a few hours earlier than planned. Alice and I packed a few perceived indispensible items in our cars and we headed off to work quite early. That evening we returned from work to find that our home and those of our neighbors were still where they had been that morning.

All of Humboldt County was spared disaster. Our neighbors to the north in Del Norte County suffered significant destruction of the home of one of their biggest industries. I really don't know whether the damage in Crescent City was truly disastrous. I hope that most of those directly affected have appropriate insurance. My closest neighbors to the west (I like that my closest neighbors to the west are on the other side of the ocean) did not fare nearly as well. At the time of this writing the estimated dead and missing humans number in the tens of thousands. It is still not clear whether the nuclear power plant will have complete melt down of one or more of its reactors. It's bad!

Membership in HDNCMS has dropped off a little bit this year. Most of the apparent membership losses seem to be delayed renewal and we expect to resolve them shortly. A few of the lost members appears to be due to miscommunication with shifting business models and out-of-area groups taking local associates. We expect that most of that will be corrected next year. The fact is, however, that there is a possibility that next year will be too late. Our medical society is on very tenuous financial footing right now. We really need all the members we can get just to stay afloat. Would it be disastrous if the medical society goes bankrupt? I think many of us are not aware of all the benefits we get from our local medical society. Penny is nearly magical in her ability to help with getting doctors new to the state licensed quickly and with getting Medicare billing issues resolved. We have an impartial intermediary to help with complaints and disputes without them going to the Medical Board. We have very real help for our colleagues who may be impaired. Hopefully most of us never need these services personally it sure is nice that they exist.

As I mentioned in my January article THERE IS GOING TO BE A LEGISLATIVE CHALLENGE TO MICRA THIS YEAR. It is still not clear when a bill will be introduced or how it may maneuver through the legislative process. It is clear that CMA will need all possible resources to fight this legislation when it is up for consideration. One of the greatest strengths that we have is a unified voice. Would it be a disaster if MICRA were repealed or significantly amended? We, we (or our groups or employers) would pay MUCH higher premiums for professional liability coverage. How much more? Based on comparisons to other states and some mathematical averaging it will cost us EACH (every single individual doctor in California) about another $63,000 per year. I don't think I can increase my gross collections by that much and I know I can't afford to take that much of a pay cut. Maybe I could find some economic balance between increased revenue and decreased expenses but it would be really tough! We need to fight this and we need as many member physicians as possible to carry that fight. §

SAVE THE DATE:

MEDICAL SOCIETY SPRING SOCIAL

MAY 13, 2011
6:00 - 9:00 P.M.
INGOMAR CLUB, EUREKA

* * *

MARK YOUR CALENDARS

The Next Step: Successfully Negotiating Health Reform

14th Annual California Health Care Leadership Academy

June 3-5, 2011

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Indian Wells, California

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

In My Opinion

Deal With the Patient, NOT the Computer

Stephen Kamelgarn, M.D.

I've made no bones about my reticence to fully embrace electronic medical records (EMR). While they do offer the advantage(s) of easy to read notes, well organized charts and tons of reminders to keep us on our toes with the P4P people and the US Preventative Health Task Force recommendations, I've found them to be klunky, user unfriendly, and designed for billers. I realize that we're in the early stages of EMR, and, as time goes on, many of these issues will be resolved. However, there are philosophical questions that don't loan themselves so easily to the technological quick fix.

When I wrote of EMR back in 2008 ("EMR: a meditation" *The Bulletin;* Oct. 2008), I stated, "But, as much as a computer may seem to be an inanimate lump of circuit boards and plastic, computer technology is not merely a passive recipient for our sophisticated software. In a weird Newtonian way, it pushes back at us and exerts all kinds of unintended subjective effects on the user." This feeling was recently confirmed when I read an article in the *New York Times* by Abraham Verghese, M.D., where he writes of his experience as a patient in the ER, among other aspects of computer technology in medicine ("Treat the Patient, Not the CT Scan" *NY Times* Feb 26, 2011).

