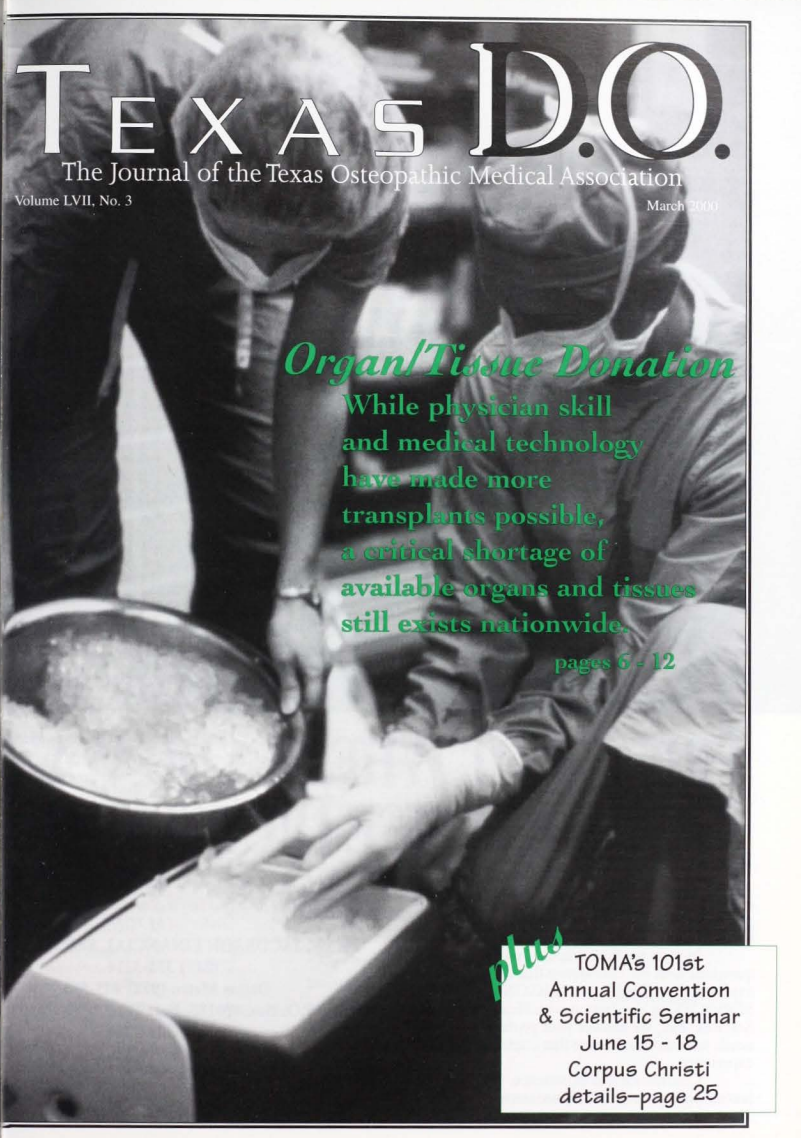
TEXAS D.O.

The Journal of the Texas Osteopathic Medical Association

Volume LVII, No. 3

March 2000



Organ/Tissue Donation

While physician skill and medical technology have made more transplants possible, a critical shortage of available organs and tissues still exists nationwide.

pages 6 - 12

plus

TOMA's 101st Annual Convention & Scientific Seminar
June 15 - 18
Corpus Christi
details–page 25

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MARCH 2000

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Inside This Issue

Articles in the ***Texas D.O.*** that mention the Texas Osteopathic Medical Association's position on state legislation are defined as "legislative advertising" according to Texas Gov't Code Ann §305.027. Disclosure of the name and address of the person who contracts with the printer to publish the legislative advertising in the ***Texas D.O.*** is required by that law: Terry R. Boucher, Executive Director, TOMA, 1415 Lavaca Street, Austin, Texas 78701-1634.

Cover Photo Courtesy of the Southwest Transplant Alliance.

