Pierce County Medical Society
BULLETIN

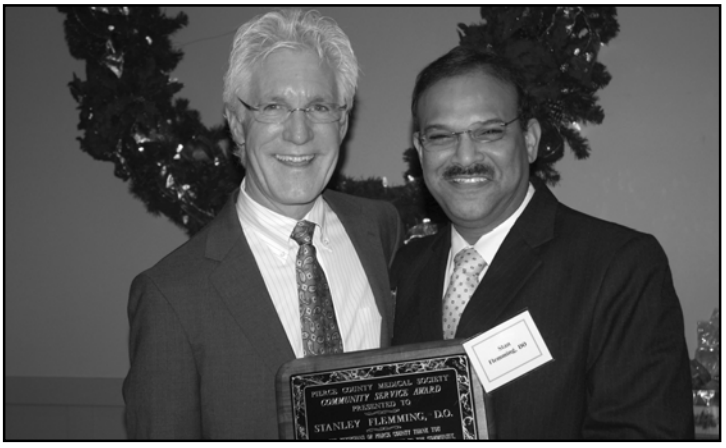
December 2010/January 2011

2010 Annual Meeting - Lots of Laughter!

Dr. Jeff Smith (right) was installed as the 2011 President and welcomed aboard by outgoing President Steve Duncan

The Presidential Hokey-Pokey! From left, outgoing President Steve Duncan, incoming President Jeff Smith, President-Elect Bill Hirota, and Past Presidents Mike Kelly and Joe Jasper

See story and more photos page 5



Dr. Stanley Flemming, right received the 2010 Community Service Award presented by Sumner Schoenike - the 2009 recipient

INSIDE:

The Bulletin is published monthly by PCMS Membership Benefits, Inc. Deadline for submitting articles and placing advertisements is the 15th of the month preceding publication.

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Table of Contents

President's Page

by Jeffrey L. Smith, MD

The Best Way to Tackle Tough Problems is Head On

Jeffrey L. Smith, MD

Happy New Year to all my colleagues in Pierce County. I hope you are ready to work together to survive these tough times. We have lots of issues and challenges facing us in the coming year, and I'll probably use this page to address some of those. The first topic I'd like to address here is the problem of narcotic overuse and abuse in Pierce County and Washington State.

As most of you know, narcotics are becoming a huge problem for all of us. At best, it can be an unwanted intrusion into your clinic day when faced with a request to refill chronic narcotics from a patient you suspect gets too many. At worst, it can lead to fatalities. I will not go into the statistics here; I think we all know them. People are dying from accidental overdosing or intentional excess. People are becoming concerned. The state has issued prescribing guidelines over the past few years with suggestions on how to prescribe and what to watch for. But still the problem increases. Narcotics are potentially dangerous and must be tightly monitored and controlled.

Community health centers face this in spades. Most community health centers see a patient mix with the majority living below the poverty level. As one King County Medical Director put it, "poverty hurts." At Community Health Care, we find it no different. A large population seeks us out solely for the purpose of obtaining narcotic medication for chronic use. Many of these have no real medical necessity nor benefit. It sometimes can feel depressing and overwhelming. In recognition of the increasing narcotic usage and alarmingly increasing death rates, many organizations throughout the state have begun restricting narcotic prescriptions or even going so far as to stop accepting new patients who are seeking narcotic management. We at Community Health Care recently experienced a couple of tragic outcomes which have forced us to reexamine our policies and procedures for narcotic prescriptions. I thought I would take this opportunity to share with the other members of the County Medical Society what we are doing.

Community Health Care will have new prescribing protocols starting soon after the New Year. We will prescribe narcotics for only four reasons. First, end of life care. Second, cancer. Third, acute injury or surgery. Fourth, those rare patients with chronic pain who have proven beneficial effects of chronic narcotic management.

As you can imagine, the crux of the matter is the fourth category. We are going to have very stringent criteria for qualifying for that category. Patients will be required to provide past medical documents with all pain management tools they have tried in the past. They will need functional assessments done which document clearly that the narcotics help them. They will need to have exhausted all non-narcotic treatment modalities. Finally, the CHC medical provider will have to recommend that chronic narcotics are the best course for this case, and have a second CHC provider consult and agree.

As you can see, this will be difficult, but not impossible. We hope to weed through the large pile of "bad medicine" out there and find the few cases who would improve. We will not "kick patients out" solely for narcotic use or requests. But we will demand that the patients work with the providers to reduce narcotic use and eliminate narcotic abuse. I suspect that as word gets out, many of you will hear stories of how the Community Health provider is heartless or denies them necessary care or some other horror. But the truth is, every patient will get a complete history, a thorough and appropriate physical exam, an appropriate assessment, and then a plan for treatment. That subjective, objective assessment plan format is the basis of how we do medicine and is what each patient deserves. Where the potential trouble will come is in formulating the plan.

Unfortunately, I am certain that many of those patients who misuse narcotics are not going to be willing to work with the provider to formulate a plan to get them off narcotics. They will instead search for another doctor who

See "Tackle" page 10

The 2010 Annual Meeting - lots of laughs

The 2010 Annual Meeting was once again a full house at Fircrest Golf Club and included a full agenda of awards and raffles, recognition and thanks. Laughter was abundant as comedian and physician Dr. Brad Nieder entertained.

Dr. Steve Duncan did the honors of moderating and announced the three raffle winners - **Dr. Mian Anwar**, retired anesthesiologist, **Dr. Anastasia Fyntrilakis**, family practice and Holly-Lu Yang, wife of **Dr. Keyi Yang**, neurologist. All won baskets of goodies as well as a $100 gift certificate to the Lobster Shop.

Dr. Duncan asked for a moment of silence in honor of colleagues that had died since last year's meeting. They included: **Drs. Raymond Ellis, Charles Galbraith, Robert Klein, John Lincoln, Richard Martindale** and **Dewey Stephens**.

For appreciation he asked all past-presidents to stand and introduce themselves. They included, by year of service: **James Early, MD** (1975), **Ralph Johnson, MD** (1978), **George Tanbara, MD** (1981), **Pat Duffy, MD** (1984), **Richard Hawkins, MD** (1986), **Bill Jackson, MD** (1988), **Bill Ritchie, MD** (1989), **Peter Marsh, MD** (1994), **Lawrence Larson, DO** (1999), **Charles Weatherby, MD** (2000), **Mike Kelly, MD** (2004), **Joe Jasper, MD** (2006), **Sumner Schoenike, MD** (2007), **Ron Morris, MD** (2008) and **Steve Duncan, MD** (2010).

The evening was highlighted by the presentation of the Community Service Award to **Dr. Stanley Flemming**. His award was presented by Dr. Sumner Schoenike, recipient of the 2009 award. Dr. Flemming received the award primarily for his life-long commitment to public service, particularly in the political arena. (See article page 7)

Dr. Duncan thanked the physicians who served on the board during his presidential year including **Drs. Jeff Smith, Dave Bales, Bill Hirota, Keith Dahlhauser, Pat Vaughan, Bruce Brazina, Raed Fahmy, Mark Grubb, Steve Konicek** and **Gary Nickel**. He also thanked the State Medical Association board members for their service, **Drs. Len Alenick, Richard Hawkins, Mike Kelly, Nick Rajacich** and **Don Russell**. He noted Dr. David Bales had been recognized and thanked at a recent Board meeting for his six years of service on the Board. He was unable to attend as he was visiting family in Singapore.

Dr. Duncan introduced Dr. Jeff Smith and presented him with his presidential gavel. Dr. Smith thanked Dr. Duncan for his service to PCMS and presented him with a thank you gift as well as a plaque noting his exemplary leadership and commitment. Dr. Smith introduced the newly elected trustees. They included **Drs. Daniel Ginsberg**, Treasurer; **Sibel Blau, Steve Litsky, Brian Mulhall** and **Rosemary Peterson**. (See board roster page 9) Dr. Smith thanked his colleagues for their support and encouragement, prior to introducing the speaker and humorist Dr. Brad Nieder. ■

See page 6 for more photos

Past Presidents L to R: Drs. Bill Jackson, Peter Marsh, Steve Duncan, George Tanbara, Sumner Schoenike, Bill Ritchie, Richard Hawkins, Ron Morris, Ralph Johnson, Mike Kelly, Joe Jasper and Pat Duffy. Attending but not pictured: Jim Early, Larry Larson and Charles Weatherby

Steve Duncan (left) thanked Dr. David Bales for his six years of service on the Board at a recent Board meeting. Dr. Bales was unable to attend the Annual Meeting as he was visiting family in Singapore

Dr. Mian Anwar, retired anesthesiologist, one of three lucky raffle winners

Annual Meeting from page 5

From left, Dr. Dan Ginsberg and wife Harumi with Donna and Joe Jasper. Dr. Ginsberg was elected Treasurer - Dr. Jasper served as President in 2006

From left, Dr. Tom Herron and his wife Verna visit with pulmonologist Manuel Iregui and his wife Chiarina

Community Health Care colleagues flank new President Jeff Smith. Dr. David Cameron left and Physician Assistant Corey Hatfield, right

Smiling faces - from left Drs. Charles Weatherby, John Hautala and Terry Torgenrud. Jan Torgenrud is at right

Past Presidents spanning 20 years, from left Drs. Joe Jasper (06), Peter Marsh (94) and Richard Hawkins (86)

Drs. Anastasia Fyntrilakis (left) and husband Dr. Fred Ehret visit with Dr. Lynne Clark. Dr. Fyntrilakis was one of the lucky raffle winners

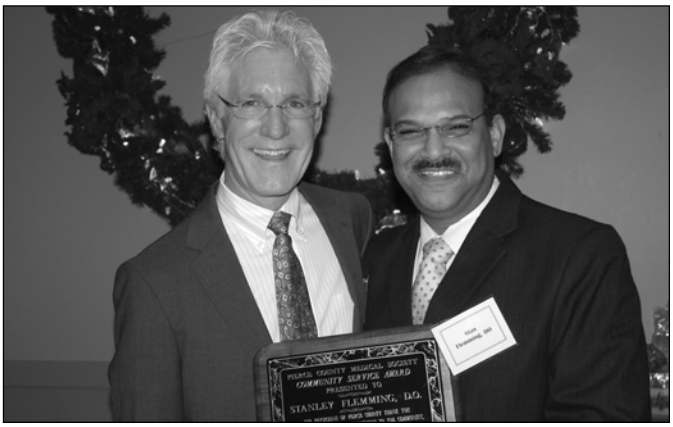
2010 Community Service Award

Stan Flemming, DO honored as the 2010 PCMS Community Service Award recipient

On the night before a very early departure to Haiti to provide medical mission work, **Dr. Stan Flemming** was honored as the recipient of the 2010 Community Service Award. The award, given annually, recognizes a member who has contributed to the betterment of the profession and the community.

Dr. Flemming has dedicated his life to serving his community via many avenues as you will read in the text below - the script of the presentation of his award.

Thanks to **Dr. Sumner Schoenike**, recipient of the 2009 award for presenting to Dr. Flemming, and to **Dr. Scott Kronlund** for helping get Dr. Flemming and his wife Martha to the meeting.



Stan Flemming, DO recipient of the 2010 PCMS Community Service Award (right) with Sumner Schoenike, MD

Many physicians have a passion for public service, but I am honored to introduce you to one tonight who is the public servant's public servant. In addition to being a physician, Stan also has the distinction of being a Brigadier General, a mayor, a state legislator of both bodies of the legislature, a CMO, a Combat Veteran, a City Council Member, a Rotarian, a Medical Missionary, and now a recently elected County Council Member…I think Stan just has an aversion to boredom.

Stan is product of parents who were both physicians, so it's easy to understand his drive for education and accomplishments – and he obviously has plenty of both. Stan has risen to the very top of our profession and, in fact, every profession that he has put his shoulder to.

With deep roots in Steilacoom since the age of two weeks, and life-long residency in Pierce County, his commitment to community has been unwavering. He has served his community in the state legislature as a 28th district representative and senator, served his community as the inaugural mayor of the City of University Place and as a City Council Member from 1995 until January of this year. He will now embark on further serving his community as the recently elected County Councilman for District 7. Stan credits "the encouragement of the people in the communities he represents and serves" with keeping him committed and energized.

In addition to being born into medical family, Dr. Flemming was also born into a military family. His father was an Army officer and Stan "eagerly" enlisted in boot camp. I have reviewed an exhaustive list of military assignments and accomplishments, so let me just summarize these by giving a few highlights…

Stan is a combat veteran of two tours of duty in the Middle East and Balkans, was a Team Leader with a special operations unit with the first Marine Division and he was Commander of medical forces in Kosovo. He culminated his career with the senior rank of Brigadier General and, in 1995, he was one of two finalists for Surgeon General of the United States.

So, what about Stan's humanitarian accomplishments? Earlier this year, in spite of many bureaucratic roadblocks, he quickly organized a medical relief team to Haiti following their devastating earthquake. There, he and his team treated nearly 900 victims. TOMORROW MORNING he just informed us, he's going to go do it again…What kind of vitamin do you take?

But tonight, thanks to our conniving and trickery, we got him here on the pretense of giving a professional presentation about his work at Northwest Physicians Network, which, of course, he was willing to do. So, let's just add "committed colleague and friend" to Stan's already long list of assets.

As many of you know, Dr. Flemming has demonstrated the highest regard for his patients, particularly those that have no means or special needs. He was a trail blazer in caring for patients with HIV/AIDS and spent many years working in community health care clinics until joining NPN in 2005. Aside from his medical degree, his formal education includes Masters in Human Relations and Social Psychology. In addition to military medicine, Stan has logged years with the public health service and in academic medicine and private practice.

In his spare time, Dr. Flemming has served as an Evergreen State College Board member and Chairman, is a long time, active Rotarian, a Chamber of Commerce member, and naturally he has received numerous awards for his humanitarian and philanthropic community involvement.

Tonight, it is my distinct honor and pleasure, Stan, to add to that list by presenting to you the PCMS Community Service Award, 2010. ■

New Board of Trustees will lead PCMS in 2011

Jeffrey Smith, MD is a family practitioner in Lakewood. He received his medical education from the University of Washington School of Medicine and completed his internship and residency at Swedish Hospital in Seattle. Dr. Smith is **President**.

Keith Dahlhauser, MD is an ophthalmologist. He received his medical education from the University of Iowa College of Medicine. He completed his internship at St. Mary's Health Services followed by residency at the University of Minnesota. Dr. Dahlhauser was elected **Vice President**.

Mark Grubb, MD practices pediatrics in Puyallup. He attended medical school at Louisiana State University Medical Center and completed his internship and residency at Baylor College of Medicine followed by a fellowship at Texas Children's Hospital. Dr. Grubb will serve as **Secretary**.

Sibel Blau, MD, **Trustee**, practices hematology/oncology. She graduated from Cerrahpasa Medical School, completed her internship and residency at Metro Health Medical Center, Cleveland, and fellowship at Case Western Reserve University Hospital.

Steven Konicek, MD, **Trustee**, practices internal medicine in Tacoma. He attended the University of Washington School of Medicine and completed his internship and residency at University of Iowa Hospital & Clinics.

Brian Mulhall, MD, **Trustee**, practices gastroenterology. He graduated from St. Louis University, completed his internship and residency at Madigan AMC and fellowship at Walter Reed AMC.

William Hirota, MD is a gastroenterologist. He received his medical education from Georgetown University and completed his internship, residency and fellowship training at Walter Reed Army Medical Center. Dr. Hirota will serve as **President-Elect**.

Stephen Duncan, MD is a Puyallup family practitioner. He received his medical education from Indiana University and completed his internship and residency at Union Hospital in Terre Haute, Indiana. Dr. Duncan is **Immediate Past President**.

Daniel Ginsberg, MD, practices internal medicine in Tacoma. He graduated from Uniformed Services University of the Health Sciences and completed his internship and residency at USAF Medical Center, Keesler. Dr. Ginsberg was elected **Treasurer**.

Bruce Brazina, MD, **Trustee**, practices palliative medicine. He graduated from Hahnemann University and completed his internship and residency at Geisinger Medical Center.

Steven Litsky, MD, **Trustee**, practices physical medicine & rehabilitation. He graduated from Sackler School of Medicine and completed his internship and residency at Sinai Hospital/DMC, Wayne State University.

Rosemary Peterson, MD, **Trustee**, practices cardiology. She graduated from Uniformed Services University and completed her internship at Wilford Hall Medical Center and residency and fellowship at Walter Reed AMC.

The trustees are responsible for governing the organization and subsidiaries, including maintaining, developing, and expanding programs and services for members, seeing that the organization is properly managed and that assets are being cared for and ensuring the perpetuation of the organization. Meetings are held on the first Tuesday of each month except for July and August. The Board of Trustees is comprised of the President, Vice President, Past President, Secretary, Treasurer, President-Elect and six trustees.

Tackle from page 3

will write their prescription, make them happy, but ignore the real problem.

And that is why I am using this column to address you all today. I would like to call for a county-wide dialogue on the narcotic problem we face. I have heard from friends and colleagues that most clinic and medical systems are working on this in some way. If we can work together and create some community standards on how and when and on whom to prescribe narcotics, we might be able to minimize this anticipated migration of patients from practice to practice. The message should be consistent and clear. Narcotics are dangerous drugs. Doctors should take great care in prescribing them. Non-narcotic treatments should be our primary pathway. Patients deserve to be heard, examined and treated appropriately. But sometimes that treatment may not be what they want nor ask for. It will be our job to educate them, just as we do for every other medical condition. Let's start the dialogue. I would be glad to meet with or speak with any physicians or groups who would like to continue this on a larger scale.

Have a great 2011. I look forward to an exciting year. ■

In My Opinion

by Richard Waltman, MD

***The opinions expressed in this writing are solely those of the author**. PCMS invites members to express their opinion/insights about subjects relevant to the medical community, or share their general interest stories. Submissions are subject to Editorial Committee review.*

Thoughts on CME

Richard Waltman, MD

Coming from the didactic halls of medical school, with lecture after lecture, one of the most exciting things for me when I reached the hospital for my first rotation was seeing what for me was a very new method of teaching: everyone was teaching everyone. The attending physicians were teaching house staff, the chief resident was teaching the residents, the residents were teaching interns, the interns were teaching the medical students, and the medical students were teaching each other. If a new issue came up, you went and looked it up - and these were the days before the Internet - and then you presented the information to the members of the team. "See one, do one, teach one," became a concept I eagerly embraced. It is fair to say that I spent the rest of my medical school training teaching by learning, learning by teaching. I have tried to do that ever since. I still learn most when I teach.

When I came to Tacoma, I received several invitations to talk to medical audiences, being told to "tell us what you have been learning, bring us up to date." Those were great opportunities for me to meet many physicians in the community and build my practice, and I was most appreciative. That indeed was the policy then: new physicians were invited to make such presentations, both to educate community physicians and to meet them. It was a wonderful experience for me, and to have asked for financial compensation never occurred to me. Better for me to pay them!

That was the way we did back then. We found local colleagues who could talk about important issues, or we found people at Madigan, in Seattle, or in Portland, all of whom were happy to come and speak. I don't believe anyone received financial compensation; it was still considered a privilege to make a presentation, still a good way to gain referrals.

Then something happened: all of a sudden, we were being offered "national speakers" on any and all topics, fully compensated by pharmaceutical companies. It seemed like a great deal to have the famous Dr. X speaking in the Allenmore cafeteria, and in fact many of those talks were excellent.

Gradually, however, things changed. Companies did not want to present talks on topics, so much as they wanted to present talks on medication, and increasingly these presentations were product-oriented and why the medication being featured was better than the options. I think we all had a sense that the quality of these talks was declining, and that was even before information came out indicating that many of the speakers were receiving substantial compensation from pharmaceutical companies and that some of their research and presentations were thereby questionably influenced.

Then just recently, the pharmaceutical door slammed shut: no speakers from them, and no money from them for us to obtain our own speakers. At about the same time, hospital support for educational offerings also disappeared as did grant funding and support for the College of Medical Education – Pierce County Medical Society's CME division

So for the last few years, we have struggled. We have tried to obtain more objective speakers with less pharmaceutical support but less active involvement in choice of speaker and topic, not very successfully. And we have tried to get support from the local hospitals, sometimes with good result, as both the MultiCare and the Franciscan systems seem now to realize an obligation to continue to educate their employed staff. The College has reduced expenses significantly and has had to increase course fees.

And we have started to do something else: we are inviting community physicians to speak again, established physicians with experience and expertise in various areas, and new physicians joining our medical community. By necessity, we have returned to the method that worked so well for many of us in training, and so far, the results have been good. The established physicians enjoy speaking with their colleagues and sharing their expertise, and the new physicians have enjoyed the opportunity to present themselves to the medical community. Looking at the evaluations of many of these programs, our colleagues are quite pleased with these presentations, and in fact several of the regularly scheduled presentations are being better attended. I've even had a few calls from people offering their services.

But there has also been another trend: a good number of the younger

See "CME" page 12

CME from page 11

physicians are not attending these sessions, some having told us that they prefer to obtain CME online and at work at their own pace. And even those of us with gray hair have learned to take advantage of the wonderful CME opportunities that are available online. I love it too. I do all of my required CME on line now.

Still, I find great satisfaction in attending a live educational event, with an enthusiastic presenter and with a receptive and active audience. I enjoy the interactions and the discussion. I also still find it is a very good setting in which to meet colleagues, "touch base," and help maintain the community of medicine in Pierce County. We have always had an outstanding medical community, and I sincerely believe that the very active CME program that has existed here for so many years has been a contributing factor to that success.

So as we go forward now, what is to be done?

It is very clear that the mega funding from pharmaceutical companies is gone forever. Further, I don't think we want speakers with strong pharmaceutical bias. We need to ask ourselves what do we expect from local CME. What do we want? What do we need?

With the Internet such an immediate and remarkable source of information, we actually need information less. It's there whenever we want it — 5 minutes with Up-to-Date or a 10-hour review course you can do online from home. What we need more of is how to effectively apply that information taking care of our patients. That means to me, that physicians who actually are utilizing new information and new techniques in their daily work are of most importance, and that speakers who can reiterate studies and recommendations are less important. That's the stuff I can find on the Internet; I want to know where to put the needle, what test will be most helpful, what's the best question to ask, when to get help. I want to know what I can do in my office today to improve the care I give my patients.

I'd like to keep the tradition of excellent CME alive and well in Pierce County, and here are my recommendations as how we might do so:

1. Let's ask our experienced colleagues to share their expertise and wisdom with us.

2. Let's invite our newly arrived colleagues to bring their new skills and talents to us.

3. Let's insist that our hospital systems support educational efforts – including those of our independent College of Medical Education CME programs. CME funding is now provided in most contracts; support for local educational events should be as well—and is likely to be more cost-effective for the hospitals as well.

4. Let's focus on topics that will

See "CME" page 18

In My Opinion

by J. David Bales, MD

***The opinions expressed in this writing are solely those of the author**. PCMS invites members to express their opinion/insights about subjects relevant to the medical community, or share their general interest stories. Submissions are subject to Editorial Committee review.*

Dave's Leadership Library

J. David Bales, MD

Early in my career, the American College of Physicians would periodically publish a very helpful list of recommended books for the Internist's Library. The Pierce County Medical Society, through the initiation and drive of **Dr. William Hirota**, will have a Leadership Conference for physicians in the Spring of 2011. With the current Tsunami of changes in Health Care, I thought it might serve a useful role to suggest a list of recommended books for physician leadership. This list is my own and I cannot attribute it to anything beyond my own bias.

I also need to explain that my definition of "Leadership" is broad and inclusive of the roles of "Management" – I often define Leadership as "doing the right thing" and Management as "doing things right." Both have a necessary role and there is considerable overlap, but each can be done by itself to the detriment of the whole. Neither leading an inefficient organization nor mismanaging an appropriately focused organization would be economic or successful.

LEADERSHIP

Biography of effective leaders would be the first "bunch" on my list and can be left to the individual to select. My own bias reflects my military career and includes Churchill (*The Last Lion* by William Manchester – 1988 - Two Volumes – Little, Brown & Co), MacArthur (*American Caesar* by William Manchester - 1978 – Little, Brown & Co), and Eisenhower (*Eisenhower At War 1943-1945* by David Eisenhower – 1986 – Random House). Medically, the biography of William Osler by Harvey Cushing – 1925 – Oxford University Press is lengthy (two volumes) but useful if you can find a copy.

The "trilogy" of Stephen R. Covey's books (*The 7 Habits of Highly Effective People*; *First Things First*; and *Principle Centered Leadership* - Simon and Schuster) progress from personal dependence to independence to interdependence. His *The 8th Habit* moves from effectiveness to greatness through inspiring and empowering others.

Jim Collins' books *Good to Great* and *Build to Last* (Harper Business) are both excellent reviews of successful organizations and a look at common factors that drove the turning point from being a good company to being a great one and sustaining it. Of course, when macroeconomics hit a snag – even some of the great companies can tank – so reading a list of these companies today may not be as impressive as they were for the study. Nonetheless, the principles leading to a transition remain valid.

Wess Roberts wrote a short work called *Leadership Secrets of Attila the Hun* – 1985 – Warner Books - that caught the eye of Ross Perot about the time he was made head of the Saturn Division of General Motors. While this reference dates me and my reading, it is a short and engaging read. Mr. Perot insisted that his staff read it and I like to think it had an impact despite his short tenure with GM.

Medical Leadership is addressed by Jack Silversin and Mary Jan Kornackiin, *Leading Physicians Through Change* – 2000 – American College of Physician Executives - and addresses a lot of familiar barriers. Since change is upon us, leading through it successfully may make the survival difference.

MANAGEMENT

Much of the last 30 years of "Manage-Speak" has centered on the concept of Quality Management. I date the "current era" from the early 1980's when NBC did a documentary for television called "If Japan Can Do It . . . Why Can't We?" and discovered that many of the concepts for the Japanese industrial miracle came from a few consultants from the United States – the most notable at the time being William Edwards Deming. He was born 14 October 1900 in Wyoming so was already 80 years old when he was "discovered" in the U.S. Even then he was noted for making killer martinis. He was a statistician and his books (*Out of the Crisis*; *The New Economic* – MIT press - to name two) certainly read like it – but wading through his work can drive you to pay attention to the foundations of Continuous Quality Improvement. A quicker and easier read are two books by Mary Walton, *The Deming Management Method* and *Deming Management at Work* (Perigee Books by Putnam Publishing Group) and are my

See "Library" page 14

Library from page 13

recommendations for diving into Deming.

Peter M. Senge instituted the concept of the "Learning Organization" through the publications *The Fifth Discipline* and *The Fifth Discipline Fieldbook* (Currency Doubleday). His various "disciplines" are somewhat reminiscent of Covey's "Habits" - the First "Personal Mastery;" the Second "Mental Models;" the Third "Shared Vision;" the Fourth "Team Learning;" and the Fifth "Systems Thinking." The concepts are once again timely but difficult to institute in organizations if their focus remains on production and "inspecting" in quality through "Quality Assurance" and "Service Recovery."

To balance the above deep thinking resources I heartily recommend Scott Adams' books *The Dilbert Principle* and *Dogbert's Top Secret Management Handbook* – 1997 – HarperCollins Publishers. As I get older, cartoon characters seem to gain more credibility!

Two final general management recommendations are James P. Womack and Daniel T. Jones *Lean Thinking* (Free Press) and Peter S. Pande, Robert P. Neuman, and Roland R. Cavanagh *The Six Sigma Way* (McGraw Hill). Both are further iterations of the quality improvement movement in the manufacturing world progressing to system reengineering in addition to process improvement.

HEALTH CARE QUALITY MANAGEMENT

Much of the press – and many of the complaints from physicians – focuses on industrial management and improvement. The retort from the medical profession is that we are not in the business of making "widgets" and that all of the statistical process control for minimizing variation is minimally applicable to the Art of Medicine. It has taken several years for the health care profession's quality management publications to catch up with manufacturing's publications but I think we are about there. My top recommendation here would be Nelson, Batalden and Godfrey's 2007 work *Quality by Design* (Jossey Bass) which is not only a book about Dartmouth's Clinical Microsystems but includes an entire, step by step, curriculum which thankfully starts with the means to having effective meetings!! A worthy predecessor (1994) for medical group practices is Balestracci and Barlow's *Quality Improvement – Practical Applications for Medical Group Practice* (MGMA/CRAHCA). Porter and Teisberg's *Redefining Health Care* (Harvard Business School Press) is a 2006 addition to the library. Even the Baldrige National Quality Program has moved into the health care arena with its yearly updated *Health Care Criteria for Performance Excellence* and "The Baldrige" has been awarded to several health care entities. Their success stories are widely distributed via publications, meetings, and the web (www.baldrige.nist.gov).

The Institute of HealthCare Improvement (IHI) is a gold mine of activity for medically focused, systems thinking, progressive improvement. They have a plethora of information and resources and the web site (www.ihi.org) is worth exploring.

Finally, the most recent arrivals to my library are the works by Dr. Atul Gawande – *Complications*, *Better*, and *The Checklist Manifesto* (Metropolitan Books). These are entertaining works that put healthcare improvement in a readable framework that is as current as today's newspaper.

I'm sure I've left some very worthy works (and no doubt some of your favorites) off the list – but I admit to bias and an incomplete listing. I can only hope that the library will stimulate reading, thinking, and acting on the future of medicine. ■

The Health Status of Pierce County

by Anthony L-T Chen, MD, MPH
and Diane Westbrook, MS

Eat, Drink and Be Merry - and Healthy!

Anthony Chen, MD

The holiday season is a time of sharing with friends, family, colleagues, and others. Those who attended the Annual Meeting and dinner had the chance to catch up with colleagues, provide a gift for the needy, laugh with the physician comedian, and enjoy a delicious meal. At home, many of us will be inviting friends and family for a buffet or potluck to celebrate the holidays. While we encourage, but cannot protect you from overindulging in food or drinks, the Health Department can help keep you from getting sick when you are at the Fircrest Golf Club or any restaurant. I have been out with my staff inspecting restaurants and the Puyallup Fair and have seen how well they balance regulation, education, and cooperation to make sure safe food handling practices are followed.

So, unless you own a restaurant, you are on your own when you host that buffet or potluck at home. If food is left out for long periods of time, cross-contaminated, or not handled properly, you may find that you have uninvited guests that crash the celebration: bacteria that cause foodborne illness. Since you often cannot taste, smell or see the bacteria that cause illness, you cannot tell if food is contaminated until someone gets sick.

Common bacteria we worry about include Salmonella, Campylobacter, and E. coli. Symptoms from eating contaminated food may be similar to flu symptoms: fever, headache, nausea, diarrhea, and abdominal pain. While the food supply in the United States is one of the safest in the world, each year about 76 million illnesses occur, more than 300,000 persons are hospitalized, and 5,000 die from foodborne illness. You have probably heard on the news about some recent high profile food contamination cases: Salmonella in peanut butter and eggs, E coli in lettuce, and Listeria in goat cheese.

What can you do to prevent foodborne illnesses? You can follow several basic safe food handling practices:

- Wash hands: always begin by washing your hands with warm water and soap for 20 seconds before and after handling food.
- Clean surfaces: clean kitchen surfaces, dishes and utensils with hot water and soap.
- Always serve food on clean plates – never those previously holding raw meat or poultry.
- Keep hot foods hot: hot foods should be held at 140 degrees F or warmer. On the buffet table you can keep hot foods hot with chafing dishes, slow cookers and warming trays.
- Keep cold foods cold: cold foods should be held at 41 degree F or colder. Keep foods cold by nesting dishes in bowls of ice. When food is in the "danger zone" – between 41 degrees F and 140 degrees F – foodborne bacteria multiply.
- Safely sauced: If your recipes call for uncooked eggs, you can modify them by using pasteurized eggs, pasteurized egg product or cooking the egg mixture on the stovetop to 160 degrees F.
- Follow the 2-hour rule: foods should not sit at room temperature for more than two hours.
- Store food safely: divide pre-cooked foods into shallow containers to store in the refrigerator or freezer until serving - this encourages rapid, even cooling. When ready to serve, reheat foods to 165 degrees F.

Following these simple yet important food safety tips will help keep your friends and family free from foodborne illnesses. Of course, eat and drink in moderation and try to get some exercise in as well. Please contact Tacoma-Pierce County Health Department Food Safety Program staff at (253) 798-6460 if you have any questions.

Happy Holidays!

Resources

1. Centers for Disease Control and Prevention Food Safety www.cdc.gov/foodsafety.

2. Tacoma-Pierce County Health Department Consumer Food Safety http://www.tpchd.org/page.php?id=75.

3. Safe Kids USA: Cooking and kitchen safety tips for children over the holidays http://www.scfpd1.com/prevention/documents/Cooking_Safety.pdf. ■

Applicants for Membership

Christopher Arroyo, MD
Urology
Franciscan Urology Associates (FMG)
6401 Kimball Dr NW, Gig Harbor
253-858-9192
Med School: University of Washington
Internship: University of Washington
Residency: University of Illinois

Mark T. Bahnam, MD
Ob/Gyn
Commencement Health Care, PS
314 ML King Jr Way #400, Tacoma
253-627-0666
Med School: University of Vienna
Internship: Mt. Sinai Hospital
Residency: W Virginia Univ Hospital

Michelle J. Cox-Porter, PA-C
Family Medicine
Franciscan Prompt Care (FMG)
15214 Canyon Rd E Ste 120, Puyallup
253-539-4200
Training: Eastern Virginia Med School

Ellen G. Hu, MD
Commencement Health Care, PS
314 ML King Jr Way #400, Tacoma
253-627-0666
Med School: Shandong Med Univ
Internship: Monmouth Med Ctr
Residency: Monmouth Med Ctr

Adam Kuten, MD
Pathology
Tacoma Digestive Disease Center
1112 Sixth Ave #200, Tacoma
253-272-8660
Med School: New Jersey Med School
Residency: Beth Israel Deaconess
Fellowship: Brigham/Women's Hospital

Filiz Millik, MD
Pediatrics/Allergy & Immunology
Allergy, Asthma & Sinus Care Center, PS
10049 Kitsap Mall Blvd NW #265,
Silverdale
360-698-2500
Med School: Hacettepe Med School
Internship: Hacettepe Med School
Residency: Columbus & St. Joseph's
Fellowship: Rush University

Mark L. Nelson, MD
Ophthalmology - Retina
Sound Retina, PS
2245 S 19th St #200, Tacoma
253-572-1444
Med School: F. Edward Hebert SOM
Internship: Madigan AMC
Residency: Madigan AMC
Fellowship: Wills Eye Hospital

Gabriela Loperena Oropeza, MD
Endocrinology
MultiCare Endocrinology
1901 S Cedar #205, Tacoma
253-301-6999
Med School: Universidad De LaSalle
Internship: Ball Memorial Hospital
Residency: Ball Memorial Hospital
Fellowship: University of Washington

Nathaniel Schlicher, MD
Emergency Medicine
1717 South J Street, Tacoma
253-426-6963
Med School: University of Washington
Internship: Wright State University
Residency: Wright State University

John J. Simmer, MD
Otolaryngology/Head & Neck Surgery
MultiCare ENT Specialists
7424 Bridgeport Way W #305, Lakewood
253-301-6960
Med School: University of Minnesota
Internship: Hennepin County Med Ctr
Residency: San Antonio Military Medical
Consortium

Alison C. Welch, MD
Physical Medicine & Rehab
Rainier Rehabilitation Associates
8012 - 112th St Ct E #120, Puyallup
253-286-2711
Med School: University of Virginia
Internship: Christian Care Health
Residency: University of Washington

Katie E. Wilkinson, MD
Pathology
Puget Sound Institute of Pathology
1001 Klickitat Way SW #205, Seattle
253-426-6164
Med School: USC
Residency: LAC/USC Med Ctr
Residency: Loma Linda Univ Med Ctr
Fellowship: Puget Sound Blood Center

COLLEGE OF MEDICAL EDUCATION

Upcoming CME Programs

Pain Management Symposium
March 25, 2011 - Tacoma, WA
(6 AMA PRA Category 1 Credits)

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April 21, 2011 - Fircrest, WA
(4 AMA PRA Category 1 Credits)

Internal Medicine Review
May 20, 2011 - Fircrest, WA
(6 AMA PRA Category 1 Credits)

Continuing Medical Education

Register Now! CME at Whistler January 26-30, 2011 at the Beautiful Fairmont Chateau Resort

CME at Whistler is a great program that combines family vacationing and skiing in a resort atmosphere, along with ten hours of Category 1 continuing medical education. Whistler offers alpine skiing, cross-country skiing, and many other winter activities at both Whistler and Blackcomb. You will also find many superb dining options and excellent shopping for the relaxed afternoon. Whistler is a great destination for families, as it offers many entertainment options and relaxation options.

This year's Whistler CME is being held at the beautiful Fairmont Chateau Resort. We have negotiated incredible room rates starting at $219 CDN per night. Please visit www.fairmont.com/whistler or call the Inhouse Reservations Department at 1-800-606-8244 to make reservations. You will need to mention you are with the College of Medical Education in order to receive the contracted group rates.

The conference registration fee is $350 for PCMS members, $425 for non-PCMS physicians and $275 for non physicians. Late registration after January 14, 2011 will be an additional $100 to these fees.

To register for this program or if you have any questions, please call the College of Medical Education at 253-627-7137. ■

Thank you for very generous Foundation contributions

The PCMS Foundation raised $20,700 via the 2010 Holiday Sharing Card project thanks to the generous, sharing nature of Pierce County Medical Society members. This is a $1,360 increase over last year's contributions of $19,340 which was the most money raised in the ten year history of the foundation. The money is raised for grants which are awarded to Pierce County non-profit organizations. Funds were raised by contributions to the holiday sharing card, member contributions, and raffle ticket sales at the annual meeting. **Thank you** to everyone who contributed. **Grant recipients for 2010 included:**

Catholic Community Services, Homeless Adult Services
Crystal Judson Justice Center
Family Renewal Shelter
Neighborhood Clinic
New Phoebe House
Pierce County AIDS Foundation
Pierce County Project Access
St. Leo Food Connection
The Rescue Mission
Trinity Neighborhood Health Clinic

Grant recipients are required to spend their grant money in Pierce County for direct services to residents in need of assistance. The Foundation has no administrative overhead; consequently all contributions are donated to 501(c)(3) organizations that are selected as grant recipients. Your contributions to the PCMS Foundation are tax deductible.

PCMS is grateful to the following physicians who contributed to the Foundation after the deadline to be listed on the holiday sharing card:

Gregory & Karen Arnette
Dr. & Mrs. Tarek Baghdadi
Judy Bass
Leaza Dierwechter, MD
Gregory Popich, MD
Tail Ted Song, DO
Robert Wilson, MD

PCMS again thanks everyone for their generosity and their participation in this important and meaningful project. ■

CME from page 12

have a positive impact on the care we provide to our patients and find areas where with more education we might do better.

5. Let's let regional academic centers know that we expect educational support from them — and that our professional collegiality should constitute just compensation. After all, isn't making presentations part of the job for an academic physician and shouldn't they be committed to increasing the quality of care in the region?