He notes that we now have the computer technology to really help us in our diagnostics, and treatments since the computers can rapidly scan data bases far more extensively than any human can hope to achieve, and make almost as many abstruse connections; witness the recent success of Watson in handily defeating two *Jeopardy* champions several weeks ago. The designers of Watson have stated that their next goal is to aid in medical diagnoses and treatments. However, not all is perfect, and there is a downside. Dr Verghese writes:

"But the complaints I hear from patients, family and friends are never about the dearth of technology but about its excesses. My own experience as a patient in an emergency room in another city helped me see this. My nurse would come in periodically to visit the computer work station in my cubicle, her back to me while she clicked and scrolled away. Over her shoulder she said, 'On a scale of one to five how is your ...?'

"The electronic record of my three-hour stay would have looked perfect, showing close monitoring, even though to me as a patient it lacked a human dimension. I don't fault the nurse, because in my hospital, despite my best intentions, I too am spending too much time in front of the computer: the story of my patient's many past admissions, the details of surgeries undergone, every consultant's opinion, every drug given over every encounter, thousands of blood tests and so many CT scans, M.R.I.'s and ultrasound images reside in there.

"This computer record creates what I call an "iPatient" — and this iPatient threatens to become the real focus of our attention, while the real patient in the bed often feels neglected, *a mere placeholder for the virtual record*." (Italics mine)

Now, be honest, how many of you that use EMR have fallen into the same trap that Dr Verghese outlined here? I'm raising my hand; despite my best intentions I know that I spend far too much time clicking mouse buttons, entering text and just eyeballing that damn computer screen rather than interacting face-to-face with the person sitting in the room with me. We can't help it.

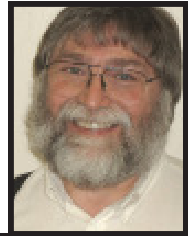
Humans seem to be hard-wired to respond to novelty, and the flashing images on a computer screen, popping up all over the place, are far more novel than looking at a poorly lit patient from the same camera angle. There have been many, many studies (usually using "starving" undergraduates, who need the money, as test subjects) that seem to indicate that we are biologically programmed to respond to the screen rather than a person just sitting and talking—no matter how important it is to pay full attention to that person. Despite our hubris, none of us is truly capable of multi-tasking, and one task will necessarily suffer when we're paying attention to something else. Witness the law prohibiting talking on a cell phone while driving. Even if, while clicking all over the screen we can fully imbibe the patient's story we're still missing something important: ritual.

An interaction with a patient is a ritual, and it is this ritual that is part of the healing process. Multiple studies have shown that patients derive more satisfaction from their visit and do better when the doctor actually lays hands on them. Obtaining a history and talking *with* the patient is part of this same ritual. Patients feel that you're really listening to their concerns when you shove the monitor aside and look them in the face. The way it's set up now is that the computer robs us of this interaction, and the ritual gets short-circuited. Not only are we missing part of their story, we're also missing an opportunity to indulge in a bit of healing and treating. Most of what we do doesn't require extensive searches of data bases or googling the latest treatments, or even buzzing through a million old labs or reports. But we must engage in human to human rituals with every patient visit, and this provides the basis for healing to occur.

"Patient", continued on pg 25

The Drug Expiration Date: A Costly Illusion, Part III

SCOTT SATTLER, MD



Review

This is the third article of a series investigating misrepresentation of the expiration dates by the pharmaceutical industry (PhRMA). Please refer to the previous two issues of the Bulletin for details and documentation of the following:

1. The U.S. Food and Drug Administration (FDA) regulations of 1979 required that drug manufacturers determine the expiration date for all drug products through extensive stability testing, and label each product accordingly. For decades PhRMA has failed to do so. Instead, for marketing purposes, drug manufacturers project an arbitrary date 1-5 years into the future and document that the drug will remain safe and potent up to this date. They continue to label this arbitrary quality assurance date as the drug's expiration date.