CALENDAR OF EVENTS

APRIL

7 – 8

"Texas Osteopathic Medical Association House of Delegates Meeting"

Location: DoubleTree Hotel North
6505 IH-35 North, Austin, Texas
Contact: Paula Yeamans, 512-708-8662 or 800-444-8662

15 – 16

"14th Annual Spring Update for Family Physicians"

Sponsored by the University of North Texas Health Science Center at Fort Worth

Location: Dallas Southwest Medical Center
Dallas, Texas
CME: 12 hours category 1-A credits
Contact: UNTHSC Office of Continuing Medical Education
817-735-2539 or 800-987-2CME
Web site: http://CME.cjb.net

MAY

3 – 6

"92nd Annual Clinical Assembly & Scientific Seminar"

Sponsored by the Pennsylvania Osteopathic Medical Association

Location: Adam's Mark Hotel, Philadelphia, PA
CME: Over 40 hours category 1-A credits anticipated
Contact: Mario Lanni, POMA Executive Director
1330 Eisenhower Blvd., Harrisburg, PA 17111
717-939-9318; in PA 800-544-7662
FAX: 717-939-7225, E-mail: poma@poma.org

4 – 7

"103rd Annual Convention"

Sponsored by the Indiana Osteopathic Association

Location: Sheraton Hotel/Westin Suites, Indianapolis, IN
CME: 30 hours category 1-A credit anticipated
Contact: IOA, 800-942-0501 or 317-926-3009

JUNE 8 – 11

"OMT With a View: Pain Management by the Sea"

Sponsored by the Osteopathic Physicians and Surgeons of California

Location: Marriott Laguna Cliffs Resort, Dana Point, CA
CME: 20 hours category 1-A credits
Contact: 916-561-0224, FAX: 916-561-0728

JUNE 15 – 18

"TOMA's 101st Annual Convention & Scientific Seminar –The Century of Tomorrow Touching Our Communities Today–"

Sponsored by the Texas Osteopathic Medical Association

Location: Bayfront Plaza Convention Center and
Bayfront Omni Hotel, Corpus Christi, Texas
Contact: Sherry Dalton, TOMA Conventions Coordinator
800-444-8662 or 512-708-8662
FAX: 512-708-1415
E-mail: sherry@txosteo.org

JUNE 28 – JULY 2

"20th Annual Primary Care Update"

Sponsored by the University of North Texas Health Science Center at Fort Worth

Location: Radisson Resort, South Padre Island, TX
CME: 24 hours category 1-A credits
Contact: UNTHSC Office of Continuing Medical Education
817-735-2539 or 800-987-2CME
http://CME.cjb.net

JULY 27 – 30

"TxACOFP Annual Clinical Seminar"

Sponsored by the Texas Society of the American College of Osteopathic Family Physicians

Location: Arlington Hilton Hotel, Arlington, Texas
Contact: Janet Dunkle, TxACOFP Executive Director
888-892-2637

AUGUST 11 – 13

"25th Annual Convention"

Sponsored by the Pennsylvania Osteopathic Family Physicians Society

Location: Hotel Hershey, Hershey, PA
CME: 16 hours category 1-A credits
Contact: Mario Lanni, POFPS Executive Director
1330 Eisenhower Blvd., Harrisburg, PA 17111
717-939-9318; in PA 800-544-7662
FAX 717-939-7255; E-mail poma@poma.org

SEPTEMBER 22 – 24

"The Successful Osteopathic Practice: Wine Country Revelations"

Sponsored by the Osteopathic Physicians and Surgeons of California

Location: Embassy Suites, Napa Valley, CA
CME: 20 hours category 1-A credits
Contact: 916-561-0224; FAX 916-561-0728

ww.txosteo.org

ON THE WEB in March

N THE WEB is a monthly feature of the *Texas D.O.* announcing headlines and trailers of timely osteopathic news articles, pertinent information on healthcare and education, legislative updates and much more; all of which can be found on our website <www.txosteo.org>.

In Brief

Health Notes

Washington Update

TRICARE News and Other Military Issues

Texas Stars
A Listing.

People who have made pledges or have contributed to TOMA's Building Fund Campaign are known to TOMA as "Texas Stars" due to their commitment to the osteopathic profession.

Thank You
A Listing.

Thank you to "Texas Stars" who have contributed above the $1,000 donation level to TOMA's Building Fund Campaign.