6. Let's make the pharmaceutical companies know that we welcome their support — but we'll choose the speakers and they can pick up the costs. Let's ask for unrestricted educational grants. (If their product really is better, a fair presentation will make that clear.)

And finally, let's keep the collegial aspect of CME alive and well in Pierce County — seeing old colleagues, meeting new ones, sharing coffee and experiences, because it's tough being out here, and working together we can do better.

Because as Sir William Osler said in 1909, "Even in populous districts, the practice of medicine is a lonely road which winds up-hill all the way and a man may easily go astray and never reach the Delectable Mountains unless he early finds those shepherd guides."

Your thoughts? ■

Dr. Waltman is employed by MultiCare Health System and serves as a Board Member of The College of Medical Education.

Classified Advertising

POSITIONS AVAILABLE

Western WA – Internal Medicine. MultiCare Health System, seeks multiple BE/BC internal medicine physicians for outpatient settings. Located 40 minutes south of downtown Seattle WA, the area boasts the advantages of an active Northwest Lifestyle; from big city amenities to the pristine beauty and recreational opportunities of the great outdoors. As an employed physician, you will enjoy excellent compensation and system-wide support, while practicing your own patient care values. Email your CV to Provider Services at blazenewtrails @multicare.org, apply for this job on-line or view other opportunities at www.blaze newtrails.org or fax your CV to 866-264-2818. Refer to Opportunity #5906 or 7188 when responding.

Madigan Healthcare System. Community Based Clinic Puyallup & Lacey, Washington. Patient Centered Medical Home Practice. Exceptional civilian opportunities to join a first class Family Medicine team for a board eligible or board certified Family Physicians in a in outpatient settings. The U.S. Army is implementing Patient Centered Medical Home Model Clinics in Lacey and Puyallup, Washington to serve active duty families. Join a team that is committed to moving patients toward healthy lifestyles. Excellent benefits are available including competitive salary, malpractice, health, life and disability coverage, dual retirement plan including the civil service variation of a 403b, and CME allowance. Contact our Medical Provider Recruiter @ (253) 968-4994 or send CV to henry.laguatan@us. army.mil or apply on-line @ http://careers-civilian medicaljobs.icims.com/jobs/job

OFFICE SPACE

Great location 13th & Union. **3rd floor** - Rainier view. 2,500 sq. ft. remaining (divisible). Contact Carol 206-387-6633.

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Pierce County Medical Society
BULLETIN

February 2011

Washington University School of Medicine

INSIDE:

The Bulletin is published monthly by PCMS Membership Benefits, Inc. Deadline for submitting articles and placing advertisements is the 15th of the month preceding publication.

The Bulletin is dedicated to the art, science and delivery of medicine and the betterment of the health and medical welfare of the community. The opinions herein are those of the individual contributors and do not necessarily reflect the official position of PCMS. Acceptance of advertising in no way constitutes professional approval or endorsement of products or services advertised. The Bulletin reserves the right to reject any advertising.

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Pierce County Medical Society
BULLETIN

February 2011

Table of Contents

President's Page

by Jeffrey L. Smith, MD

Do We Really Have a Safety Net?

Jeffrey L. Smith, MD

It is with a heavy heart that I write this month's column. The state is facing a severe financial crisis. The expenditures are greater than income from taxes by millions of dollars. Since we, the taxpaying voters passed or rejected several propositions which would fund programs (like the tax on candy), it is very difficult for the state legislature to increase its income. Top that off with the new requirement for a 2/3 majority for any new tax, and it will be nearly impossible. Unfortunately, that leaves them with only one option, cut spending. To further compound this, many programs are protected in various manners, leaving health care with a large target painted on our chest.

Many of you will be faced with difficulties posed by cuts to translation services, maternity support services, disability lifeline (the program for temporary medical insurance for people unable to work, but who could return to work if their medical problem were taken care of), etc. All of these cuts will hit all of us to varying extents. Both of our hospital systems in the county will take big hits with the cuts in Medicaid rates.

The cuts will be devastating for our "safety net," however. Community clinics statewide depend upon state Medicaid rates, with a Federal enhancement, to pay for services to our underserved poor patients. We can then utilize our Federal 330 grant to provide services for the uninsured. However, one part of the state's planned cuts is to reduce our Medicaid rate by 25%. We will be unable to cover the costs of serving Medicaid clients. We could utilize our entire Federal 330 grant allocation ($2 million) to subsidize this, and still not meet the need. The total cuts from the proposed budget (at the time of this writing) total $6.8 million for Community Health Care (25% of our total budget!) This leaves no money to cover what is a major need in our community and one of our missions, to serve the uninsured. Additionally, we have endured cuts from most of our funding sources over the past couple of years. The TPCHD gave us nearly half a million dollars just a couple of years ago for primary care for uninsured. Now, we get $188,000. With these large cuts, we will have no choice but to downsize, leaving even more uninsured without access to medical care. There are 19 community health clinic systems in Washington. I am certain that several of them will not survive these cuts. At last count, there were nearly 100,000 uninsured people in Pierce County. That number will continue to grow as the economy continues to stall and the state slashes insured rolls.

Lots of bad news. But I don't want to end there. I'd like to encourage you to get involved. Send an email to or call your local representative. Let them know if you are worried and how you expect things to impact you and your neighbors. Many years ago, people respected and sought out the opinions of doctors. We still have some of that residual influence with our positions. I'd suggest we try to utilize it to save our safety net.■

WSMA targets top Legislative priorities

Emergency Care Reimbursement and Ban on Balance Billing

The WSMA opposes efforts to set emergency care reimbursement in statute and banning balance billing of patients.

Legislation is expected to be introduced to ban balance billing and set the reimbursement rate in statute for a patient's non-participating physician. Under the measures, balance billing will be stricken and it is likely that physicians providing emergency care in a hospital who are not a participating provider with the patient's insurer will only receive as compensation the greater of:

* UCR (defined by the health plan);
* The median amount paid by the health plan to a participating physician; or,
* Medicaid

Should this legislation become law, physicians would be stripped of any ability to negotiate reimbursement with a health care insurance company because the insurer will rely on what is in statute. Reimbursement over time would be reduced.

This legislation threatens the trauma and emergency safety net because specialty physicians will no longer provide services in the emergency rooms in hospitals. They will rely on outpatient services

Physicians must have the ability to balance bill in order to keep the insurer engaged in negotiations over rates.

It is not appropriate for the state to set reimbursement arrangements in statute. Rates should be the results of negotiations between physicians and Health Plans. Pegging reimbursement in statute is a recipe for the continuing decline in reimbursement for emergency care.

Medical Assistance, Basic Health Plan and Other Budget Items

It is the Legislature's obligation to make sure that patients covered by both Medicaid and the BHP receive health care services – in the right setting, at the right time and appropriate to their needs. The state has been under-funding these programs and their physician payments have not kept up with the cost of delivering care for too long. Continuing adequate funding of these programs is critical to securing physician participation in these programs.

The governor's budget includes some positive news:

*Adult physical, occupational and speech therapies did not end on January 1.

*The adult hospice benefit did not end on January 1.

*The State Alien Medical (AM) program did not end on January 1.

*The First Steps/Maternity Support Services program will not end on March 1, but the program will be retooled to match a 50 percent cut in funding.

*Adult (age 21 and older) pharmacy benefits will not end on March 1.

*The Take Charge family planning program will not end on March 1.

The governor also is recommending that the legislature restore the Adult Hearing, Adult Vision and Adult Dental benefits for aged, blind and disabled and pregnant women in July, when the new biennium begins.

Medical assistance programs to be cut include:

* Adult Dental for most clients. (The exception will be clients with developmental disabilities.) January 1

* Many podiatric services. (Foot care necessary for acute conditions will continue.) January 1

* Medicaid's participation in school-based medical services (primarily physical, occupational and speech therapy). Those services may be continued if they are funded by school districts. January 1

* Medicaid will no longer provide eyeglass frames, lenses and contacts for adults. January 1

* Medicaid will no longer provide hearing aids, other equipment or repairs for adults. January 1

* The state will no longer pick up the cost of small Rx co-pays for dual eligible clients with Medicare Part D. January 1

* The Interpreter Services program. March 1

* The Children's Health Program. March 1

* Medical coverage and cash grants for the Disability Lifeline program – formerly known as the General Assistance-Unemployable – and ADATSA are scheduled to end March 1.

* The Basic Health Plan. (The big cut for the Health Care Authority, with 57,000 enrollees dropped with about 120,000 on the waiting list).

The Medicaid savings only include the state's contribution to the programs, not any federal match. They are, however, discretionary for the state.

Medical Assistants Licensure and Scope of Practice

The WSMA supports legislation that will grant specific licensure to Medical Assistants (MAs). Medical Assistants are presently recognized in state statute as Health Care Assistants.

The WSMA will introduce legislation that would license medical assistants and permit them, under the supervision of a physician, osteopathic physician, ARNP, podiatrist, nurse, or naturopath, to perform the following functions:

1. Perform clinical procedures to include:
   a. Prepare and assist in aseptic and sterile procedures;
   b. Taking vital sign;
   c. Prepare patients for examination;
   d. Venous and capillary blood withdrawal and nonintravenous injections with limitations; and,
   e. Observing and reporting patients signs or symptoms;
2. Administer basic first aid;
3. Assist with patient examinations or treatment;
4. Operate office medical equipment;
5. Collection of routine laboratory specimens;
6. Administering medications by unit, single, or calculated

See "Priorities" page 9

Online death filing starts in early 2011

The Washington State Department of Health is releasing a new online Electronic Death Registration System (EDRS) to Pierce, Thurston, Mason, Benton, Franklin and Spokane counties in early 2011, with a statewide release to follow. Those who file death records in Washington State are encouraged to enroll in the new system. EDRS will streamline the death registration process, improve the quality of the death data collected, improve communication among those who file, and use the internet to make filing faster.

Physicians will quickly complete a death record from any computer with internet access and file it with a single click. This paperless system does not require extensive computer knowledge. It will streamline communication between funeral directors and physicians and eliminate the need to fax or sign paper records. It will offer a fast, easy, more accurate way to file.

Families will get death certificates faster because delays with paper processing will be reduced. Funeral homes will view cases online and get death certificates faster. The people of Washington will benefit by having immediate and accurate death data used to combat public health threats.

To enroll or request information, please contact the Department of Health at 855-562-1928 or EDRS@doh.wa.gov. ■

The Health Status of Pierce County

by Anthony L-T Chen, MD, MPH

As the World Turns, Around and In the Health Department

Anthony Chen, MD

Each year, I am honored to be invited to speak to the Medical Society's Board of Trustees at their Retreat in January. It is not as grand as President Obama's address, but the medical systems and I get to tout the state of our fiefdoms. Let me share some of the conversation with the trustees.

When the Health Department looked at the environment around us last year, two forces stood out: the economy and health care reform. Neither was new last year and both will have long lasting effects into the future.

The economic recession has led to big drops in local and state revenues, big budget deficits, and statewide cuts in higher education, social services, health care, and public health. For our county residents, these statewide cuts in services come at the same time as more people are losing jobs, income, health insurance, and homes. In addition to the immediate impact on basic needs, we are also worried about longer term health impacts because the declines in socioeconomic status and increases in stress will negatively impact health status and outcomes.

The Health Department has seen cuts in state and county funding as well as drops in permit and license revenues. Our budget and staff have steadily shrunk, we have not filled vacancies that make up about 5% of our staff, and last year we closed for 13 furlough days. Luckily, through hard work of our staff and cooperation from our unions, we are doing as well as we can. To minimize impact on the public, we will limit furlough days for 2011 to five and achieve savings in other ways.

One program that I am particularly concerned about is tobacco prevention, where the state has essentially eliminated all funding. Smoking is the number one cause of preventable deaths and we cannot allow our past gains to slide. Smoking in adults has decreased steadily for the past ten years, but has flattened out recently. What is more worrisome is that smoking in teens similarly declined but in the past few years has flattened and may be starting to tick up. We will be rethinking what we should do and how we will fund it.

Physical inactivity and poor nutrition is the number two cause of preventable deaths, but we have not had much state funding for our prevention efforts. As obesity rates continue to climb, we have used our own flexible funds supplemented by grants to promote active living and healthy eating. This is a prime example of why our top legislative agenda in 2011 is to maintain the flexible public health funding that allows us to continue working on vital local concerns and priorities.

Health care reform brings the promise of increased access for millions and increased funding for prevention and public health. While some benefits have already occurred, others will phase in through 2014. Some people are excluded, such as low income recent legal immigrants and those with undocumented immigration status. Of course, while national health care reform is coming, local erosion is occurring of the Basic Health Plan, Apple Health for Kids, Disability Lifeline (formerly GAU), and oral health programs. This is why it is important for the Health Department to work with the Medical and Dental Societies to continue Project Access, Pierce County Dentists Care, and Access to Baby and Child Dentistry (ABCD) and with the free and community clinics to maintain a community safety net.

Other forces in the environment are in the social and physical realms. Increased demand on social services comes at the same time as United Way is cutting by two-thirds its funding to community service providers. Similarly, as more people are depending on buses for transportation, Pierce Transit is facing service cuts if it is unable to pass Proposition 1 on the February ballot. Decreasing bus service frequency from 15 to 30 minutes or from 30 to 60 minutes will have serious ramifications on those who need to work, access health care or social services, or otherwise function in their daily lives.

In the physical environment, the good news is we are making progress in cleaning up Puget Sound and contaminated sites (brownfields), the Center for Urban Waters opened, and garbage

See "TPCHD" page 8

YWCA thanks PCMS for holiday gifts

Each year at the PCMS Annual Meeting, members bring unwrapped toys for children and gifts for women for the YWCA Support Shelter. The gifts are delivered to the shelter the morning after the annual meeting via PCMS staff members.

The Women's Support Shelter opened in 1976 as the first domestic violence shelter in Washington. The Shelter provides basic needs for women and children for up to 90 days, during which time these women and their families are encouraged to begin rebuilding their lives through individualized case management, education, counseling, support groups, children's services and 24-hour on-site advocacy. For many, the Shelter and its related services form a sturdy base from which to start fresh, stable, safe, self-sufficient lives.

The gifts provided for the women and their children help make their holidays a little brighter and the YWCA is always extremely grateful for the efforts of PCMS and the generous contributions of our members. The thank you note received this year from the shelter speaks directly to their gratitude….

Dear PCMS: Thank you for donating to our Holiday Gift Center. Your donations helped make Christmas bright for our clients. We appreciate your ongoing support and feel very lucky to have it. In gratitude….

And another: *Thank you so much for sharing your generous hearts with the YWCA. We are so grateful that you care about our 'clients.' You certainly helped bring joy to their lives this holiday season. With appreciation….*

PCMS gives hearty thanks to members who have participated in this project over the years. It is always nice to know that your efforts are worthwhile and do make a difference is someone else's life. ■

TPCHD from page 7

dumped at the landfill slowed as the economy plummeted. The Health Department partnered with law enforcement to install secure medication return boxes at 16 police stations in Pierce County which collected and disposed of over 900 pounds of medicines that otherwise could have ended up in the wrong hands or in the landfill and—eventually—our water. The bad news is that Tacoma's air quality continues to be at unhealthy levels for fine airborne particulate matter (Pm 2.5) and may also be for ozone. This will increase respiratory and cardiovascular deaths, emergency room visits, and asthma exacerbations. In addition, there may be economic consequences if the Federal Government starts withholding transportation funding or imposes industrial restrictions to control the problem. For years, the Health Department has worked on indoor (the Clean Air for Kids program) and outdoor air quality (through programs to replace wood burning stoves, the major cause of Pm 2.5). In 2011, we will be coordinating with the City, County, and the Puget Sound Clean Air Agency to tackle air quality in a comprehensive way.

The Health Department is wrapping up its strategic plan and in this time of significant external policy and economic changes, the timing could not be better for us to be able to lead with our heads rather our shrinking pocketbooks. In a future article, I will share our roadmap to achieve our vision of Healthy People in Healthy Communities. ■

Priorities from page 5

dosage including vaccines;
7. Perform laboratory procedures; and,
8. Perform office procedures, including all general administrative duties.

Physician practices employ a good number of Medical Assistants in their practices. With the health care system changing, clarifying and updating the MA's scope of practice is necessary.

Non-English Speaking Interpreter Services in Medicaid Program

Washington state has adopted a sound fiscal strategy of funding Interpreters' services for Medicaid patients with Limited English Proficiency. That approach helps to ensure that accurate clinical examinations and treatment options are pursued, avoiding possible medical errors or adverse patient health outcomes.

Eliminating or even reducing the funding for Interpreters' services without a doubt will have negative downstream effects on access to health care services, as practices will not be able to absorb the added overhead expense of paying for Interpreters' services.

Medical practices already absorb financial losses due to Medicaid's underpayment of services (that is, payment rates that are below the practice's cost of providing care.) Practices will not be able to absorb these added overhead expenses, or be able to care for these patients.

Example: typical Office Visit (CPT code 99213)

Practice's cost of providing this service (estimated average)[1]	$90.00
Medicaid reimbursement (as of July 1, 2009)	$ 37.45
Current Loss to practice in providing this service	-$52.55

Option: Using Telephone service (estimated range)

Added expense of Interpreter's service	-$60.00 to -$120.00
Increased Loss to practice in providing this service	-$112.55 to -$172.55

Option: Using in-person Interpreter service (estimated range)[2]

Added expense of Interpreter's service	-$ 75.00 to -$175.00
Increased Loss to practice in providing this service	-$127.55 to -$227.55

[1] Language translation requirements typically increase the duration of Office Visits. However, that increased time does not increase the reimbursement for the service.

[2] Practice pays the full rate, not the discounted rate available through Medicaid's brokered arrangement. In-person service rate can include travel time and a minimum charge of one to two hours of service.

Volunteer at Pierce County Free Clinics All Year

Chad Krilich, MD, Regional Medical Director, MMA, has been leading a group interested in providing health care to our most vulnerable community members, the homeless. Members of the medical community and organizations focused on care for this group of people have identified some different ways that physicians and other health care providers can help. Listed below are clinics in our community that need volunteer medical staff and their contact information. They are looking for MDs, DOs, PAs, ARNPs, LPNs and RNs.

Metropolitan Development Council Mobile Clinic

Based at MDC-Healthcare for the Homeless Clinic
2342 Tacoma Avenue S, Tacoma WA 98402

Operates at shelter sites in Pierce, lower King and upper Thurston Counties. Open several evenings a month.

If you would like to volunteer, please contact:
Sheri Adams 253-597-4194

Neighborhood Clinic

1323 South Yakima St, Tacoma WA 98405

Open Monday and Thursday evenings from 5pm until patients are seen

If you would like to volunteer, please contact:
Pascal Debons, email pascal.nhc@gmail.com

RotaCare Tacoma

Chronic Healthcare Clinic
Pacific Luther University
Facilities Management Building
124th Street S, Tacoma WA 98447

Open Wednesday evenings

If you would like to volunteer, please contact:
Jan Runbeck 253-370-3988 or email janetrunbeck@harbornet.com

Trinity Healthcare Clinic

1615 6th Avenue, Tacoma WA 98405

Open at 5pm on Tuesday evenings, patients may sign in until 7pm

If you would like to volunteer, please contact:
Jeanne McGoldrick, 253-884-4096 ■

Thank You to PCPA Partners and Volunteers

Pierce County Project Access would like to thank our partners and volunteers for donating care to the low-income residents of Pierce County!

Health Systems: • Franciscan Health System • MultiCare Health System

Providers:

James Abrams, MD
Wendall Adams, MD
Sanjay Agrawal, MD
Steven Alabaster, MD
Irfan Ansari, MD
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- Franciscan Family Medicine - Canyon Road
- Rainier Orthopedic Institute
- Tacoma Digestive Disease Center
- Tacoma Family Medicine
- The Lakewood Clinic

Allied Health/Medical Services:

- Apple Physical Therapy
- Diagnostic Imaging Northwest
- Labs NW
- Medical Imaging Northwest
- MVP Physical Therapy
- PacLab
- Puget Sound Institute of Pathology
- TRA Medical Imaging
- Western Washington Pathology

Pierce County Project Access Update

An infection of the best kind is happening in Pierce County. Pierce County Project Access (PCPA) is working. It is working for you, the physicians, to improve the outcomes of your volunteer medical care for low-income, uninsured patients. It is working for the patients who have nowhere else to go.

Project Access started with a brave band of volunteers who participated in last summer's pilot project. Word has spread among the Pierce County medical community and we now have more than 130 participating volunteer providers. Wonderful stories of successful collaborations through the PCPA network are being created every day as this program continues to grow.

One outstanding example is the story of a 63 year old woman who was originally referred from a free clinic with a lesion on her hand. Assigned to primary care, she had her first visit and then discovered a lump in her breast. She called the PCPA office in a panic to find out what to do next. She went back to her PCP who then made a referral to Project Access for a mammogram. PCPA staff made a call to Carol Milgard Breast Center, with whom we did not have a formal relationship, to see how to get this patient care. They accepted the patient at 100% charity care and on that same day she received a mammogram and ultrasound. When the PCP received the results, both he and the radiologist were concerned about the finding and recommended this patient to a general surgeon. The PCP recruited the general surgeon to donate care to this patient and she is now waiting for her scheduled surgery.

All of this care was brokered around an original agreement from a PCP who agreed to see two patients per year. One can make a fairly reasonable assumption that this patient would not have sought care, upon discovering the lump, had it not been for her relationship with Project Access and a very compassionate primary care provider. Perhaps this is a life saved.

Pierce County Project Access is providing the system which makes this kind of collaboration possible, effective, and efficient. Every person involved with this story deserves recognition and appreciation - the primary care provider and office staff, the general surgeon and staff, and the Carol Milgard Breast Center. The power of the network is experiencing the result of improved patient outcomes and we encourage you to become a part of it. ■

Happy 90th Birthday TOA!

In 1921 a group of Tacoma women got together deciding they would discontinue their support of Seattle's Children's Hospital. Instead, they would turn their efforts toward assisting Tacoma's own new Mary Bridge Children's Hospital.

That group became the Tacoma Orthopedic Association and has met many diverse needs of the hospital. It has donated $29,000,000 to the hospital budget over the years.

The Pierce County Medical Society joins with many others in our state in saluting these remarkable, unselfish, and kind women. Many contributed countless hours and generous funds to help children in ill health.

And many continue to this day, ensuring that our children have the best of health care, at home in their own community. Isn't it amazing what a group of Tacoma women can accomplish in 90 years! ■

PCMS thanks Carol Hazelrigg, wife of ***Dr. James Hazelrigg*** *(who died in 2009) for submitting this information for the Bulletin.*

Applicants for Membership

Yuriy Bilan, PA-C
Family Medicine
Community Health Care
1708 E 44th St, Tacoma
253-471-4553
Training: MEDEX

Jonathan K. Borchers, MD
Family Medicine
Community Health Care
1708 E 44th St, Tacoma
253-471-4553
Med School: U Missouri, Kansas City
Internship: Cox Family Medicine
Residency: Cox Family Medicine

Youssef G. Chami, MD
Interventional Cardiology
Franciscan Cardiology Associates (FMG)
1708 S Yakima Ave, Tacoma
253-779-6220
Med School: Universite Claude Bernard
Internship: University of Montreal
Residency: University of Montreal
Fellowship: University of Montreal
Addl: Medical College of Virginia

Harbir K. Juj, MD, MPH
Pediatrics
Pediatrics Northwest
316 Martin L King Jr Way #212, Tacoma
253-383-5777
Med School: Oregon Health & Science
Internship: UW/Seattle Children's Hosp
Residency: UW/Seattle Children's Hosp

Lily T. Kregenow, MD
Pediatrics
Pediatrics Northwest
4700 Pt. Fosdick Dr NW #211, Gig Harbor
253-851-5665
Med School: Med College of PA/ Hahnemann University
Internship: UC, San Diego
Residency: UC, San Diego

Cleotilde C. Nimietz, PA-C
Family Medicine
Community Health Care
1708 E 44th St, Tacoma
253-471-4553
Training: University of Washington

Personal Problems of Physicians Committee

Medical problems, drugs, alcohol, retirement, emotional, or other such difficulties?

Your colleagues want to help

*Robert Sands, MD, Chair	752-6056
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May 20, 2011 - Fircrest, WA
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Continuing Medical Education

Second Annual Pain Management Symposium 2011 - March 25

The *2nd Annual Pain Management Symposium 2011* will be held Friday, March 25, 2011 at St. Joseph Medical Center in the Lagerquist Conference Center, Rooms A & B. Program Director is **C. Stephen Settle, MD**.

Tremendous changes have affected the practice of pain management, particularly in relation to advances in pharmacologic and intervention aspects. The goal of this symposium is to promote a better understanding of the pathophysiology of acute and chronic pain and to enhance the knowledge regarding various chronic neuropathic pain conditions as well as to critically review the novel state-of-the-art interventional and non-interventional techniques in diagnosis and management of chronic pain.

Topics and speakers include:

Measuring Pain: Tools to Help Guide Pain Management - Steven H. Litsky, MD

Opioid Therapy Re-Examined...Past, Present & Future - Edgar Steinitz, MD

Take Two Breaths and Call Me in the Morning: A Behavioral Medicine Toolkit for Treating Pain - Jeffrey Okey, Ph.D

Introduction to Advanced and Interventional Techniques for Acute and Chronic Pain - Daniel T. Warren, MD

Pain in Primary Care: Why and How - David Tauben, MD

At the end of the conference participants should be able to:

• Discuss and explain to the care provider a framework and knowledge of qualitative & quantitative pain measurement tools to help guide pain management practices. • Understand the different spectra and types of pain and learn different expressions of pain. Discuss subjective versus objective dilemmas and pain and function. • Understand how opioids have been regulated in the U.S.A. from the Harrison Act of 1918 to the present; and the recent major changes in policy at the state & federal levels. • Understand the trends in opioid use and abuse, legally & illegally, in Washington State & discuss its consequences. Understanding and identifying risk stratification for opioid abuse & diversion; and dealing with non-compliance. • Understand the principals, guidelines & medical-legal framework for the comprehensive management of chronic intractable pain to include utilizing opioids: Assessment, Prescription & Monitoring. • To identify psychosocial factors in pain, and to recognize the risk factors for development of chronic pain syndromes. • Understand and discuss when and how to incorporate behavioral medicine approaches in pain management and to become familiar with the toolkit of specific techniques and local resources. • Appreciate the role and value of effective pain care in the primary care practice. • Understand the value and utility of validated tools that measure mood, function, global improvement, and compliance in the treatment of chronic pain. • Improve capability to diagnose and treat common pain problems in the primary care practice. • Know when, why, and who to refer for pain not responding to expected treatments. • Understand indications and contraindications for peripheral nerve catheters, spinal cord stimulation, implantable intrathecal drug delivery pumps, implanted epidural catheters, and ketamine infusions. • Appreciate the support systems necessary to successfully implement interventional pain therapy. • Identify patients likely to benefit most from advanced and interventional pain therapies.

Six Category I CME credits are available for this program. To register call COME 253-627-7137. Registration fee is $90 for PCMS members (active and retired) and $130 for non-PCMS members. ■

Pierce County Decreases Exemption Rates in Rural School Districts

by Robin Peterson RN/MSN, Coordinator, Multicare-Good Samaritan Mobile Health Services

In Pierce County, we find higher immunization exemption rates in rural school districts. Reasons that add to such high rates in rural school districts include:

- Lack of access to convenient immunization services
- Ease of obtaining exemption
- Misconceptions or lack of knowledge about immunizations
- Less funding for school-based health services. Some school nurses must manage health-related needs of an entire district!
- School office staff often collect immunization information, but may not clearly understand it
- These same school office staff may also work with parents who wish to exempt their children from immunizations

Mobile Immunization Program staff members from Multicare Health System and Franciscan Health System worked with the Tacoma Pierce County Health Department to decrease exemption rates and improve compliance with immunizations. The plan had two phases.

In Phase One, we identified students with signed exemptions and those "out of compliance" with school immunization laws. The team checked each student's record in the Child Profile Immunization Registry (CPIR). We added immunization information found in CPIR to the student's school record.

After this activity, an immunization nurse called parents of students still out of compliance and offered information about immunizations. The nurse talked about the importance of immunization to protect against disease and to prepare for future needs (i.e. college, work, travel). The nurse also let parents know about free vaccines for children through age 18. Parents also got written immunization information to read.

In Phase Two of the project, we offered free immunization clinics at the schools during and after school hours. We didn't require parents to come during immunization for middle and high school students. School phone blast messages reminded parents of upcoming clinics.

We made many observations during the project:

- Districts underutilized CPIR. Checking the registry alone improved immunization rates by about 50%.
- Some vaccine records in student files did not get entered into school databases.
- Staff entering data made frequent errors, because they were unfamiliar with their own database system and did not have a clear understanding of vaccine names. For example:
  - MMRV got entered as MMR
  - Tdap got entered as Td only. This happened because of database formatting.
  - Errors in data entry were more frequent when the source was a print out form from the MD office rather than the school Certificate of Immunization Status (CIS).
- Staff perception and forms influenced compliance:
  - Outdated forms (those with the Certificate of Exemption on the back of the CIS) increased out of compliance and exemption rates.
  - Parents used exemptions commonly for convenience to get children in school, and schools did no follow up.
- Parents generally supported the project:
  - They did not always realize their child needed vaccines.
  - Many had vaccinated their children but had not turned the vaccine record into the school.
  - Many expressed gratitude for the convenience of school vaccine clinics.
- True Exemptions were RARE
- School phone automated messaging proved very effective
- Obvious overall improvements district-wide took place:
  - Completely immunized increased by 21.5%
  - Exemptions decreased to 3.1% from 10%
  - Conditional exemptions decreased 4.9%
  - Out compliance decreased 13.5%

The "Take Away" messages of this project were:

- School secretarial staff is critical to immunization compliance.
- Staff has frequent contact with parents and need to know and support the value of vaccination.
- Staff must know immunization abbreviations, get training to correctly document vaccines in the school database, and have time to enter data.
- Use of CPIR by school secretarial staff saves a great deal of time and energy in maintaining student compliance with immunizations.

Our project shows that school immunization compliance increases with support from school administration. Policies must support vaccine standards and enforce the standards essential. Policies that do not allow class registration or attendance without completing vaccine records, and do not allow convenience exemptions prove very effective to get compliance. It is much easier and less time consuming to make sure that policies are in effect.

All of these actions will save countless hours of school staff time and improve the health of the school community. Staff hours saved can be spent on other important student needs. ■

Classified Advertising

POSITIONS AVAILABLE

Western WA – Internal Medicine. MultiCare Health System, seeks multiple BE/BC internal medicine physicians for outpatient settings. Located 40 minutes south of downtown Seattle WA, the area boasts the advantages of an active Northwest Lifestyle; from big city amenities to the pristine beauty and recreational opportunities of the great outdoors. As an employed physician, you will enjoy excellent compensation and system-wide support, while practicing your own patient care values. Email your CV to Provider Services at blazenewtrails @multicare.org, apply for this job on-line or view other opportunities at www.blazenewtrails.org or call 800-621-0301 for more information. Refer to Opportunity #5575 or 5906 when responding.

POSITIONS WANTED

Solo physician with medical specialty, interested in opening a satellite site in Tacoma area, would like to share space in an office with an existing practice, for 2 days a week. If interested, please call (253) 445 2385.

OFFICE SPACE

Great location 13th & Union. 3rd floor - Rainier view. 2,500 sq. ft. remaining (divisible). Contact Carol 206-387-6633.

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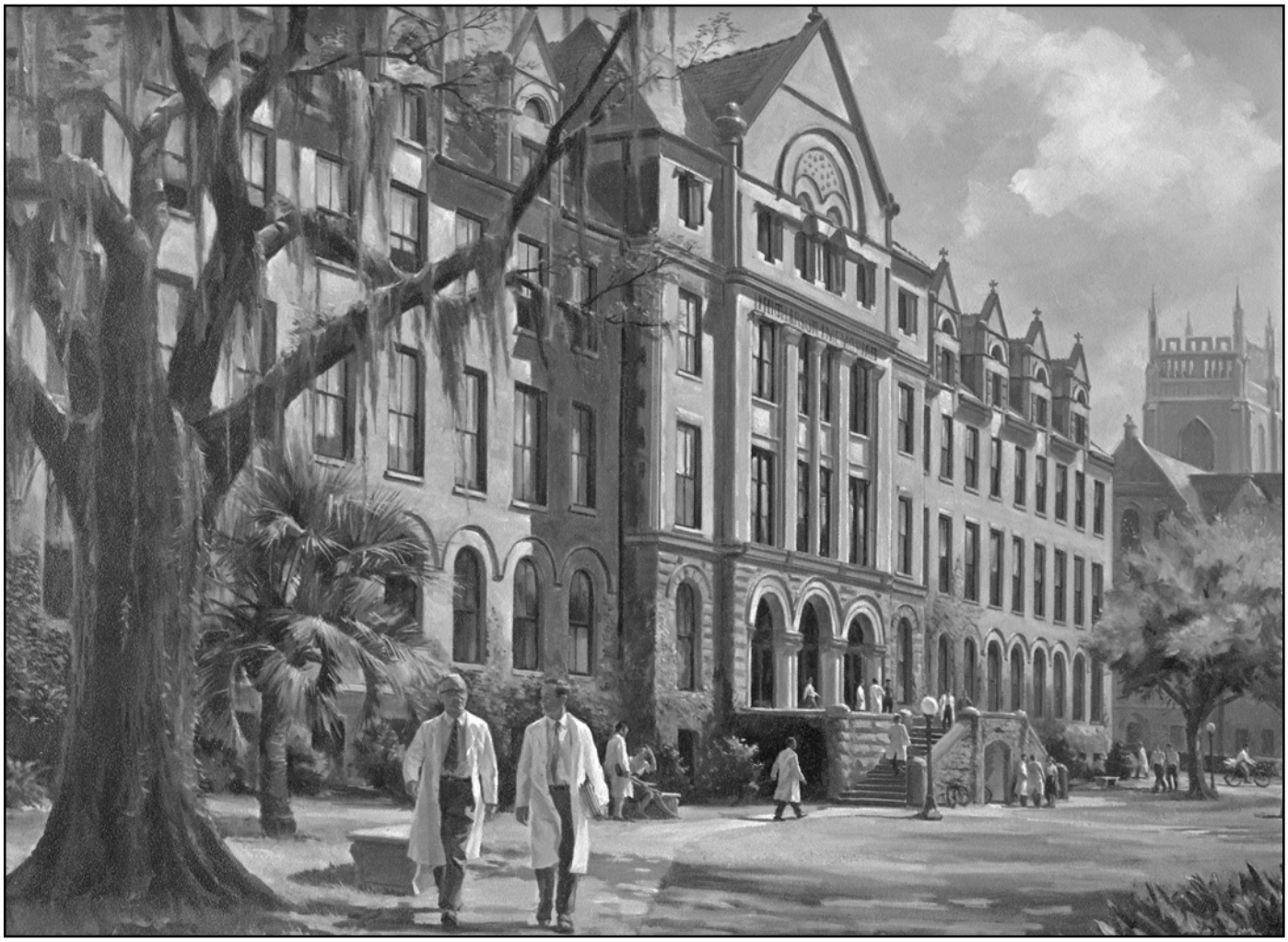
Pierce County Medical Society
BULLETIN

March 2011



Tulane University School of Medicine

INSIDE:

The Bulletin is published monthly by PCMS Membership Benefits, Inc. Deadline for submitting articles and placing advertisements is the 15th of the month preceding publication.

The Bulletin is dedicated to the art, science and delivery of medicine and the betterment of the health and medical welfare of the community. The opinions herein are those of the individual contributors and do not necessarily reflect the official position of PCMS. Acceptance of advertising in no way constitutes professional approval or endorsement of products or services advertised. The Bulletin reserves the right to reject any advertising.

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Pierce County Medical Society
BULLETIN

March 2011

Table of Contents

Pierce County Project Access

by Leanne Noren, Executive Director

Project Access - Bringing Hope to Pierce County

Leanne Noren

What if hope blooms and a life is changed through the simple act of enrolling in Pierce County Project Access?

Pierce County Project Access is making a difference to the low-income, uninsured in our community. I have had the pleasure of talking to many volunteer physicians and other providers who are excited about the opportunity to participate in a volunteer network that coordinates their donated care and protects them from becoming overwhelmed. In almost every instance, these physicians want to hear the positive stories that are coming from the patients they serve through Project Access.

One such story has emerged from a patient who was enrolled in February, 2011. The patient is a 41 year-old female who was referred to Project Access in January from a MultiCare ED after having three visits in two months. She has been unemployed and uninsured for two years and therefore not treating her depression, hypoglycemia or pulmonary embolism. She needed a primary care provider and access to the Coumadin clinic. She promptly completed her paperwork for PCPA and was enrolled the first week in February. Shortly after her enrollment she called the office and wanted us to know that by simply enrolling in Project Access she had become motivated to look for employment again and had found a job and would be insured in 90 days! Her message to all of you is this: "I could not be more grateful for the physician volunteers who want to help people in the community who do not have other resources for their medical needs. It's an incredible thing what Project Access does. God bless you all!"

The belief in the future is bleak when faced with no job, no health insurance, and chronic illness. By simply enrolling, this patient was inspired to take the next step and find a job; a job with health benefits. Pierce County Project Access will carry this client through the next three months until her health insurance begins.

Hope is the belief things will be better in the future without evidence that anything will change. Pierce County Project Access brings a sense of hope to the hopeless in its vision that every Pierce County resident will have access to medical care. No broader good can be imagined than bringing hope to the stranger we do not know, our neighbor, our family, and our friends. This is something to celebrate. ■

** See page 5 for listing of Pierce County Project Access partners and volunteers **

Thank You to PCPA Partners and Volunteers

Pierce County Project Access would like to thank our partners and volunteers for donating care to the low-income residents of Pierce County!

Health Systems: • Franciscan Health System • MultiCare Health System

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- Diagnostic Imaging Northwest
- Labs NW
- Medical Imaging Northwest
- MVP Physical Therapy
- PacLab
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- TRA Medical Imaging
- Western Washington Pathology

Volunteer at Pierce County Free Clinics All Year

We need MDs, DOs, PAs, RNs, LPNs and ARNPs

Metropolitan Development Council Mobile Clinic

Based at MDC-Healthcare for the Homeless Clinic
2342 Tacoma Avenue S, Tacoma WA 98402

Operates at shelter sites in Pierce, lower King and upper Thurston Counties.
Open several evenings a month.