2. In 1985 the U.S. Food and Drug Administration (FDA) tested the stability of expiring stockpiled medications at the request of the U.S. military. They discovered that 88% of the drugs they tested remained stable for an average of 66 months longer than their labeled expiration dates. Some, like Cipro, were shown to be stable for up to 13 years. They extended the drugs' shelf life accordingly on a lot-by-lot basis. The head of this testing program concluded that labeled expiration dates had essentially no bearing on whether or not a drug was usable for a longer period, and that the stated expiration date did not mean or even imply that a given drug would stop being effective or become harmful after that date.

3. The U.S. Department of Defense (DoD) and the FDA subsequently created the Shelf Life Extension Program (SLEP) to provide ongoing drug stability testing for the military and other select federal entities. It continues to this day. SLEP currently contains the most extensive source of pharmaceutical stability data in the world. This program saves its participating federal organizations, and hence the taxpayers, many millions of dollars yearly by not destroying perfectly good medicines such as tetracycline, aspirin, atropine, doxycycline, penicillin, Lasix, Tagamet, Dilantin, potassium iodide, cefoxitin and captopril, just to name a few.

4. In 1985 the pharmaceutical industry via the United States Pharmacopeia (USP) took a major step that expanded this costly illusion. The USP unilaterally declared that once the manufacturer's original shipping container was opened and the drug product was transferred to another container for dispensing or repackaging, the expiration date no longer applied. They urged that all secondarily dispensed medications be relabeled with a one-year maximum "Beyond Use" date stating, "Do not use after ___." In 1997 the USP made this a requirement for participating pharmacists and by 2000, 17 states had passed laws mandating that their pharmacists comply. According to the AMA, there is little scientific basis for this action.

Questions that must be asked:

1. Why the costly secrecy surrounding the SLEP database?

Not only is participation in SLEP restricted to a limited number of federal organizations, but also access to SLEP's drug stability database is severely restricted by the DoD. My attempts to review this data online were met with popup notices threatening confiscation of my computer and storage media as well as criminal prosecution should I persist.

Why are only these few participating federal organizations allowed to share this information or submit drugs for testing? As of 2009 the list of SLEP participants included only the Army, Navy, Air Force, Marines, the U.S. Department of Veterans Affairs (the VA), the CDC's Strategic National Stockpile (SNS), the U.S. Postal Service and the Defense Supply Center-Philadelphia (DSCP). The U.S. Public Health Service and U.S. Coast Guard are excluded. State and local emergency response centers are not permitted to participate. No similar shelf life extension program exists for these organizations that are required to stockpile many of these same medications[1]. As a consequence some states have abandoned their emergency medical stockpiles because they cannot afford to replace them when they outdate. Ironically the federal government has subsidized such states to allow them to keep their medicine stockpiles current,[1]authorizing our tax dollars to be used for the destruction and replacement of drugs that the FDA knows are safe and effective. For more information on this bizarre and costly state of affairs, please see this timely article[1]

All across the nation, hospitals, clinics and pharmacies waste millions of dollars yearly by disposing of nominally outdated medications known by SLEP to have much longer shelf lives than PhRMA will acknowledge. These facilities also expend a great deal of resources tracking and controlling product outdates with unnecessary frequency.

2. What are the costs of the discarded usable medicines?

The CDC reported that in 2008 the USA spent $234.1B on prescription drugs. This figure had doubled since 1999. This equates to $670 per person per year, or about $2,700 for a family of four. 48% of us took at least one prescription drug within the last month. Over a third of Americans 60 years or older take 5 or more prescription drugs a day. Over 75% of this age group takes 2 or more meds regularly. It's a big market.