For Your Information
A Listing.

Phone numbers of Federal agencies, osteopathic agencies and state agencies useful to the osteopathic healthcare community.

Your TOMA Staff and the Services They Provide

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dical Practice Issues
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dicare, Medicaid, Workers' Compensation Issues
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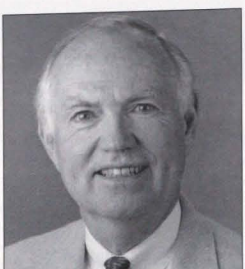


"Were it not for the ***love*** *of a young housewife, I would never have had the opportunity for my second chance.*

Imagine *what I would have missed:*

My 33rd anniversary with my wife, Karen,

Walking all three of my daughters down the aisle in marriage,

Finally, getting the sons I've always wanted after having three terrific daughters,

Holding my three beautiful grandchildren close to me,

Seeing sunrises and sunsets each and everyday,

and...

having no more bad days, ever!"

Help Us Help Ther

By Phil Berry, M.D.

It seems like forever ago. They told me I had about 3 weeks to live. My were sunken deep into their sockets, my feet were about 2-3 times normal and my abdomen was distended to about '8 months' size. My skin was a co nation color of ashen gray and pale yellow, the color of death. I was dying...

Three years before, while operating on a patient in a trauma environme nicked myself through my surgical gloves and contracted Hepatitis B unknowingly gave it to my wife. She got well, but I didn't; and over the cour the next few years, I found myself in the condition described above. I had d oped cirrhosis and now liver failure and I was dying, without a chance of sur without a liver transplant.

I called Pittsburgh, the 'liver capital' of the world, and talked to Dr. Tom S who knew more about liver failure and transplantation than anyone else. He me he had helped develop a liver program at Baylor in Dallas, and he had tr a young Swedish surgeon, Goran Klintmalm, M.D., who could do my sur allowing me to stay in my home town. We made our way to Baylor an Klintmalm confirmed what we all knew - I would need a transplant for sur Using typical solutions as orthopaedists do, I said to him, "Well, let's just fi How naive, and how little I knew! I began to understand the enormity of the ation when he told me I would now have to go on 'the list.'

There are now more than 67,000 people on the waiting list, over 8,00 livers. A new name is added to the list every 16 minutes. The sad thing is that 4,500 will die this year, not because we don't know what to do, or how to but because we don't have enough organs. Before you go to sleep tonight, an 12 people will have died, needlessly, because no one gave them a chance wit gift of life. Over 140 million people worldwide now have Hepatitis C, the f growing reason to have a liver transplant, and there are over 4 million in the U States. In the next 10 years, the need for liver transplant will go up over 585

I waited, and waited, and got so weak I could not even turn over in be myself. A 30-year-old housewife from Brazoria, Texas, collapsed w bleeding aneurysm, and she had made a very important commitment to h and her family prior to her death. She had shared with them her desire to someone else in the event she could ever do so, and she gave me her liver. be forever grateful...

Three years ago, as I served as president of the Texas Medical Associatio developed an organ donor awareness program called *Live and Then Give* program was designed for the physician members of TMA, their spouses, and patients and we asked them to be leaders, to commit to being organ donors, a show others the way. Thousands signed donor cards and the program rec several state and national awards. The American Medical Association has ad the program and it has become a national effort. Several of the states are spreading the word, and we hope we can begin to make a difference for the the waiting list.

Would you, the osteopathic physicians in our state, join us in our conti effort to increase organ donation in Texas? I would like to encourage you just that. We can supply you with the necessary information to produce rials specific for your membership along with a 'how to do it' manual jus the one we used so successfully with our spouses (TMA Alliance). We ca provide you with enough encouragement to make the program as successf you as it was for us.

Don't you think all the patients on that waiting list should have the chance I received? Won't you please help us help them?