If you would like to volunteer, please contact: Sheri Adams 253-597-4194

Neighborhood Clinic

1323 South Yakima St, Tacoma WA 98405

Open Monday and Thursday evenings from 5pm until patients are seen

If you would like to volunteer, please contact: Pascal Debons, email pascal.nhc@gmail.com

RotaCare Tacoma

Chronic Healthcare Clinic
Pacific Luther University
Facilities Management Building
124th Street S, Tacoma WA 98447

Open Wednesday evenings

If you would like to volunteer, please contact: Jan Runbeck 253-370-3988 or email janetrunbeck@harbornet.com

Trinity Healthcare Clinic

1615 6th Avenue, Tacoma WA 98405

Open at 5pm on Tuesday evenings, patients may sign in until 7pm

If you would like to volunteer, please contact: Jeanne McGoldrick, 253-884-4096

Psychologists seek prescribing rights in 6 states

Proponents say psychologists would better meet patient needs, but opponents say a lack of training would threaten patient safety

Psychologists in six states are seeking the authority to prescribe drugs, saying it would allow them to serve patients better in a mental health system stretched thin without enough physicians to meet growing demands.

Legislators in Arizona, Hawaii, Montana, New Jersey, Oregon and Tennessee are considering bills that would allow psychologists to prescribe psychotropic medications. But the measures are staunchly opposed by the American Medical Association, the American Psychiatric Association, state physician organizations and others who maintain that the proposals would jeopardize patient safety.

"Psychologists are important to the health care team, but a psychologist's education and training does not equip them with the ability to prescribe potentially dangerous psychotropic drugs," said Denver psychiatrist Jeremy A. Lazarus, MD, speaker of the AMA House of Delegates.

Proposals in Hawaii, Montana, New Jersey, Oregon and Tennessee would require psychologists to have a master's degree in clinical psychopharmacology or its equivalent, pass a national examination and have a set amount of clinical experience. Psychologists in Hawaii would have to maintain a collaborative agreement with a physician.

In Hawaii and Oregon, psychologists first must get a conditional prescribing certificate and then qualify for a full certificate after two years. Prescribing rules in Arizona have yet to be set. Similar legislation in Utah failed to be approved in committee.

Psychologists already prescribe in the military and the Indian Health Service. At the state level, they gained prescribing rights in New Mexico in 2002 and in Louisiana in 2004.

Beyond mental health professionals, some nonphysicians have prescribing rights in certain states. For example, advanced practice nurses have limited prescribing authority in at least 40 states, many of which require a collaborative practice agreement between the nurse and a doctor.

Several health professions are seeking to expand prescribing rights this year. Advanced practice nurses in Illinois, Mississippi and New York want to eliminate the collaborative practice requirement. Naturopaths in more than 15 states are pushing for advanced prescriptive authority.

The number of states considering prescriptive authority for psychologists this year is not unusual, but the issue is alarming, said James H. Scully Jr., MD, medical director and CEO of the American Psychiatric Association. "These bills essentially grant psychologists the authority to practice medicine," he said.

> *"Shortages of psychiatrists mean that primary care physicians are seeing more mental health patients and prescribing drugs for many who would be better served through other treatment."*
>
> - John Caccavale, PhD, NAPPP

Proponents of the bills say patients in many areas can't access mental health services in a timely manner. Shortages of child psychiatrists mean that many families wait months to get needed medication for their children, and many pediatricians are reluctant to prescribe psychotropic drugs, said Katherine C. Nordal, PhD, executive director for professional practice at the American Psychological Association.

"It's an access question, particularly in rural areas," she said. "We feel like it is more cost efficient [to allow psychologists to prescribe], and it is less hurdles the patient has to jump through."

Speaking before Utah's bill failed to be approved in committee, Nanci Klein, PhD, director of professional affairs for the Utah Psychological Association, said long waits to see a psychiatrist can be devastating for patients. A survey by the association two years ago found that the average patient in Utah waits eight weeks for a psychiatric appointment.

For example, she said, a bipolar patient, who could not see a psychiatrist for eight weeks, was hospitalized after a suicide attempt. "If he had been able to be seen sooner, his deterioration and subsequent suicide attempt could have been averted."

The National Alliance of Professional Psychology Providers supports prescribing rights for psychologists, but only with strict training, said NAPPP Executive Director John L. Caccavale, PhD, a California clinical psychologist. The NAPPP has more than 10,000 practicing psychologists.

Shortages of psychiatrists mean that primary care physicians are seeing more mental health patients and prescribing drugs for many who would be better served through other treatment, Caccavale said. "NAPPP subscribes to psychotherapy as a first line of treatment, not medications," he said. "Our mission is to get mental health back to where it belongs — with mental health professionals."

Questioning the need

The National Alliance on Mental Illness, however, opposes the prescribing bills. There is no evidence that allowing psychologists to prescribe would address shortages in mental health, NAMI said.

"We really see these medications as having very significant side effects, and we think that the people who prescribe that medication should have significant medical training," said Mike

See "Prescribing" page 8

Prescribing from page 7

Fitzpatrick, NAMI's executive director. "We advocate for training of primary care physicians in prescribing for serious mental illness."

Numerous medical conditions can mimic mental health conditions, and only physicians are trained to recognize the differences, medical organizations said. Hypothyroidism, hyperthyroidism and adrenal insufficiency are a few that can mask themselves as depression, and lupus may be mistaken for a psychotic break.

Psychologists have limited pharmaceutical training and little, if any, exposure to diagnosing illnesses, said the AMA's Dr. Lazarus. "Physicians have more than 10,000 hours of specific training in diagnosing conditions and determining when pharmacological interventions are appropriate," he said. "During their medical residency, psychiatrists spend more than four years developing the skills and experience necessary to safely prescribe — or not prescribe — powerful psychotropic medications." ■

Reprinted from AMNews, 3/7/2011

COLLEGE OF MEDICAL EDUCATION

April 21 - New Developments in Primary Care CANCELLED

The *New Developments in Primary Care* CME course scheduled for April 21, 2011 has been cancelled.

The *Internal Medicine Review* on May 20 features new topics pertinent to family practitioners as does the *Pain Management Symposium* on March 25.

The CME course calendar for September 2011 - June 2012 is now being developed and will be posted late Spring. ■

Continuing Medical Education

Internal Medicine Review 2011 Friday, May 20 - Register Now

Internal Medicine Review 2011 will be held Friday, May 20, 2011 at the Fircrest Golf Club. Program Director is **Neena Chawla, MD**.

This one day program will provide primary care physicians the opportunity to discuss and better understand key aspects of contemporary obesity treatments, including therapeutic options, post surgery care, as well as practical techniques for identifying and assessing appropriate candidates.

Topics and speakers include:

Bariatric Surgery: When to Refer and What to Expect
- Myur Srikanth, MD

Dietary Management of Obesity: Before and After Bariatric Surgery
- Tiana Colovos, RD

Obesity and It's Effect on Respiratory and Sleep Medicine
- David Shaw, MD

Obesity in Pregnancy: A High Risk Condition
- John Read, MD

Update in Diabetes Pharmacologic Therapy
- K. David McCowen, MD

Six Category I CME credits are available for this program. To register call COME 253-627-7137. Registration fee is $90 for PCMS members (active and retired) and/or Tacoma Academy of Internal Medicine members and $130 for non-members. ■

Applicants for Membership

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Franciscan Neurology Clinic
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Residency: Boston University Med Ctr

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Group Health Cooperative
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Med School: University of Cincinnati
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Pierce County Medical Society
BULLETIN

April 2011

University of Maryland School of Medicine

INSIDE:

The Bulletin is published monthly by PCMS Membership Benefits, Inc. Deadline for submitting articles and placing advertisements is the 15th of the month preceding publication.

The Bulletin is dedicated to the art, science and delivery of medicine and the betterment of the health and medical welfare of the community. The opinions herein are those of the individual contributors and do not necessarily reflect the official position of PCMS. Acceptance of advertising in no way constitutes professional approval or endorsement of products or services advertised. The Bulletin reserves the right to reject any advertising.

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Pierce County Medical Society
BULLETIN

April 2011

Table of Contents

President's Page

by Jeffrey L. Smith, MD

The Safety Net

Jeffrey L. Smith, MD

Many of you may have seen my clinic on the front page of the News Tribune on Tuesday, March 22. The headline and article highlighted the fact that we are closing this clinic after more than 20 years of service to the Tillicum community. I have been the lead physician here for nearly 12 years. As much as it hurts us, our patients and our community, we are forced to close due to the cuts in funding from grants and most significantly, from decreased Medicaid rates and decreasing rolls. These changes were the basis of the February President's column. In response to that column, I have received several questions about "the safety net" and what that is.

The "safety net" has many components. President George W. Bush famously commented that we had an existing nationwide safety net, the emergency rooms. Of course, that is not a wise use of our medical resources. Nevertheless, MultiCare and Franciscan system emergency rooms do millions of dollars of care for the poor or indigent or uninsured.

Second, we have several free clinics in our area: Trinity Healthcare Clinic on Tuesday evenings, RotaCare Tacoma Clinic on Wednesday evenings, Neighborhood Clinic on Monday and Thursday evenings, and the Metropolitan Development Council Homeless Clinic several days per month. All are great efforts to meet the need of these underserved, but overall, the capacity is still severely limited.

Third, we have two community health centers in Pierce County. SeaMar has two clinics here and we (Community Health Care) have six (soon to be five, as Tillicum closes). Both systems have been trying to increase capacity over the years. But decreased funding has lead to contraction rather than expansion for about four years running. Community health centers are being hit very hard by the state budget cuts. This was the basis for my column two months ago. If community health centers can not see even the previous numbers of uninsured patients, these disenfranchised patients will very quickly overload the available spots in the "safety net" described above. People will have difficulty getting access to needed care.

One creative solution that we've started in Pierce County is Project Access. Even with the great first year performance of Project Access, there will not be adequate capacity for the thousands that are going to lose care.

I'll end with another reminder to you, my fellow professionals, to get involved. We have knowledge and perspective that is needed. The State Legislature will embark upon the 2011-13 budget now. The TNT reported recently that the expected budget shortfall for that biennium will be $5.8 Billion. We should look to other alternatives than cutting access and services to our most needy patients, neighbors and friends. ■

Are ACOs Unaffordable?

The accountable care organization might be the Department of Health and Human Services' healthcare reform darling, but some industry players are urging healthcare providers to be wary.

Startup costs to join an ACO—large networks of hospitals, physicians groups, specialists, and ancillary healthcare providers—are likely too high for many healthcare providers to overcome in the near term, according to a report authored by executives from group purchasing organization VHA that was published on the *New England Journal of Medicine* website.

The authors are joining a growing chorus of constituents that are concerned about the potentially anticompetitive forces that ACOs might wield on the market—from acquiring supplies and equipment to entering insurance contracts.

In the article, Drs. Trent Haywood and Keith Kosel write that HHS is underestimating the anticipated three-year period that it will take providers to recoup the average $1.7 million investment (startup costs and first-year operating expenses as estimated by the Government Accountability Office) in an ACO. For many, even the best-equipped provider groups, it could take seven years or more before they achieve any financial benefit.

Their conclusions are based on the Centers for Medicare & Medicaid Services' Physician Group Practice Demonstration, conducted between 2005 and 2010, which used a hybrid Medicare fee-for-service and shared-savings bonus payment model to compensate 10 large, fiscally healthy physician groups.

Only two of the 10 participants received shared savings payments in the first year, with only half qualifying for the bonus by year three. The report concludes that groups investing $1.7 million would need a 20 percent margin to recoup their investment within three years.

The authors insisted they're not discouraging hospitals from exploring ACOs, but are suggesting that flaws, including investment costs, must be addressed or it simply won't make sense for most physician groups to participate.

"We published the article to make certain that executives fully weigh the risks before becoming swept up in the moment, said Trent Haywood, VHA's chief medical officer and co-author of the article. He adding that they even took a very conservative approach to their analysis by considering physician groups' operating expenses for the first year alone.

Because ACOs have yet to prove success, the authors recommend that CMS modify the current model by limiting participation to only the largest and strongest hospitals and physicians groups that could absorb the early losses. Or CMS could change the pay-

See "ACO" page 8

Alderbrook Leadership Conference receives rave reviews

Thanks to **William Hirota, MD,** gastroenterologist and PCMS President-Elect, the PCMS Leadership Symposium - Strategies to Execute the Vision held at Alderbrook Resort in early March was a huge success. With 68 physicians attending and many more serving on the faculty, the one and a half day conference to learn how to become leaders in this ever-changing health care environment received very positive reviews from participants. With topics from Quality in Health Care to Understanding the Basics of Balance Sheets, there was something for everybody.

Dr. Hirota made an excellent choice of Dr. Stephen Beeson, whose talk on Enhancing Quality while Motivating the Core was most highly rated. Keynote dinner speaker Dr. Colleen Hacker, PLU professor and Women's National Soccer Consultant, spoke on Peak Performance and the Slight Edge for Leadership. She did not disappoint.

Dr. Anthony Haftel and **Dr. Lester Reed**, presented Quality Metrics Which Work, from the Franciscan Health System and MultiCare Health System experience, respectively. Garrison Bliss, MD, President of Qliance, evaluated as the most interesting and provocative of the conference presenters, told the story of his patient-centered primary care clinic which does not accept insurance and is meeting with much success as a medical practice model.

A huge debt of gratitude is due to the conference supporters. Without their financial assistance this leadership conference would not have been possible. It is because of their support and their commitment to the Pierce County medical community that opportunities to continue learning and collaborating

See "Leadership" page 8

Dr. William Hirota (right), conference director and PCMS President Elect, chats with Dr. Don Russell, WSMA Trustee

Health Information Exchange. A local panel of experts discussed what's possible in Pierce County

L to R - Drs. Robert Wright, Bill Pollard, Mark Grubb and Robert Modarelli. Drs. Kirk Harmon and Smokey Stover visit in the background

PCMS President Dr. Jeff Smith (left) visits with CHC colleagues, Drs. David Cameron and Tim Panzer

Thank You to PCPA Partners and Volunteers

Pierce County Project Access would like to thank our partners and volunteers for donating care to the low-income residents of Pierce County!

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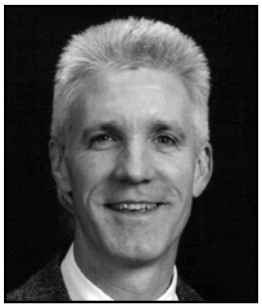
Pierce County Project Access by Sumner Schoenike, MD

Pierce CountyProject Access - Feeling Great About Donated Care



Sumner Schoenike, MD

One of the biggest frustrations of being a physician today is the inability to provide medical care to all comers. We are burdened with considerations of payer mix and business survival. It is a well-known fact that, to open your doors publicly to the uninsured would result in an overwhelming influx of non-paying, uninsured patients. Because of the unsustainability of this action, most donated and charity care is provided "under the radar" to avoid public notice.

Pierce County Project Access, on the other hand, allows physicians to openly participate in the care of low income, uninsured patients in need of specialty or primary care services. Project Access provides insulation between physicians and the public in such a way that allows them to see more patients on a charity basis without opening the floodgates on their practices. Project Access also celebrates public recognition for that effort. It acknowledges publicly our commitment to provide care to all those in need.

Physicians participating in Pierce County Project Access (PCPA) have been uniformly pleased with this aspect of care. Additionally, we have heard from physicians commenting on the patients they have seen through Pierce County Project Access. They have told us that PCPA patients understand their rights and responsibilities, that they arrive on time with their records, and that referrals are appropriate and work-ups have been satisfactorily completed before the patient's arrival. PCPA provides patient management to guarantee this compliance. "The first patient that I saw through Project Access came to me well prepared, in a timely manner and it was a seamless interaction. It was a regular part of my schedule and she received great follow-up. She was very grateful for the care she received," said William Holderman, MD from Digestive Health Specialists.

Occasionally, a project comes along where every effort to move it forward is simple and unobstructed. Pierce County Project Access has been one such project. The message to others and me is that this therefore must be the "right thing to do." Since PCPA began in earnest in September 2010, we have enrolled more than 175 physicians/providers and received enthusiastic support, not only from the medical community, but also from those patients who have been enrolled and received care in Project Access. Project Access has not only been easy to explain to the medical community, but has been easy to explain to others as well. People get it.

In retrospect, the enthusiasm from our physician community should come as no surprise. Pierce County Project Access is turning out to be much more than simply a system for fairly allocating donated care. It is becoming an expression of who we are as physicians. ■

Leadership from page 5

to improve health care for patients in our community are possible.

Many thanks to:

Platinum Sponsors: Community Health Care; Franciscan Health System; MultiCare Health System

Diamond Sponsors: Digestive Health Specialists; Medical Imaging Northwest; Northwest Medical Specialties; Tacoma Digestive Disease Centers; Tacoma Radiology Associates

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Dr. Hirota clearly understands Dr. Beeson's concept in his presentation quoting Thomas Edison that 'vision without execution is hallucination' as Dr. Hirota's vision for a leadership conference was executed expertly.

PCMS extends thanks to Dr. Hirota, as well as conference supporters, speakers, attendees and all participants! ■

ACO from page 4

ment design from an annual model to a cumulative one—allowing for shared savings in which the regulator would assess the aggregated performance of a healthcare provider over several years and reduce the payment threshold for shared saving accordingly.

"We know that CMS successfully implemented a bundled-payment pilot in the past and that it improved quality, generated shared savings and did not pose the financial risks that are embedded in the ACO model," said Haywood, formerly the deputy chief medical officer with CMS.

Haywood is optimistic that groups such as VHA still have CMS' ear before it soon decides on ACO participation requirements. CMS has until Jan. 1, 2012 to establish the driving force behind ACOs—the Medicare Shared Savings Program—according to regulations published in the Accountable Care Act. ■

Reprinted from HealthLeaders Media, March 28, 2011

Spending will surpass total revenues in 2016

The Congressional Budget Office expects health entitlements and other mandatory spending programs to start surpassing federal revenues in 2016.

Social Security, Medicare, Medicaid, defense spending and net interest will exceed 18% of GDP in 2016, CBO Director Douglas Elmendorf recently told the National Assn. for Business Economics. Projected revenues during that year would just cover the costs.

"Fiscal policy cannot be put on a sustainable path just by eliminating waste and inefficiency; the policy changes that are needed will significantly affect popular programs or people's tax payments, or both," Elmendorf said.

The Medicare program represented 23% of total mandatory spending in 2010, and Medicaid and other health programs made up 15%. ■

Reprinted from AMNews, 3-21-11

The Health Status of Pierce County

by Anthony L-T Chen, MD, MPH

Safety Is All of Our Responsibility

Anthony Chen, MD

As we heard the news and saw the images from the earthquake and tsunami in Japan, we were each touched by the scale of destruction and devastating human toll. What seemed so abstract and distant became much more real when we found that we knew someone personally or knew someone who had a friend, relative, or colleague in Japan. Natural disasters are unavoidable, but we cannot sit back and watch as human lives are lost because of complacency.

Whether it was the tsunami evacuations on our shores or the news stories about our earthquake faults, the recent events should have reminded each of us to review our emergency plans at work and home. Being prepared ahead of time helps us stay safe during a disaster.

While natural disasters are sudden events, we should not forget about ongoing occurrences that quietly take their toll. Every year in the United States nearly 150,000 people die from injuries and almost 30 million people are injured seriously enough to warrant a trip to the emergency room[1]. These numbers dwarf most natural disasters, yet they do not command media attention except for an occasional news story about an isolated event. Preventable injuries rank among the top ten causes of death for people of all ages[2]. Reducing this number does not take rocket science, but does require that we all take responsibility for creating safe environments.

During National Public Health Week (April 4-10) this year, please join the American Public Health Association (APHA) in encouraging all Americans to work together to make our nation safe and injury-free. With the slogan "Safety is No Accident," APHA reminds us that injury prevention starts…at home, at work, at play, on the move, and in the community.

As physicians, you have witnessed the devastating effects of injuries and poor safety. Yet many injuries can be prevented with even the simplest of safety measures. For example, two-thirds of children killed by bicycle-related injuries could have been saved by wearing a helmet. Helmets reduce the risk of head injury by as much as 85% and the risk of brain injury by as much as 88%.[3] If everyone wore a seatbelt, properly installed and used child safety seats, wore a helmet, and stored cleaning supplies in locked cabinets, we could dramatically reduce the burden of leading injuries in this country and save lives.

As you interact with patients, remember to remind them about simple safety practices. Ask children whether they wore a helmet the last time they rode their bike. Talk to the teenager about texting while driving. Remind the busy mom that buckling her seat belt each time she gets in the car to run errands is not only good for her, but sets a great example for her children. Ask the warehouse manager if all his employees wear proper eye protection. Talk to neighborhood groups and your local authorities about pedestrian or road improvements that will prevent accidents. You can help influence patients, families, workplaces, and communities.

You can also support Pierce County during an emergency by joining the Medical Reserve Corps. More information about this important service is available at http://piercecountymrc.org/. At the Health Department, we rely on your partnership to help protect the people of Pierce County. We encourage you to join us in advocating for safer practices and environments not just during National Public Health Week, but every day throughout the year. ■

[1]National Center for Injury Prevention and Control. CDC Injury Research Agenda, 2009–2018. Atlanta, GA: U.S. Department of Health and Human Services, Centers for Disease Control and Prevention. (2009). Available at: http://www.cdc.gov/ncipc.

[2]Centers for Disease Control and Prevention, National Center for Injury Prevention and Control Web-based injury statistics query and reporting system (WISQARS). (2010). Available at: http://www.cdc.gov/injury/wisqars.

[3]Safe Kids USA. Factsheet on Bicycle Injury. (2007). Available at: http://www.safekids.org.

51 died under Washington's assisted-suicide law in 2010

Fifty-one patients in Washington died after taking lethal medication prescribed by physicians under the first full year of the state's aid-in-dying law, according to a state health department report released in March.

Sixty-eight physicians wrote life-ending prescriptions for 87 patients, 51 of whom took the medication and died. As of February 9, fifteen died of their illnesses before taking the lethal medication, and another fifteen patients were still alive. For the remaining six deaths, it is unclear whether the patients ingested the medication prescribed under the law, the report said.

The physician-assisted suicide total represents a 42% rise from the 36 doctor-aided deaths in 2009, though the law didn't take effect until March of that year. In Oregon, the only other state with a law authorizing physician-assisted suicide, 65 patients died last year after taking life-ending medication prescribed by their doctors, according to a state report released in January. Oregon has allowed physician-assisted suicide since 1998.

In all, 612 patients have died with physicians' help under Oregon's and Washington's assisted-suicide laws. In both states, the vast majority of patients using the law were white, well-educated, insured, dying of cancer, receiving hospice care and most concerned about loss of autonomy, dignity and joy in living.

"There are no surprises here," said Robb Miller, executive director of Compassion & Choices of Washington, an organization that helps patients access aid in dying. "We are seeing a steady increase in the number of participating physicians and a continuation of a very small percentage of dying patients who use the law. About one-tenth of 1% of all people who die in Washington elect to self-administer life-ending medication. It's a very, very small number."

"Sixty-eight physicians wrote life-ending prescriptions for 87 patients, 51 of whom took the medication and died."

Jennifer Lawrence Hanscom, senior director of the Washington State Medical Association, said she is glad the state is collecting and releasing information on how the state's Death with Dignity Act is being used. The association opposes the physician-assisted suicide law but is not trying to get it repealed.

"We're not vocal opponents," she said.

The Oregon Medical Association is neutral on the matter of physician-assisted suicide, but the association supported a 1997 ballot initiative to repeal the state law, approved by voters in 1994. The Oregon association reaffirmed its pro-repeal position in 2005.

American Medical Association policy "strongly opposes any bill to legalize physician-assisted suicide" because the practice is "fundamentally inconsistent with the physician's role as healer."

In Oregon and Washington, doctor-aided dying is available to patients who have been judged terminally ill by two physicians. Patients must make an oral request and a witnessed written request. Another oral request must be made 15 days later.

The Montana Supreme Court ruled in December 2009 that physicians who prescribe life-ending medication to patients with terminal illnesses are not subject to state homicide statutes. The state Senate in February tabled two bills related to physician-assisted suicide — one to regulate the practice and protect doctors from discipline for participating, and another that would have banned aid in dying. ■

Reprinted from AMNews, March 28, 2011

IN MEMORIAM

GLENN G. MCBRIDE, MD

1913 - 2011

Glenn McBride, MD

Glen was born in Vancouver BC. He graduated from the University of Washington in 1935 and received his M.D. from Northwestern University in 1939. He interned at Swedish Hospital and in 1940 he and his wife Margaret moved to Tacoma for a residency at Pierce County Hospital.

He enjoyed 39 years of Family Practice in Tacoma serving in many positions including President of PCMS (1966) and PCMB. He was chief of staff at Tacoma General and the Doctors Hospital, a member of the AMA, WSMA and AAFP.

During WWII he was a medical officer in the Army Air Corps retiring as a major.

He had many interests including photography, gardening and has written three books. He was always into fitness and was an avid walker and swimmer. He was extremely proud of his three daughters and their husbands and his 10 grandchildren and 24 great grandchildren.

Glen was very helpful to so many young physicians coming to Tacoma to begin a new practice. His patients revered him and his many fellow colleagues will truly miss him.

He will be remembered as an outstanding role model for any physician.

Ken Graham, MD

IN MEMORIAM

MICHAEL OLEJAR, MD

1934 - 2011

Michael Olejar, MD

Dr. Michael Olejar passed away February 5, 2011 at the age of 76.

With no English language skills when he arrived in the United States at age 13, Dr. Olejar became a diligent and accomplished student, earning a Chemical Engineering degree at Youngstown University in 1956 and a B.A. in Mathematics in 1958. He received a Master of Science in Biophysics and a Doctor of Medicine from Ohio State University in 1963. As part of his research while working on his biophysics degree, he split atoms at a cyclotron. Dr. Olejar interned in the U.S. Public Health Service in Staten Island, NY with a rank of Senior Assistant Surgeon. This was followed by a residency in internal medicine at the University of California at San Diego. He then completed a fellowship at Seattle's Swedish Hospital Tumor Institute. Dr. Olejar practiced in West Seattle for 17 years and in 1987 moved to Tacoma where he practiced until retiring in 1997.

Dr. Olejar was a member of the Pierce County Medical Society and the Washington State Medical Association since 1987.

PCMS extends sincere sympathies to Dr. Olejar's wife Janet and their family.

Bill would set Rhode Island physician pay minimum

Rhode Island lawmakers are set to take up a bill that would set the minimum physician pay rate at 125% of what Medicare pays in an effort to bring pay rates closer to those in neighboring states.

The bill's sponsor, Democratic state Rep. Donald Lally Jr., said he worked with physicians to draft the bill after learning that low pay rates were driving physicians and dentists out of state and making it difficult to recruit young doctors to Rhode Island.

"As our physicians and dentists get older, it's going to hit a crisis point where we'll be in dire need of specialists in Rhode Island," Lally said.

No other state sets a minimum level of physician pay that commercial payers are required to meet.

The bill requires commercial insurers to pay a physician at least 125% of Medicare rates. In exchange, however, physicians must participate in Rhode Island's Medicaid program and devote at least 5% of their practices to free care.

Although it says physician pay is a problem in the state, the Rhode Island Medical Society opposes the bill.

"Those floors rapidly have a way of becoming ceilings, and getting it changed once it's made law becomes very difficult," said Steven DeToy, director of public and government affairs for the society.

DeToy said the group testified against a similar bill introduced in 2010 and would do so again this year if necessary.

However, Paul Carey, practice administrator for Urologic Specialists of New England, which has 11 offices and a surgery center in Rhode Island, said his practice has advocated for the minimum pay rate bill.

"We're one of the worst-reimbursed states in the country, and we've been fighting this battle for a long time," he said.

Carey said the group makes less than comparable practices in neighboring states — anecdotally speaking, 95% to 105% of Medicare compared with 125% to 130% of Medicare in Massachusetts and Connecticut. The disparity makes it difficult to recruit young physicians, he said.

"We were looking for somebody for two or three years, and it's been very difficult," he said. The practice has turned to helping train young, homegrown physicians, he said. "They know the reimbursements are terrible, but we hope they will stay because they have family in this state."

DeToy and Carey said the pay disparity stemmed from the dominant position that the state's Blues plan historically held.

"They did suppress rates in Rhode Island for a long time," DeToy said.

Blue Cross & Blue Shield of Rhode Island held 69% of the market for PPO and HMO coverage in the state, according to the American Medical Association's most recent research report on competition in the health insurance market, which is based on enrollment figures from Jan. 1, 2008. ■

Reprinted from AMNews, 3-28-11

Applicants for Membership

Jennifer E. Biggs, PA-C
Family Medicine
Sound Family Medicine
3908 10th Street SE, Puyallup
253-848-5951
Training: Samuel Merritt University

Boguslawa G. Dudkowska, MD, PhD
Internal Medicine
Franciscan Inpatient Team
1717 South J Street, Tacoma
253-426-6341
Med School: University of Lublin
Internship: Hospital of the Univ of PA
Residency: Hospital of the Univ of PA

Catrina Funk, MD
Ob/Gyn
MultiCare Health System
315 Martin L King Jr Way, Tacoma
253-403-7518
Med School: University of Oklahoma
Internship: Butterworth Hospital
Residency: Butterworth Hospital

COLLEGE OF MEDICAL EDUCATION

April 21 - New Developments in Primary Care CANCELLED

The *New Developments in Primary Care* CME course scheduled for April 21, 2011 has been cancelled.

The *Internal Medicine Review* on May 20 features new topics pertinent to family practitioners.

The CME course calendar for September 2011 - June 2012 is now being developed and will be posted late Spring. ■

Continuing Medical Education

Internal Medicine Review 2011 Friday, May 20 - Register Now

Internal Medicine Review 2011 will be held Friday, May 20, 2011 at the Fircrest Golf Club. Program Director is **Neena Chawla, MD**.

This one day program will provide primary care physicians the opportunity to discuss and better understand key aspects of contemporary obesity treatments, including therapeutic options, post surgery care, as well as practical techniques for identifying and assessing appropriate candidates.

Topics and speakers include:

Bariatric Surgery: When to Refer and What to Expect
- Myur Srikanth, MD

Dietary Management of Obesity: Before and After Bariatric Surgery
- Tiana Colovos, RD

Obesity and It's Effect on Respiratory and Sleep Medicine
- David Shaw, MD

Obesity in Pregnancy: A High Risk Condition
- John Read, MD

Update in Diabetes Pharmacologic Therapy
- K. David McCowen, MD

At the end of the conference participants should be able to:

- Understand and discuss indications for bariatric surgery and increase the participant's knowledge in better understanding the early and late post operative complications of bariatric surgery.
- Provide a better understanding of the dietary management requirements for patients before and after having bariatric surgery.
- Understand and discuss the effects of obesity on pulmonary and sleep diseases.
- Understand the potential co- morbidities associated with obesity in pregnancy and possible prevention.
- Understand the two classes of incretin hormone therapy.
- Understand the use of combination therapy in diabetes

Six Category I CME credits are available for this program. To register call COME 253-627-7137. Registration fee is $90 for PCMS members (active and retired) and/or Tacoma Academy of Internal Medicine members and $130 for non-members. ■

Payor Audits: Strategies for Responding; Protecting Your Practice

The level of intense scrutiny of physicians' health insurance claims, and the potential risks to their practices, have never been greater. Many practices receive refund requests in the hundreds and even thousands of dollars, for alleged errors in chart documentation, code selection or in submitting claims. Even when those claims were for medically appropriate services, physicians and practices can be required to refund payments.

Government programs and commercial health insurers alike are mounting increasingly intrusive and potentially damaging initiatives to review your claims, leaving you vulnerable to repayments and even charges of fraud and abuse.

Physicians and practice administrative staff need to understand the risks posed by audits and take proactive steps to achieve compliance and reduce exposure. Practices need to be prepared to comply with audits within the established timeframes, as well as to defend against allegations of improper billing. Learn how to protect and defend yourself and your practice!

Objectives: You will learn: Medicare and Medicaid Recovery Audit Contractors (RACs); their mission and functions; Commercial Health Insurance Payor Audits; Audit activities that will impact physicians' practices; How audits and auditors work; Preparing for audits - Strategies for Prevention and Defense; Specific issues under review by the various audits; Other audits: CERT, PERM, ZPIC, SURS, and HPMP - How these differ; Navigating and Appealing an alleged overpayment finding; Physician Databases: NPDB and HIPDB – Avoiding adverse actions.

Presenter: Stephen D. Rose, J.D., M.B.A., is the chair of the Garvey Schubert Barer Health Law Department. Stephen has more than 25 years experience representing clients in the healthcare industry. His practice focuses on HIPAA, Medicare/Medicaid reimbursement, defending healthcare providers during and after government audits, and developing and implementing corporate compliance plans. He has been one of the educators for WSMA since the HIPAA Privacy Rules were first issued and has defended numerous healthcare providers during HIPAA investigations and audits by the Office for Civil Rights (OCR).

Who Should Attend: Physicians, Practice Administrators, Office Managers, Medical Coders, and Clinical Staff

Tuition: WSMA and WSMGA members can attend for $149 per person, and may sponsor staff in the same practice for the member rate. Three or more members or sponsored staff from the same practice may register for a group discount of $129 per person. Non-members: Please call for pricing. Cancellations received within five full business days prior to the seminar receive a full refund. Cancellations thereafter receive a refund less a $50 cancellation fee. Space is limited, so register early!

Dates/Times: The seminar will be on **Friday, April 29 at Allenmore Hospital** in Tacoma. Seminars run from 12:30 – 4:30 p.m. Check in and on-site registration begins ½ hour before start time.

Call Jenelle Dalit 1-800-552-0612 at the Washington State Medical Association or email her at jcd@wsma.org for registration or more information. You may also visit the WSMA Practice Resource Center online at www.wsma.org.

Classified Advertising

POSITIONS AVAILABLE

Internal Medicine or Geriatric Opportunities - Western Washington. MultiCare Health System seeks BE/BC internal medicine and geriatric physicians to join a growing practice in a congenial setting. Position will provide both inpatient and outpatient medicine. Call is currently 1:6 and utilizes a Consulting Nurse Service. Located 40 minutes south of downtown Seattle WA, the area boasts the advantages of an active Northwest Lifestyle; from big city amenities to the pristine beauty and recreational opportunities of the great outdoors. As an employed physician, you will enjoy excellent compensation and system-wide support, while practicing your own patient care values. For more information regarding these fantastic opportunities contact Provider Services at 800-621-0301 or send your CV to BlazeNewTrails@multicare.org or apply on-line at www.BlazeNewTrails.org.

POSITIONS WANTED

Solo physician with medical specialty, interested in opening a satellite site in Tacoma area, would like to share space in an office with an existing practice, for 2 days a week. If interested, please call (253) 445 2385.

OFFICE SPACE

Great location 13th & Union. **3rd floor** - Rainier view. 1,500 sq. ft. remaining (divisible). Contact Carol 206-387-6633.

Medical office lease/sub lease. Fully furnished: St. Joseph Medical Clinic Tacoma 1,100 sq. ft. sublease $100/d. University Place 1,000 sq. ft. $1,600/m or $100/d. Contact Marlys 253-573-0460.

Office Space To Share. Centrally located between all hospitals in the Tacoma area. Contact Pati 253-572-7120.

Personal Problems of Physicians Committee

Medical problems, drugs, alcohol, retirement, emotional, or other such difficulties?

Your colleagues want to help

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Bill Dean, MD	272-4013
Tom Herron, MD	853-3888
Bill Roes, MD	884-9221
F. Dennis Waldron, MD	265-2584

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Pierce County Medical Society
BULLETIN

May 2011

Loma Linda University School of Medicine

INSIDE:

The Bulletin is published monthly by PCMS Membership Benefits, Inc. Deadline for submitting articles and placing advertisements is the 15th of the month preceding publication.

The Bulletin is dedicated to the art, science and delivery of medicine and the betterment of the health and medical welfare of the community. The opinions herein are those of the individual contributors and do not necessarily reflect the official position of PCMS. Acceptance of advertising in no way constitutes professional approval or endorsement of products or services advertised. The Bulletin reserves the right to reject any advertising.

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Pierce County Medical Society
BULLETIN

May 2011

Table of Contents

President's Page

by Jeffrey L. Smith, MD

Expanding Medical Training in Pierce County

Jeffrey L. Smith, MD

I believe we have a strong medical community here in Pierce County. We have two superior hospital systems, and multiple medical organizations ranging from managed care organizations to community health clinics. We have our own Family Medicine Residency at Tacoma Family Medicine which is nationally recognized as a top notch program. We are close enough to the University of Washington that we frequently have students and residents work in our community as part of their training. But today, I'd like to talk about some changes that are coming that are very exciting and hold the promise of finally meeting our community's needs for primary care physicians.

First, MultiCare is returning a residency to the east part of the county by expanding into East Pierce Family Medicine which will be based at Good Samaritan. They will be a six resident per year program hoping to start in July 2012. Second, the Puyallup Tribe is planning to start a two resident per year program, Takopid Family Medicine, also hoping to start July 2012. Finally, my organization, Community Health Care, is planning to start a Teaching Health Center Family Practice Residency. Our target date is a little further out for the first class of residents, July 2014. We plan to have six residents per year here.

As you can see, we will be expanding our available pool of family practice physicians graduating each year from six to twenty. There are many factors which have led to our current primary care physician shortage. I remember a couple of years ago being so dismayed to read that only three percent of the graduates from medical schools were entering a primary care residency. There has been resurgence in interest and support for primary care, and the current demographics predict a reversal in this trend. Experts are actually predicting that all of the family medicine residency slots will fill with domestic students in just a few years. We'd like to be on the positive side of that trend and fill our hospitals and clinics with well trained and locally trained family practice physicians.

Pierce County Medical Society has been a strong advocate for medical education at all levels. CME historically has been a major activity. Over the coming months, we will be taking a look at how medicine has changed and how medical education has changed. A subcommittee of the PCMS Board of Trustees is currently working on a membership survey to see how PCMS can best serve our members. I don't have an estimate for that survey, but watch for it soon. Having a vibrant, active medical community is key, and taking an active role in teaching and training and mentoring young physicians will only make our community stronger. I'll probably be talking to some of you about this in the coming months, and I hope you will share my excitement in developing strong teaching programs with awesome teaching experiences. ■

SB 5005 will help improve the health of Pierce County

Editor's Note: Special thanks to Tacoma Pierce County Health Department Director ***Anthony Chen, MD*** *and his staff for their leadership role in passage of SB 5005*

Washington has one of the highest school immunization exemption rates in the nation. On Tuesday Governor Gregoire signed a bill requiring a parent or guardian to show that they have received information from a health care provider on the benefits and risks of immunization before opting out of school vaccination requirements.

"Childhood immunizations save lives and are one of the most effective ways to protect kids from serious, preventable illnesses," says Secretary of Health Mary Selecky. "There's a lot of confusing information about vaccine circulating around, this law makes sure that parents will get reliable facts from one of their most trusted sources — a health care provider."

Previous state policy made it easy for parents to exempt their child from school immunization requirements based only on convenience. Washington's exemption rates have more than doubled over the last 10 years — during the 2009-2010 school year, 6.2 percent of children had a signed exemption. The national average for exemption rates is estimated at less than 2 percent.

Unvaccinated kids are more likely to catch and spread serious illnesses like whooping cough and measles, which can be prevented by vaccines. Making sure kids have all recommended immunizations protects them, their classmates, friends, and families from preventable diseases. Kids who aren't fully immunized may be excluded from attending school, preschool, or child care if a disease outbreak occurs.