I then wondered how to express the price of medications in a way one could relate to them, and decided to compare the cost of their active ingredients with the price of gold. As of late February 2011, gold sold for $1,356 per troy ounce, or 4.35¢ per milligram of pure gold. A 100mg tablet of gold would cost $4.35. Are you with me so far? I then checked the current Forbes listing for the USA's ten most prescribed medications and checked Epocrates for their standard doses and costs (**drugstore.com**). The number one drug, the hydrocodone prescribed in generic Vicodin, costs 36¢/mg which is eight times the current price of gold. I didn't count the acetaminophen, as it is virtually free by comparison. Then I averaged the cost per milligram of the active ingredient of the others, namely simvastatin, lisinopril, levothyroxin, azithromycin, metformin, atorvastatin (Lipitor), amlodipine, amoxicillin and hydrochlorothiazide. The average price of the active ingredient in these ten drugs on a milligram-by-milligram basis was 21 times the price of gold. And all these drugs were generics. We throw away a lot of money when we discard perfectly good medications.

3. Why were the FDA regulations changed in April of 2010, bypassing the requirement to establishing a valid expiration date?

In April 2010, FDA regulation 21CFR 211.166 was changed to allow verification of a 'tentative expiration date' to suffice for labeling as the expiration date, preempting any requirement to determine drug stability or efficacy after that date. Thus the previous FDA regulation requiring a scientific determination of a true expiration date after which a drug has been demonstrated to no longer be safe or effective is now history. But the disingenuous label "Expiration Date" lives on. How was this allowed to happen?

5. How often is PhRMA utilizing the FDA regulation that allows drug manufacturers to reprocess expired medications?

The current FDA regulation 21CFR211.204 allows pharmaceutical manufacturers to retest outdated drugs returned to them and, if they meet quality standards, they may be reprocessed and re-sold. For example this would allow Cipro, given the SLEP findings, to be resold 3 or 4 times.

Conclusion:

For decades multinational corporate drug manufacturers have been allowed to label medications sold in the U.S. with expiration dates that do not reflect their true stability. This comes at a considerable cost to people and to the state and federal budgets. Congress has the ability to change this process through its role as regulator of the FDA. I urge that you let your colleagues and your congressmen know of this costly and unjustified illusion.

1.
Maximizing State and Local Medical Countermeasure Stockpile Investments Through the Shelf-Life Extension Program. Brooke Courtney, Joshua Easton, Thomas V. Inglesby, and Christine SooHoo. Biosecurity and Bioterrorism: Volume 7, Number 1, 2009
© Mary Ann Liebert, Inc. DOI: 10.1089/bsp.2009.0011 http://www.upmc-biosecurity.org/website/resources/publications/2009/2009-03-27-max_st_local_med_cntr.html

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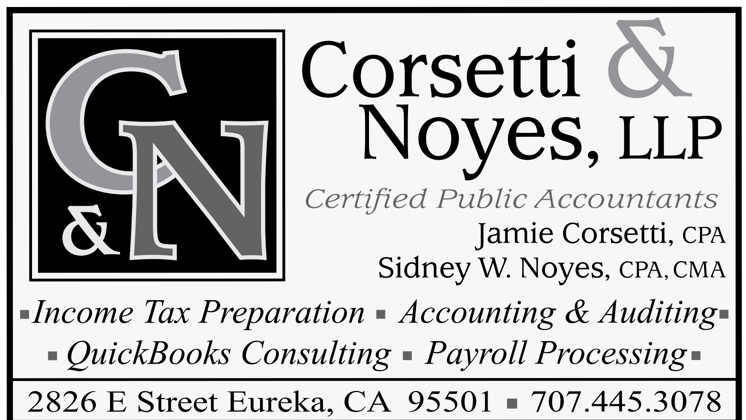
1.

EHR MODEL CONTRACTS

We are pleased to announce a new member benefit which will assist physicians with the difficult task of negotiating an EHR Contract. The Model EHR Contract is a template which may be used to identify standard EHR contract language which will provide physician protection and calls out key business issues to be considered. Common "hot spots" are identified including meaningful use certifications, third party requirements for purchase, liability, payment terms, transferability and licensing/training/support provisions. The Model Contract will be available to all CMA members within the CMA HIT Resource section of the website, www.cmanet.org/hit.