Transplant Milestones in the United States and Canada

esearchers began experimenting with organ transplantation on animals and humans 18th century. Over the years, scientists experienced many failures, but by the mid- entury, successful organ transplants had been performed. Transplants of kidney, hearts, pancreases, lungs, and heart-lungs are now considered an accepted part of al treatment.

the last 20 years, important medical breakthroughs such as tissue typing and nosuppressant drugs have allowed for a larger number of organ transplants and a r survival rate for transplant recipients. The most notable development in this area ean Borel's discovery of an immunosuppressant drug called cyclosporine in the 970s. This drug was approved for commercial use in November 1983.

nfortunately, the need for organ transplants continues to exceed the supply of organs. s medical technology improves and more donors become available, thousands of e each year will live longer and better lives because of organ transplantation.

Milestones

First successful kidney transplant*
Dr. Joseph E. Murray
Brigham & Women's Hospital, Boston, Massachusetts

First successful pancreas transplant
Drs. William Kelly and Richard Lillehei
University of Minnesota, Minneapolis, Minnesota

First successful liver transplant*
Dr. Thomas Starzl
University of Colorado Health Sciences, Center, Denver, Colorado

First successful heart transplant
Dr. Norman Shumway
Stanford University Hospital, Stanford, California

First successful heart-lung transplant
Dr. Bruce Reitz
Stanford University Hospital, Stanford, California

First successful single lung transplant
Dr. Joel Cooper
Toronto Lung Transplant Group, Toronto General Hospital, Canada

First success double lung transplant*
Dr. Joel Cooper
Toronto Lung Transplant Group, Toronto General Hospital, Canada

First successful living-related liver transplant
Dr. Christoph Broelsch
University of Chicago Medical Center, Chicago, Illinois

First successful living-related lung transplant
Dr. Vaughn A. Starnes
Stanford University Medical Center, Stanford, California

transplant was the first of its kind in the world

United Network for Organ Sharing)

Donor Cards Available from TOMA

Live & Then Give, an organ donor awareness campaign, was begun in 1997 as a joint project of the Texas Medical Association, Texas Medical Foundation, TMA Alliance, and the Texas Transplantation Society. The impetus for the program was Dr. Phil Berry, then president of TMA. Dr. Berry received a life-saving liver transplant in 1986, and has since become a nationally-known proponent of organ donation.

Since its inception, *Live & Then Give* has focused on encouraging both the physician audience and the general public to sign a donor card and talk to their family about their wishes to be a donor. TMA produced a 10-minute video featuring Dr. Berry that was distributed to county medical societies, and a manual outlining how to conduct a *Live & Then Give* campaign at the local level was also created. Public service announcements have been aired on radio and TV, and TMA continues to receive calls from the public and from physician offices requesting materials and information.

During the past two years, more than three million donor cards have been printed, and cards are now available free of charge for distribution in physician offices and other public places. The cards are available in both English and Spanish, and may be obtained by calling Mary Waggoner at 512-708-8662 or 800-444-8662; or by e-mail at <MaryW@txosteo.org>.

Do You Have What it Takes to be an Organ Donor?

"Even if you have signed a donor card or have a driver's license indicating your wish to donate, your family's consent is still necessary..."

It's such a simple question, yet such a personal decision that most people never do the one thing that ensures their wishes about donation will be honored. The most important step in becoming a donor is making sure your family members know that's what you want. This is the most important step because the donation system in this country is based on altruistic motives and on public trust.

So, at the time of your death, if you are medically suitable to be a donor, your family will be approached and asked for its consent. If you have told your family this is what you want, family members will be able to peacefully consent to donation, knowing they are carrying out your wish. If, however, you've never talked with your family members about donation, they may believe this decision is too difficult to make in the midst of such a difficult situation. Even if you have signed a donor card or have a driver's license indicating your wish to donate, your family's consent is necessary because of the desire to keep public support of the donation system. Can you imagine, for example, how a family might react if their loved one's organs are recovered for transplant without their consent?

Although you may be concerned that your family members do not support donation and, therefore, would not consent to the donation of your organs, experience shows that family members carry out the wishes of their deceased loved ones in most cases, even if those wishes are contrary to their own.

A simple conversation with your family could save someone's life. Dallas' Jennifer Cox underwent a kidney transplant at Methodist Hospital and has since met Beverly Jones, the wife of her donor. They often speak publicly about how donation has impacted their lives. Beverly recalls that after her husband of 29 years died, she donated his organs, because remembered him telling her that was his wish, back when they were dating.