A health care provider does not need to sign the Certificate of Exemption form for parents or guardians who show membership in a church or religious group that does not allow a health care provider to provide medical care to a child.

Beginning July 22, 2011, parents or guardians who want to exempt their child from school or child care immunization requirements must fill out and submit the updated Certificate of Exemption form to their school or childcare.

"Beginning July 22, 2011 parents or guardians who want to exempt their child from school or child care immunization requirements must fill out and submit the updated Certificate of Exemption form to their school or childcare."

More information and an updated Certificate of Exemption form will be available online as soon as the forms are finalized. Health care providers can use the CHILD Profile Immunization Registry to help parents with the necessary paperwork by printing it from the CHILD Profile system. ■

Payment for on-call coverage becoming more common

Rates must be fair market value to avoid violating rules on doctor-hospital alliances

A growing percentage of physicians get some form of payment for providing on-call coverage, according to a report issued April 20 by the Medical Group Management Assn.

Hospitals have had a harder time securing on-call coverage during the past few years, and the number of physicians receiving compensation for the service grew from 59% in 2009 to 65% in 2010.

"Physicians want to be compensated for call, and your younger, newer physicians are much more tuned into that than older physicians," said Jeffrey B. Milburn, an independent consultant with MGMA Health Care Consulting Group in Englewood, Colo. "Physicians realize the value of their time and services and are negotiating compensation for on-call coverage."

How physicians are compensated for on-call coverage shifted slightly. A daily stipend was the most common form of payment, with 35% of physicians providing call coverage paid this way in 2010 compared with 33% in 2009. But more are being paid annually. An additional 21% received annual pay in 2010, an increase from 14% in 2009. About 6% were paid by the hour in 2010, down from 8% in 2009.

But experts said physicians seeking payment for on-call coverage need to balance several concerns. Any money paid must be fair market value to avoid running afoul of regulations governing hospital-physician relationships. Nonprofit hospitals need to be aware of Internal Revenue Service regulations to maintain that status.

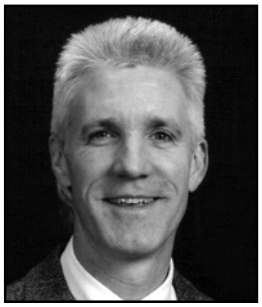
Experts said that although payment for call coverage is becoming more common nationally, there are wide variations by region, group size and medical specialty.

"Payment for call is a trend, but it depends on your market," Milburn said. "In some areas, paying for call coverage is solidifying. In other areas, it hasn't even started."■

Reprinted from AMNews, May 9, 2011

Pierce County Project Access by Sumner Schoenike, MD

The Benefits of Workup Standards



Sumner Schoenike, MD

As the number of uninsured in Pierce County rises above 100,000 and the medical safety net is saturated and over-stretched, our medical community is struggling to create systems of care for those with the greatest need. Pierce County Project Access is one such system of care dedicated to the fair allocation of uninsured, low-income patients to volunteer primary and specialty care physicians.

One element of Pierce County Project Access (PCPA) that does not reflect the national model is the standardization of workups before referral to specialty care. We interviewed a large number of specialists prior to the formation of PCPA and almost every specialist told us that one of their biggest frustrations in providing donated care was how commonly such patients were referred inappropriately and with incomplete workups. Due to the importance of bringing value to the process of providing donated care, the creation of a standardized workup prior to referral to a specialist became absolutely necessary.

A second benefit of this process becomes creating community standards of workups for certain diagnoses and conditions leading to creation of a set of local standards and "best practices." With diligent case management, it was hopeful that we could improve physician satisfaction by ensuring that patients arrive for their specialist visits on time and with appropriate records. In several instances PCPA has referred patients to physical therapy prior to referring to an orthopedic specialist resulting in successful physical therapy outcomes.

We are committed to making all of these elements of Pierce County Project Access occur with each and every patient visit. And so far so good! The feedback we have been receiving from specialists providing care for PCPA patients has been that they have uniformly been appropriately worked up and referred, have arrived on time and with their pertinent records. It is our commitment to continue this success. We know that it is essential to the success of the program.

Interestingly, we have received additional feedback from the specialty groups in our medical community telling us that the standardization of workup has been not only beneficial for the PCPA patients, but also for other specialty referral patients within our community. It is the development of standards such as these that should drive down the cost of medicine, provide better patient care and avoid unnecessary diagnostic procedures and interventions.

PCPA has initiated a quarterly meeting of the statewide Project Access programs. There has been general interest in our standardization component. We believe that we will see more standardization of this nature within Project Access programs and elsewhere as we go forward.■

CEOs of top health plans rake in up to $20 million

Some of the chief executives at the country's seven largest publicly traded health insurance companies saw their own economic recovery in 2010, earning total compensation from $6.1 million to more than $20 million.

Executive pay at the largest health plans didn't follow any broad pattern, though some executives saw dramatic pay increases compared with 2009.

That wouldn't be unusual in the context of all large corporations, said Aaron Boyd, head of research at Equilar, an executive compensation consulting and research firm in Redwood City, Calif.

"What we saw, at least at big companies, was that pay was up in 2010," he said.

Compensation for executives of health plans was toward the high end of all large corporations, but the increases in 2010 were slightly lower than in some other industries, Boyd said.

The average total compensation at 299 of the companies in the S&P 500 Index was $11.4 million, according to the annual AFL-CIO analysis of executive pay. The average total compensation was $4.8 million for insurance carriers included in that analysis.

As has been true in the past, 2010 base pay for most chief executives at major health plans hovered around $1 million, but incentive pay, retirement and pension contributions and stock awards made their total compensation packages worth far more.

The base pay is a result of rules that made up to $1 million in CEO pay tax-deductible for most companies. As part of the Patient Protection and Affordable Care Act, which became law in March 2010, only $500,000 of any executive's compensation is tax-deductible, and that total includes any money earned in one year but not paid out until future years. Performance-based pay is no longer deductible.

The bulk of most compensation for CEOs of health plans rests in stocks and stock options, tying compensation to the value of shares in the company, and, in theory, aligning a CEO's incentives with what's in the interest of shareholders.

The bias toward equity-based compensation doesn't mean, however, that CEOs of the most profitable companies made the most or saw the largest pay raises. Jumps in pay didn't necessarily mirror huge increases in profitability or revenue in 2009 or 2010.

According to SEC filings covering 2010, two CEOs saw their compensation more than double from 2009: Health Net's Jay Gellert and Cigna's David Cordani. Health Net saw a dramatic improvement in profit in 2010 from 2009, going from a loss to a $204 million net profit. But Cigna's profits were up only

See “CEOs” page 10

The Health Status of Pierce County

by Anthony L-T Chen, MD, MPH; Frank Dibiase, MA, RS; and Kirsten Frandsen

The Never-Ending Struggle to Put Out the Smoke

Anthony Chen, MD

In the movies, actors—whether tough guys or sexy leading ladies—are often lighting up cigarettes. Fortunately, this is happening less but most of us are old enough to remember when everyone smoked on screen and some may remember when even fellow moviegoers were smoking in the theater!

Tobacco smoke causes cancers and pulmonary, cardiovascular, and oral disease. It remains the number one cause of preventable death. May is Allergy and Asthma Awareness Month and Clean Air month and we should be reminded of tobacco's contribution to these problems.

Through education, policy, and other medical and public health interventions, there has a dramatic reduction in adult smoking rates. Nationally, 42% of adults smoked in 1965[i] but this rate dropped to 24% in 1999 and to 21% in 2009[ii]. Halving the national smoking rate in 45 years and dropping 12% in the last ten years is great progress. In Pierce County, 17% of adults smoke[iii], which is below the national average but higher than the rest of the state. Remember that 17% still represents 100,000 adults in our community that are threatening their own health and the health of those around them.

More frightening still, 20% of 12th graders in Pierce County report that they have smoked in the last 30 days[iv]. When youth repeatedly watch their parents, peers, heroes, or favorite stars light up, they begin to believe it is normal or desirable. We need to help the youth in our communities live healthy lives instead of letting glamorized portrayal of tobacco in the media and other insidious marketing strategies lure them into a smoking habit.

As traditional smoking becomes more socially taboo, there are alarming new products that look innocent enough to children and may tempt them to smoke. E-cigarettes are electronic devices that simulate the act of smoking. They are designed to look like traditional cigarettes and produce a white, nicotine-laden vapor that looks like smoke. While proponents claim e-cigarettes are safe and help smokers quit smoking, the FDA has shown their vapor contains carcinogens and toxic chemicals and there are no rigorous scientific studies that show they help smokers cut down or quit. What is most troubling is that these nicotine delivery systems are unregulated by the FDA. Their documented poor quality control and variability in nicotine delivery raise safety and effectiveness questions. Also, they can legally be sold to youth and used in public places where they may be perceived as regular cigarettes and perpetuate the notion that smoking is acceptable.

Some e-cigarettes come in candy flavors like Gummy Bears, Peanut Butter Cup and Orange Creamsicle and may prove appealing to a younger crowd. In addition, tobacco companies have rolled out dissolvable tobacco products that look like Tic-Tac candies (Camel Orbs) or breath freshener strips (Camel Strips). In the smokeless tobacco market, snuff prepackaged in small pouches (snus) is marketed as more inconspicuous and eliminating the need to spit.

In the coming weeks, the Tacoma-Pierce County Health Department will be proposing regulations on the sale and use of e-cigarettes. As a medical community, I hope you will support our efforts and share our position that e-cigarettes and other unregulated nicotine or tobacco products pose a risk to the health of the people in Pierce County.

Lastly, I want to remind you that Tuesday, May 31 is World No Tobacco Day. This is a good time to strengthen your existing screening process for patient tobacco use. I encourage you to talk with your patients about the risks of tobacco and help them develop a quitting plan. Cessation resources are available at the Health Department to assist with this. It's good for your patients, their families and for our community as a whole. For information to help patients quit smoking, visit http://tpchd.org/health-wellness-1/tobacco-prevention-control or www.quitline.com. ■

[i]"Trends in Current Cigarette Smoking Among High School Students and Adults, United States, 1965–2009," last modified September 29, 2010, http://www.cdc.gov/tobacco/data_statistics/tables/trends/cig_smoking/index.htm.

See "Smoke" page 12

CEOs from page 8

about 3%.

Gellert's total compensation jumped from $3.6 million in 2009 to $7.6 million in 2010, Cordani's from $6.7 million to $15.2 million.

The highest-paid chief executive of the seven largest shareholder-owned plans was on his way out the door: Aetna's Ronald Williams retired as CEO on Nov. 29, 2010, and as chair on April 8. He made a total of $20.7 million in his last year as CEO, $14 million of it in stock awards.

But not all health plan CEOs received a compensation increase in 2010. Aetna's Mark Bertolini, who took over for Williams after serving as president for several years, received stock awards and options worth less in 2010 than in 2009, resulting in a 30% drop in total compensation, to $8.8 million. Humana's Michael McCallister saw a slight drop in total compensation, from $6.5 million in 2009 to $6.1 million in 2010.

Coventry Health Care's CEO Allen Wise also earned more in stock options in 2009 than in 2010, so his total pay was down to $13.6 million in 2010.

Compensation for Angela Braly, who heads WellPoint, the largest health plan by membership, rose slightly, from $13.1 million in 2009 to $13.4 million in 2010. Stephen Hemsley, who heads UnitedHealth Group, the largest health plan by revenue, earned $10.1 million in 2010 compared with $8.9 million in 2009. ■

Reprinted from AMNews, May 9, 2011

Directory Changes

Please make the following changes to your 2011 PCMS Physician Directory:

Robert Ettlinger, MD
Change Suite # to 103; Change fax number to 274-5018

George McClure, MD
Change phone to 253-301-5120; Change Zipcode to 98405

Edward Williams, MD
Change office address to 5006 Center Street Ste R, Tacoma WA 98409 ■

NDM-1Enzyme Produces Carbapenem Resistance*

International travel is playing a role in the spread of antibiotic resistance. The New Delhi metallo-ß-lactamase (NDM-1) enzyme, identified in *Enterobacteriaceae* isolated from patients with travel to India or Pakistan, is one of several metallo-ß-lactamase enzymes with the potential to cause multi-drug resistance.

Carbapenem Resistance

Bacteria in the *Enterobacteriaceae* family have once again figured out how to elude our antibiotic arsenal. NDM-1 *Enterobacteriaceae* have been isolated in patients from or who recently traveled to India and Pakistan. This enzyme generates resistance to all beta-lactams, even carbapenems (except for aztreonam).

The first case of a NDM-1 producing bug was in a 59 year old Swedish male who traveled to New Delhi, India and was hospitalized for a gluteal abscess.[1] He acquired a urinary tract infection (UTI) caused by a carbapenem-resistant *Klebsiella pneumoniae*, which was later identified as a NDM-1 producer.

Recent Studies

One study isolated 44 and 26 NDM-1 producing bacteria from Chennai and Haryana in India, respectively, along with 73 isolates from other cities in India and Pakistan.[2] Most notably, of the 44 isolates from Chennai, 19 were resistant to tigecycline and three to colistin. This study also identified 37 isolates in the United Kingdom (UK) and found the majority of carriers had links to, or had traveled to, India or Pakistan within the past year.

The bacteria in this study were all from the *Enterobacteriaceae* family and the majority of them were either *K. pneumoniae* or *Escherichia coli*. Among the antibiotics tested against the UK isolates, only tigecycline and colistin remained active. This was a retrospective surveillance study, therefore proper identification, isolation, and treatment of patients may not have occurred.

Another study published in India in 2011 isolated three NDM-1 producing bacteria from surgical site infections and found these bacteria were only susceptible to tigecycline and colistin.[3]

A 2009 study found the NDM-1 gene to have significant genetic mobility between bacteria.[1] This study hypothesized that the transfer of NDM-1 between gram-negative bacteria is very easy. It should be kept in mind that this very rare NDM-1 enzyme may be present in difficult to treat infections, especially if the patient has a history of recent international travel and hospitalization.

NDM-1 producing bacteria identified in North America

In February 2011, a staff person at Centers for Disease Control and Prevention (CDC) confirmed (by email correspondence) that only seven NDM-1 producing *Enterobacteriaceae* cases have been reported to CDC: one in 2009, five in 2010, and one in 2011. The isolates were identified as *K. pneumoniae, E. coli*, and *Enterobacter cloacae* species.

In all seven cases the patients reported recent international travel. Five patients were hospitalized in India or Pakistan; one patient received outpatient medical care while abroad; and, one patient reported several active medical issues while abroad but no international medical care. Of the isolates with reported sensitivities, all were resistant to beta-lactams, including carbapenems and aztreonam. Resistance to aztreonam likely occurred through a mechanism other than the NDM-1 enzyme.[4]

Canada is also starting to identify NDM-1 producing bacteria: three case reports have been recently published.[5,6,7] All three patients developed UTIs caused by either one isolate or multiple strains of *E. coli* or *K. pneumoniae* that carried the NDM-1 enzyme. All three patients reported recent hospitalization in India while traveling. Resistance patterns were similar among all the isolates, being resistant to all beta-lactams, aminoglycosides, fluoroquinolones, and trimethoprim/sulfamethoxazole. One isolate was susceptible to aztreonam and chloramphenicol, another to fosfomycin, and all isolates were susceptible to tigecycline and colistin.

No Mandatory Surveillance in USA

Systematic U.S. national surveillance does not exist for these organisms. Identification of any carbapenem-resistant *Enterobacteriacea*e (CRE) from U.S. patients with a history of receiving medical care abroad is forwarded to CDC on a voluntary basis.

For this reason, it is likely that the prevalence of NDM-1 producing bacteria in the U.S. is higher than what is actually reported; however, the prevalence is still estimated to be very low.

Although we have recently begun to see NDM-1 producing bacteria in the U.S., *K. pneumoniae* carbapenemase (KPC) enzyme isolates have been identified in the U.S. since the early 2000s. These KPC enzymes remain the most common and the most important mechanism of carbapenem-resistance for *Enterobacteriaceae* in the United States.

Recommendations from the World Health Organization (WHO)

World Health Day on April 7, 2011 is devoted to raising awareness of antibiotic resistance. More information is available at: www.who.int/world-health-day. WHO recommends that governments increase surveillance for antibiotic resistance, educate on the appropriate use of antibiotics, not allow the sale of antibiotics without a prescription, control the use of antibiotics in food animals, and promote adherence to infection control policies/procedures.

See "Resistance" page 12

Resistance from page 11

What should we do?

Be aware of NDM-1, monitor for NDM-1, and (when NDM-1s are present) prevent transmission to others. Cultures and sensitivities should be taken from sites of infection. All acute care facilities should implement contact precautions for patients colonized or infected with CRE.[8] Simple handwashing when done properly and consistently continues to be a very effective method of infection control.

Antibiotic streamlining should always be performed when treating infections. It is especially important because one of the above studies isolated several NDM-1-producing *Enterobactericiae* species that were already resistant to tigecycline and colistin.

Facilitating appropriate use of antibiotics will help ensure bacterial resistance occurs as slowly as possible. It is also very important to inform CDC and local health jurisdictions of CRE isolated in patients with recent travel and medical care in India or Pakistan. For more information on CDC guidance in reporting CRE, please visit: www.cdc.gov/mmwr/preview/mmwrhtml/mm5810a4.htm

Establishing proper notification practices will help expedite the identification and control of NDM-1 producing organisms in the United States. Time will tell how the NDM-1 enzyme will impact us. Remember that awareness, judicious antibiotic use, and good infection control practices are currently our best weapons.

Resources

1. Yong D, Toleman MA, Giske CG, et al. Characterization of a New Metallo- ß-Lactamase Gene, blaNDM-1, and a Novel Erythromycin Esterase Gene Carried on a Unique Genetic Structure in *Klebsiella pneumoniae* Sequence Ttype 14 from India. *Antimicrob Agents Chemother*. 2009

See "Resistance" page 14

Smoke from page 9

[ii] "Trends in Current Cigarette Smoking Among High School Students and Adults, United States, 1965–2009," last modified September 29, 2010, http://www.cdc.gov/tobacco/data_statistics/tables/trends/cig_smoking/index.htm.

[iii] "2008-2009 Behavioral Health Risks of Pierce County Adults," July 2010, http://www.tpchd.org/files/library/411ee3dbf66b886d.pdf.

[iv] "Healthy Youth Survey (2010)," last updated February 26, 2010, http://www.hys.wa.gov/. ■

COLLEGE OF MEDICAL EDUCATION

Continuing Medical Education

Internal Medicine Review 2011 Tacoma Academy of Internal Medicine - Friday, May 20

Internal Medicine Review 2011 will be held Friday, May 20, 2011 at the Fircrest Golf Club. Program Director is **Neena Chawla, MD**.

This one day program will provide primary care physicians the opportunity to discuss and better understand key aspects of contemporary obesity treatments, including therapeutic options, post surgery care, as well as practical techniques for identifying and assessing appropriate candidates. Some focus will include discussion on obesity and its co-morbidities along with the medical, surgical and dietary management of patients.

This program is offered to members of the Tacoma Academy of Internal Medicine as well as local physicians and physician assistants.

Topics and speakers include:

Bariatric Surgery: When to Refer and What to Expect - Myur Srikanth, MD

Dietary Management of Obesity: Before and After Bariatric Surgery - Tiana Colovos, RD

Obesity and It's Effect on Respiratory and Sleep Medicine - David Shaw, MD

Obesity in Pregnancy: A High Risk Condition - John Read, MD

Update in Diabetes Pharmacologic Therapy - K. David McCowen, MD

At the end of the conference participants should be able to:

- **Understand and discuss indications for bariatric surgery and increase the participant's knowledge in better understanding the early and late post operative complications of bariatric surgery.**
- **Provide a better understanding of the dietary management requirements for patients before and after having bariatric surgery.**
- **Understand and discuss the effects of obesity on pulmonary and sleep diseases.**
- **Understand the potential co- morbidities associated with obesity in pregnancy and possible prevention.**
- **Understand the two classes of incretin hormone therapy.**
- **Understand the use of combination therapy in diabetes.**

Six Category I CME credits are available for this program. To register call the College of Medical Education at 253-627-7137. Registration fee is $90 for Pierce County Medical Society members (active and retired) and/or Tacoma Academy of Internal Medicine members and $130 for non-members. ■

Resistance from page 12

December; 53 (12): 5046-5054.

2. Kumarasamy KK, Toleman MA, Walsh TR, et al. Emergence of a new antibiotic resistance mechanism in India, Pakistan, and the UK: a molecular, biological, and epidemiological study. *Lancet Infect Dis*. 2010;10 (9):597-602.

3. Sarma JB, Bhattaacharya PK, Kalita D, Rajbangshi M. Multidrug-resistant Enterobacteriaceae including metallo-ß-lactamase producers are predominant pathogens of healthcare-associated infections in an Indian teaching hospital. *Indian J Med Microbiol*. 2011;29(1):22-27.

4. Centers for Disease Control and Prevention (CDC). Detection of Enterobacteriaceae isolates carrying metallo-ß-lactamase - United States, 2010. *MMWR Morb Mortal Wkly Rep*. 2010;59(24):750

5. Tijet N, Alexander DC, Richardson D, et al. New delhi metallo-ß-lactamase, Ontario, Canada. *Emerg Infect Dis*. 2011;17(2):306-307

6. Peirano G, Ahmed-Bentley J, Woodford N, Pitout JD. New delhi metallo-ß- lactamase from traveler returning to Canada. *Emerg Infect Dis*. 2011;17 (2):242-244.

7. Mulvey MR, Grant JM, Plewes K, Roscoe D, Boyd DA. New delhi metallo-ß -lactamase in Klebsiella Pneumoniae and Escherichia coli, Canada. *Emerg Infect Dis*. 2011;17(1):103-106.

8. Centers for Disease Control and Prevention. Guidance for Control of Infections with Carbapenem-Resistant of Carbapenemase-Producing *Enterobacteriaceae* in Acute Care Facilities. *MMWR Weekly*. 2009/58(10);256-260. ■

*Dan Fleischman, PharmD, Franciscan Health System. Reviewed by members of the Antibiotic Utilization Committee of the Pierce County Antibiotic Resistance Task Force including PCMS members David Bales and Mark Grubb.

Applicants for Membership

Patrick W. Fisher, DO, PhD
Cardiovascular Disease
Cardiac Study Center
1901 S Cedar St Ste 301, Tacoma
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Internship: NW University
Residency: NW University
Fellowship: Medical College of Virginia
Addl Training: Stanford University

Amanda B. Steen, MD
Physical Medicine & Rehab
Franciscan Physiatry (FMG)
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Internship: Ochsner Foundation Hosp
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Classified Advertising

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Internal Medicine or Geriatric Opportunities - Western Washington. MultiCare Health System seeks BE/BC internal medicine and geriatric physicians to join a growing practice in a congenial setting. Position will provide both inpatient and outpatient medicine. Call is currently 1:6 and utilizes a Consulting Nurse Service. Located 40 minutes south of downtown Seattle WA, the area boasts the advantages of an active Northwest Lifestyle; from big city amenities to the pristine beauty and recreational opportunities of the great outdoors. As an employed physician, you will enjoy excellent compensation and system-wide support, while practicing your own patient care values. For more information regarding these fantastic opportunities contact Provider Services at 800-621-0301 or send your CV to BlazeNewTrails@multicare.org or apply on-line at www.BlazeNewTrails.org.

Certified Coder. South Sound Neurosurgery in Puyallup looking for a Certified Coder with surgical office experience. Responsible for managing the coding functions of the practice to include denial management, surgery authorizations, payment appeals, and provider education. Required education includes a high school diploma, GED, or equivalent skills and education and a certificate in coding. Preferred education includes graduation from an accredited medical office/billing or coding program. Preferred work experience in an orthopedic or neurosurgery practice, healthcare revenue cycle processes, and using Centricity Practice Management and EMR. Excellent customer service skills and professional appearance a must. Excellent benefits. Salary DOE. Email resumes to info@southsoundneurosurgery.com or fax to 253-841-5944, attn: Human Resources.

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Pierce County Medical Society
BULLETIN

June 2011

MBI says goodbye to President Jeff Nacht, MD

Pierce County Medical Society's for-profit subsidiary MBI says goodbye to President Jeff Nacht, MD. From left: Drs. Dan Ginsberg, Jeff Nacht, Keith Demirjian, Drew Deutsch and Mark Gildenhar. Not pictured: Drs. Steve Duncan, Steve Settle and Joe Wearn

See story page 7

INSIDE:

The Bulletin is published monthly by PCMS Membership Benefits, Inc. Deadline for submitting articles and placing advertisements is the 15th of the month preceding publication.

The Bulletin is dedicated to the art, science and delivery of medicine and the betterment of the health and medical welfare of the community. The opinions herein are those of the individual contributors and do not necessarily reflect the official position of PCMS. Acceptance of advertising in no way constitutes professional approval or endorsement of products or services advertised. The Bulletin reserves the right to reject any advertising.

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Pierce County Medical Society
BULLETIN

June 2011

Table of Contents

President's Page

by Jeffrey L. Smith, MD

The Future of Medicine?

Jeffrey L. Smith, MD

I've been attending several continuing medical education conferences with titles like "The Future of Medicine." I wish I could claim to be any more enlightened afterwards. Unfortunately, I remain mired in a thick haze when thinking about exactly what will happen in our profession. But I have seen a few glimpses of things I'd like to see in our profession.

First, I'd like to see us regain our social leadership status. Remember when television commercials would use us as a mark of truth and quality. "Four out of five dentists recommend Brand X for cleaner and whiter teeth." "I'm not a doctor, but I play one on TV." Heck, even an actor who pretended to be a doctor had some claim to authority. We know medicine will continue to change in myriad ways; financial, regulatory, technologically, etc. It's good to see some physicians stepping up to leadership roles in the new world. The PCMS sponsored a physician leadership weekend CME a couple of months ago, organized by next year's President, **Dr. Bill Hirota**. The conference was well attended and well structured. Refreshing.

Second, I'd like to see the profession explore alternatives to the fee for service model of payment. I know many can't think beyond the old model, since our paychecks may depend upon it. But the Medical Home model of care makes a lot of sense and delivers what I like to think of as old fashioned care. Patients are encouraged to make a bond with their primary care giver and start their care there. The medical home will not only care for the problem presented, but will take care of any and all preventive issues as well. The primary care physician will arrange for other care as needed. Several years ago, when I first heard of this model, I thought, "what's the big deal, we do this all the time." But in reality, too many of most of our encounters are still episodic care paid for by insurers or patients based on what we do in an office visit. Few organizations except for closed managed care systems are able to fully implement a true Medical Home Model. I'd like to see that change. I'd like to see more (every?) payor using a model where we were paid for keeping folks healthy. The third future item I'd love to see in medicine is reform of physician reimbursement. It's no secret that primary care payment is the lowest in the industry. It makes no sense that we have a nationwide crisis in the lack of primary care physicians, except that the pay and frequently the hours are much better in specialty care. If we are to attract and keep a larger number of good primary care physicians, we'll need to change that.

A while back, I read a survey of physicians asking if they would recommend medicine as a profession for their children. I could not find that for reference in today's column, and my memory is a bit hazy, so I won't guess. But I will tell you that I was astounded by the number of my colleagues who would not recommend medicine to the next generation of bright young high achievers. The only way we can have a future that includes the items above, a future better than the past, is to recruit and train the next generation of physicians and show them how to be leaders of their society.

So even though I didn't learn what I wanted about the future, I learned enough to keep hope for the future, to keep working to make our profession better, and to encourage my colleagues to do the same.

Have a great summer. ■

David Bales, MD replaces Rebecca Sullivan, MD on Pierce County Board of Health

The Pierce County Board of Health said goodbye to PCMS representative **Rebecca Sullivan, MD** at their June meeting. Dr. Sullivan served on the board since 2008 when she replaced **Dr. James M. Wilson** who had been the physician representative for many years.

The Pierce County Board of Health governs the Tacoma Pierce County Health Department and is comprised of elected officials from Pierce County, the City of Tacoma, Pierce County cities and the at-large representative recommended by PCMS.

In saying goodbye to Dr. Sullivan, each board member paid tribute to her contributions and accomplishments which have been many. Board of Health Vice-Chair and physician colleague, **Dr. Stan Flemming** recalled the history of their relationship going way back to when his physician mother believed that her own physician, Dr. Rebecca Sullivan "walked on water." He commented on Dr. Sullivan's tenure, not only to the health department, but also to Pierce County Medical Society and the medical community. "She is truly a physician mentor and teacher" he said and she has taught many of us well.

Rick Talbert, Pierce County Council Member, noted that he was on the Board of Health when Dr. Sullivan joined. He said the impact of having a physician on the board is tremendous in helping with decisions. "The medical background, which others do not have, is very important," he added.

Dick Muri, Board Chair, presented Dr. Sullivan with a certificate of appreciation, noting their gratitude for her service and well wishes for her future.

Dr. Sullivan outlined her long relationship with the Health Department, noting her service as both an employee and a board member. She commended **Dr. Chen** and his staff for their very hard work and all that they accomplish in our community.

After farewells to Dr. Sullivan the Board voted to appoint **David Bales, MD** to the board and **Ron Morris, MD** as alternate. Both physicians were unanimously appointed after Drs. Flemming and Sullivan gave high recommendations.

PCMS thanks Dr. Sullivan for her participation and service. ■

Busy at tending to Pierce County's health needs - from left, Dr. Stan Flemming, Dick Muri and Dr. Rebecca Sullivan

Dr. Sullivan with Board Chair, Dick Muri

Physician colleagues and Board of Health members Drs. Rebecca Sullivan and Stan Flemming

PCMS says goodbye to MBI President Jeff Nacht, MD

At their early June meeting, the PCMS Membership Benefits Board of Directors said goodbye and thank you to **Jeffrey Nacht, MD** as he ended his tenure as President of the Board of the wholly owned for-profit subsidiary of PCMS.

Jeff Nacht, MD

Dr. Nacht has been a very active PCMS member for many years serving on numerous committees, including the PCMS Board of Trustees, the MBI Board of Directors and the College of Medical Education Board of Directors as well. He has held officer positions in all three organizations. His service and contributions have been long and many, respectively.

Dr. Nacht is winding down his work with MultiCare Orthopedics and Sports Medicine as he transitions to Vancouver B.C. Up north he will serve as the Director of the University of British Columbia, Faculty of Medicine, Third Year Orthopedic Clerkship and the Director of the Foot and Ankle Screening and Triage Clinic for the Department of Orthopedics.

Dr. Nacht has been transitioning back to Canada, where he is from, mostly to be near his daughter and son-in-law and particularly his three year old granddaughter Maya. His grandson Henry James is due August 3. Unfortunately, Maya's daddy has accepted a job opportunity too good to turn down in San Francisco, so his grandchildren will be moving to San Francisco after Henry is born. It's too late, he has already committed to the University in B.C. (We asked the same question.)

At the same meeting, the board welcomed new President **Dr. Stephen Duncan**. Dr. Duncan is well positioned to lead the for-profit corporation as he has been a member of the MBI board for several years, has served many years on the PCMS Board of Trustees, including as President, and has also served on the College of Medical Education Board. He is well informed about the organizational workings of PCMS and subsidiaries.

Steve Duncan, MD

PCMS extends heartfelt thanks to Dr. Nacht and wishes him well. He will be missed but he has promised to keep in touch. PCMS also welcomes Dr. Duncan as President of MBI, there is no doubt the organization will have excellent leadership. ■

Visits to ER rise despite health law

Emergency room visits have been on the rise in Massachusetts since the passage of the 2006 health care law, much to the chagrin of supporters who projected that the opposite would happen as more people had insurance and were connected with primary care providers.

A new study published online shows that the issue may be a bit more nuanced.

While overall emergency room visits increased about 4.1 percent between 2006 and 2008, visits for "low severity" problems fell slightly, by 1.8 percent, among patients who are poor or uninsured, according to the study posted last month by the Annals of Emergency Medicine.

The decline is a small step in the right direction, but it also provides a reality check, said the lead author, Dr. Peter Smulowitz, an emergency physician at Beth Israel Deaconess Medical Center.

Smulowitz said the 2006 law has done what it was designed to do, expand health insurance, but its success has been unfairly measured by emergency room usage.

The idea that the law has failed if it has not reduced those visits is "nonsensical," he said.

The reasons why people go to an emergency room versus a primary care doctor are complex and subject to social conditions and people's perceptions of the seriousness of their problem, Smulowitz explained. The unavailability of most primary care physicians during off hours and on short notice is also a major driver.

The finding that even for more minor issues like strep throat and sprained ankles, few people with insurance are bypassing the emergency room in favor of a primary care office should "dispel the notion that providing health insurance will suddenly make [emergency departments] obsolete," he said.

The researchers looked at billing data for about 578,000 emergency room visits to 11 hospitals during the year before the law took effect in 2006 and two years afterward.

MIT economist Jonathan Gruber, who helped legislators draft the law, said some people who avoided emergency rooms because they were too expensive in the earlier period may be using them more, now that they have coverage, offsetting the progress of moving some people into primary care practices.

He said more work is needed to deter people from using the emergency room for problems that are not urgent, through charging higher copayments or developing programs that target chronic users.

"I think the lesson here is you don't save as much on emergency rooms as you'd think from universal coverage," he said. "It's not clear why." ■

Reprinted from The Boston Globe, 6/7/11

The Health Status of Pierce County

by Anthony L-T Chen, MD, MPH

Smoke on the Water...Pierce County's Air Quality Problem

Anthony Chen, MD

After one of the longest, wettest winters on the record books, we are finally seeing the sun again and can breathe a sigh of relief. Fortunately, as winter exits, that deep breath in Pierce County is less likely to be of dirty air.

Paradoxically, those beautiful, cold, sunny winter days often bring an unhealthy brownish smog to Tacoma, the Tideflats, and much of Pierce County. The smog means that fine particles from wood stoves and fireplaces in South Tacoma are floating up only to be trapped under a dense, cold air layer (an "inversion"). I always used to associate smog with Southern California rather than our beautiful South Sound, but am sobered to learn that we are one of the worst violators of particulate air quality standards in the country and the only one in the whole state.

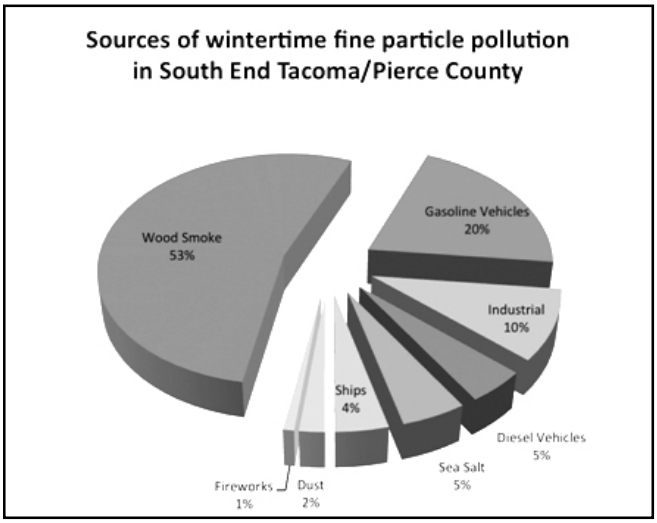
We are especially concerned about these fine particles less than 2.5 micrometers in diameter (Pm 2.5) because they are not filtered out by the nose and can penetrate deep into the lungs. The pollutants are tiny, but the problem is really quite large: exposure to Pm 2.5 is linked to increased hospital admissions and emergency room visits. It can trigger health problems like asthma attacks, heart disease, strokes, and cancer and can lead to premature death.

Often times, especially in the winter, the pollution levels in Pierce County violate the U.S. Environmental Protection Agency's health standards for air quality. Our area is now under EPA mandate to develop a plan to lower the levels of these harmful particles and improve the air quality in Pierce County.

The chart below shows wintertime pollution sources, which is when this pollution builds up and poses the greatest risk. You can see that one of the biggest contributors is burning wood. Obviously this presents a challenge in the winter, as many Pierce County residents rely on wood burning stoves and fireplaces to heat their homes. Many are surprised that cars, trucks, and industry are lesser contributors, but years of regulation and implementation of controls have made them relatively clean.

The Health Department is working with the Puget Sound Clean Air Agency to address the problem. Over the past several years, we have worked with the EPA and the City of Tacoma to help homeowners replace inefficient and polluting wood burning stoves with better, cleaner alternatives. We have convened the Tacoma-Pierce County Clean Air Task Force to work with the community to evaluate possible solutions to improve air quality and make Pierce County a healthier place to live.

I would like to ask the members of the Pierce County Medical Society to join the efforts. When seeing patients who suffer from asthma and heart and lung disease, please ask them how they heat their homes. You can imagine whatever is going up their chimneys is much more concentrated in the confines of their home. You can learn more about the Tacoma-Pierce County Clean Air Task Force and get involved at www.CleanAirPierceCounty.org. This endeavor, if successful, will have a positive impact on the health of you and your patients. ■



MQAC Punts on WSMA/WAFP Request for Amendment of MQAC Rules on Chronic Non-cancer Pain

The poorly drafted, and now adopted, pain management rules remain hostage to an approval process run amuck. The situation has reached a point that the WSMA and the Washington State Academy of Family Physicians (WAFP) presented a request for formal amendment of the rules at the MQAC's June 3rd meeting.

Following a fairly brief and process focused discussion, the Commission deferred possible action on the petition to its July meeting. Evident in the discussion is the tension between Department of Health staff and some Commission members and their staff over the Department's slavish adherence to the perceived benefits of a unified process and rules among the five other boards and commissions required to issue the new rules pursuant to a law passed in 2010. Rationalizations aside, it is frustrating to see common sense sacrificed for the sake of process uniformity – particularly when it isn't mandated by law or precedence.

The rules are to take effect July 1, with an effective enforcement date of January 1, 2012. If the Commission finds the wherewithal to buck the rulemaking process aficionadas we believe things could be corrected by the end of the year. So far, the Commission's actions to date have neither complied with the intent of the rules' enabling legislation, nor have been taken in compliance with the Administrative Procedure Act (APA).

The WSMA pointed out in their letter and comments at the meeting:

* The rules as adopted exceed the legislative mandate:

* The Commission has not provided a small business economic impact statement, as required because the rules mandate treatments that may not be compensated and other actions which will place increased administrative burdens on physicians and medical practices; and

* Most importantly, the language the Commission included in its April letter to the WSMA that went a long way to addressing many of our concerns that the rules are too proscriptive, has now been opined by DoH staff and its assigned Attorney General to constitute a substantive change to the rules which is not permitted. An improved intent section to the rules – as was included in the final version of the rules – or having the Commission craft an interpretive statement regarding the newly adopted rules cannot approach the sort of necessary substantive clarification reflected in our earlier agreement.