Protecting our patients from skin cancer

Farshad Dana, M.D.

Now that spring is here we have more daylight hours and that means many of us are anxious to start spending more time in the great outdoors. Whether it be gardening, playing sports, hitting the beach or walking the dog, it also means more sun exposure.

According to the Skin Cancer Foundation, each year there are more new cases of skin cancer than the combined incidence of cancers of the breast, prostate, lung and colon. Melanoma is the most serious form of skin cancer. As physicians, you already know the consequences of too much sun exposure. So, in observation of next month, May, being Melanoma Awareness Month, I'd like to remind all of you to help make sure your patients are protecting themselves from this potentially deadly disease.

There are several easy preventative steps everyone can take. Before heading out the door, make sure you apply sunscreen, wear sun-protective clothing, hats and accessories. Also be sure to avoid outdoor activities between 10 a.m. and 4 p.m. when the sun's rays are the strongest. It's also important for patients to frequently examine their skin to check for changes in moles and to see a physician every year.

In addition, don't let that summer fog we know all too well on the coast fool you. Up to 80 percent of the sun's rays can penetrate light clouds, and your skin can be damaged or even burned on even the grayest of gray days if you aren't careful.

In observation of Melanoma Awareness Month, I will be holding a free mole screening on May 7th at Humboldt Medical Specialists – Dermatology in Eureka from 10 a.m. to 2 p.m. Please help spread the word by informing your patients of this valuable service. No appointment or referral is needed.

The Skin Cancer Foundation says 1 in 5 Americans will develop skin cancer in the course of a lifetime and thousands will die each year. Let's all do our part in helping local patients safely enjoy the beautiful outdoors this spring, summer and throughout the year.

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Why MICRA Is Good Public Policy

1. **MICRA moderates the cost of malpractice coverage to preserve access to care.**

MICRA's reasonable provisions (limits on attorneys fees and "pain and suffering" damages; periodic payment of awards over time instead of in a lump sum; etc.) have reduced California's malpractice coverage costs and thus kept more scarce health care dollars available to provide direct patient care. The overall average cost of California malpractice insurance ranks in the lower half among all states, and the cost in Northern California ranks in the lower third. In urbanized states with no effective tort reforms (typically New York, Florida, Illinois, Michigan, Pennsylvania), average medical professional liability premiums are about two and one-half times higher than California's highest average rate. Additionally, in a study of $1 million+ awards performed by Medical Underwriters of California (a subsidiary of the Alameda-Contra Costa Medical Association), over the last two years the average award in California was about 30% lower than other states. These savings translate into more patient care. This most dramatically affects care for our most vulnerable and uninsured patients who receive care from county health systems, University of California's health system, obstetricians, emergency physicians and hospital emergency departments, community clinics, Planned Parenthood, highly specialized surgeons, and others. And it ultimately affects all providers of care, particularly our fragile network of primary care physicians, who find it increasingly difficult to maintain a viable medical practice.

2. **MICRA's $250,000 cap on "pain and suffering" damages properly balances a societal goal to preserve access to care.** In 1975, the California Legislature consciously chose not index this cap to inflation. Its reasoning was that putting a limit on awards for non-quantifiable "pain and suffering" serves society's greater need to make more scarce health care dollars available for patient care. MICRA places no limit on quantifiable economic losses, and they are calculated at current and future values as appropriate. MICRA also places no limit on punitive damages, which may be assessed in cases where egregious behavior and intentional harm can be proven. The last time the personal injury lawyers challenged MICRA malpractice insurance experts anticipated that an increase in the cap would exponentially increase malpractice insurance rates because higher awards would also stimulate more frivolous litigation. In 2003 Milliman USA, an independent actuarial consultant, determined from studying data in the National Practitioner Data Base that professional liability claims losses are significantly lower in states that have caps on non-economic damages. Additionally, a study of empirical data generated an estimated increase in annual health care costs by nearly $10 billion in California if the cap is doubled to $500,000.