Questions or concerns about the WSMA's work with the MAQC on these guidelines should be addressed to their Senior Director of Legislative, Regulatory and Legal Affairs Tim Layton at tim@wsma.org. ■

Reprinted from WSMA Monday Memo 6/6/11

Personal Problems of Physicians Committee

Medical problems, drugs, alcohol, retirement, emotional, or other such difficulties?

Your colleagues want to help

*Robert Sands, MD, Chair	752-6056
Bill Dean, MD	272-4013
Tom Herron, MD	853-3888
Bill Roes, MD	884-9221
F. Dennis Waldron, MD	265-2584

Confidentiality Assured

Measles cases in the U.S. highest in 15 years

Due to an uptick in measles cases in the United States, the Centers for Disease Control and Prevention is encouraging physicians to be vigilant about identifying the illness in their patients.

Doctors should consider the respiratory disease as a diagnosis in patients who have a febrile rash illness, a cough, coryza or conjunctivitis, said Greg Wallace, MD, MPH, lead of the CDC's Measles, Mumps, Rubella and Polio Team. He recommends that physicians isolate such patients to prevent transmission of the virus, notify public health departments of a possible measles case and test the individual.

"Measles is probably the most contagious of the vaccine-preventable diseases," Dr. Wallace said. "The rates of complications and deaths have been low [in the U.S.] ... but if the virus gets into one of those communities [where people are not vaccinated against the disease] it can spread."

There were 118 reported cases of measles from Jan. 1 - May 20, according to the May 27 issue of the CDC's *Morbidity and Mortality Weekly Report*. That is the greatest number of cases to occur during a similar period since 1996. In that year, there were 301 cases reported from Jan. 1 - May 31.

Eighty-nine percent of the cases this year stemmed from infections acquired outside the U.S. in places such as Europe and Southeast Asia, where measles is prevalent, the CDC said. The source of the remaining cases could not be identified, but experts think those cases also were related to diseases contracted abroad.

"From a U.S. standpoint, it's certainly concerning. It's a warning sign of how easily measles can return," Dr. Wallace said.

Impact of vaccine

Before the measles vaccine was licensed in 1963, about 48,000 Americans were hospitalized due to the disease each year, and as many as 500 died, the CDC said.

The *MMWR* report found that of the 118 measles cases reported so far this year, 47 people were hospitalized, and there were no deaths. Measles cases were reported in 23 states.

The largest outbreak occurred in Minnesota, where 23 cases were reported as of April 27, according to the state's Dept. of Health. A majority of the people infected nationwide were not immunized against the disease, the CDC said.

The CDC recommends that physicians administer the first dose of the measles, mumps and rubella vaccine to children age 12 to 15 months. The second dose should be given when a child is between age 4 and 6. Doctors can, however, administer the immunization to children as young as six months who are going to travel to countries where measles is prevalent.

For adults with no evidence of measles immunity, one dose of MMR vaccine is recommended. If adults are in a high-risk group, which includes health care personnel, they should receive two doses. ■

Reprinted from AMNews 6/6/11

State Department of Health updates maternal, infant, child and adolescent health guidelines

The Washington State Department of Health Maternal, Infant, Child and Adolescent Health Section has recently revised and updated several guidelines which are listed here with the url where the materials have been posted.

* Guidelines for management of HIV+ Pregnant Women: Hospital Checklist: http://here.doh.wa.gov/materials/hospital-checklist-HIV-pregnancy

* Guidelines for management of HIV+ Pregnant Women: Prenatal Checklist: http://here.doh.wa.gov/materials/prenatal-checklist-HIV-pregnancy

* Guidelines for testing and reporting Drug Exposed newborns in Washington State: http://www.doh.wa.gov/cfh/mch/documents/HospTestDrug.pdf

Coming soon: Spanish and Russian versions of Healthy Weight Gain During Pregnancy tips for Women and Spanish version of Your Reproductive Life Plan!

For more information you may contact Polly Taylor, CNM, MPH, ARNP, Public Health Nurse Consultant with the Department of Health at 360.236. 3563 or by email at polly.taylor@doh.wa.gov. ■

Directory Changes

Please make the following changes to your 2011 PCMS Physician Directory:

Khash A. Dehghan, MD
Change office address to: 3515 South 15th St, Tacoma 98405

Applicants for Membership

Kathryn J. Drennan, MD
Ob/Gyn, Maternal-Fetal Medicine
MultiCare Maternal-Fetal Medicine
1105 N Division Ste 201, Tacoma
253-403-9200
Med School: University of Washington
Internship: University of Rochester
Residency: University of Rochester
Fellowship: Wayne State University

Jeremy Van Gieson, DO
Family Medicine
Sound Family Medicine
3908 - 10th St SE, Puyallup
253-848-5951
Med School: Des Moines University
Internship: St. John Malcomb
Residency: St. John Malcomb
Residency: St. John Malcomb

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POSITIONS AVAILABLE

Madigan Healthcare System - McChord Medical Clinic Now Hiring Civilian Family Physicians - Lakewood, Washington. Where people, purpose, passion, patients and patriotism are of greatest importance! Become a key member of a patient centered medical home, multi-disciplinary team of professionals. To meet most of your patient care needs we have on-site obstetrics and gynecology, pediatrics, behavioral health, pharmacy, laboratory, and a physical therapy clinic. Competitive salary and comprehensive benefits: Pay incentives * Malpractice coverage is provided * Lifetime health insurance you can carry into retirement (Army pays portion of you premium, you pay your portion with pre-tax dollars) and NEW Dental/vision plans * Retirement plan (basic benefit annuity plus social security and 401-K-type investment plan w/employer matching and flexibility to retire between 55-57 with 10 years of service) * Health/dependant care flexible spending accounts * Long term care insurance * Life insurance (Army pays portion of your premium) * 13-26 paid vacation days each year * 13 paid sick days each year * 10 paid federal holidays each year Employee-friendly flexibilities. Requirements: * Accredited MD/DO/ECFMG/5th Pathway * Active/unrestricted Physician license awarded by any state * At least 4 years FP experience (includes completion of internship/residency in the specialty) * U.S. citizenship is required * Board Certification in FP is required. Apply now: Please forward your CV to: Henry.Laguatan@us.army.mil or apply on-line @ http://careers-civilianmedicaljobs.icims.com/jobs/1213/job. For questions please call LTC Kristie Lowry, MD at: 253-306-0471.

Internal Medicine or Geriatric Opportunities - Western Washington. MultiCare Health System, seeks multiple BE/BC internal medicine or geriatric physicians. Choose from 100% outpatient or a mix of inpatient and outpatient settings. Located 40 minutes south of downtown Seattle WA, the area boasts the advantages of an active Northwest Lifestyle; from big city amenities to the pristine beauty and recreational opportunities of the great outdoors. As an employed physician, you will enjoy excellent compensation and system-wide support, while practicing your own patient care values. Email your CV to Provider Services at blazenewtrails@multicare.org, apply for this job on-line or view other opportunities at http://careers.blazenewtrails.org or call 800-621-0301 for more information.

Certified Coder. South Sound Neuro-surgery in Puyallup looking for a Certified Coder with surgical office experience. Responsible for managing the coding functions of the practice to include denial management, surgery authorizations, payment appeals, and provider education. Required education includes a high school diploma, GED, or equivalent skills and education and a certificate in coding. Preferred education includes graduation from an accredited medical office/billing or coding program. Preferred work experience in an orthopedic or neurosurgery practice, healthcare revenue cycle processes, and using Centricity Practice Management and EMR. Excellent customer service skills and professional appearance a must. Excellent benefits. Salary DOE. Email resumes to info@southsoundneurosurgery.com or fax to 253-841-5944, attn: Human Resources.

OFFICE SPACE

Great location 13th & Union. 3rd floor - Rainier view. 1,500 sq. ft. remaining (divisible). Contact Carol 206-387-6633.

Medical office lease/sub lease. Fully furnished: St. Joseph Medical Clinic Tacoma 1,100 sq. ft. sublease $100/d. University Place 1,000 sq. ft. $1,600/m or $100/d. Contact Marlys 253-573-0460.

Office space to share. Centrally lo-cated between all hospitals in the Tacoma area. Contact Pati 253-572-7120.

Pierce County Medical Society
223 Tacoma Avenue South
Tacoma, WA 98402

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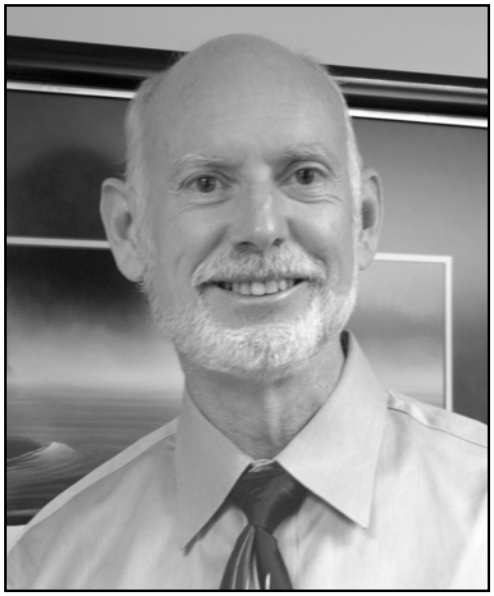
Pierce County Medical Society
BULLETIN

July 2011

Congratulations
2011 Health Care Champions

Dr. Frank Senecal
~Distinguished Service~



Dr. Patrick Hogan
~Community Impact~

See story page 5

INSIDE:

The Bulletin is published monthly by PCMS Membership Benefits, Inc. Deadline for submitting articles and placing advertisements is the 15th of the month preceding publication.

The Bulletin is dedicated to the art, science and delivery of medicine and the betterment of the health and medical welfare of the community. The opinions herein are those of the individual contributors and do not necessarily reflect the official position of PCMS. Acceptance of advertising in no way constitutes professional approval or endorsement of products or services advertised. The Bulletin reserves the right to reject any advertising.

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Pierce County Medical Society
BULLETIN

July 2011

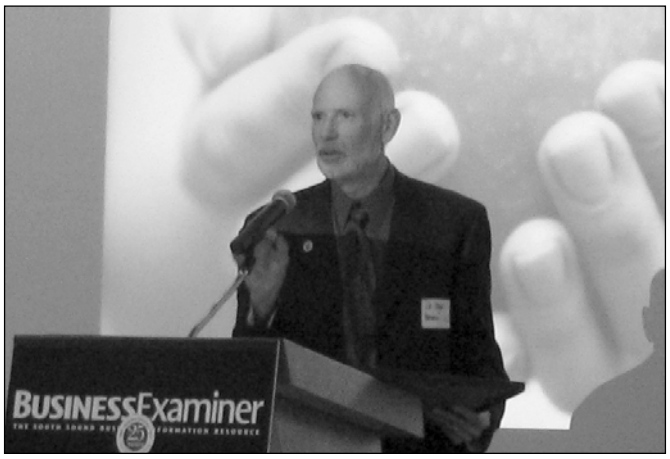
Table of Contents

President's Page

by Jeffrey L. Smith, MD

Jeffrey L. Smith, MD

How to Fill Your Heart



Dr. Pat Hogan believes the most important element is to take the time to listen and care

I was not having a good month.

With the start of a busy summer schedule, the closing of my 12 year clinic location and moving to another, on-call duties and general "busy-ness," I was feeling kind of low.

But on Wednesday, June 22 we celebrated some really cool accomplishments at the 2011 Health Care Champions event at the Tacoma Art Museum. This event is put on by the Business Examiner and was sponsored by Cornerstone Financial Strategies, as well as MultiCare and TriWest. I was there with Sue representing PCMS, which is a partner in the event. This was the 4th annual event.

From the opening music (Queen - We Are the Champions), I knew this would be good.

The first award was for Community Impact and was given to our own **Dr. Patrick Hogan** for his anti-tobacco work. Pat's comments opened the show right. He noted that our job as physicians is to inspire our patients to be better and to act better. The recognition for his work was very inspiring.

Then, I learned about several programs of which I had been unaware. Bridges, the children's grieving center at MultiCare won the Support Services award. Their program is truly heart warming and provides much needed pediatric grief counseling.

The third award, this one for Emergency Services, went to the joint Madigan/MultiCare training partnership, where armed forces nurses get extra training in a busy ER setting. This better prepares them to heal and help our troops overseas and everyone in the room felt patriotic and grateful for this program targeted at helping our family and friends in the military.

The fourth award, Military Services award, went to Maxim Healthcare, a company providing home care pediatric services.

Next, Wesley Homes received the Elder Care award. Their mission and ministry is to provide care for our elderly, and CEO Kevin Anderson mentioned his main motivation was because of great relationships he's had with seniors, from his formative years with grandparents extending to today's clients. Again, a very heart warming presentation.

Finally, they awarded the Distinguished Service award to **Dr. Frank Senecal**. His humble acknowledgment that service to patients in their time of need is really all that he does hit me at just the right place.

Listening to all these servants talk about their callings and watching the neat video presentations was an evening well spent for me.

So thank you, Health Care Champions, for reminding me of what we are doing here and why we are doing it. ■

Dr. Frank Senecal focuses every day on his ability to directly impact the quality of health care for cancer patients

Drs. Patrick Hogan and Frank Senecal: 2011 Health Care Champions

Each year the Business Examiner recognizes the contributions of health care champions in the medical community. In partnership with the PCMS, the program selects individuals or programs to receive awards in the following categories, Community Impact, Support Services, Emergency Services, Military Services, Elder Care and Distinguished Service. This year, two honorees are PCMS members and pillars of the Pierce County medical Community, **Dr. Patrick Hogan** and **Dr. Frank Senecal**.

Every day heroic acts, steadfast dedication, extraordinary service and professionalism are seen frequently in our community's medical offices, clinics, hospitals, emergency services and related organizations. The Health Care Champions program has been created to recognize the dedication and professionalism of these important members of our communities.

Dr. Hogan received the **Community Impact Award** that recognizes an individual or practice group whose involvement or innovation in health care issues has affected a broad section of the community. Dr. Hogan was recognized for his tobacco prevention work and the Freedom from Tobacco program.

Dr. Senecal received the **Distinguished Service Award**. This award is presented to an individual or practice group whose demonstrated service within the health care field has been extraordinary over an extended period of time. Dr. Senecal was recognized for his dedication and commitment to cancer patients and his work in clinical research and trials.

Other award recipients included:

Support Services Award that went to BRIDGES: A Center for Grieving Children. This award recognizes the extraordinary impacts made by a support person or group within the health care field.

Emergency Services Award is for a medical response unit with an outstanding "save" or innovators in providing emergency care and services to the community. The 2011 Honoree for this category was the Critical Care Emergency Nurse Training Partnership: Madigan and MultiCare.

Military Services Award recognizes an individual or practice group whose involvement or innovation in health care issues has benefitted the military community and Maxim Healthcare, Pediatric Services was honored.

Elder Care Award is for an individual or practice group whose dedication and innovation in the field of elder care is extraordinary and the honoree this year is Kevin Anderson, President & CEO of Wesley Homes.

PCMS thanks the Business Examiner for their dedication and commitment to honoring Health Care Champions. They accept nominations and selections are reviewed by a panel of judges including Deanna Cleaveland from Cornerstone Financial Strategies; Sue Asher, Pierce County Medical Society; Valerie Coty, Moss Adams; Lucinda Williams, Regence; and Jeff Rounce, Business Examiner.

Congratulations to both Drs. Hogan and Senecal and thank you Business Examiner. ■

Doctors and Baseball a very fun, but chilly night…

The Doctors and Baseball event was so popular this year that the party deck was oversold at 120 participants. There was plenty of food and drinks and merriment, however. Not to mention lots of baseball and a winning team. While the sun was shining at 6 pm, it quickly disappeared and the wind picked up and caught most attendees unprepared. Hot chocolate and coffee were big items as people tried to keep warm. The Rainiers won the game, there was no rain, and the food and spirits flowed. ■

Pierce County Project Access

by Leanne Noren, Executive Director

Project Access: A Growing Success

Leanne Noren

The medical community has welcomed Project Access with open arms! Volunteer providers from all sectors have easily and openly agreed to volunteer and our current capacity is beyond need.

Physician "champions" for Project Access are critical to our success. Their ability to recruit their colleagues is a very valuable asset to this program and ensures success as we grow into new specialties. Provider recruitment works best through word of mouth and colleague to colleague.

Thank you to the members of the Provider Engagement Committee for all of the hard work put toward volunteer recruitment:

Sue Asher, PCMS
Bruce Buchanan, MD
Howie Davidson, MD
Janis Fegley, MD
William Holderman, MD
Dan Jackson, CHC
John Jiganti, MD
Greg Kleiner, SeaMar
Mark Mariani, MD
Mark Murphy, MD
Bill Roes, MD
Don Russell, DO
Paul Schneider, MD
Sumner Schoenike, MD
Frank Senecal, MD
John VanBuskirk, DO

To date there are more than 350 providers participating in Project Access. Health system employed providers represent 40% of volunteers, while the independent community represents the other 60%. We have seventy percent specialists and thirty percent in primary care. More than 170 patients have been enrolled to receive donated care and six surgeries have been performed. The total value of donated care to date is almost $300,000. Our no-show rate continues to be less than 1%.

We want to express our gratitude to all of you who are participating and making Project Access a success. We recognize and appreciate you on behalf of the patients who are served. ■

WSMA Annual Meeting September 10-11 in Spokane

The Washington State Medical Association will hold their annual meeting on September 10 and 11 in Spokane at the famous Davenport Hotel. The meeting, featuring guest lecturers and policy review by the House of Delegates, is built on the theme "New Normal" as the delivery of health care has changed dramatically in our state in recent years.

Advances in health information technology, physician practices aligning with hospitals, and the pressure to reduce costs all have created a "New Normal." These are the issues that will be explored at the meeting.

This year's meeting has been condensed. The policy "heart" of the meeting will start with reference committee meetings on Saturday morning. Saturday afternoon the full House will meet and hear from three nationally known speakers on hot topics facing physicians today.

Featured presentations will include The Future of Information Technology in Health Care featuring Dr. Aaron Carroll; Making Integration Work, Dr. John Kenagy and the Don Keith Memorial Lecture on Physician Wellness - Physician, Cherish Thyself, featuring George Vaillant, MD. Category I CME will be offered for attendees.

All WSMA members are invited to attend the meeting at no charge. If you would like to serve as a delegate to the meeting on behalf of PCMS please contact Sue Asher at the PCMS office, 253.572-3667. ■

Preventive Care: Finally Covered

by Donald M. Berwick, MD, MPP, Administrator, Centers for Medicare & Medicaid Services, U.S. Department of Health and Human Services, Washington, DC

Physicians are on the front lines of improving health care. They know the value of having patients get the right preventive care -- it means healthier lives and catching problems early.

Prevention isn't just good for patients. As we're looking at how we make our health care system more sustainable in the long run, investing in prevention makes financial sense, too. That's especially true for secondary prevention -- preventing deterioration in chronic illness. As much as three quarters of the $2.5 trillion-plus that we spend on US health care each year goes to paying the bills for chronic illness, and we know a ton about how to keep chronically ill patients out of the hospital and functioning at the highest level they can.

Each dollar spent today on cancer screenings and counseling on healthy lifestyles means fewer dollars to be spent on cancer treatments, coronary bypass surgeries, and treatment for chronic conditions years down the line.

Physicians work day in and day out to help patients live healthy lifestyles. Now it's up to those in Washington to make sure that the way that health care is paid for reflects these values as well.

Fortunately, the Affordable Care Act has given physicians new tools to give patients easier access to preventive care. Starting in January, Medicare eliminated its Part B deductible and copayments for a host of proven preventive services, including bone mass measurement, some cancer screenings, diabetes and cholesterol tests, and flu, pneumonia, and hepatitis B vaccinations, among other services.

Medicare now covers annual wellness visits. It covers smoking-cessation counseling. It began paying a 50% rebate for the brand-name medications that seniors need to manage chronic conditions when they reach the coverage gap known as the "doughnut hole."

Patients in new private insurance plans also won't pay out of pocket for many preventive services, including screening blood pressure, diabetes, and cholesterol, and for certain cancer screenings; counseling to quit smoking or cut alcohol consumption; routine vaccinations; and regular well-baby and well-child visits, from birth to age 21.

We're working to make sure that physicians and their patients have the support they need to achieve better health. Our investment in prevention takes a big step in that direction. If you or your patients are looking for more detailed information, go to healthcare.gov and click on "Learn About Prevention" at the top. ■

Reprinted from MedScape Business of Medicine, June 28, 2011

The Health Status of Pierce County

by Anthony L-T Chen, MD, MPH

A Summer Without Salmonella

Anthony Chen, MD

Last month, reports surged from Europe about the deadliest recorded outbreak of E. coli in history. Contaminated bean and seed sprouts have been identified as the most likely cause, but the news reminds us that the danger of foodborne illness lurks in even the most innocuous and wholesome foods.

According to the CDC, each year contaminated food causes about 1,000 disease outbreaks (although many more may be unreported), 48 million illnesses, 128,000 hospitalizations, and 3,000 deaths. In the U.S., E. coli O157 infections have been cut in half since 1997, due in part to better detection and investigation of outbreaks by public health and improved practices and protections by regulators and the U.S. food industry. However during the same time period, Salmonella infections (which are the most common foodborne illness and occur about 20 times more often than E. coli O157) have experienced no decline in the last 15 years. Today, 1 in every 6 people becomes sick each year from food contamination. As barbecue, picnic and party season is upon us, it is important to consider food handling and preparation precautions, and practice extreme diligence when treating patients who present with symptoms.

Reducing infection from Salmonella is difficult because it is found in so many different kinds of foods. A standard summer barbecue can be a hotbed for infection with meats, egg products, fruits and vegetables all on the menu. Food can arrive contaminated from the farm or store, but can also become dangerous at home when it comes in contact with germs on cutting boards and in kitchens or is stored improperly before or after cooking. With the industrialization and globalization of food production, our exposure to possible contaminants is higher than in decades past.

At the health department, our work is focused on safeguarding food handling. From restaurants to banquet halls, large events like the Puyallup Fair and farmers markets to community fundraisers, we are working to make sure the professionals and volunteers preparing and serving food are educated and certified on the proper ways to keep people safe. In the event of an outbreak, our inspectors and communicable disease specialists work to identify the cause, track the progression of illness and help communicate with the public about the issue, prevention, and treatment resources.

As the medical community, you play a significant role in helping prevent and manage foodborne illnesses. When patients see you with suspected illness from food contamination, ask detailed questions about where they have eaten recently, where they buy their food and how they prepare them at home. Call the Health Department at (253) 798-6410 to report a suspected outbreak or ask questions. Remind patients about the importance of washing hands; washing fruits and vegetables; avoiding cross-contamination of foods; properly cleaning cutting boards, food preparation surfaces, and utensils; not re-using dishes that have come in contact with raw meats; and properly storing uncooked and cooked foods. Many people overlook the importance of measuring the internal temperatures of cooked meats: 145°F for whole cuts of beef or seafood (allowing the meat to rest for 3 minutes before carving or consuming), 155°F for ground meats, and 165°F for all poultry will ensure safe barbecues and potlucks this summer.

For some, illness from food contamination can be an unpleasant day or two, but for others it can pose serious health risk. When seeing high risk patients such as children, pregnant women, the elderly, or those with compromised immune systems, take the opportunity to discuss good food safety practices with their families and them. If we all do our part, hopefully Salmonella infection will experience a similar success story to E. coli.

Your Feedback Please

Every month I write this column hoping the information and thoughts I share are valuable to you. I would like to receive feedback from you about what you would like to hear from me and my staff at the Tacoma-Pierce County Health Department. Please send your feedback to me at director@tpchd.org. ■

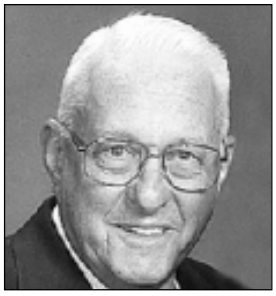
IN MEMORIAM

JOHN F. KEMMAN, MD

1929 - 2011

Dr. John Kemman passed away June 21, 2011 after a brief illness.

After undergraduate studies at the University of New Mexico he received his medical doctorate from the University of Illinois - Chicago in 1955 and completed an internship at Pierce County Hospital in 1956. He served as doctor in the Army in Cambodia then practiced family medicine in Sumner, WA for over three decades. He delivered hundreds of babies and cared for thousands of patients.



John Kemman, MD

Dr. Kemman was very active in his community and involved in his profession. He served in many capacities for the Pierce County Medical Society, as Chief of Staff at Good Samaritan Hospital and as a member of the Subscribers Advisory Committee for Washington Sate Physicians Insurance Exchange.

Dr. Kemman was a member of the Pierce County Medical Society and the Washington State Medical Association since 1959.

PCMS extends sincere sympathies to Dr. Kemman's family.

Membership in high-deductible health plans

Enrollment in high-deductible health plans paired with health savings accounts continued to grow between January 2010 and January 2011, from 10 million to 11.4 million members, according to the most recent census by health insurance trade group America's Health Insurance Plans.

The continued growth in high-deductible plans, which tend to have lower premiums but limited benefits, came from both employer-sponsored enrollment and individuals, although group coverage continued to account for most of the population and grew more quickly. Between 2010 and 2011, group enrollment increased from 8 million to 9.1 million and individual enrollment from 2.1 million to 2.4 million, according to AHIP's report, which was released June 14.

Generally, members are covered only after a deductible of $1,000 or more is met, and they must use a pre-tax health savings account for day-to-day health expenses.

Dennis Triplett, CEO of UMB Healthcare Services, a division of UMB Financial, a Kansas City, Mo.-based bank that holds thousands of HSAs, said the company saw rapid growth between the 2009 and 2010 open enrollment periods. He said UMB had a 40% increase in the number of accounts and a 46.8% increase in the total balance in those accounts, to more than $279 million.

"These plans give employees some 'skin in the game' and an incentive to not only better manage their health but also to be a more educated consumer," he said in a prepared statement.

But recent research has shown that enrollees in high-deductible plans tend to use less preventive care and that some people don't understand their coverage.

A RAND Corp. study released in March found that people with high-deductible plans saved money during the first year they were enrolled, but mostly because they received less preventive care. This was puzzling to researchers, because many high-deductible plans cover at least one annual preventive visit with no out-of-pocket cost.

Experts say employers and health plans need to make sure they do a good job explaining coverage to their employees and members.

AHIP, meanwhile, called on the government to protect high-deductible plans and HSAs on the grounds that so many people have chosen them. The group is worried that the Patient Protection and Affordable Care Act will threaten the business because health plans will face medical spending minimums.

Other statistics from AHIP's report:

· Minnesota, at 14.9%, had the highest percentage of enrollment in high-deductible plans paired with an HSA of any state. The percentage covers those younger than 65 who have private insurance. Following Minnesota were Vermont, 11.4%; Colorado, 11.3%; Montana, 10.8%; and Ohio and Indiana, each at 10.6%.

· Hawaii had the lowest percentage of enrollment in HSAs paired with a high-deductible plan — 0.2% — among those younger than 65 with private insurance. Following Hawaii were West Virginia, 2.1%; Mississippi, 2.4%; New Mexico, 2.6%; and Massachusetts, 2.7%.

· California had the greatest number of enrollees of any state, with 1,073,319. It was followed by Texas, 844,832; Ohio, 728,868; Illinois, 690,509; and Florida, 656,243.

· Preferred provider organizations, at 92%, were by far the most popular health plan type to be paired with an HSA.

· The age group 0-19 had the highest percentage of insured covered by HSAs, at 26%. Most were enrollees covered under family plans. The second-highest percentage were those ages 50-59, at 21%. The lowest percentage were those 60 and older, 9%. Those ages 20-29 and 30-39 each were at 13%, and those 40-49 were at 19%. ■

Reprinted from AMNews, June 27, 2011

Personal Problems of Physicians Committee

Medical problems, drugs, alcohol, retirement, emotional, or other such difficulties?

Your colleagues want to help

*Robert Sands, MD, Chair	752-6056
Bill Dean, MD	272-4013
Tom Herron, MD	853-3888
Bill Roes, MD	884-9221
F. Dennis Waldron, MD	265-2584

Confidentiality Assured

AMA Introduces Its First-Ever Physician App

The American Medical Association (AMA) recently introduced its first-ever app designed for physicians that will allow them to quickly find CPT billing codes. The app is available for free through the I-tunes store.

The CPT quick reference app helps physicians determine the appropriate E&M code for billing quickly, easily and accurately. Developed by the AMA for physicians, the CPT evaluation and management quick reference app is an on-the-go reference guide that helps physicians determine the appropriate CPT code to use for billing. Compatible with Apple iPhone, iPod Touch and the iPad, the app features both decision-tree logic and quick search options, allowing physicians to digitally track CPT codes and email them anywhere. Physicians can also save their most frequently used codes by location or type of service to allow for even more ease of use.

Quick access to accurate information that physicians use daily was the goal behind creating the CPT app according to the AMA and they are currently soliciting designs and ideas for additional physician friendly apps. ■

Medicare Payment Reform Must Be Part of Deficit Reduction Plans

The AMA along with many state and specialty societies recently informed the president and congressional leaders that reform of the broken Medicare physician payment formula has to be a part of any deficit reduction plan. This formula, known as the Sustainable Growth Rate (SGR), is set to trigger a drastic cut of nearly 30 percent on January 1 and threatens access to care for Medicare patients.

The physician organizations told policymakers that the cost of physician payment reform has been growing over the years as Congress enacted frequent short-terms fixes. As recently as 2005 the cost of permanent reform would have been $48 billion, but today it is estimated to be nearly $300 billion over the next ten years.

Physicians have faced the persistent threat of debilitating cuts and lagging reimbursement rates for years, forcing them to make difficult decisions about the number of Medicare patients they can see. As Medicare turns 45 and a generation of baby boomers enters the program, stability is needed now more than ever.

The AMA has called for a three-pronged approach to reforming the physician payment system, which includes repealing the failed SGR formula, implementing a five-year period of stable Medicare physician payments, and testing demonstration and pilot projects that could form the basis for a new Medicare physician payment system. ■

Applicants for Membership

Louis W. Lim, MD
Internal/Occupational Medicine
Franciscan Family Medicine
15214 Canyon Road E Ste 100, Puyallup
253-536-1020
Med School: St. Louis University
Internship: St. Louis University
Residency: Sanford School of Medicine
Fellowship: University of Washington

Directory Changes

Please make the following changes to your 2011 PCMS Physician Directory:

Ralph Katsman, MD
New office address:
2202 S Cedar St #330, Tacoma 98405
Phone: 253-272-5127
Physicians only: 253-272-1925
FAX: 253-272-0811

Delete: 1802 S Yakima Ave #201, Tacoma 98405 and all phones

Gary Taubman, MD
New office address:
2202 S Cedar St #330, Tacoma 98405
Phone: 253-272-5127
Physicians only: 253-272-1925
FAX: 253-272-0811

Delete: 1802 S Yakima Ave #201, Tacoma 98405 and all phones

Classified Advertising

POSITIONS AVAILABLE

Madigan Healthcare System - McChord Medical Clinic Now Hiring Civilian Family Physicians - Lakewood, Washington. Where people, purpose, passion, patients and patriotism are of greatest importance! Become a key member of a patient centered medical home, multi-disciplinary team of professionals. To meet most of your patient care needs we have on-site obstetrics and gynecology, pediatrics, behavioral health, pharmacy, laboratory, and a physical therapy clinic. Competitive salary and comprehensive benefits: Pay incentives * Malpractice coverage is provided * Lifetime health insurance you can carry into retirement (Army pays portion of you premium, you pay your portion with pre-tax dollars) and NEW Dental/vision plans * Retirement plan (basic benefit annuity plus social security and 401-K-type investment plan w/employer matching and flexibility to retire between 55-57 with 10 years of service) * Health/dependant care flexible spending accounts * Long term care insurance * Life insurance (Army pays portion of your premium) * 13-26 paid vacation days each year * 13 paid sick days each year * 10 paid federal holidays each year Employee-friendly flexibilities. Requirements: * Accredited MD/DO/ECFMG/5th Pathway * Active/unrestricted Physician license awarded by any state * At least 4 years FP experience (includes completion of internship/residency in the specialty) * U.S. citizenship is required * Board Certification in FP is required. Apply now: Please forward your CV to: Henry.Laguatan@us.army.mil or apply on-line @ http://careers-civilianmedicaljobs.icims.com/jobs/1213/job. For questions please call LTC Kristie Lowry, MD at: 253-306-0471.

Vice President, Primary Care – Tacoma, Washington. MultiCare Medical Associates (MMA), a multispecialty group practice of over 500 providers, seeks an experienced board certified primary care physician to provide leadership for planning and directing the medical affairs and clinical operations of the primary care offices, urgent care centers and services within MultiCare Medical Associates (MMA) and overseeing the performance of MMA's employed and contracted primary care providers. This executive physician position requires a physician with strong clinical and administrative skills and credentials. Work situations are varied, requiring analysis of information related to a variety of clinical, operational and strategic areas, the use of discretion and good judgment in decision-making, strong leadership, organizational management and communication skills. Excellent compensation, benefits and system-wide support make this a rewarding career with opportunity for personal growth and advancement. Experience the best of Northwest living, from big-city amenities to the pristine beauty and recreational opportunities of the great outdoors. Apply on line at http://blazenewtrails.org/, or email your CV to blazenewtrails@multicare.org, For more information, contact Chloe Skinner, MultiCare Provider Services and Recruitment at 800-621-0301

TACOMA/PIERCE COUNTY

Outpatient General Medical Care. Full and part-time positions available in Tacoma and vicinity. Very flexible schedule. Well suited for career redefinition for GP, FP, IM.

Contact Paul Doty
(253) 830-5450

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Great location 13th & Union. 1,700 first floor, 800 third floor. Contact Carol 206-387-6633.

Medical office lease/sub lease. Fully furnished: St. Joseph Medical Clinic Tacoma 1,100 sq. ft. sublease $100/d. University Place 1,000 sq. ft. $1,600/m or $100/d. Contact Marlys 253-573-0460.

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Pierce County Medical Society
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Pierce County Medical Society
BULLETIN

August 2011

Harvard Medical School - Francis A. Countway Library of Medicine

INSIDE:

The Bulletin is published monthly by PCMS Membership Benefits, Inc. Deadline for submitting articles and placing advertisements is the 15th of the month preceding publication.

The Bulletin is dedicated to the art, science and delivery of medicine and the betterment of the health and medical welfare of the community. The opinions herein are those of the individual contributors and do not necessarily reflect the official position of PCMS. Acceptance of advertising in no way constitutes professional approval or endorsement of products or services advertised. The Bulletin reserves the right to reject any advertising.

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Pierce County Medical Society
BULLETIN

August 2011

Table of Contents

Pierce County Board of Health welcomes David Bales, MD as new member

David Bales, MD, participated in his first Board of Health meeting July 6 at the Tacoma Pierce County Health Department (TPCHD) auditorium. Recommended by the PCMS Board of Trustees for the position, the Health Board unanimously appointed him as a member and also appointed **Ron Morris, MD** as alternate. Dr. Bales replaced **Rebecca Sullivan, MD** who served for three years following **James M. Wilson, MD** who held the post from 2000 - 2008.

The Pierce County Board of Health is comprised of the Pierce County Executive plus three Pierce County Council members; the Mayor of Tacoma plus one Tacoma City Council member; one member and an alternate from the Pierce County Cities and Towns Association, and one member at-large, a physician recommended by PCMS (and an alternate) with appointment by a unanimous vote of the appointed members. The Director serves as an ex-officio Secretary to the Board of Health and may participate in discussions but shall not have a vote on any matter before the board.

The commitment is a significant one as the board meets once a month to execute their powers and duties such as:

- Establish policy and set priorities for the health department
- Serve as liaison between the TPCHD and the County, City, and other cities and towns and their respective legislative authorities
- Adopt regulations to promote and preserve the public health within its jurisdiction.
- Establish fee schedules

Dr. David Bales (right) is welcomed as a new Board of Health member. Board chair, County Councilman Dick Muri is to his right and vice chair Dr. Stan Flemming is also pictured

The TPCHD's function is to safeguard and enhance the health of the communities of Pierce County through the core functions of public health: assessment, policy development and assurance.

Assessment means active surveillance, based upon epidemiological principles that identifies health problems and threats to the public health, provides data to inform decisions about appropriate actions, and monitors progress.

Policy development is the process by which the Board of Health considers assessment data, technical knowledge of possible solutions, and community values to set public health policy and priorities for the department and the community.

Assurance includes encouraging action by qualified providers, requiring such action through regulation, or directly acting to provide the community the services that address or prevent threats to its public health.

The core services of the Health Department include:

- Disease and Tuberculosis control
- Population based Prevention
- Environmental Health
- Emergency Preparedness
- Discretionary Programs

Dr. Bales will bring a wealth of knowledge and leadership to his new board duties. He has served as a member of many TPCHD committees and chaired them as well. His civic involvement, volunteer efforts and leadership positions are unending. In his own words, when he was presented with the PCMS Community Service Award in 2007, he noted "the most important work we can do is the work we do not get paid for." ■

Peter Marsh, MD appointed to Medical Quality Assurance Commission

Peter Marsh, MD was recently appointed to the Medical Quality Assurance Commission (MQAC). Dr. Marsh's experience in leadership roles such as PCMS president (1994), WSMA president (1997-98), board member of Physicians Insurance, etc. make him well suited for the position. He is a strong and effective physician advocate and MQAC will benefit from his experience and tenacity.

Peter Marsh, MD

He will be joining other physicians on the board including Drs. Frederick Dore (Silverdale); Mark L. Johnson (Mount Vernon); Leslie M. Burger (Vancouver), chair; William Gotthold (Wenatchee); Bruce G. Hopkins (Spokane); **Mimi Pattison** (Tacoma), vice chair; Susan Harvey (Seattle); Thomas M. Green (Seattle); Richard Brantner (Olympia); Bruce Andison (Vancouver); Bruce Cullen (Redmond); Anjan Sen (Richland); and, Anthony Robins (Bellevue).

The mandate of Medical Quality Assurance Commission (MQAC) is to protect the public's health and safety and to promote the welfare of the state by regulating the competency and quality of professional health care providers under their jurisdiction. MQAC accomplishes this mandate through a variety of activities in collaboration with the Department of Health and Health Systems Quality Assurance.

MQAC is made up of 13 allopathic physicians, six public members, and two physician assistants appointed by the Governor. Nine physician members represent their congressional districts. All members must be citizens of the United States and must be residents of Washington.

Physician and physician assistant commission members must have been licensed to practice medicine in Washington for at least the past five years.

Congratulations and thanks go to Dr. Marsh. ■

Len Eddinger, WSMA Senior Legislative Director, retires

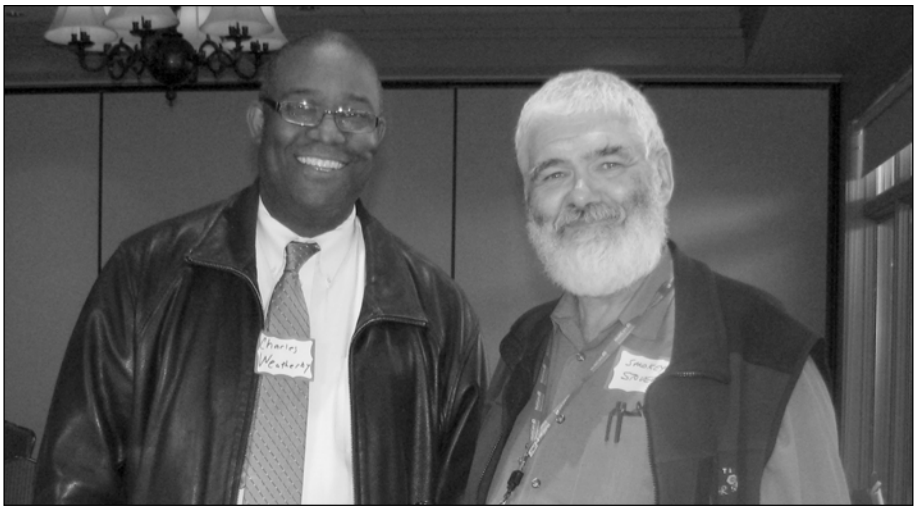
Len Eddinger, longtime WSMA staffer retired this summer from his position with the Washington State Medical Association. Len was the Senior Director, Legislative and Regulatory Affairs and worked from the WSMA Olympia office. WSMA held a retirement party for Len at Fircrest Golf Club, on June 29, bringing together a healthy mix of legislators, state employees, health care leaders, physicians, colleagues and many PCMS members. Tom Curry, CEO of WSMA noted in his message to attendees that Len's strongest skill was his ability to work with all legislators from both sides of the aisle and be respected and revered in spite of sometimes battling very contentious issues.

Len Eddinger

PCMS members attending the event included **Drs. David Bales, Anthony Chen, Bill Hirota, Ray and Vita Pliskow, Don Russell, Smokey Stover** and **Charles Weatherby**.

Len plans to ride his bike, tutor school children, read his Kindle, and enjoy life!

PCMS congratulates Len and thanks him for his many years of dedicated, professional, and first class service to medicine. ■



From left, Drs. Charles Weatherby and Smokey Stover...both happy for Len

Washington Physicians Health Program (WPHP) Appoints Medical Director

The WPHP Board announced that Gary D. Carr, MD, will become the new medical director, effective September 1, 2011. Dr. Carr has worked with physicians and other healthcare professionals with potentially impairing illness since 1997. He developed the Mississippi Professionals Health Program (MPHP) and led it for a decade. MPHP became nationally recognized under his leadership, and he has become a go-to professional throughout the addictions community.

Dr. Carr is trained in Family Practice with additional experience/qualifications in Addiction Medicine. He has held leadership roles with state and national chapters of the American Medical Association, the American Society of Addiction Medicine (ASAM), the American Academy of Family Practice and the Federation of State Physician Health Programs.

He co-chaired the ASAM Public Policy Subcommittee that produced 11 public policies on professionals with potentially impairing illness adopted by the ASAM Board of Directors in 2011, and served on the Federation of State Medical Boards (FSMB) committees that modernized the FSMB Guidelines on Professional Sexual Misconduct (2005) and Physician Impairment (2011).

The WPHP works to facilitate and monitor the rehabilitation of healthcare professionals who have medical conditions that could compromise public safety. WPHP is an independent organization governed by a dedicated and engaged Board of Directors, chaired by John Wynn, MD. The program is funded through a surcharge on licensing fees and has a staff of 11, including Addiction Psychiatrist Dr. Charles Meredith, who has served as the Interim Medical Director, and Dr. Scott Alberti, Clinical Director for the past 18 years. The program enjoys the strong support of organized medicine and participating regulatory entities, and has a reputation for excellence, with published recovery rates for its clients exceeding the national average. ■

COLLEGE OF MEDICAL EDUCATION

Infectious Diseases Update - Nov 4, 2011

The annual *Infectious Diseases Update* is set for Friday, November 4 and will be held again at the Fircrest Golf Club. The program is directed by **Elizabeth Lien, MD** and will feature nationally recognized authorities, as well as our own infectious disease specialists serving Pierce County.

Look for the conference brochure in the mail shortly or for more information call the College at 253-627-7137. ■

Continuing Medical Education

Hawaii 2012 - Make plans now!

The College of Medical Education has selected the site for our 2012 *CME at Hawaii* program – the **spectacular Westin Maui Resort & Spa on sunny Ka'anapali Beach located on Maui's west shore. Ka'anapali Beach has been voted as the #1 beach in America!**

The conference will be **April 16-20, 2012**. Plan your Hawaii trip now to get in on the fabulous deals we have negotiated and guarantee a flight to paradise!

The Westin Maui Resort & Spa offers endless activities. They host a 15,000 square foot luxury spa and modern gym, 85,000 square foot aquatic playground connecting five separate pools with a 120 foot waterslide, great restaurants, cultured entertainment, something for everyone. Please preview this fantastic facility at www.westinmaui.com.

This course is designed for practicing primary care providers, practicing internists, physician assistants and specialists interested in expansion of their primary care knowledge and skills. The curriculum will feature a diverse selection of up-to-date practical topics in primary care medicine. Our approach is to combine the best evidence-based medicine with the day-to-day realities of patient care.

We have negotiated exceptional rates for airfare, car rental and rooms. Room rates start at $249 and are nearly 50% off the rates offered by the resort. Please book early to take advantage of these reduced rates through Tammy Langlo with Thomson Travel and Cruise. Her contact information is 253-627-8221 or email her at tammy@thomsontvl.com to start your planning now.

We hope you will plan to join your colleagues and their families next spring for our *CME at Hawaii* program. The conference brochure will be mailed out shortly. ■

CME at Whistler - Save the Date!

CME at Whistler is a great program that combines family vacationing and skiing in a resort atmosphere, along with ten hours of Category 1 continuing medical education.

This year's Whistler CME is being held at the beautiful Fairmont Chateau Resort. With true ski-in and ski-out convenience, the classic elegance of this landmark Whistler hotel offers a modern alpine setting for unsurpassed guest service, exceptional dining, full resort amenities, and a world class spa.

Baiya Krishnadasan, MD is the program director and has lined up a great list of speakers to ensure this course meets your educational standards, combined with quality skiing and family vacationing.

The program brochure will be available shortly or if you have any questions, please call the College of Medical Education at 253-627-7137. ■

State disciplines health care providers

The Washington State Department of Health has taken disciplinary actions against the following health care providers in our state.

The department's Health Systems Quality Assurance Office works with boards, commissions, and advisory committees to set licensing standards for more than 70 health care professions including physicians, nurses, counselors, etc.

In July, 2011 actions included:

- The Nursing Commission charged licensed practical nurse Amos P. Brinkley III (LP00037369) with unprofessional conduct. He allegedly administered insulin to a patient without an order and without consulting other members of the patient's medical team.

- The Nursing Commission amended the statement of charges against licensed practical nurse Clarice C. Freeman (LP00046535). In 2009 she was convicted of reckless driving and two counts of hit and run unattended vehicle, and in 2010 she was convicted of failure to remain at injury accident.

- The Nursing Assistant Program charged certified nursing assistant Brandi D. Parker (NC10093525) with unprofessional conduct. In 2001 she was convicted of possession of marijuana, in 2008 she was convicted of theft, and driving under the influence. In 2009 she was convicted of custodial assault, driving under the influence, attempted unlawful possession of controlled substance, theft, negligent driving, bail jumping, and in 2010 she was convicted of trafficking in stolen property.

The Health Care Assistant Program charged Jennifer J. Sterling (HC00154061) with unprofessional conduct. In January 2011 she entered into a deferred sentence for the charge of unlawful solicitation to possess a controlled substance. ■

IN MEMORIAM

DOUGLAS P. BUTTORFF, MD

1916 - 2011

Dr. Douglas Buttorff passed away July 3, 2011.

He received his medical degree from Northwestern University Medical School in 1944 and completed an internship at Bellevue Hospital in New York City and residency at Passavant Hospital in Chicago.

Dr. Buttorff practiced Obstetrics and Gynecology in Tacoma from 1950 until his retirement in 1983.

Dr. Buttorff was a member of the Pierce County Medical Society and the Washington State Medical Association since 1950.

PCMS extends sincere sympathies to Dr. Buttorff's family.

The Health Status of Pierce County

by Anthony L-T Chen, MD, MPH

A (Safe) Day at the Beach

Anthony Chen, MD

Now that it is summertime, I hope that you are getting out of the office and enjoying our county's great outdoors. We are lucky to have several bodies of water—from the Puget Sound to various lakes and ponds—where we can play, relax, or even find food. For our Health Department staff, however, this convergence of many people and potential hazards means summer is a season of increased diligence to protect the residents of Pierce County. Whether it is a day at the pool or the beach, our staff is quietly working to make it a safe one.

Thankfully, we no longer have outbreaks of polio, but swimming pools still have potential infectious and physical health hazards. We add staff during the summer to inspect swimming pools so patrons can focus on having fun instead of worrying about illness or injury. We review plans for all new and remodeled public swimming pools, hot tubs, wading pools and spray parks to ensure they meet safety and health codes. There are nearly 450 pools and spas in Pierce County and we perform two to three routine inspections on each throughout the summer, checking for everything from water quality to barrier protection to first aid supplies. When there is a report of pool-related illness or safety hazard, our team investigates and works with the pool and spa operator to correct the situation.

At popular lake and salt water public beaches as well as the streams, seeps and pipes that flow into shellfish areas, our Surface Water Team is busy sampling water for toxins and bacteria that pose health risks. In Pierce County this summer, we are monitoring six lake beaches, eleven salt water beaches, and ten shellfish areas; a high number but fitting for a county defined by water. This is in addition to the Department of Health's Shellfish and Water Protection Program.

For the shellfish areas, our team spends its time examining the marine shorelines in Pierce County and collecting samples. On a recent trip to Filucy Bay on the Southwest tip of Key Peninsula, a raccoon was spotted making its home at a sampling site. The sample from that location came back with an unusually high count of fecal coliform bacteria so the team will spend more time at the site to determine whether the masked varmint, a failing septic tank, or something else is the source.

The majority of Vaughn Bay on the Key Peninsula has been closed to shellfish harvesting for more than 30 years due to high pollution that made the oysters, muscles and geoducks unhealthy for human consumption. Recognizing the health and economic impact of the long closure, the Health Department joined forces with seven other public, private and nonprofit organizations in 2006 to address the issues affecting water quality in Vaughn Bay. Through our collective sampling and analysis, we identified failing septic systems and farms with poor animal-keeping practices that were major sources of pollution. Working with property owners, we helped address the problem. As a result, since 2008 more than 150 acres of Vaughn Bay have been reopened for shellfish harvest as of this summer.

Our work is not limited to salt water, but also focuses on the many freshwater lakes and ponds in the county. Warm sunny days make lakes a popular recreation destination for people and their pets. Warm sunny days also make lakes a great environment for toxin producing algae to flourish. The Health Department's Toxic Algae Program monitors toxic algae blooms and notifies citizens when a public health concern exists. We do some sampling but have very limited funding and rely on neighbors, boaters and fishers to help identify potential problems in the more than forty lakes in our county. If it appears that there is a toxic algae problem, algae samples are collected and tested. Algae densities and toxin concentrations vary tremendously by lake and from week to week, so it is a season-long effort to keep track of algae levels. This summer, we have already issued advisories for Clear, Steilacoom, and Harts Lakes and there is an ongoing

See "Beach" page 14

Rebuff patient Facebook friend overtures, British Medical Association advises

A Facebook friend request from a patient lands in your inbox. What should you do?

"Politely refuse," according to new guidance issued by the British Medical Association.

Many medical associations in the United States, including the American Medical Association, have approached the concerns about social media with guidance that avoids steadfast rules but rather advises physicians to exercise caution.

But the BMA's guidance, issued in mid-July, has received a lot of attention internationally because of its clear-cut recommendations that physicians not accept Facebook friend requests at all. That's because of the increased likelihood that the relationship could become inappropriate, according to the BMA.

"Given the greater accessibility of personal information, entering into informal relationships with patients on sites like Facebook can increase the likelihood of inappropriate boundary transgressions, particularly where previously there existed only a professional relationship between a doctor and patient," according to the BMA.

"Difficult ethical issues can arise if, for example, doctors become party to information about their patients that is not disclosed as part of a clinical consultation. The BMA recommends that doctors and medical students who receive friend requests from current or former patients should politely refuse and explain to the patient the reasons why it would be inappropriate for them to accept the request."

The Ohio State Medical Association issued guidance to members more than a year ago after it received several requests from doctors who wanted advice on how to handle unsolicited social media friend requests from patients.

Jason Koma, director of communications and marketing for the OSMA, said the association recognized the importance of physicians using social media to connect with patients professionally. Therefore, "To not utilize social media at all was not the intent of our guidance," he said.

Similar to policy adopted by the AMA, the guidance issued by the OSMA encourages physicians to consider the ethical and legal boundaries that have the potential of being crossed by each online relationship. One recommendation is to create separate profiles for personal and professional use.

Koma said that, especially in rural areas where physicians are more likely to have relationships with patients outside the physician-patient sphere, social media can be considered an extension of what has been going on for decades. Using the same judgment that would be used in face-to-face social interactions, physicians must adhere to professional boundaries, he said.

In November 2010, the AMA adopted policy acknowledging that social networking websites can be an effective and efficient way to communicate with patients, but advising doctors to maintain an appropriate physician-patient relationship.

Koma said the OSMA plans to revisit the issue in coming months to revise its guidance to include warnings to medical students and residents to keep their personal profile pages clear of content that could be deemed unprofessional to potential employers. As the BMA guidance warns, privacy settings go only so far in protecting online content.

"Although the way medical professionals use social media in their private lives is a matter for their own personal judgment, doctors and medical students should consider whether the content they upload onto the Internet could compromise public confidence in the medical professional," the BMA guidance says.

The BMA acknowledged that it appears few physicians are accepting patients' Facebook friend requests. It cited a survey, posted online Dec. 15, 2010, by the *Journal of Medical Ethics*, that found medical residents and fellows in France were very unlikely to accept a patient's friend request, fearing it would alter the doctor-patient relationship.

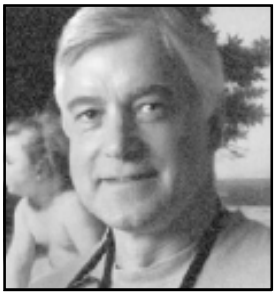
However, the same survey of 202 residents and fellows found that those concerns didn't extend to the doctors refusing to post personal information about themselves on Facebook. ■

Reprinted from AMNews, Aug. 1, 2011

IN MEMORIAM

JOSEPH A. ROBINETTE, MD

1946 - 2011



Joseph Robinette, MD

Dr. Joseph Robinette, ob/gyn/fertility specialist, died in June surrounded by his family.

He was raised in LeMars, Iowa where he met his wife, Judy, in kindergarten. Their 45 year marriage saw him through medical school and a move to Tacoma where they raised their three children and watched their five grandchildren grow.

Dr. Robinette completed his pre-med and medical school education at the University of Iowa in Iowa City. He began his medical practice at MAMC, leaving in 1975 to join Stork Associates and later GYFT Clinic.

He touched the lives of many through his 33-year career as an ob/gyn/fertility specialist. He brought countless babies into the world through his obstetrics and fertility expertise. He was greatly revered for his ability to listen and treat every one of his patients as the most important one.

Dr. Robinette was also committed to caring for the under-served of our community, volunteering for the past several years at Neighborhood Clinic, a free walk-in clinic for those unable to access or afford medical care.

Dr. Robinette loved his work, the outdoors, traveling, golfing, writing, playing music and spending time with family and friends.

Memorial contributions may be sent to The Neighborhood Clinic, 1323 South Yakima Ave, Tacoma WA 98405.

PCMS sends condolences to Dr. Robinette's family.

MQAC Rules for Management of Chronic Noncancer Pain

On May 24, 2011 the Medical Quality Assurance Commission (MQAC) filed its final rules for management of chronic, noncancer pain. The Medical Commission's rules for physicians and physician assistants **WILL NOT** become effective until **JANUARY 2, 2012****. This was done in order to provide the physician community with enough time to prepare for and implement the many practice requirements set forth in the rules and to satisfy the CME requirements.

****PLEASE NOTE**: The MQAC pain rules and effective date apply only to MDs and physician assistants. Rules pertaining to DOs and osteopathic physician assistants, nurses, podiatrists and dentists all became effective on July 1, 2011.

To access MQAC's letter to licensees regarding pain rules go to: http://www.doh.gov/hsqa/mqac/files/painrulesletter.pdf

To access the MQAC pain rules go to: http://www.doh.gov/hsqa/Professions/PainManagement/files/mdpapainmgmt.pdf

Background: The rules include a preamble, or intent section, which describes some of the background for the rules, and outlines MQAC's approach to evaluating practitioners' compliance with the rules. The rules themselves list very detailed requirements for patient evaluation, treatment plans, informed consent and written agreement for treatment, periodic review, and a mandatory consultation requirement for any patient that meets or exceeds a per day dosage amount of 120 milligrams morphine equivalent dose (MED). In addition, the rules identify certain exemptions from the consultation requirement, and outline the requirements of pain management specialists.

It is important to be aware that the requirements in the pain rules apply to all patients being treated for chronic, noncancer pain as defined in the pain rules no matter the dose of medications they are receiving. The only dosage criteria relate to the mandatory referral for consultation for patients receiving more than 120 MED per day (unless an exception applies), and a one-year periodic review (rather than a six-month review) for patients on a non-escalating dose of 40 MED per day or less.

Educational Outreach: In the meantime, the MQAC is offering an educational program on the new pain rules, which includes a video which can be part of a free 4 hour CME offering available through L&I. The MQAC has created a patient information pamphlet and FAQs. Go to the MQAC Pain Management website at http://www.doh.gov/hsqa/mqac/Pain Management.htm for details on their educational outreach.

Physicians Insurance (PI) is also preparing a detailed educational module for its insureds. Information regarding the PI program is not currently available, but check the PI website at http://www.phyins.com for updates.

The University of Washington (UW) presented a program on the pain rules, "Legislating Pain Care," on June 18, 2011. This 7-hour program was recorded for future playback on TVW. Information about when this will be broadcast has not yet been released. Check the TVW website, http://www.tvw.org for updates.

Other pain management guidelines:

- Washington State Agency Medical Directors Group's Opioid Dosing Guideline for Chronic Non-cancer Pain at http://www.agencymeddirectors.wa.gov/guidelines.asp
- Washington State Agency Medical Directors Group's Antiepileptic Guideline for Neuropathic Pain at http://www.agencymeddirectors.wa.gov/guidelines.asp ■

WSMA Members: Update On-line Profile

The Washington State Medical Association website has been redesigned! You can now update your WSMA profile and pay your dues online.

If you are a new or current member who has NOT created a personalized user name or password yet, you must create a NEW ACCOUNT for full access to your membership information.

Here is how to create your account for new and existing members:

Go to wsma.org. Click on Create account in the gray bar at the top of the Member Center webpage and you will be prompted to fill in the required identifying information. An email will be sent to your address with a link to create your account. (If the email address you enter does not match our records, this step will not work properly—please contact Karen Chapman at kcc@wsma. org for assistance.)

Do not click on "Manage contact and profile information" until you have created an account and logged in with your personalized user name and password.

The WSMA no longer stores your old username and password. If you forget your new login information, you will be able to reset both your username and password on your own using the Member Center webpage.

We hope that you find the new Member Center user friendly. If you have any problems on the site, please contact Karen Chapman at kcc@wsma.org and let her know where the error occurred. ■

Applicants for Membership

Aashiyana F. Koreishi, MD
Pathology/Hematopathology
Puget Sound Institute of Pathology
1001 SW Klickitat Way #205, Seattle
253-426-6690
Med School: SUNY Upstate University
Residency: Massachusetts Gen Hosp
Fellowship: Memorial Sloan Kettering
Addl Training: UW Medical Center

Mark W. Roberts, MD
General Surgery
Franciscan Medical Group
11307 Bridgeport Way SW, Lakewood
253-944-3278
Med School: Univ Med Ctr, Loma Linda
Internship: UC Davis Med Ctr
Residency: UC Davis Med Ctr

Lisa V. Thomassen, MD
Pathology
Puget Sound Institute of Pathology
PO Box 34245, Seattle
206-622-7747
Med School: Emory University
Residency: University of Washington
Fellowship: University of Washington

Free CME on Pain Management/ Opioid Prescribing

Four hours of free CME on Pain Management/Opioid Prescribing are available at the following site: http://www.agencymeddirectors.wa.gov/

For more information, go to the following sites:

- For Pain Management: www.doh.wa.gov/hsqa/Professions/PainManagement
- For MQAC: http://www.doh.wa.gov/hsqa/mqac/
- For Take as Directed: http://www.doh.wa.gov/hsqa/TakeAsDirected/
- For Prescription Monitoring Program: http://www.doh.wa.gov/hsqa/PMP/ ■

Beach from page 9

advisory for Waughop Lake. You can see the advisories at http://www.tpchd.org/environment/surface-water-lakes-beaches-shellfish/current-surface-water-advisories/.

Public Health strives to keep surface water out of the news. You will not often hear of outbreaks of vibriosis or paralytic shellfish poisoning, gastrointestinal illness from swimming, or toxic algae poisoning. Similarly, swimming pool accidents are rare. However, these programs are in jeopardy as federal, state, and local resources are dwindling, so it is our job to keep the issues on legislators' and citizens' minds and remind everyone that a healthy Puget Sound makes for a healthy Pierce County. ■

Classified Advertising

POSITIONS AVAILABLE

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Office space to share. Centrally located between all hospitals in the Tacoma area. Contact Pati 253-572-7120.

MultiCare campus office space: Jackson Hall, 1400 sq ft, first floor, furnished, negotiable sublet. 253-279-4900.

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Duke University School of Medicine

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Pierce County Medical Society
BULLETIN

September 2011

Table of Contents

President's Page

by Jeffrey L. Smith, MD

A Response to a Previous Article

Jeffrey L. Smith, MD

A couple of months ago, I wrote a President's Column encouraging physician leadership participation in all areas of decision making and dialogue on the future of health care. I received immediate feedback from an unexpected source. Mrs. Lorna Burt sent me a letter telling me about her background. Her husband, Robert Burt, MD was a longtime physician in Tacoma and past president of our PCMS. She had been very active in the past with the Society and the PCMS Auxiliary/Alliance. She provided me a phone number contact and offered to talk to me a bit about "how things used to be." My words about doctors taking control of our future sparked her interest, especially since she lived through that time when physicians did have much more control of health care. I called her, intending a brief conversation. However, I found Mrs. Burt to be charming, intelligent, well spoken, and fascinating. She asked how she could be of service to us (a fantastic offer, reflecting a lifetime of family service to the community already). We decided to start with an article here in the newsletter and "go from there."

So please read and enjoy the following article. And join me in thanking Mrs. Burt for her and her husband's past and ongoing commitment to PCMS, our doctors, our patients, and our communities.

Take Back the Past?

I opened the Pierce County Medical Society June Bulletin and the words "The Future of Medicine?" by Jeffrey L. Smith, MD jumped out at me! Statistics indicate that by 2013 less than a third of physicians will be in private practice, many pushed into employment with larger health systems. This leaves us pondering what is the future of medicine?

Right now there is talk of "Boutique Medicine," where small private offices offer the best medical care available, but only to those who can afford to pay a fee on top of their insurance and normal physicians' fees. This is to compensate the doctors for seeing fewer patients and spending more time with each patient. However, shouldn't this be the way for all patients in a quality medical system without creating an elite program for the wealthy? Perhaps we should look to the past for answers.

In 1947 WWII was over and my husband, Robert T. Burt, MD, a Captain in the U.S. Army Medical Corps, turned down an offer to become a Major and stay in the service. He wanted to return home to establish a private medical practice. Arriving in the Tacoma area, Bob took over the general practice and office of a retiring doctor located in Parkland. In those days, general practitioners were highly trained in the treatment of patients and were also diagnosticians. He often assisted in surgery on the patients he referred to specialists. He ran his office with a nurse/receptionist/bookkeeper. Back in Bob's era, the physicians often got together and decided to agree on specific fee schedules for their area.

He was considered a "Family Doctor." He knew the families and was part of their lives. There was more personal connection and caring. The cold term "Primary Care Doctor" has become popular and lacks the warmth and feeling of being connected with the families.

Dr. James Vadheim, a leading Tacoma surgeon, encouraged Bob to pursue his dream of becoming a surgeon. Putting aside his "little black bag" (yes, he carried that bag to do house calls, unheard of today!) Bob spent the next several years at the Mayo Clinic in Rochester, Minnesota where he worked long hours and achieved his American Board in Surgery.

In late 1954, we returned to Tacoma and set up a surgical practice. The 50's, 60's and 70's were the best of times… "The Golden Age of Medicine" here. Pierce County Hospital was fully staffed with doctors, interns and nurses. Patients who could not afford to pay for care were treated free of charge. PCMS doctors donated the best of care, taking turns each month staffing the hospital. Pierce County Hospital was also a trauma center and my husband would say, "If we are in an accident, I hope they take us to County Hospital. We will get the best care there."

We had many fine private hospitals in the area: St. Joseph, Tacoma General, Doctor's Hospital, Allenmore, Lakewood Hospital and Good Samaritan in Puyallup. There was the new, state-of-

See "Past" page 8

Pierce County Project Access

by Leanne Noren, Executive Director

Project Access Patient Success Stories

Leanne Noren

The care that generous physicians and other health care providers in Pierce County are offering through Project Access to the uninsured is making a difference. It is my delight to share with you a couple of success stories. These are real people who have received donated care and it has made a difference in their lives.

One such patient, Steve, is a 58 year old male who was referred to Project Access through Project Homeless Connect. His passion is being a basketball official for high school, but he was unable to perform that job because of vision problems. He came to Project Access for cataract surgery. In his assessment for cataract surgery, it was found that his diabetes was out of control and he was not a good surgical candidate. He was assigned a primary care provider who worked with him to better understand and control his diabetes. After six months he was cleared for cataract surgery. His first surgery went wonderfully and he is waiting for the second surgery to do the second eye. Upon healing from both surgeries, Steve will be able to apply for officiating jobs again within Pierce County. He says, "I appreciate everything everyone has done for me. You all probably saved my life. I lost two jobs because I could not see and now I look forward to getting those jobs back." On behalf of Steve, we want to say thank you to Franciscan Family Medicine - Canyon Road and Cascade Eye and Skin.

A female patient, 62 years old, was referred to Project Access from a local free clinic. She was originally referred for a lesion on her hand, but needed to establish primary care. She was referred to a PCP and then discovered a lump in her breast. She called Project Access for help. Through the collaboration of her PCP, Carol Milgard Breast Center, a general surgeon, and oncology services she was able to have the lump removed. "Without Project Access I would have ignored the lump in my breast. At that time our total household income was $650 for three people. There just wouldn't have been money to see a doctor. Knowing I could get care provided peace of mind to find out what the lump was. All the doctors said that it was cancer and they all went above and beyond what they had to do. Project Access is wonderful - a true godsend to us!" Cedar Surgical Associates, the office of Dr. Richard Waltman, Carol Milgard Breast Center and MultiCare Regional Cancer Center collaborated to ensure this patient had a successful experience.

These are just two examples out of hundreds of stories that are happening in our community through the generosity of Project Access participants. Thank you to everyone in our network of over 400 providers who are giving of their time, talent and treasure to improve lives in our community.■

The Health Status of Pierce County

by Anthony L-T Chen, MD, MPH

Pertussis is Nothing to Cough At

Anthony Chen, MD

Last month, the Communicable Disease team at the Tacoma-Pierce County Health Department was busy investigating a high number of pertussis cases in the county. In July, there were 17 confirmed cases of pertussis, one probable, and one suspected case. Seeing the rise in pertussis, we issued a health advisory to all medical providers in the county and a press release to raise awareness among the public. One such case in Pierce County reminds us to maintain our vigilance.

In mid-June, a late-term obstetrical patient who had not received a pertussis booster developed a cough two weeks before delivering her healthy baby at a local hospital. A week after the delivery, she was seen by her family physician, and subsequently sent to a different hospital's emergency department for a post-partum issue. Upon arrival at the ED, she was placed in respiratory isolation, tested and subsequently diagnosed with pertussis. The second hospital notified the Health Department, and we began our investigation.

As you can imagine, this patient had contact with many healthcare workers, friends, and family members in the final weeks of her pregnancy, during her delivery, and in the postpartum period. We first identified 24 hospital staff that had been exposed to the patient and infant at the delivery; we initiated prophylaxis and active symptom watch. The family physician and office staff were also contacted, with 28 healthcare workers started on prophylaxis. Then there were the four medics who transported the patient to the ED. Luckily, only one employee at the second hospital did not wear appropriate PPE and required prophylaxis. Tracing back, the obstetrician who saw the mother in the final days before delivery had also been exposed to pertussis. Nine expectant mothers and their birth coaches were potentially exposed at the patient's birthing class. All told, at least 65 people were exposed by just one ill patient. This patient also had contact with family members, members of her pregnancy support group, and people in the community, so this number is likely an underestimate.

"Think pertussis. When seeing patients with coughing illnesses, maintain a high suspicicion for pertussis."

We all are more interconnected than we realize and cases of communicable disease can easily impact us. There are several lessons we can learn from this case.

Vaccinations are for everyone, especially you and your staff. While we focus our immunization efforts primarily on children, adults also need immunizations like flu and Tdap boosters. These are particularly critical for healthcare workers. Of the 17 confirmed pertussis cases in July, six had sought care at more than one medical facility. The Advisory Committee on Immunization Practices (ACIP) recommends that all adults receive a single dose of Tdap as soon as feasible if they have not previously received it regardless of the time since their last tetanus booster.

Be aware of high risk patients. Women who are more than seven months pregnant and infants are at a significantly higher risk than others. Be aware of their needs and susceptibility to pertussis even when seeing them or their household contacts for other issues. If you care for women of reproductive age, proactively check for pertussis booster status and vaccinate with Tdap as necessary. ACIP has approved Tdap for pregnant women, so all practices caring for pregnant women should implement protocols to vaccinate women who have not received a booster during the late second or third trimester. If this does not occur, the patient should be vaccinated immediately postpartum.

Think pertussis. When seeing patients with coughing illnesses, maintain a high suspicion for pertussis. Symptoms are often nonspecific and milder than the classic paroxysmal cough and inspiratory "whoop" we learned in medical school. We now know that neither immunization or disease confers lifelong immunity. While deaths and

See "Pertussis" page 10

Past from page 3

the-art, fourteen-story Medical Arts Building between St. Helens Avenue and Market Street. "Live" operators manned elevators. This building housed the office of PCMS, a pharmacy, medical equipment, many doctors' offices and a small hospital for minor surgery.

In those days, doctors billed their patients according to the fee schedule they agreed to set by PCMS standards. Usually, the receptionist/bookkeeper did the billing. Patients paid by cash, check, insurance or monthly installments until paid in full. Many had insurance through Pierce County Medical Bureau. My husband deferred some of the PCMB payments and they were held and invested. When Bob retired in 1984, we had a nice income from this for the next 18 years. Patients who were in dire circumstances and could not pay were "written off." Those who were able to pay but didn't were turned over to collectors after six months.

Doctors in this era prospered. Patients were well cared for and satisfied with their treatments. Doctors made rounds in the hospital each day to leave orders and reassure their patients. This personal touch was welcomed by the patients and their families and facilitated good communication. Nurses often accompanied the doctor. Bob said that his three years in family practice was very beneficial in his surgical career. Surgeons covered for one another in seeing patients when one had to be away.

PCMS was not only a chance for doctors to get together, socialize, exchange ideas and make their own rules, it was the voice of the medical community.

Doctors' spouses formed a group called Pierce County Medical Society Auxiliary to assist the doctors in setting up meetings, social events and raising money for nursing and medical school scholarships. They had a page in the monthly PCMS Bulletin. Many of us also worked with the Tacoma Orthopedic Association to raise money to build the Mary Bridge Hospital. It was at one of our Auxiliary meetings we began to hear about some new health care systems being planned. Members were disturbed by this news. We sent Nadine Kennedy, a urologist's wife, to sit in on their meetings and find out what they were planning. Nadine reported that they were printing reams of paperwork, useless statistics, in order to get grant money from Washington, D.C. for their project. Concerned about this, we contacted a reporter for the Tacoma Times Newspaper who wrote a weekly column titled, "Our Gal, Emily Walker, in Washington, D.C." She was there to cover news of Senator Harry Cain of Tacoma. Emily replied that she, too, was concerned about this. She said, "It is like the camel with his nose under the edge of the tent, working his

See "Past" page 12

Half of Americans Will Suffer From Mental Health Woes, CDC Says

Much more needs to be done to help spot those at risk and assist them, experts say

About half of Americans will experience some form of mental health problem at some point in their life, a new government report warns, and more must be done to help them.

Mental health issues run the gamut from depression to post-traumatic stress disorder to suicide, and many of those suffering presently do not get help, experts say.

The new report, from the U.S. Centers for Disease Control and Prevention, tallied the national burden of mental illness based on country-wide surveys.

There are "unacceptably high levels of mental illness in the United States," said Ileana Arias, principal deputy director of the CDC. "Essentially, about 25 percent of adult Americans reported having a mental illness in the previous year. In addition to the high level, we were surprised by the cost associated with that — we estimated about $300 billion in 2002."

The high cost includes care for the illness and lost productivity, Arias said.

It isn't clear why so many Americans suffer from mental illness, Arias added. "This is an issue that needs to be addressed," she said, not only because of the illness itself, but because mental disorders are associated with other chronic illnesses such as heart disease and cancer.

And while having a psychiatric illness is tough enough, the stigma surrounding these diagnoses adds to the burden, experts said.

"Mental illness is frequently seen as a moral issue or an issue of weakness," Arias explained. "It is a condition no different from cancer or other chronic diseases. People need to accept the difficulties they are having and avail themselves of the resources that are available."

The report was published Sept. 2 as a supplement to the CDC's Morbidity and Mortality Weekly Report.

One survey done in 2009 by the Substance Abuse and Mental Health Services Administration found that 11 million people — nearly five percent of the population — experienced serious mental illness during the past year, defined as conditions that affected the ability to function.

In addition, some 8.4 million Americans had suicidal thoughts in the past year and 2.2 million made plans to kill themselves. One million attempted suicide, the report found.

"...about 25 percent of adult Americans reported having a mental illness in the previous year."

Information from other sources confirmed these numbers, with slight variations, the report said.

Dr. John Newcomer, professor of psychiatry and behavioral sciences at the University of Miami Miller School of Medicine, believes the problem may be even bigger than the CDC report indicates.

For example, state Medicaid programs spend a great deal on drugs to treat mental illness, which the CDC didn't take into account, Newcomer said. "For several years the top three drugs were antipsychotic drugs," he noted.

Also, many people with mental illness hide the problem from others, Newcomer said. The CDC report looked at people already in the health-care system, "but there is a big problem with underdiagnosis and undertreatment," he said.

Dr. Alan Manevitz, a clinical psychiatrist at Lenox Hill Hospital in New York City, said healthy living — getting enough sleep, eating right, exercising — can help people avoid some mental illness.

"Understanding how to deal with psychological stresses is also important," he said. "How to deal with emotional reactivity and stress tolerances are also important skills to develop early in life."

Manevitz said people should always seek help for mental health troubles whenever "you are not functioning well in your life and isolating yourself." ■

Reprinted from HealthDay, Sept. 1, 2011

Pertussis from page 7

epidemics have been greatly reduced with the advent of immunization, pertussis is still very present and in fact quite common in our region during this time of year.

Make infection control a priority in your practice. Just as we practice universal precautions to guard against bloodborne infections, we need to maintain respiratory precautions. Make sure you have tissues and/or facemasks available in your waiting and exam rooms and make their use routine. Think about how you might be able to separate waiting rooms, entrances, exits, and isolation rooms to minimize transmission of respiratory illnesses. Of course, if you or your staff will be obtaining nasopharyngeal swabs for pertussis, make sure to wear appropriate PPE since the process often elicits coughing or sneezing. Finally, start post-exposure antimicrobial prophylaxis for anyone who may have unprotected exposure to pertussis and are likely to expose any high-risk individuals.

At the time of this writing, increased reports of pertussis are continuing into August, several of which occurred in high-risk patients including pregnant mothers and neonates. Infants are the most susceptible to severe complications and most likely to be not fully immunized. Unfortunately, an infant in Snohomish County has died from pertussis. Staying on top of pertussis is a community effort, and I appreciate your vigilance in helping protect the people of Pierce County from this illness.

For more information about ACIP Recommendations, visit www.cdc.gov/vaccines/recs/provisional/default.htm.

Free Tdap vaccines are available for uninsured, low-income new parents and contacts of newborns through our partnership with the Pierce County Immunization Coalition. Please call 253-798-6500 or one of the following providers to find an immunization site nearby.

Franciscan Health Services: (253) 426-6938

Mary Bridge: (253) 403-1767

MultiCare Mobile Health Services: (253) 697-4010 ■

Nearly all physicians must revalidate Medicare enrollment by 2013

Roughly 750,000 physicians in the Medicare program soon will be asked to revalidate their individual enrollment records during a massive anti-fraud effort required by the health system reform law. The Centers for Medicare & Medicaid Services hopes to weed out only the people who shouldn't have billing privileges, but physicians are concerned that legitimate health professionals could get caught up in the enrollment sweep by mistake.

CMS gradually will send revalidation requests by mail to more than 1.4 million health professionals — more than half of whom are doctors — between now and March 23, 2013, the agency announced on Aug. 10. Physicians who have enrolled since March 25, 2011, will not be required to revalidate, because their applications were scrutinized under new screening criteria, CMS said. Those receiving a request would have 60 days to recertify their enrollment information, which for some doctors will be similar to the process they first used to sign up with the program.

"Failure to submit the enrollment forms as requested may result in the deactivation of your Medicare billing privileges," CMS stated in the notice.

Previous revalidation efforts have targeted much smaller segments of physicians, such as those who had not updated their enrollment within the past five years or medical suppliers in areas known to be at high risk for fraud. Medicare administrative contractors across the country process about 27,000 new enrollments and more than 30,000 reassignments, or changes to billing and payment information, each month.

Doctors have described Medicare enrollment as tedious and confusing at times. Attempts to strengthen safeguards in the process have created problems for those caring for Medicare patients in recent years. In March, CMS implemented additional program integrity defenses mandated by the health reform law to prevent fraud. Physician practices have reported long wait times for new applications to be approved since then.

"We have very significant concerns with this revalidation effort in light of the problems physicians have had with enrollment and revalidation efforts in the past," said American Medical Association President Peter W. Carmel, MD. "The AMA is making this a priority and urging CMS to reconsider this action."

Health professionals are subject to different screening criteria during the Medicare enrollment process. Physicians and nonphysician practitioners fall in the limited-risk category; physical therapy, x-ray suppliers and currently enrolled home health agencies are in the moderate risk category; and new home health agencies and new equipment suppliers are in the high-risk category.