3. **MICRA's reforms ensure that injured patients are adequately compensated for their losses and receive the highest percentage of the award possible.** MICRA places no limit on payment of actual losses, such as medical bills, lost wages, future earnings, custodial care and rehabilitation, etc. As a result, over the years malpractice awards in California have far exceeded increases in the consumer price index. In an annual study of major malpractice awards conducted by Medical Underwriters of California (MUC), by decade starting in 1980 the total number of $1+ million cases has doubled from 163 to 330. The *average* indemnity awarded also increased in those cases from $2,685,212 in 1990-1999 to $3,308,152 in 2000-2009. Additionally, MICRA ensures that a higher percentage of awards go to injured patients instead of attorneys. MUC's annual analysis of malpractice awards also found that of the 248 cases it found from 2002-2008, injured patients received $180,138,659 more because of MICRA's limits on attorneys fees.

4. **MICRA has not stifled patients' access to the courts.** Personal injury lawyers argue that decreased numbers of malpractice claims demonstrate that MICRA is preventing legitimate cases from reaching the courts. But this decrease is taking place in almost every state, whether or not tort reforms are in place, and there is a nationwide decline in tort actions of most kinds. In fact, other types of personal injury filings (such as auto and product liability claims) have declined faster than medical liability claims. Further corroboration that personal injury lawyers are still taking on malpractice claims can be found in the 2010 report on Kaiser-Permanente's arbitration system, which notes that 77% of the cases closed in 2009 involved legal representation for the claimants (plaintiffs). This percentage is consistent with previous reports on the system.

5. **Defenders of MICRA come largely from public health advocates, safety net providers, and coop-like malpractice insurers, not a profit-minded insurance industry.**

In the last legislative battle challenging MICRA, safety net providers were MICRA's front-line defenders. This included county health systems, the University of California's Medical Centers and other teaching hospitals, Planned Parenthood, community

clinics, Kaiser-Permanente, large multi-specialty groups, and professional associations representing physicians and other health care professionals. Many of these providers of care are self-insured and represent about 50% of the total malpractice coverage in California. Only about 10% of coverage is provided by traditional commercial insurers, and the balance is provided by "co-op" type organizations formed by various groups to protect themselves. This includes: California's doctor-owned professional liability insurers, the ultimate consumer-driven insurance company where the insured's are also the *owners* of the company; captive insurers created specifically to insure one group or organization; and cooperatives that pool contributions from health care providers to cover losses.

6. Weakening MICRA would run counter to efforts to adopt its provisions in other states. Virtually every state and the District of Columbia have adopted some form of tort reform. More than half of the states place some limit on awards for damages. Since 2002, 16 states have adopted reforms.

7. Malpractice insurance rate reductions are not attributable to Prop. 103 Personal injury lawyers make baseless assertions that professional liability rate reductions are attributable to the passage of Proposition 103, an initiative enacted in 1989 to reform automobile insurance rates. When Proposition 103 was enacted professional liability insurance rates were already declining because MICRA's cap on non-economic damages was finally influencing malpractice awards after being upheld by the California Supreme Court in 1986. Malpractice rates continued to decline through the first half of the 1990s, and no challenge to malpractice insurance rates was even asserted by regulators using the provisions of Proposition 103 until 2003.

Thank you to the Alameda-Contra Costa County Medical Association for permission to reprint this article from their Jan-Feb 2011 "ACCMA Bulletin".

Did You Know....

The HDN Medical Society's Physician Residence Directory is ONLY available to members. 2011 Directory available soon.

MEMBERSHIP V.I.P. PROGRAM

New member benefit...... V.I.P. Program! Discounts at local restaurants, health clubs, hotels, entertainment, etc. List of participating businesses are posted in the Members Only section of the Medical Society website: www.hdncms.org and updated as the program expands - we encourage all members to help solicit businesses participation in the program. Members will soon receive a key-chain membership card to identify eligibility in the V.I.P. Program.