Physician practice administrators are being told to watch for the letters requesting revalidation, said Allison Brown, a senior advocacy adviser with the Medical Group Management Assn. in Washington. Practices are urged to begin revalidation as soon as they receive a request, she said. Physicians can revalidate using paper applications or by using CMS' online enrollment system, called PECOS, the Provider Enrollment, Chain and Ownership System, which CMS says is the most efficient way to submit necessary information.

But even if every practice complies with the letters as soon as they receive them, the plans to revalidate all health professionals who enrolled before March 25 would require contractors to process thousands of additional applications a day on top of the ones they already receive. Practices also must wait until their Medicare contractor sends them a request before they can revalidate.

"We may end up with enrollment backlogs just given the scope of the revalidation effort," Brown said.

Bureaucratic Brick Walls

The Neurology Medical Group of Diablo Valley in Pleasant Hill, Calif., saw the hassles of the Medicare enrollment process when it attempted to change the practice address for a neurologist who was starting at the medical group in September 2009.

The initial enrollment application sent in August 2009 went missing. A second application was denied on a technicality, and a third application was approved in February 2010. But the Medicare contractor would backdate the physician's enrollment status only to late November 2009. The contractor has denied the practice $30,000 in Medicare charges billed by the neurologist between September and November of 2009.

"It was insufferably delayed, so we could not serve Medicare patients," said Steven Holtz, MD, a neurologist at the group.

The practice recently hired another neurologist, who will start on Sept. 1. The practice sent the physician's Medicare enrollment application in July, but the contractor returned the application and noted that it was sent too early, said Nadia George, the practice administrator. Resending it on Aug. 1 resulted in an approval two weeks later, but that was short-lived. "The next day I re-

See "Medicare" page 13

Past from page 8

way in." She promised to do what she could.

However, by the early 1980's the large health care systems began to take over and it has grown substantially since then. Today, many doctors and patients are dissatisfied. Doctors have found their rights as professionals in the field of medicine have been eroded away by the rules and regulations set forth by the health care systems. Instead of making their own decisions, they have become employees of "the system" and are told how to run their office practices. For example, when this first began, my husband was reprimanded by the health care system when he refused to send a patient home from the hospital the day after a major surgery. He was furious saying, "I'm not going to let someone sitting at a desk in an office tell me what to do!" As it was, the patient needed more time for healing and the bureaucrat had no knowledge of the possible complications and personal circumstances of the patient. Not all cases are alike. People are individuals, not robot machines. Yet with this system, the procedures are categorized and classified in only one way. Bob and his colleagues were all saying, "I'll be glad when I can retire."

I've asked numerous people and the complaints about health care today are many! How long have you waited for a scheduled appointment? Many have spent over an hour. Have you tried to schedule an appointment with a specialist recently? First, most need to be referred by the primary care doctor. Even then, after calling five neurologists to get an appointment, my daughter finally gave up because they were booking five months out and she needed someone immediately. For some, it is hard to find a doctor, as many are not taking new patients. Patients are turned off by the non-personal approach and the ten minute time limit and no chance to ask questions. There is fear created by patients being released from the hospital too soon and not having family to help out. These issues are not the doctors' fault; they are only following guidelines set forth for them in the health care system.

"The Future of Medicine?" What will the answer be? Will doctors choose Boutique Medicine, employment with the big health care systems, or take back the past? The Pierce County Medical Society is the voice of the doctors, their "union" so-to-speak. In my opinion, a start would be for its members to begin little by little taking back their right to control their offices and practices. There is strength in numbers if all work together. The past may hold the answer. ■

Medicare from page 11

ceived an email that said [the application] was rejected," she said.

She followed up with a phone call to the contractor's enrollment department and was told the application appeared to be approved. George is planning to have the new hire treat one Medicare patient before Sept. 1 and have him submit a claim to ensure that the physician is in the Medicare system.

Such an experience is not unique. Physicians tend to find enrolling in the Medicare program an unnecessarily long, complicated and bureaucratic process, said Donald Waters, executive director of the Alameda-Contra Costa (Calif.) Medical Assn. It's a task often left to professional credentialing staff and practice administrators. But even the most experienced staffers encounter problems with confusing language on enrollment forms and vague instructions that cost physician practices time and money, Waters said.

The MGMA's Brown said CMS has planned improvements to the enrollment website. Changes would allow physicians to sign online applications electronically, instead of having to print a certification statement for the application and mail it to a contractor. The improvements could be implemented by January 2012, she said.

A Massive Re-Enrollment Effort

Medicare plans to revalidate the enrollments of more than 1.4 million individuals and facilities by March 23, 2013. Physicians account for more than half the list.

Doctors Considered Low Risk

Health professionals are subject to different screening criteria during the Medicare enrollment process. Physicians and nonphysician practitioners fall in the limited-risk category; physical therapy, x-ray suppliers and currently enrolled home health agencies are in the moderate risk category; and new home health agencies and new equipment suppliers are in the high-risk category. ■

Reprinted from AMNews, Aug 29, 2011

DOH records copying fee increased

Effective July 1, 2011 through June 30, 2013, the maximum charge for copying medical records is $1.04 per page for the first 30 pages and $0.79 per page thereafter. A $23 clerical searching and handling fee may be charged under state law, but federal law prohibits charging this fee to the patient or to someone authorized to make health care decisions on behalf of the patient.■

State disciplines health care providers

The Washington State Department of Health has taken disciplinary actions against the following health care providers in our state.

The department's Health Systems Quality Assurance Office works with boards, commissions, and advisory committees to set licensing standards for more than 70 health care professions including physicians, nurses, counselors, etc.

In July, 2011 actions included:

- The Dental Hygienist Program charged Deborah J. Almario (DH00006246) with unprofessional conduct. Allegations include providing dental services to a patient in the dental office of another dentist without his permission, taking dental supplies from his office and giving them to the patient, and purchasing and delivering a controlled substance through an online pharmacy without a valid prescription. She also used the patient's debit card for the purchase of controlled substances without the patient's permission.

- The Nursing Assistant Program charged registered nursing assistant Patrick Crews (NA00170767) with unprofessional conduct. He allegedly stole checks from a coworker and wrote and cashed a check to himself for $350. He also allegedly purchased oxycodone without a prescription.

- The Nursing Assistant Program granted the application of registered nursing assistant Charles Andrew Siler (NA60231621) and placed his registration on probation. In 2009 his credential to practice as an emergency medical technician was placed on probation. He must comply with terms and conditions set against his registration.■

Applicants for Membership

Lissa S. Brod, MD
Psychiatry & Neurology
Franciscan Neurology (FMG)
1802 S Yakima Ave Ste 208, Tacoma
253-985-2722
Med School: Mt. Sinai
Internship: Univ Hospital - Newark
Residency: Oregon HSU
Fellowship: OHSU/Portland VA

Jorge M. Chaves, MD
Hematology/Oncology
Northwest Medical Specialties, PLLC
1624 South I Street #305, Tacoma
253-428-8700
Med School: U Texas Medical Center
Internship: Boston University
Residency: Boston University
Fellowship: Yale University

Joshua E. Levin, MD
Colon & Rectal Surgery
MultiCare Colon & Rectal Surgery
1307 11th Street, Tacoma
253-274-9732
Med School: Boston University
Internship: Rhode Island Hospital
Residency: LSU - Shreveport
Fellowship: U Texas - Houston
Fellowship: SUNY Stony Brook

Viveca B. Livezey, MD
Neurology
South Puget Sound Neurology
2201 S 19th St Ste 200, Tacoma
253-284-4488
Med School: University of Maryland
Internship: Washington Hospital Ctr
Residency: University of Maryland

Aaron Pace, MD
Dermatology
Pace Dermatology Associates
1901 S Union Ave Ste B3003, Tacoma
253-572-2842
Med School: Loyola University
Internship: MacNeal Hospital
Residency: Loyola University

Douglas M. Sorensen, MD
Otolaryngology/Head & Neck Oncology
Tacoma Ear & Balance (FMG)
1708 S Yakima Ave Ste 112, Tacoma
253-426-6731
Med School: Uniform Svcs University
Internship: Madigan AMC
Residency: U Colorado - Denver
Fellowship: U TX - Anderson Cancer Ctr

Raul E. Villanueva, MD
Pathology/Clinical Microbiology
Puget Sound Institute of Pathology
PO Box 34245, Seattle
206-622-7747
Med School: Loma Linda University
Residency: Loma Linda Univ Med Ctr
Fellowship: Indiana University

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Internal Medicine or Geriatric Opportunities - Western Washington. MultiCare Health System, seeks multiple BE/BC internal medicine or geriatric physicians. Choose from 100% outpatient or a mix of inpatient and outpatient settings. Located 40 minutes south of downtown Seattle WA, the area boasts the advantages of an active Northwest Lifestyle; from big city amenities to the pristine beauty and recreational opportunities of the great outdoors. As an employed physician, you will enjoy excellent compensation and system-wide support, while practicing your own patient care values. Email your CV to Provider Services at blazenewtrails@multicare.org, apply for this job on-line or view other opportunities at http://careers.blazenewtrails.org or call 800-621-0301 for more information.

Would you like to have fun playing with kids, while you are taking care of their medical needs? Would you like to join a family of pediatric providers that genuinely enjoys taking care of children? If you are, we're looking for a full-time PNP/ARNP to join us at the Evergreen Children's Clinic in Puyallup, WA. Experience caring for children is a plus. We have Epic as our EHR and a medical laboratory in the office that is capable of doing most basic diagnostics testing on site. The staff is wonderful to work with. If this sounds like a place you would like to work, please send your resume to sroach@ evergreenchild.com or fax it to 253-848-8956.

OFFICE SPACE

Great location 13th & Union. **1,700** first floor, 800 third floor. Contact Carol 206-387-6633.

Medical office lease/sub lease. Fully furnished: St. Joseph Medical Clinic Tacoma 1,100 sq. ft. sublease $100/d. University Place 1,000 sq. ft. $1,600/m or $100/d. Contact Marlys 253-573-0460.

Office space to share. Centrally located between all hospitals in the Tacoma area. Contact Pati 253-572-7120.

MultiCare campus office space: Jackson Hall, 1400 sq ft, first floor, furnished, negotiable sublet. 253-279-4900.

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Tacoma, WA 98402

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Pierce County Medical Society
BULLETIN

October 2011

2011 WSMA Delegates

Drs. from left: PCMS President Elect Bill Hirota, Dan Ginsberg, Ron Morris, Kevin Murray, PCMS President Jeff Smith, Anthony Chen, Keith Dahlhauser (kneeling), Sumner Schoenike, Len Alenick, David Bales, Don Russell, Mark Grubb, Cecil Snodgrass and Richard Hawkins. Attending but not pictured: Dr. Nicholas Rajacich

More photos, story page 5

INSIDE:

The Bulletin is published monthly by PCMS Membership Benefits, Inc. Deadline for submitting articles and placing advertisements is the 15th of the month preceding publication.

The Bulletin is dedicated to the art, science and delivery of medicine and the betterment of the health and medical welfare of the community. The opinions herein are those of the individual contributors and do not necessarily reflect the official position of PCMS. Acceptance of advertising in no way constitutes professional approval or endorsement of products or services advertised. The Bulletin reserves the right to reject any advertising.

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Pierce County Medical Society
BULLETIN

October 2011

Table of Contents

President's Page

by Jeffrey L. Smith, MD

Proving Myself Wrong

Jeffrey L. Smith, MD

This month, I attended my first Washington State Medical Association Annual Meeting in Spokane. I didn't really want to go, but felt like it was my duty as the Pierce County Medical Society President. You might be shocked at the last sentence. How could someone not want to go to a weekend long meeting where they probably were going to discuss a bunch of issues that don't really concern me? Let me explain.

I have worked in Pierce County for 15 years, all of them as an employed physician at Community Health Care. Before I took the job as Medical Director there, I was never very interested in Medical Society stuff, local, state or national. Employed physicians, it seemed to me, had vastly different concerns than private practice doctors, who seemed to make up the majority of medical association memberships. Eight years ago, when I took a leadership role at the largest local community health center, I decided I probably needed to become more politically aware. Or at least aware of the issues important to a community health center. At the urging of **Dr. George Tanbara** (who served for many years on our CHC board of directors) and of past president **Dr. Sumner Schoenike**, I joined the PCMS Board of Trustees. Partly, I wanted to explore getting more active in my community with other physicians, and partly because Sumner was going to make "Access" one of his priorities that year, and I wanted to be involved in that. That turned out to be a great decision. Our work back then has now blossomed into Pierce County Project Access, which is doing great work and for which our Medical Society can be very proud. But even with that success, I still was not that interested in spending my weekend talking about a bunch of issues in Spokane when there are so few nice weekends left in the summer.

I was wrong. Well, I was partly right. There was still a large amount of discussion time allotted to issues that seemed to be local or personal in nature and not really the business of the WSMA. However, the part I got wrong was that the weekend was productive and stimulated much interesting discussion. And talking to my colleagues, all of whom share my interest in keeping medicine a great profession, was enriching. As I read the newspaper, listen to the radio, or catch the TV news, I can't help but review conversations from that weekend. When I would get down about the problems facing us (economy, regulation, malpractice, regulation, insurance, regulation, etc.), I can be encouraged that so many of my colleagues, who have so much experience and wisdom and energy, are right there beside me. And you.

So, as I've done several times in this column this year, I will end with an exhortation. If you are one of the physicians who participate in PCMS activities and business, please continue. You've done a great job so far and are appreciated. Those of you who have not, please get involved. We have several opportunities in the upcoming year. Call or email Sue Asher or me or any Trustee. We'd love to have you more involved.

PCMS members visit Spokane; participate in WSMA Annual Meeting

PCMS members **Drs. Anthony Chen, David Bales, Kevin Murray, Sumner Schoenike** and **Cecil Snodgrass** and Board of Trustee members **Drs. Jeff Smith, Bill Hirota, Keith Dahlhauser, Dan Ginsberg** and **Mark Grubb** joined WSMA Representatives **Drs. Len Alenick, Richard Hawkins, Ron Morris, Nick Rajacich**, and **Don Russell** in representing Pierce County at the WSMA Annual Meeting that was held in Spokane September 9-10th at the fabulous Davenport Hotel. All served as Delegates and had voting privileges on the House of Delegates floor.

There was debate and discussions on many resolutions ranging from privatization of alcohol sales and protecting physicians' personal data to MQAC's new pain medication rules. Several resolutions were adopted, some not adopted and many were amended - thanks to the hard work of the reference committees prior to the final House of Delegate voting on Sunday morning.

The House voted to oppose privatization of retail alcohol sales and to educate members and the public about the adverse health outcomes of increased alcohol use due to privatization of alcohol sales. They also voted to support a healthcare professional's right to practice within their Right of Conscience and opposes discriminatory policies against physicians who exercise those rights. And, that physicians may choose whom to serve, however they should provide emergency care when appropriate and refer to another physician under normal healthcare circumstances.

Of three Pierce County resolutions that were submitted, two were referred and one was adopted. They directed the WSMA to:

1) Seek legislation that clarifies that Internal Medicine, Family Practice, Urgent Care, Pediatrics and Obstetrics/Gynecology are separate specialties, and that for payment purposes, they cannot be lumped together as Primary Care which the House voted to Refer to the organization's leadership for further study/consideration.

2) Support the interconnectivity of proprietary Electronic Medical Record products so that they can readily interface securely with a centralized health information exchange to improve quality, cost efficiency and patient safety which was adopted.

3) Continue to work with MQAC regarding the pain medicine issue and introduce legislation that would require re-opening the rule making process in order to make changes. The resolution was referred for further study.

Dr. Bill Hirota chaired Reference Committee C, which had the most reports and business to conduct with 16 resolutions accompanied by lots of testimony to digest and incorporate into recommendations to the house.

New WSMA Board of Trustee members were elected, and WSMA President and neurosurgeon Dr. Dean Martz of Spokane turned over the gavel to Dr. Doug Myers, otolaryngologist from Vancouver WA. **Pierce County's Nick Rajacich, MD was elected President-elect**.

PCMS extends a huge thank you to all delegates for their personal contribution of valuable time to participate in the WSMA Annual Meeting.

More WSMA Annual Meeting happenings and photos page 7

L to R: Drs. Bill Hirota, Len Alenick and Cecil Snodgrass study resolutions at breakfast before the House opens

First row L to R: Drs. Keith Dahlhauser and Mark Grubb, back row L to R: Drs. Ron Morris and Len Alenick, seated and studious at the House of Delegates

Nicholas Rajacich, MD - President-Elect of Washington State Medical Association

Nicholas Rajacich, MD

Dr. Nick Rajacich, orthopedic surgeon, was elected President-Elect of WSMA at their annual meeting in Spokane in September. Dr. Rajacich, when he takes over the reigns as President of the organization in September of 2012 in Tacoma, will be well seasoned. A firm supporter of both Pierce County Medical Society and the Washington State Medical Association he has been active with both groups for many years.

He was first elected as a WSMA Trustee in September 2000 and served in that capacity until 2008 when he was elected as 2nd Vice President. In 2009 he was elected 1st Vice President and served until September 2011 when he was elected President-Elect. He will become President in September 2012 and will serve until September 2013 when he automatically becomes Immediate Past President and will then serve one more year on the Executive Committee. Wow!

Since 2007 when he became 2nd Vice President, Dr. Rajacich's service has included being a member of the Executive Committee which is a significant time commitment. Keeping apprised of state legislative and regulatory issues can be daunting, in addition to the numerous meetings, social functions, phone calls and study time required.

PCMS extends a hearty thank you and congratulations to Dr. Rajacich for his long term service to his professional associations. We look forward to supporting Dr. Rajacich in his leadership role. ■

Pierce County's Senator Randi Becker (R-2nd) named WSMA's Legislator of the Year

Senator Randi Becker (2nd Legislative District) was honored in September at the Washington State Medical Association's Annual Meeting as their Legislator of the Year. The ranking minority member on the Senate Health and Long Term Care Committee received the award at the WSMA's Annual President's Banquet in Spokane.

Each year the Association honors a Washington State Legislator whose knowledge and influence helps improve the health of people in our state. Senator Becker, having spent the bulk of her professional career working in physicians' practices, clearly understands the issues.

Senator Becker began her career as a medical receptionist, working her way up to the administrator for a multi-million dollar surgical center in Puyallup. In addition, she helped develop an Obesity Surgical Practice in South King County and worked for Good Samaritan Hospital, where she started several hospital-owned clinics including an urgent care center.

Senator Becker is a stalwart advocate for physicians and has helped with numerous legislative issues that would impact physicians. She understands and has true concern for the profession.

PCMS extends a huge thank you and congratulations to Senator Becker. ■

L to R: Drs. David Bales, Anthony Chen, Keith Dahlhauser and Dan Ginsberg - 7:00 am TOO early for such serious study!

PCMS Delegates study and discuss issues at breakfast prior to attending the House of Delegates session

Revenue sluggish, patient volume dropping at nonprofit hospitals

A still-sputtering economy is creating a dismal forecast for nonprofit hospital finances, as patients defer care.

This is the conclusion of an annual report issued Aug. 30 by Moody's Investors Service, which analyzed the financial statements of 401 freestanding hospitals and single-state medical systems, along with 16 multistate health care systems.

About half of all hospitals are nonprofit, and, according to the report, median inpatient admissions declined 0.4% in fiscal year 2010, following no growth for fiscal year 2009. Median total operating revenues went up by 4%. This was a decrease from the approximately 6% growth in 2009 and 7% in 2008.

"These are the most challenging numbers that we can remember," said Beth Wexler, author of the report and vice president/senior credit officer at Moody's. "This is a precipitous decline."

Growth in the use of emergency and outpatient services also slowed. The median number of emergency department visits increased 2.7% in 2009 but only 1.1% in 2010. Outpatient visits went up 3.7% in 2009 but only 1.5% in 2010.

Analysts said the numbers were the result of an unemployment rate that is expected to continue to be stubbornly high. Unemployment was 9.1% in August, and Moody's predicts it will remain higher than 8% through 2012.

The way these hospital services were paid for also shifted, which Moody's said probably had an additional negative impact on hospital finances. Medicaid represented 11.9% of median gross revenues in 2009 and increased to 12.4% in 2010. The median gross revenue from Medicare increased from 42.5% in 2009 to 43% in 2010. Payment rates for both programs have either been reduced or are expected to go down in the immediate future. But Moody's said payments from commercial insurers are expected to decline as well.

"The federal deficit will further pressure hospital revenues, and we also expect lower rate increases from commercial payers as they face their own increased regulatory requirements under reform," Wexler said. ■

Reprinted from AMNews 09/19/11

The Health Status of Pierce County

by Anthony L-T Chen, MD, MPH

Think Pink, But Also Think Mammogram

Anthony Chen, MD

At this time of year, it is nearly impossible not to receive a message about breast cancer. On a simple trip to the store, shoppers are inundated with pink: yogurt, ice cream, bottled water and lipstick all wear pink ribbons bearing promises of more breast cancer research and raising awareness of the disease. Television commercials celebrate large community events and we all seem to be running, walking, rowing, rallying and even cooking for the cure. From food processors to football players, the pink ribbon is the IT accessory of the season.

Since 1985, National Breast Cancer Awareness Month has thrown incredible momentum and awareness at the second most common cancer affecting women. Combined with other efforts and advances in treatment, the results have been significant: mammography rates have more than doubled for women age 50 and older and breast cancer deaths have declined.

Such progress and the volume of the public rallying cry are certainly inspiring. But in spite of the increased awareness, there is still a significant part of the population that does not take advantage of early detection at all. National research shows the following:

* Women age 65 and older are less likely to get mammograms than younger women, even though breast cancer risk increases with age and mammograms are recommended until age 74.

* Hispanic women have fewer mammograms than Caucasian women and African American women.

* Women below poverty level are less likely than women at higher incomes to have had a mammogram within the past two years.

* Mammography use has increased for all groups except American Indians and Alaska Natives.

"...there is still a significant part of the population that does not take advantage of early detection."

These issues often affect minority or low-income populations of Pierce County, and we have a program in place to screen more women for breast health and other diseases. Women between the ages of 40 and 64 with limited income and no health insurance may qualify for a women's health exam and mammogram from the Health Department's Breast, Cervical, and Colon Health Program (BCCHP).

Sometimes the biggest hurdle is just getting a woman to be screened, but if the results are abnormal, the journey they face may seem insurmountable. Through BCCHP, we can work with her to get further diagnostic testing and—if cancer is diagnosed—coordinate her enrollment in the Medicaid sponsored Breast and Cervical Treatment Program. This program is available to help cover expenses and identify local resources for care.

We are also privileged to partner with the Carol Milgard Breast Center, Franciscan Health System, MultiCare Health System, and community organizations to help provide resources and address the breast cancer issues specific to Pierce County.

For information about the BCCHP Program or make referrals, medical providers can call the program at (253) 798-4971. Patients can contact the program at (253) 798-6410 or visit our website at http://www.tpchd.org/health-wellness-1/breast-cervical-colon-health-program/. Search our website for "breast cancer" for resources such as cancer support groups, cancer navigators, or county statistics. Breast cancer screening recommendations can be found at: http://www.uspreventiveservicestaskforce.org/uspstf/uspsbrca.htm.

On a different topic, just a reminder that Project Homeless Connect (http://www.pchomelessconnect.org/) will be taking place on Wednesday, October 26th at the Tacoma Dome. The protracted economic downturn has led to growing homelessness. Tacoma School District last year had the most homeless students in the state. Thanks to all of you who will be volunteering, donating, and supporting this wonderful community effort. ■

Be on Alert to Licensing Background Scam

Please be on alert: The WSMA has been notified of a person calling physician offices claiming to be an investigator from the WSMA. The caller claims to be doing a licensing background investigation and demanding information such as a physician's date of birth and social security number. He threatens cancellation of the physicians' licenses to practice if they are non-compliant with his requests. This individual is NOT associated with the WSMA or the Medical Quality Assurance Commission (MQAC).

The MQAC has been alerted. If you have questions or receive such a call, do not give out your personal information. If anyone contacts you claiming to be a Medical Commission Investigator requesting social security information or credit card information, please report the contact to your local law enforcement agency immediately and to the Medical Quality Assurance Commission as soon as possible. Contact MQAC at 360.236.2770. ■

Personal Problems of Physicians Committee

Medical problems, drugs, alcohol, retirement, emotional, or other such difficulties?

Your colleagues want to help

*Robert Sands, MD, Chair	752-6056
Bill Dean, MD	272-4013
Tom Herron, MD	853-3888
Bill Roes, MD	884-9221
F. Dennis Waldron, MD	265-2584

Confidentiality Assured

Many Physicians Feel They're Delivering Too Much Care

Your doctor may secretly think you're making too many office visits and getting too many drugs and tests.

A survey of primary-care doctors conducted in 2009 finds that 42% of the 627 respondents believed the patients in their own practice were getting too much care. Just 6% of doctors believed their patients were getting too little care. (The rest thought the level of care was just right.)

And 28% of the doctors thought they themselves were practicing more aggressively than they would prefer to.

The response rate to the mailed survey was 70%, suggesting this is a topic of interest for doctors — as well as for a health-care system struggling to control costs while helping to improve people's health.

The survey, the results of which were published in the latest *Archives of Internal Medicine*, found 76% of doctors blamed malpractice worries for their over-aggressive care. The impact of defensive medicine has been debated, but "it is certainly the most widely endorsed external factor cited by physicians," says Brenda Sirovich, an author of the study and a staff physician and research associate in the Outcomes Group at the VA Medical Center in White River Junction, VT.

Sirovich, also an associate professor of medicine at the Dartmouth Institute for Health Policy and Clinical Practice, notes that 83% of physicians thought they could easily be sued for failure to order a test that was indicated, but only 21% thought they could be sued for ordering a test that wasn't indicated.

The incentives point toward "when in doubt, do more," she says.

Some 52% of physicians cited clinical-performance measures, which gauge how closely doctors or institutions adhere to recommended protocols for a certain disease or condition, as a reason for excessive care. "Almost universally, they're in place to make sure you're doing enough" for the patient, says Sirovich. Rarely do they attempt to make sure physicians aren't doing too much.

And 40% of doctors surveyed said inadequate time to spend with patients led them to order tests or refer patients to specialists rather than use other, less-aggressive ways of addressing patients' issues.

Financial incentives were also cited, but "most thought they affected other physicians," the study found. Only 3% said financial considerations influenced their own care decisions while 39% said they affected other primary-care doctors and 62% thought they affected sub-specialist physicians.

While the notion that our health-care system delivers too much care to some people is often framed as a cost issue, there's plenty of reason to believe it can also cause harm, says Sirovich. (Read our Q&A with an author of "Overdiagnosed." Two of its co-authors, Lisa Schwartz and Steven Woloshin, are also authors of this study.)

Given that so many of these incentives are tied up with the very structure of the malpractice, reimbursement and quality-measurement systems, what can be done? "I don't think every change has to be sweeping," says Sirovich. Almost half (45%) of the doctors surveyed estimated that at least 10% of the patients they see on a typical day could be dealt with using an alternative to a full physician's visit such as a visit with a nurse or an email or phone consultation.

Better reimbursement for those less-intensive ways of following up would help, she says.

And Sirovich notes that "as a profession and as a society, it's good for us to think about doing a better job of educating patients and the public that more care isn't necessarily better," she says. "There's such a thing as too much." ■

Reprinted from The Wall Street Journal, 9-26-11

IN MEMORIAM

HAROLD B. JOHNSTON, MD

1924 - 2011

Dr. Harold Johnston passed away June 4, 2011 at the age of 87.

Dr. Johnston attended the University of Washington and was a graduate of the University of Texas Medical School at Galveston. He completed his internship at Pierce County Hospital and residency in psychiatry at Tripler Hospital in Honolulu, HI in 1954, after which he started a private practice in Tacoma that lasted 37 years, until his retirement in 1991.

He was a member of the American Medical Association, Washington State Medical Association and Pierce County Medical Society since 1954 and was a Life Fellow of the American Psychiatric Association.

PCMS extends sincere sympathies to Dr. Johnston's family.

Harold Johnston, MD

IN MEMORIAM

ROBERT M. FERGUSON, MD

1925 - 2011

Robert Ferguson, MD

Dr. Robert Ferguson passed away on September 10, 2011 after a short illness.

Dr. Ferguson graduated from the University of Illinois College of Medicine in Chicago and moved to Tacoma in 1950, where he began his 34-year practice in family medicine. He was Chief of Staff at Tacoma General and Allenmore Hospitals, served as president of the Pierce County Medical Society in 1970, board chairman of the Pierce County Medical Bureau and was a charter fellow of the American Academy of Family Physicians.

After retiring from clinical practice he became the medical director of United Pacific Life Insurance Company. He continued serving the medical community as a physician for the homeless at the Community Health Care Delivery System.

Dr. Ferguson was a member of Pierce County Medical Society and the Washington State Medical Association since 1951.

PCMS extends sincere sympathies to Dr. Ferguson's family.

Applicants for Membership

Ngim C. Carmichael, PA-C
Family Medicine
Sound Family Medicine
10004 - 204th Ave E, Bonney Lake
253-848-5951
Training: Medex Northwest

Elizabeth A. Friesema, MD
Pediatrics
Community Health Care
1708 E 44th St, Tacoma
253-471-4553
Med School: Med Coll of Wauwatosa
Residency: Children's Hospital of WI
Fellowship: Children's Hospital of WI

Amardeep K. Gill, MD
Internal Medicine
Franciscan Medical Group
1708 S Yakima Ave Ste 110, Tacoma
Med School: Dayanand Med College
Internship: Univ of Missouri
Residency: Univ of Missouri

Sabrina Shaheen, MD
Cardiology
Cardiac Study Center
1901 S Cedar St #301, Tacoma
253-572-7320
Med School: Kempegowda Institute
Internship: SUNY Health Sciences
Residency: SUNY Health Sciences
Fellowship: SUNY Health Sciences

Carri Jo Timmer, DO
Family Medicine
Community Health Care
11225 Pacific Ave, Tacoma
253-284-2203
Med School: Western University of Health Sciences COMP
Internship: Tacoma Family Medicine
Residency: Tacoma Family Medicine

Kent R. Walker, DO
Family Medicine
Sound Family Medicine
10004 - 204th Ave E, Bonney Lake
253-848-5951
Med School: U of Osteopathic Medicine & Health Science
Internship: Michigan Osteo Med Ctr
Residency: William Beaumont AMC
Fellowship: Darnell Army Comm Hosp

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Internal Medicine or Geriatric Opportunities - Western Washington. MultiCare Health System, seeks multiple BE/BC internal medicine or geriatric physicians. Choose from 100% outpatient or a mix of inpatient and outpatient settings. Located 40 minutes south of downtown Seattle WA, the area boasts the advantages of an active Northwest Lifestyle; from big city amenities to the pristine beauty and recreational opportunities of the great outdoors. As an employed physician, you will enjoy excellent compensation and system-wide support, while practicing your own patient care values. Email your CV to Provider Services at blazenewtrails@multicare.org, apply for this job on-line or view other opportunities at http://careers.blazenewtrails.org or call 800-621-0301 for more information.

Would you like to have fun playing with kids, while you are taking care of their medical needs? Would you like to join a family of pediatric providers that genuinely enjoys taking care of children? If you are, we're looking for a full-time PNP/ARNP to join us at the Evergreen Children's Clinic in Puyallup, WA. Experience caring for children is a plus. We have Epic as our EHR and a medical laboratory in the office that is capable of doing most basic diagnostics testing on site. The staff is wonderful to work with. If this sounds like a place you would like to work, please send your resume to sroach@evergreenchild.com or fax it to 253-848-8956.

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Medical office lease/sub lease. Fully furnished: St. Joseph Medical Clinic Tacoma 1,100 sq. ft. sublease $100/d. University Place 1,000 sq. ft. $1,600/m or $100/d. Contact Marlys 253-573-0460.

Office space to share. Centrally located between all hospitals in the Tacoma area. Contact Pati 253-572-7120.

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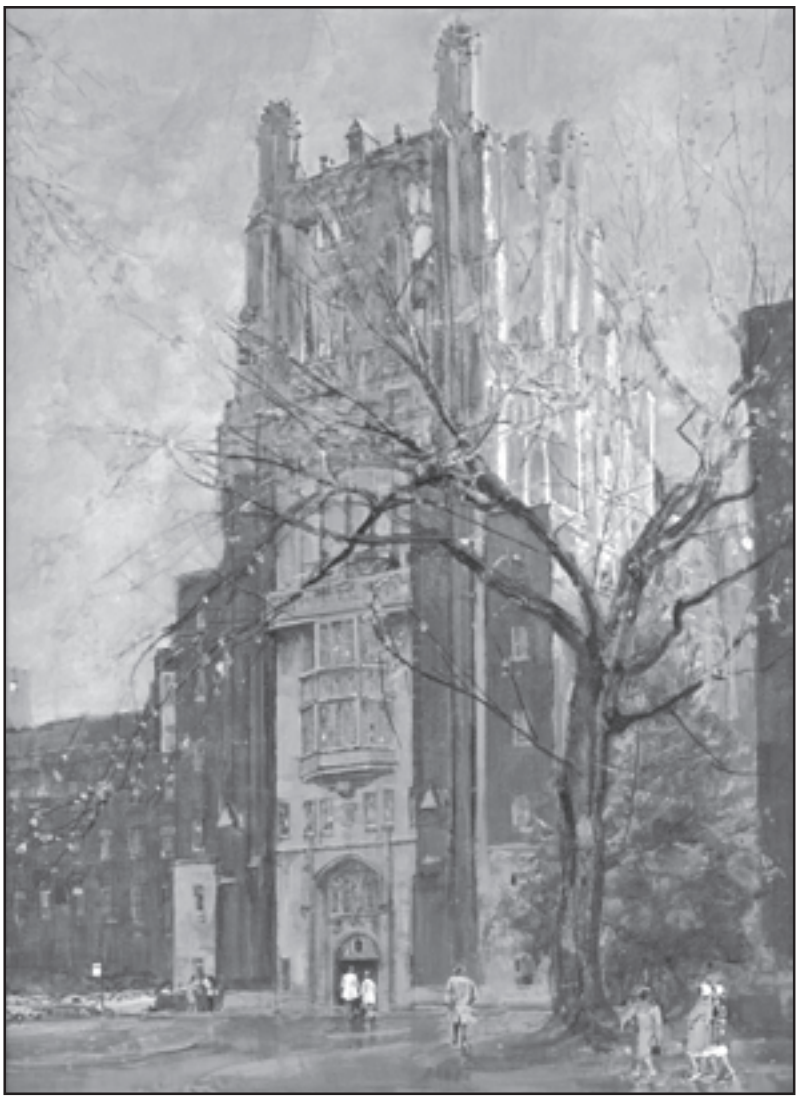
Pierce County Medical Society
BULLETIN

November/December 2011



The University of Iowa College of Medicine

INSIDE:

The Bulletin is published monthly by PCMS Membership Benefits, Inc. Deadline for submitting articles and placing advertisements is the 15th of the month preceding publication.

The Bulletin is dedicated to the art, science and delivery of medicine and the betterment of the health and medical welfare of the community. The opinions herein are those of the individual contributors and do not necessarily reflect the official position of PCMS. Acceptance of advertising in no way constitutes professional approval or endorsement of products or services advertised. The Bulletin reserves the right to reject any advertising.

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Pierce County Medical Society
BULLETIN

November/December 2011

Table of Contents

President's Page

by Jeffrey L. Smith, MD

"It's Been an Honor"

Jeffrey L. Smith, MD

Recently, I have been thinking about what we do here at the PCMS. What is our mission? Who are we and who should we be? Where are we headed in the future? To help answer some of these questions, the Board of Trustees recently formed a Task Force including members of the board, the executive committee and the community. It was a very interesting exercise and one that will continue for a few more months as we form not only an answer to those questions, but hopefully map out a plan for how to get where we want to be.

The first item I'd like to discuss here is who we are now and who we've been. The PCMS was formed in 1888 (yes, 123 years ago) by eight local physicians "in order to improve themselves…and better serve the public." We're not too far from that original mandate today. Through activities such as CME, Member Benefits, community service, social interactions, political advocacy, medical leadership, and recognition of excellence in our membership, we continue to follow that original goal.

The second item I'd like to discuss is what I'd like to see more of. Leadership development, through programs like this year's CE event could be a mainstay of our society activity. Encouraging activism and community engagement would be top topics. I envision the PCMS as being a recorder or registry of volunteer activities that our members engage in. To that effect, I'd like to collect a list of "notable things" that each member participates in, whether it is feeding hungry, working in your church or school, volunteering your time for caring for the less fortunate, or even being involved in a book club. I think it would be great if we could look online at the PCMS website and find out what great things or fun things our cohorts are involved in.

The third item I wanted to mention today was pride in our county medical society. I mentioned the Washington State Medical Association annual meeting that I attended last month. Despite the fact that it was on the other side of the state in Spokane, we were the best represented, the most active, and the strongest delegation there. Our members did some of the best work there, in my opinion, from chairing reference committees to serving as Speaker of the House, our team rocked. Nick Rajacich is the President Elect for WSMA. Bill Hirota is our President Elect for PCMS. Both docs will do a great job representing our county and our physicians in both roles. We have repeat commitments from several returning Board of Trustee members, and have a couple of new ones to add, I hope, with the upcoming elections.

Finally, I want to say thank you to all of you for this past year. I consider it an honor to serve as the President this year and look forward to many more years of practice, service and fun in Pierce County. Have a great winter and holiday season. See you at the annual meeting December 7. ■

In My Opinion

by Richard Waltman, MD

***The opinions expressed in this writing are solely those of the author**. PCMS invites members to express their opinion/insights about subjects relevant to the medical community, or share their general interest stories. Submissions are subject to Editorial Committee review.*

Who can solve the healthcare crisis? Physicians can - and must!

Richard Waltman, MD

I have worked here for 31 years. I won't mention the name of the company, but I'm not hiding it either. I love what I do, and for the most part, I believe we provide excellent care and service. And, for the most part, I do believe that those who lead this company are kind, capable, and well-intended people. I like them. Still, recent developments here make me feel that we have lost our way in admittedly stormy seas, and I feel obliged to write this essay with the hope that we can change our course and make things right again.

I am a positive and optimistic person. I am opinionated, I am outspoken, and I am passionate, but I have always tried to look for improvements, for solutions, for ways to make things better. It is in the spirit of "Let's fix this thing" that I make this presentation.

And I write to you, my colleagues, because what is happening here may be happening to you now—or may happen to you soon. Now is the time for all of us to join together and make some positive and meaningful interventions.

As the Kingston Trio warned us years ago, "Citizens, hear me out. This could happen to you!"

My Email

I received an email from our chief executive officer (CEO) indicating that the healthcare system for which I work was going to reduce the workforce by 350 people—as "phase 1 in dealing with the budgetary crisis." She blamed progressively reduced state and federal reimbursement, increasing costs, and higher expenditures for "uncompensated care." Of course, her message did not use the word "people." Rather, it indicated a reduction in 350 FTE—FTE somehow being just a number on a page rather than an actual living and breathing soul.

Reflecting on this message for several days, I found many Yellowstonian geysers erupting in my head. What about the huge salaries so many of our top executives receive? What about the extensive administrative structure that has developed over the past few years? What about all the money the company has put into beautiful buildings and state-of-the art technology? What about addressing nonhuman efficiencies in the business model? And most of all, what would happen to these people, people with whom I work every day?

So I sent an email (see Sidebar 1 - page 9) to all company employees—more than 9,000 of them. Within minutes of pressing the send button, I was deluged with responses:

"As an employee who is facing the real possibility of losing my job, I want to say thank you for your kind and compassionate email. I am a single mother of four beautiful children, three at home and one getting ready to begin her second year of college. I am the sole support for my children and the possibility of being without a job is frightening. The last time I was out of work was when I was 12 years old!"

"I am a receptionist at the Internal Medicine Clinic. I cannot say "thank you" enough to you for your touching email. Thank you for standing up for all of us "little people" whose lives would be in complete turmoil with the loss of our jobs."

"I, too, am a long-time employee and have been a nurse in many areas of our organization as well as a patient. I completely agree that our people is what makes us strong."

"I would forgo a raise for the next 2 years if it would help save jobs and help the hospital."

"Your email almost brought a tear to my eye...it really touched a lot of hearts. My mom retired from this company. My aunt, cousin, and brother all worked here at one time, and I have been in the IS dept. for almost 10 years. I love it here and look forward to coming to work every morning.

I have been a patient as well and I agree 100% about the people being the main reason patients continue to come to here."

"I work in the O.R. I'm not management but I would be willing to take a pay freeze for 2 years if that would help save jobs. I'm like most people who live paycheck to paycheck and would be devastated if I was laid off. My heart goes out to anyone who loses their job and I hope it doesn't come to that. Thank you for stepping up and helping us out."

That went on for about 2 hours, at which time I had received well over 300 emails. Then Outlook crashed. For several hours, the entire system was down.

See "Crisis" page 6

Crisis from page 5

When the connection was re-established, it was impossible for anyone to answer me.

But that didn't stop them. We got phone call after phone call, and some employees even came by the office to thank me. And it still hasn't stopped. Over a month later I am still getting thank-you letters, still getting handshakes and hugs in the hallways.

Meanwhile, the company has terminated more than 300 people, and plans are for more cuts later this year.

I had a cordial but orchestrated meeting with the CEO, whose focus was on showing me the details of lost revenue and rising costs rather than addressing my proposals. She did thank me for my concern. The Executive Committee of the medical group also addressed my email—in closed session—concluding that, "While many members appreciate Rick's heartfelt concern for our employees, a significant number appear to believe that his call for a 10% across the board pay cut is ill-advised from a business development standpoint."

What the heck does that mean?

Receiving such a strong and emotional response to my email was most gratifying for me, confirming what I already knew; we have wonderful people here. What was and is very sad to me, though, is that I got a total of six responses from employed physicians, a group that numbers close to 300. Three were supportive, three were critical. And no one else even bothered to respond.

Trying to make some sense of what has happened, and with the understanding that it is and will be happening in many other places, I have some thoughts I'd like to share with you. What I recommend won't solve the healthcare crisis in its entirety, but it may point us in the right direction.

Reassessing Executive Salaries

By last report, our CEO makes more than $4 million a year, our chief financial officer (CFO) makes more than a million, and all of our 26 vice presidents (VPs) make six-figure incomes, plus benefits and perks. That they happen to be nice people trying to do good work is acknowledged, but are they really worth that much, while the x-ray tech gets $50,000 and the ER RN gets $70,000?

And there is an irony here: Put the x-ray tech in the CEO seat, and he could probably get by for a few days and do a relatively good job. The company would not crash and burn. But put the CEO in the x-ray suite, and she won't be able to do a thing. She couldn't take one x-ray. No work would be done.

Of course, these folks have executive skills, but are they really more complicated than those of the x-ray tech and the ER nurse? I think not. And do they justify a paycheck 10 or 20, or even 50, times as much? Not in my opinion.

I don't favor huge salaries for anyone who does not make or do something that benefits others. I am a football fan, but I don't favor a minimum salary of $850,000 for first-year NFL players. I know lots of good ex-college ballplayers who would play just as well for less.

Healthcare executives aren't the only ones being paid too much in our society, but it is particularly disturbing in our business, where the executives are not involved in the primary process of taking care of people and whose historic legacy is attracting people who want to help people, not make money. Bottom line is that in healthcare, the people at the top need to be paid LESS, and the people down below need to be paid MORE.

Changing the Corporate Structure

There are about 9,500 employees in our company, but how many of them are directly or indirectly involved in patient care is not clear. It seems to me that over the years there has been a significant increase in administrative positions with little, if any, increase in clinical spots.

I understand that there has been considerable increase in the complexities of managing a healthcare system, but I wonder if there are areas that could be reassessed. If we really do need to reduce staff, perhaps those reductions would be better coming from nonclinical areas.

When I opened my office, the hospital had one administrator, one DNS, and one executive assistant. Things worked incredibly well. When I became a founding member of the health system medical group there was a CEO, a CFO, and four VPs. Today, this company has 32 VPs, seven of whom are physicians, none of whom are active clinicians, and of course, every VP has a staff.

With all due respect to these VPs and staff members, is it not time to reconsider this administrative structure? Might there be some economies here that would not negatively impact on the care we provide?

Sizzle Versus Steak

Over the last 10 years, I have watched this company invest in every new piece of technology that comes along and build lavish buildings that look more like hotels than they do medical clinics.

We bought a very expensive electronic medical record (EMR) system very early in the process, and, because we were early, we spent even more money fixing glitches and inadequacies. We now have an EMR that works relatively well but is still very cumbersome and costly. It has some costly bells and whistles we don't even need. Clinically active physicians had almost no input into this process, by the way.

It seems to me that we have every new "toy" out there, some of which have been great help for patient care, some of which are seldom used and are of questionable benefit.

And the buildings. Our newest medical clinics and our newest hospital are architectural masterpieces—beautiful lobbies, elegant grounds, striking artwork.

But as the saying goes, people don't come for the sizzle, they come for

See "Crisis" page 7

Crisis from page 6

the steak. They don't go to a restaurant because the décor is beautiful. They go because of the great food—and the great service.

And that's even more true for healthcare. People don't go to a physician or to a hospital because of the stylish buildings or the manicured flower beds. Nor, frankly, do many of them go because the hospital has the newest surgical robot or the most sophisticated EMR.

Why do people come to a physician or to a hospital? For the same reasons that you and I do—because the medical care is good and because we receive good service. And that means THE PEOPLE, not the physical plant or the gadgets.

In the Pacific Northwest, Virginia Mason is considered the Gold Standard. Their main hospital complex is old and rather unattractive. The halls are narrow and dark, the rooms are small, and the elevators are slow. But they attract great physicians, and patients travel long distances to be treated there. Why? Because the care is outstanding and the service is wonderful. Everyone there is helpful, everyone there is competent, everyone there has a smile. Years ago, Virginia Mason made their highest priority a commitment to having the best people, and they are now reaping the benefits of that wise decision.

And something to consider: The CEO of Virginia Mason is a physician.

In our system, we also have truly remarkable people who continue to provide excellent medical care and wonderful service every day. I am repeatedly impressed by how well my patients are treated, and how much they appreciate such care. No one ever tells me they love to come here because the artwork is so beautiful or because the VPs are so capable. They tell me they come back because the lady at the lab remembered them from their last visit and asked about their granddaughter, that the evening nurse offered them coffee and a foot massage, and that Genell greets them by name and with a smile before they even get their second foot into the waiting room. They say they come because "Dr. Wilson really cares about me."

It is the people who make this a wonderful place—for me and for my patients. But somehow, over the years, our leaders have forgotten this. Too often they take what our people do every day for granted, without acknowledgment or recognition. You get a birthday card every year and a pin after 5 years of service, but with the exception of a few unusual people who are most supportive of their staff members, rarely, if ever, in this organization does a supervisor just walk up to you and tell you what a good job you are doing.

I am so grateful for the wonderful people with whom I work and equally saddened by the way this company often treats them.

I spoke with one of our VPs at a meeting several months ago and told her what a great job our people do and how much we should value them. "I agree," she said. "How do you think we can make people feel valued?" I answered very briefly and I think clearly: "BEGIN BY VALUING THEM."

It is time to change priorities. Let's pay less attention to the physical plant and the new equipment and focus on what makes this place truly special: our people. Let's train our people, let's pay our people, let's support our people, and let's value our people.

A thought: rather than having the Mary and Fred Thompson X-ray Suite or the Robert James Foyer, let's ask donors to start sponsoring what is really important: our people. How about the Mary and Fred Thompson X-ray Technician Endowment and the Robert James Nursing Education Fund?

And here is the text for our next TV or newspaper spot: Other hospitals have state-of-the-art imaging systems. We do too, but we have MaryBeth, and they don't."

Blaming "Uncompensated Care"

Uncompensated care is like the word "FTE"—it sounds like a line item on a sheet of numbers, one that can simply be reduced or even eliminated without difficulty to make the bottom line look better.

But of course, that's not what uncompensated care actually is. Rather, it means the medical care we provided to people who are ill but who cannot afford to pay for healthcare. It means Fred Jones, the 56-year-old who lost his healthcare benefits when his job of 29 years was terminated and who now cannot afford to pay for office visits and medications for his diabetes, ulcerative colitis, and hypertension. It means Robert Cavanaugh, the 8-year-old whose treatment for acute myelocytic leukemia has bankrupted his family. And it means 20-year-old Mary Talbert, who is unpartnered, unemployed, pregnant, and cannot afford prenatal care, putting herself and her baby at increased risk.

It's easy to reduce or even cross out a number in a column of numbers, but can you really say no to Fred, to Robert, and to Mary face-to-face?

Of course we must improve our healthcare system, increase personal responsibility, address abusive behavior, and focus on proven preventive interventions, but, in the end, can we really deny basic healthcare to our brothers and sisters?

I for one cannot. It has been estimated that increasing the taxes by those in the higher brackets by 5% would pay for all "uncompensated care." Am I willing to tolerate a 5% tax increase to achieve that goal? I am. I know how fortunate I have been, and I know well that there but for the grace of God, goes—me.

To blame our budgetary crisis on uncompensated care just doesn't pass the sniff test. Not the way our society spends money. We cannot blame the poor and the sick for our problems. They have more than enough problems already.

See "Crisis" page 8

Crisis from page 7

And Where Are the Physicians?

I received such a poor response from my physician colleagues to my email that I sent another one to physicians only (see Sidebar 2 - page 10). Again the response–or lack thereof—saddened me. A few supportive emails, a few critical and thoughtful: not realistic, not addressing the real problems, not going to happen, and more than 200 sounds of silence. This from a group of physicians who produced 100+ emails when there was a minimal change in the way that patient satisfaction data was collected.

What do I make of that? I believe this response—and we must call it the lack of response—reflects what has become a typical physician response to the important healthcare issues: Let me do my job and take care of my patients. I don't have time for that other stuff.

My father was a surgeon, a very good one and a very hard-working one. He never got involved in nonclinical aspects of healthcare, and when as a medical student I asked him why, he honestly answered that he was too busy taking care of patients and never thought there would be any problems with "the other stuff."

Well, sorry, Dad, while you and your colleagues were taking care of your patients—and doing a great job I should add—the suits, some physicians, some not, were taking control. It was so incremental that you didn't see it coming, and I understand that. Now 96, my father recently told me, "We should have paid more attention to what was going on around us."

But my generation of physicians has done no better. We have been working hard taking care of patients while a new generation of MD and nonMD suits have taken even more control and have gained more power. We have to pay physicians to serve on committees, and our Executive Committee cannot find volunteers to put on a ballot, so that many of the current members aren't able to leave.

And now is it too late? Our CEO is not a physician. We have two physicians on our 12-person Board of Directors. Almost all of our VPs are not physicians. Yes, we have physician administrators, but they are nonclinicians who no longer even pretend to represent me. As a prior Medical Director said when I asked for more support on a project, "I don't see your name on the bottom of my paycheck." And he added, "The company is my patient now. You are just a random aging cell."

What Needs To Be Done

As I said, I consider myself to be an optimist, someone who is part of the solution rather than part of the problem. So I write to you not to complain about what is wrong but to ask for your support to make things right.

Nor do I like the concept of our healthcare system being "broken," because that implies it cannot be fixed. I prefer to say that the current healthcare system is "not doing well," which means that we as physicians must work together to do what we do best: MAKE IT BETTER.

Clearly, some major societal changes must occur to fully solve the multiple problems we now face, but I believe there are things that all of us can do right now to help.

Our local and national organizations are not the answer. They have been too busy with turf battles and their own well-being to address key healthcare issues. When is the last time the American Medical Association asked you what was important to you?

No, the solution, my friends, is us. The docs in the exam rooms, the foot soldiers in the trenches.

I do not propose that we take over the healthcare system. That's a full-time job I don't want. But we physicians need to step up and demand a seat at the table, and regain some of the power and influence we once had. That means we need to devote more of our time and more of our energy to an area that was not covered in medical school or residency: management of the healthcare system.

What Can We Do?

1. ***Start showing up at Board of Director and Executive Committee meetings and letting them know what is important to us.***

Become informed, then become involved. These decision-making people are too removed from your day-to-day work to know what you need, feel, or struggle with. If you don't state your case, don't complain when your case isn't heard.

2. ***Demand more representation on hospital and health system boards.***

It is clearly time for physicians to have more representation on these decision-making bodies. Even if it means seeing a few less patients and going to a few more meetings—something most physicians dislike. Too much goes on in these meetings for us not to participate.

3. ***Insist on more realistic salaries for healthcare executives.***

It is time for top healthcare executives to take voluntary pay cuts, and it is time for Boards of Directors to reduce compensation to high-level executives.

In the 1980's, Ben and Jerry's Ice Cream had a policy that the highest paid employee (the CEO) could make no more than five times what the lowest paid employee made, and this was subsequently raised to eight times. (This policy was scrapped when the company sold to a multinational conglomerate.)

My proposal: the CEO's salary never can be more than 10 times the salary of the lowest paid employee in the system, and everyone else is within that range.

And am I willing to take a pay cut to save jobs of important co-workers? Yes, I am.

4. ***Become more involved in the planning of our hospital and systems, in terms of new equipment and new***

See "Crisis" page 9

Crisis from page 8

buildings.

We know what we need—and what we don't need. We need equipment that will help us take better care of our patients, and we don't need stained glass windows in the hallway. Demand the best tools and speak out against unnecessary expenditures.

5. ***Support the workers who stand by us every day.***

These are well-trained and hard-working people who work WITH us, not FOR us, and we could not do our jobs without their help and support. They are overworked, underpaid, and not adequately appreciated. We need to demand that the company take better care of its workers—and we need to be better to them too. Let's stand up for them, and let's remember to thank them.

6. ***State with certainty that providing healthcare to all is a basic premise of a compassionate society.***

Let's not blame the poor or the ill—they chose to be neither one. Our society has ample resources to provide capable and kind care to ALL of us. Let's just allocate those resources appropriately to do so.

7. ***Strive for all legitimate efficiencies in healthcare.***

We see waste every day—mass mailings to employees that could be done by email, unnecessary lighting, repetitive or nonindicted testing, inefficiencies in ordering supplies, too many meetings. The healthcare system didn't need to worry about such matters previously. Now we must.

8. ***Make certain our patients gain a better understanding of the healthcare crisis and what they can do to help.***

I don't offer information, but I am now more willing to spend a few minutes providing information and answering questions when I am asked. They are the customers, after all, and they deserve to know the product. They also need to become advocates and demand the very best of care and service.

9. ***Learn more.***

Particularly with the Internet so available, find some time to read about areas of healthcare systems you might not yet understand. If such exposure piques your interest, take a few classes. And if it really excites you, consider a degree in healthcare management.

10. ***Maximize revenue.***

Truly successful companies do not succeed by reducing costs. Rather, they do so by increasing revenue. I believe we are leaving money on the table and can do a better job in this area.

First of all, we can make certain that our billing and coding is at optimal levels. Primary care physicians are notorious undercoders, and that needs to stop.

Second, we can look at some of the higher paying elective areas of medicine that are now being primarily captured by other entities: We should be doing cosmetic surgery and other elective procedures here, and I am all for a concierge service for people who want and can afford it.

We should make our hospital pharmacies competitive with commercial pharmacies in the community. We also need to get more actively involved in the business of providing medical equipment. I sign forms for such equipment every day, all provided by for-profit companies, some of which are as far away as Tennessee and Florida. We can probably provide this service to our patients more economically and more efficiently—and also make some money. We need to keep everything as much as possible, we need to keep profit-making interventions "in house."

And of most importance, it is time to restore the primacy of the physician in healthcare. Only with our commitment and our leadership can a kind, caring, and efficient healthcare system be established, nurtured, and maintained. It is now our time.

Closing Statement and Challenge

I feel overwhelmingly privileged and blessed to have been a physician since my medical school graduation in 1975. It has been a wonderful and inspiring experience.

I have a wonderful job.

I have impressive and appreciative patients.

I have dedicated and kind co-workers.

I am so privileged and so grateful.

And even with the multiple concerns and issues I have, and even with all the mistakes that have been made, I love this company. I want to see this company succeed, prosper, and be a force for good in our community.

This company and the entire healthcare system is composed of many players of diverse talents, skills, and interests. Lots of people are needed if the team is to be successful. But physicians are the most important players on the team. A little out-of shape, perhaps, a little hard to coach, not always the easiest to get along with, but when ready to play, still the most important players on the team, still the ones who can make the difference.

I cannot stand on the sidelines and watch this vital game be lost. I am strapping on my helmet and getting on the field, and I shall do my best to win this thing.

Are you with me? I sure hope so.

Sidebar 1: Letter To My Co-Workers

Hear, hear for the new buildings and the exciting new equipment, but what has always been special about our company is our people. We have special people.

I have been a physician here for 30+ years, I have been a patient, and I was the anxious husband when my wife had surgery, the anxious father when my son had surgery. I have always been impressed and pleased by the technical expertise of our employees, but even more by their compassion, their kindness, and

See "Crisis" page 10

Crisis from page 9

their warm hearts.

It saddens me to think that we may lose 350 good and dedicated colleagues. We need to do everything we can to increase revenue and reduce expenses such that we can keep our wonderful workforce intact.

I understand we are in a budgetary crisis now, but I cannot make peace with losing good people or the impact that losing their jobs will have on them and on their families.

First of all, I request that we make a strong effort to maximize revenue in every area of the organization. I don't believe we have done that yet.

Second, I propose that all higher-level staff members, starting with our chief executive officer and our vice presidents, take a 10% voluntary pay cut. That won't solve the problem long-term, but it will at least address the realities of this acute budget crisis and prevent the need for termination of 350 of our colleagues.

And am I willing to take a voluntary 10% reduction in my pay to save 350 jobs? Yes, I am.

I firmly believe that only a few people come to us because of the futuristic machinery and that almost no one comes because we are "better connected." They come because of our people, they receive exceptional care—because of our people, and they return because of our people. I am privileged to work with these people, and I am standing in support of them today.

Together, we can fix this. Together, we are a great company. Together, we can do anything.

Thank you for the wonderful and important work you do.

With my best wishes,

Richard E. Waltman, MD

Sidebar 2: Letter To the Physicians

To my physician colleagues:

Recently, in response to an announcement from the administration that they were going to lay off 350 (or more) employees, I sent an email to all employees suggesting we strive to increase revenue, search for nonhuman cost savings, and that senior leadership take a voluntary 10% pay reduction.

I have received close to 300 responses, almost all of them supportive and positive.

But I have heard very little from physicians, and I am asking myself why.

Do you agree with my proposal? If so, I'd like to hear from you.

Do you disagree with me and support the administration's proposal? Fine, but I'd like to hear from you, too.

Or are you choosing to sit this one out, feeling it does not concern you? If so, may I suggest you are mistaken?

First of all, these are not 350 FTE; rather, they are 350—or more—of our colleagues who work by our sides every day. This will have a devastating effect on their lives and the lives of their families. As caring physicians, we must feel their pain. Further, not having them will have a negative impact on our workplace—things will not go as well for us or for our patients.

Moreover, this proposed action will not solve our financial problems; it will only buy some time, perhaps just a few months. More cuts will come, and what makes you think physicians will not be targeted?

Perhaps we shall lose benefits, perhaps our productivity requirements will be increased. Or perhaps instead of the voluntary reduction I proposed, we will be given involuntary pay cuts. (And perhaps the less "cost-effective" of us will be terminated as well.)

Our physicians cannot be nonplayers in this vital game. After all, we are the real revenue source. No physicians = no patients = no revenue. Therefore, we DO have power, but power is not given, it must be taken.

It is time for our physicians to come together, stand together, and do what is right for our company, for our co-workers, and for our patients.

We can demand more efficiency while insisting we not lose clinical and support workers. We can demand more involvement in the purchase of equipment and in the development of sites. We can go on record that we believe that the primary reason that patients come to us is because of our people, not because of a beautiful waiting room or futuristic machinery and that we, therefore, stand solidly in support of our people. People—workers and patients—MUST come first.

And we can offer to voluntarily reduce our salaries and demand that the senior level people in the company do as well.

I am not proposing an uprising against the administration. They are good people and they are trying to do the right thing.

Rather, I am suggesting we step forward and work with them to achieve effective and ethical solutions to our problems. I am suggesting we step forward in support of the people who matter most—our co-workers and our patients.

I look forward to your comments. ■

Reprinted from Modern Medicine, 9/25/11

Even in changing times, MultiCare remains committed to the community and our patients

By MultiCare Medical Associates Leadership

MultiCare Health System has been an integral part of Pierce County for nearly 130 years. In that time, we have evolved from a community hospital with fewer than 20 beds on Starr Street in Tacoma to an integrated health care delivery system, partnered with physicians, in multiple clinics spanning the South Sound.

In that time, medicine has advanced too. Diseases that used to challenge our doctors now are conquered with the aid of modern treatment and technologies.

Those amazing advances came because of the visionary leaders who forged this health care system in our area. They sought out cutting edge therapies, tracked down revolutionary medicines and recruited top physicians to our community.

They were able to do that because MultiCare Health System, under continuous leadership by a board of community volunteers, stewarded the financial security of the organization. As a result, MultiCare is one of the healthiest systems in the state and is able to reinvest in the communities we serve to make sure our citizens have access to the right care, at the right time, close to home. MultiCare also has invested in a robust electronic health record, increasing efficiency and adding layers of safety. That system was implemented with clinically active physicians playing a major role. As a result, we have one of the highest rates in the country of physicians using the electronic record. Thanks to the leaders in our organization we are a reliable destination for health care – a place with the latest treatments, compassionate employees and healing facilities.

Much of that is thanks to our employees - from the kitchen staff to the x-ray technician to the billing specialist to the primary care physician - who we compensate at a comparable level to other similar organizations. Our workers make, on average, $66,000 a year, making MultiCare a primary source of family-wage jobs in this community.

Paying competitive wages ensures that we attract and retain the amazing workers who make MultiCare a great place to seek care and a great place to work. It also ensures outstanding leadership. Many of the leaders have clinical backgrounds and keep a connection to the care we provide. Nearly half of the physicians who serve MultiCare as vice presidents maintain active clinical practices. MultiCare's chief executive officer, a registered nurse with decades of clinical and leadership experience, manages one of the most complex organizations in the state. MultiCare also is the largest employer in Pierce County. Her compensation for 2010 was $1.8 million, in line with her peers in the state and around the country. Her expertise and management have allowed MultiCare to thrive and expand to communities such as Puyallup and Covington that previously had fewer options for health care.

"Health care is changing and we must change with it."

Still, we recognize it's a tough time in health care, with many forces outside our control. We are facing major cuts in reimbursement from Medicare and Medicaid, as are all health systems across the country. We also are seeing more patients seeking health care who cannot pay. Our charity care and uncompensated care amounts have increased 73 percent in the last three years. Our dedication to serving everyone who comes to us for care remains unwavering. As a mission-driven organization, we will continue to treat patients regardless of their ability to pay.

In the past few years, MultiCare has worked hard to weather the faltering economy and reduced reimbursements, implementing cost-savings programs across our health system. During the summer it became clear to us that we needed to take immediate action to re-size our organization in response to current realities.

Health care is changing and we must change with it. In October, we re-aligned the size of our work force to meet the realities. We took care to minimize the impact on our workers' lives. Most of our job reductions came from voluntary resignations and the elimination of unfilled positions. About 318 workers volunteered to leave the organization. In the end, we trimmed 561 position from our work force of 9,400 and 76 of those were through involuntary separations.

During our work force reductions, we also worked hard to preserve our patients' experience. Many of the reductions came from business support and service positions rather than direct care positions. We also decreased the number of managers.

Our work to lower the costs of providing care to this community will continue. We are committed to ensuring that we are around for the next 130 years to provide the care that people in the South Sound have come to expect. ■

IN MEMORIAM

WAYNE W. ZIMMERMAN, MD

1919 - 2011

Dr. Wayne Zimmerman passed away October 24, 2011 at the age of 91.

Dr. Zimmerman received his medical degree from Northwestern University Medical School in 1944, completed an internship at Cook County Hospital and orthopedic residency at Northwestern University.

He moved to Tacoma in 1952 where he practiced orthopedic surgery for more than 30 years, retiring in 1984.

Dr. Zimmerman served as President of the Pierce County Medical Society in 1969. He was a member of the Pierce County Medical Society and Washington State Medical Association since 1953.

PCMS extends sincere sympathies to Dr. Zimmerman's family.

Wayne Zimmerman, MD

The Health Status of Pierce County

by Anthony L-T Chen, MD, MPH

2011 Influenza Update

Anthony Chen, MD

The Tacoma-Pierce County Health Department staff still has fresh memories of the H1N1 influenza pandemic from 2009-2010. We learned some valuable lessons in organizing the community, getting the message out and raising awareness about this serious illness that is often dismissed as a mere nuisance. We are always preparing to respond to the next pandemic, while continuing to promote education and immunization that are key to disease prevention.

Influenza is not the common cold. Some years, more than 50,000 people die from the disease in the United States alone. It can bring down even the healthiest person, but is especially dangerous for the young, old, pregnant, and those with coexisting medical conditions. Creating high levels of influenza vaccination will help slow transmission by reducing circulating levels of virus and helping to protect the most vulnerable members of the community who cannot be vaccinated.

There are new developments in the influenza vaccination this year that we hope will lead to a greater rate of immunization and more effective community immunity. This year's vaccination contains the H1N1 strain that caused so much illness in 2009. The CDC now recommends that everyone over the age of six months gets vaccinated. The new recommendation for vaccinating children is partly to address their role in transmission. Not only do children get sick with the flu, they are very effective at spreading it. By vaccinating them, we can help prevent the flu from traveling from child to child, from classroom to classroom, from school to home, and from younger to older generations. We will prevent rapid spread and also protect vulnerable younger siblings, parents, or grandparents. Remember that children under 9 years of age need two doses at least a month apart if they did not receive any doses of flu vaccine last year.

"The CDC now recommends that everyone over the age of six months gets vaccinated."

In addition to the standard shot (trivalent inactivated vaccine), this year we are encouraging the use of live, attenuated intranasal vaccine (FluMist®, MedImmune). The nasal spray is quick to administer and particularly useful in children and those scared of needles. We use nasal spray in school vaccine events and can quickly and easily vaccinate large numbers of children. Remember that the nasal spray is indicated for those aged 2 through 49 years old and is contraindicated in those with allergy to eggs, gentamicin, and any chronic health condition. There is also a new vaccine for patients 65 and older. The high dose influenza vaccine (Fluzone® High-Dose, Sanofi-Pasteur) has four times the strength of regular flu vaccine and has been shown to create a stronger immune response in the elderly although there is no data showing that translates into a decrease in influenza disease or complications. Our arsenal against flu is steadily growing. Experts are awaiting the day when we will have a long-term universal flu vaccine that does not have to be given annually.

You may have heard of an article recently published *The Lancet Infectious Diseases* (www.thelancet.com/journals/laninf/issue/current) that provides a review of existing flu vaccine efficacy studies. The review reported that flu vaccines can provide moderate protection against confirmed flu illness, but that protection can be lower – sometimes substantially so – in some flu seasons. The authors highlight the importance of the continued use of current flu vaccines. Flu vaccinations are not perfect, but are effective, with the effectiveness varying from year to year depending on how well the vaccine matches the circulating virus. Providers should remain confident in recommending influenza vaccination to their patients, but this does highlight the need for new and better vaccines. However, new vaccine technology on the horizon is likely to address this need over time.

As medical professionals, we

See "Influenza" page 14

Influenza from page 13

should be advocating for influenza immunizations to our patients, but we must practice what we preach. The selfish reason is that during the cough and flu season, we will be less likely to get sick. The public health reason is that we will be less likely to spread influenza to our patients and office staff. In general, Pierce County providers are doing exceedingly well. According to the Washington State Hospital Association, influenza immunization rates for our county hospitals range from 83 to 93%. At the Health Department, we encourage vaccination and provide it free to all staff. If a flu shot event is not on your office's calendar, think about planning one.

Our county's population lags significantly behind the impressive rates of hospital staff. Although data suggest that following H1N1, vaccination rates in high risk groups such as young children and pregnant women have increased, last year, overall less than 40% of Pierce County residents were vaccinated. This is a 9% increase from just four years ago, but still leaves a majority of the community vulnerable to a widespread influenza.

Throughout the course of the season, we will communicate with you about the current rates of influenza in our county and we hope they will be low. Email me at director@tpchd.org if you would like to be on the distribution for the flu update reports. It is nearly inevitable that flu will visit Pierce County this year, but the magnitude of its effects is something we can influence. ■

Pierce County Project Access

by Leanne Noren, Executive Director

Pierce County Project Access: Patients Giving Back

Leanne Noren

"Volunteers don't get paid, not because they're worthless, but because they're priceless." ~ Sherry Anderson

A key element of Pierce County Project Accesses success lies within our Patient Rights and Responsibilities. Those statements are the boundaries of the program for the patients. One of those statements plants a seed with our patients about showing appreciation for the services that have been donated to them by participating in an appropriate volunteer opportunity within their community.

Recently we have had an opportunity to bring together a group of patients who are working hard to show appreciation to the PCPA volunteers. They are putting together a plan for how they, with the help of PCPA, can show thankfulness and gratitude to all of the physicians and other providers who have so generously donated care.

Showing gratitude is a value we hold dear at PCPA because it is the only form of payment our volunteers receive. We strive to be intentional about saying "thank you" and encourage our patients and their loved ones to send thank you notes.

As we near Thanksgiving Day, we want to say thank you to you, our network of providers which is now slightly over 500! In November you will see an advertisement in *The News Tribune* which will publicly recognize your contribution of donated care which is nearing $950,000 for 2011. Incredible!!!

Thank you for paying it forward. For giving when you knew you would not get anything in return. On behalf of more than 300 patients who have received care in 2011 - THANK YOU! ■

WSMA Legislative Summit, January 26; Your Profession, Your Patients, Your Voices

The Washington State Medical Association's 2012 Legislative Summit will be held on Monday, January 23 at the Red Lion Hotel in Olympia. Speakers will include Republican Governor Candidate Rob McKenna and Democratic Governor Candidate Jay Inslee. We envision a lively and spirited discussion of health care issues.

Rob McKenna, Attorney General

Jay Inslee, Congressman

The agenda for the day includes continental breakfast followed by the program including both gubernatorial candidates and a briefing on the WSMA's priority legislative issues. Lunch is provided prior to attendees boarding buses, which run every 15 minutes, to go to the hill to meet with their representatives and senators. Handout materials will be provided to leave with the legislators after the briefing. Afternoon briefings are scheduled with Mike Kreidler, Washington State Insurance Commissioner and Jonathan Seib, the Governor's Health Care Policy Director.

The program is free for WSMA members and the importance of getting to know you legislative leaders cannot be emphasized enough. During times of rampant budget reductions and profession changes, physician voices are crucial.

Please register today at wsma.org or by calling WSMA at 1.800.552.0612. ■

Washington State health facts

And just how does Washington State compare to other states and to the U.S. collectively when it comes to health? Here are some interesting statistics taken from statehealthfacts.org:

- The U.S. population is 303,343,300 and 6,574,400 of those people live in Washington State.
- 15% or 992,100 of Washingtonians live in poverty. Nationally, 20% are poor.
- $58,964 is the median income of Washington citizens, while nationally it is $49,945.
- 9.1% of our population is unemployed, both state and nationwide.
- 1,075,482 residents received food stamp assistance as of July, 2011.
- Washington's health care spending per capita is $5,092 while it is $5,283 nationally.
- The average employee contribution for family premium for health care is 26% statewide and 27% nationally.
- Washington's uninsured totals 838,600 or 13% compared to the national uninsured total of 17%.
- 18% of Washington citizens receive Medicaid assistance and 17% are Medicare beneficiaries, compared to state percentages of 20% and 15% respectively.
- 29.5% of Washington's children are obese compared to 31.6% nationally.
- 12% of Washington's adults are disabled.

State health facts website compares state to state or state to nation on numerous categories such as demographics, economy, health costs, health coverage, health status, HIV/AIDS, Medicare and Medicaid, providers and service use and women's health. ■

COLLEGE OF MEDICAL EDUCATION

CME at Whistler - Save the Date!

CME at Whistler is a great program that combines family vacationing and skiing in a resort atmosphere, along with ten hours of Category 1 continuing medical education.

This year's Whistler CME is being held at the beautiful Fairmont Chateau Resort. With true ski-in and ski-out convenience, the classic elegance of this landmark Whistler hotel offers a modern alpine setting for unsurpassed guest service, exceptional dining, full resort amenities, and a world class spa.

Baiya Krishnadasan, MD is the program director and has lined up a great list of speakers to ensure this course meets your educational standards, combined with quality skiing and family vacationing.

You should have received a program brochure in the mail. You can also view it on our website, www.pcmswa.org. If you have any questions, please call the College of Medical Education at 253-627-7137. ■

Continuing Medical Education

CME at Hawaii April 16-20, 2012 - Make plans now!

The College of Medical Education has selected the site for our 2012 *CME at Hawaii* program – the **spectacular Westin Maui Resort & Spa on sunny Ka'anapali Beach located on Maui's west shore. Ka'anapali Beach has been voted as the #1 beach in America!**

The conference will be held **April 16-20, 2012**. Plan your Hawaii trip now to get in on the fabulous deals we have negotiated and guarantee a flight to paradise!

The Westin Maui Resort & Spa offers endless activities. They host a 15,000 square foot luxury spa and modern gym, 85,000 square foot aquatic playground connecting five separate pools with a 120 foot waterslide, great restaurants, cultured entertainment, something for everyone. Please preview this fantastic facility at www.westinmaui.com.

This course is designed for practicing primary care providers, practicing internists, physician assistants and specialists interested in expansion of their primary care knowledge and skills. The curriculum will feature a diverse selection of up-to-date practical topics in primary care medicine. Our approach is to combine the best evidence-based medicine with the day-to-day realities of patient care.

We have negotiated exceptional rates for airfare, car rental and rooms. Room rates start at $249 and are nearly 50% off the rates offered by the resort. Please book early to take advantage of these reduced rates through Tammy Langlo with Thomson Travel and Cruise. Her contact information is 253-627-8221 or email her at tammy@thomsontvl.com to start your planning now.

We hope you will plan to join your colleagues and their families next spring for our *CME at Hawaii* program. The conference brochure will be mailed soon. ■

Applicants for Membership

Colin Y. Daniels, MD
Psychiatry
Sound Family Medicine
10004 - 204th Ave E, Bonney Lake
253-848-5951
Med School: Uniformed SHS
Internship: Walter Reed AMC
Residency: Walter Reed AMC

Richard R. Harris, MD
Family Medicine
St. Anthony Prompt Care (FMG)
4700 Pt. Fosdick Dr NW #102, Gig Harbor
253-853-2050
Med School: U Colorado HSC
Internship: Swedish Hospital
Residency: Swedish Hospital

Thomas K. Hirota, DO
Dermatology
Cascade Eye and Skin Centers
5225 Cirque Dr W #200, University Pl
253-848-3000
Med School: Texas College of Osteopathic Medicine
Internship: Fitzsimons AMC
Residency: San Antonio USHEC

June Kim, MD
Dermatology
Cascade Eye and Skin Centers
5225 Cirque Dr W #200, University Pl
253-848-3000
Med School: UT Southwestern
Internship: Stanford
Residency: U New Mexico
Fellowship: Stanford

Michael M. Nelson, MD
Dermatology
Cascade Eye and Skin Centers
5225 Cirque Dr W #200, University Pl
253-848-3000
Med School: Vanderbilt University
Internship: Geisinger Medical Center
Residency: Washington University
Fellowship: Washington University

Kenneth W. Sheil, Jr. PA-C
Interventional Radiology
TRA Medical Imaging
1304 Fawcett Ave Ste 200, Tacoma
253-284-0841
Training: University of Washington

Olympia A. Tachopoulou, MD
Infectious Disease
Northwest Medical Specialties
1624 South I Street Ste 405, Tacoma
253-627-4123
Med School: Aristotle University
Residency: Long Island College Hosp
Fellowship: Cleveland Clinic Foundation

Classified Advertising

POSITIONS AVAILABLE

Would you like to have fun playing with kids, while you are taking care of their medical needs? Would you like to join a family of pediatric providers that genuinely enjoys taking care of children? If you are, we're looking for a full-time PNP/ARNP to join us at the Evergreen Children's Clinic in Puyallup, WA. Experience caring for children is a plus. We have Epic as our EHR and a medical laboratory in the office that is capable of doing most basic diagnostics testing on site. The staff is wonderful to work with. If this sounds like a place you would like to work, please send your resume to sroach@evergreenchild.com or fax it to 253-848-8956.

OFFICE SPACE

Great location 13th & Union. 1,700 first floor, 800 third floor. Contact Carol 206-387-6633.

Medical office lease/sub lease. Fully furnished: St. Joseph Medical Clinic Tacoma 1,100 sq. ft. sublease $100/d. University Place 1,000 sq. ft. $1,600/m or $100/d. Contact Marlys 253-573-0460.

Office space to share. Centrally located between all hospitals in the Tacoma area. Contact Pati 253-572-7120.

MultiCare campus office space: Jackson Hall, 1400 sq ft, first floor, furnished, negotiable sublet. 253-279-4900.

Prime medical office space for rent near Good Samaritan Hospital in Puyallup. 1,900 sq. ft. Call 253-841-4341.

Personal Problems of Physicians Committee

Medical problems, drugs, alcohol, retirement, emotional, or other such difficulties?

Your colleagues want to help

*Robert Sands, MD, Chair	752-6056
Bill Dean, MD	272-4013
Tom Herron, MD	853-3888
Bill Roes, MD	884-9221
F. Dennis Waldron, MD	265-2584

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