CMA Center for Economic Services 2011 Webinars At-A-Glance

Apr 6: Coding for Medical Necessity and Quality Care
Mary Jean Sage • **12:15-1:15pm** & **6:15-7:15pm**

April 13: EHR Overview
David Ford • **12:15-1:15pm** & **6:15-7:15pm**

Apr 20: Implementing a Compliance Program - A Practical Perspective"
Mary Jean Sage • **12:15-1:15pm** & **6:15-7:15pm**

May 4: Dealing with Sensitive Personnel Issues
Debra Phairas • **12:15-1:15pm** & **6:15-7:15pm**

May 18: Finding Answers to YOur Legal Questions in 5 Minutes or Less: A Guide to CMA's Amazing Legal Library
CMA Center for Legal Affairs • **12:15-1:15pm**

All CMA hosted webinars are free for CMA members. You may also visit **www.cmanet.org/calendar** *to view all education events and to register. Questions? CMA Member Help Center: 800.786.4262*

MARCH 16, 2011

The meeting was called to order by President, Hal Grotke, M.D. at 7:00 P.M.

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

-Minutes (2/16/11)

-Society Budget Report/ Balance Sheet, approved as presented.

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

-Membership Cmt Minutes (3/7/11)

-Public Service and Medical Ethics Committee (2/17/11)

-Physician Well Being Committee Meeting Minutes (3/8/11)

-Talent Show Planning Committee (3/14/11)

-CPPPI Contribution *Thank You*, acknowledged receipt.

-Key Contact Alert re: Budget Cuts, acknowledged receipt.

-Health Care and You Patient Website, acknowledged receipt.

-Letter of Grant Support ULHF, approved as presented.

REVIEWED and discussed list of members who have not yet paid for 2011. Mentioned that follow-up contacts continue to be made and written communications have been sent regarding the April 1st deadline. Peer-to-Peer contact works best. Mentioned we will also be working with CMA and Inalink on follow-up calls.

SHARED updated MICRA Chart specific to Humboldt-Del Norte. The chart was published in *The Bulletin*. Distribution has also gone to the Hospital Medical Staff Coordinators asking for them to post the chart in the Library, Physician Lounges, etc. Encourage posting on other bulletin boards as appropriate.

UPDATE was presented regarding the State Budget and the proposal being made to take funding out of the MADDY Fund to offset proposed cuts in the Medi-Cal program. CMA has been working very hard to prevent shifting of these funds.

REPORT was presented regarding severe drug shortages locally. Hospitals state and nationwide are having difficulties obtaining adequate stock due to strict allocation and/or insufficient supplies to meet needs. Morphine, furosemide injection, erythromycin injections, calcium gluconate, epinephrine, leucovorin, etc. Mentioned forwarding concerns through our CMA Federal Relations staff and through Congressman Thompson's office.

PRESIDENT'S UPDATE was presented, as follows:

-reported having conversation with a couple of our local representatives regarding the difficulties in physician recruitment locally and the suggestion to get our elected officials and the community more involved in the recruitment process similar to what has been set up in Del Norte County. Agreed to talk with members of the Del Norte Physician Recruitment and Retention Committee

TREASURER'S UPDATE was presented, as follows:

-reported on additional request for Hardship Waivers for 2011. Mentioned we will be reviewing the Hardship Waiver protocol and application form as well as the approval letter, which will be changed to include mores specific assignments for in-kind services expected, including assignments that generate income for the Society (recruitment, directory sales, advertising solicitation, etc. as well as the promoting participation in the VIP Program).

EXECUTIVE DIRECTOR UPDATE was presented, as follows:

-reported that the updated Federal Advocacy Update was forwarded out with "Talking Points" to meet with local legislators.

-Legislative Key Contact Alert re: Maddy Fund was forwarded to the membership (and Office Managers) for action.

-Legislative Key Contact Alert re: Budget cuts to Medi-Cal and Healthy Families - sent to membership and Office Managers for action.

-reported coordinating appointments with neighboring counties for the CMA Legislative Day on April 4th in Sacramento. Governor Jerry Brown has confirmed attendance.

-Notice sent to members re: Humboldt Health Alert website "Emergency Preparedness" which includes file and links to help you and your office prepare for a public health related emergency or disaster. *http://humboldthealthalert.org/emergency-preparedness-and-response*

-reported notices will be going out soon for the Spring Social, scheduled for May 13, 2011 @ the Ingomar. 6-9 p.m. Noted that the date for the Talent Show has been moved to a Saturday night, September 24, 2011.

-reported the "What Every Physician Needs to Know About their Practice" Seminar held on March 9, 2011 went well

-Update on the VIP Program was presented. Continuing to solicit local businesses re: participation in the V.I.P. Program. Members are encouraged to help make "contacts" with local businesses and encourage their participation. Program will continue to grow. Working towards posting the VIP Program on the website with links to participating businesses. Periodic updates will be

"BRIEFS", Continued Next Page

published in *The Bulletin*. *Added Carter House and HealthSport.* Cards have been ordered.

-Forwarded calendar of CMA webinars to Membership AND to Office Managers.

-Forwarded information re: HSU Course for Child Abuse Mandated Reporter Training (April 8th)- to Office Managers.

- working on revision of the article for Public Service and Medical Ethics Committee AND developing a communication to go out to members (along with a complaint form) so they can use it if they'd like help in mediating a patient-physician dispute.

-working on designing a poster for the Physician Well Being Committee for posting @ hospitals, doctor lounges, etc.

- working with CMA Center for Economic Services to get the Medical Students access to the CMA Educational Webinars, CPR Newsletter and CMA Alert. "Code" will be assigned that they will need to go through the Medical Society to get.

-Notified Physician Managers and Office Managers re: local Medicare Education Seminar scheduled for 5/26/11 in Eureka AND Anthem Blue Cross Meeting scheduled for June 7, 2011 in Eureka.

-Working with HDN IPA, as CalHIPSO "Service Provider" in coordinating meetings with Office Managers in Eureka, Arcata and Fortuna to discuss CalHIPSO.

-Several Networking surveys have been sent out to Office Managers re: billing fees, confirmation calls, policy on discharge for missed appointments, interested in Certified Medical Coder Course, etc.

COMMITTEE UPDATES were presented.

HEALTH DEPARTMENT UPDATE. Shared a copy of the Humboldt Health Alert notification that was sent out regarding the nuclear reactor in Japan. Reminded the Board of the Humboldt Health Alerts that are posted regularly on www.humboldthealthalert.com

DEL NORTE UPDATE was presented.

CMA TRUSTEE UPDATE was presented, as follows:

-reported on extensive discussions at the Board of Trustees meetings regarding MICRA, the Strategic Plan and Long Range Planning - including closer alignment with component medical societies. It has been suggested that a separate reference committee be set up at the CMA House of Delegates to deal with resolutions specific to long-range planning.

-reported that the new CMA website will roll-out early April. An announcement will come out encouraging members to review the newly designed site.

LEGISLATIVE UPDATE was presented, as follows:

-reminder was presented regarding the upcoming CMA Legislative Leadership Day on April 5th in Sacramento. Drs. Cobb, Grotke, Mizoguchi and poss. Jutila will be attending the event this year.

-reported that Dr. Cobb will be attending the CMA Counsel on Legislation meeting later this month to go over the hundreds of legislative bills that have been introduced for this year that may have impact on physicians and health care. A report will be given at the next meeting.

DISCUSSION followed regarding scheduling a webinar to review the DocBooksMD application for SmartPhones, Droids, etc. Agreed to send out a note to try to pin down a convenient date for those interested in participating.

The meeting was adjourned at 8:00 P.M. Next meeting is scheduled for April 20, 2011 at 7:00 p.m.§

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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)*

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