Every day people get transplants. Dallas' V Holland is alive today because someone like decided to donate, and shared that decision family members. Ms. Holland had a heart tr plant at Medical City Dallas Hospital and is back to her active life, raising two children, vo teering at her church, and much more. She play her church's flag football team that beat a tea media personalities at softball!

These are just a few reasons to think about te your family you want to be a donor. And if you an organ transplant, you'd hope a lot of people had shared this important information their family members.

If you need a transplant, some of the wo best transplant hospitals are in Dallas. B University Medical Center, Children's Me Center, Medical City Dallas, Meth Hospital of Dallas, Parkland Health Hospital System, and St. Paul Me Center all have outstanding transplant survival rates. And Southwest Trans Alliance, Dallas' organ donation age consistently ranks among the nation's best in organ procure But that medical expertise helps only if families take time to about their wishes regarding donation.

If you have the heart to be an organ donor, make sure family knows you're a lifesaver. If you haven't told your fa you want to be an organ donor...you won't be.

For more information call Southwest Transplant Allian 214-522-0255 or visit its Web site at www.organ.org.

Waiting for an Organ – National Figures –

of January 30, 2000, the United Network for Organ (UNOS) national Patient Waiting List for organ trans- cluded the following:

transplant	44,117
ransplant	14,554
as transplant	829
as islet cell transplant	182
-pancreas transplant	2,148
ne transplant	124
ransplant	4,076
ung transplant	221
ansplant	3,600

***67,491**

ill value is less than the sum of the organs. This is due to the fact that ents list for multiple organs. These patients are counted under each are waiting for, but only once in the overall. This is updated weekly.

Texas and Oklahoma Figures

OS has divided the U.S. into 11 geographic regions for tation purposes. Texas and Oklahoma make up Region 4. cember 31, 1999, the number of Texas/Oklahoma patient ons on the national transplant waiting list is as follows:

transplant	3,006
nsplant	803
s transplant	40
-pancreas transplant	98
e transplant	3
ansplant	404
ng transplant	7
nsplant	175

4,536

list is updated monthly.

Number of Transplants Performed in 1998*

pancreas	973
	(4,153 were living donors)
s	248
	4,487
ng	47
	2,345
	862
	69

21,197

UNOS Scientific Registry data as of September 14, 1999. Double ole lung and heart-lung transplants are counted as one transplant. t to change due to future data submission or correction.

FACTS

ABOUT TRANSPLANTATION IN THE UNITED STATES

A New Chance at Life

Provided by the Gift of Organ, Tissue Donors

By Emily Palmer
Communications Division
Texas Department of Health

One patient suffers from end-stage renal disease, undergoing dialysis, life on hold. Another struggles to survive daily with a severely damaged heart. A child faces early death from leukemia. Each of these people waits, often with diminishing hope, for a potentially life-saving transplant; kidney, heart, bone marrow. Up to 25 different organs and tissues can be donated, some allowing for multiple transplants.

The heart, kidney, pancreas, lungs, liver and intestines can provide new life for the ill.

Donation of tissue can include cornea, skin, heart valves, connective tissue, bone and bone marrow.

A Growing Need

The first corneal transplant took place in 1905; the first successful kidney transplant nearly half a century ago; and the first heart transplant in 1967. Yet while physician skill and medical technology increasingly have made more transplants possible, a continuing shortage of available organs and tissues exists despite efforts to increase donation. The numbers themselves tell the story. According to the United Network for Organ Sharing (UNOS), which maintains the U.S. organ transplant waiting list, more than 66,000 people currently are registered. In 1998, a total of 21,197 lifesaving transplants were performed - 5,799 from cadaveric donors and 4,274 from living donors. However, another 4,855 people died while waiting for a transplant. Every 16 minutes, a new name is added to the UNOS waiting list; and every 24 hours, 13 people die because suitable organs are not available." We need to continue to communicate the importance of organ donation," said Dr. William R. Archer III, Texas Commissioner of Health. "We need to educate ourselves and our patients universally about all aspects of organ and tissue donation and transplantation. How much better to talk about the issues during calm situations rather than in a time of crisis. We at the Texas Department of Health want to help facilitate discussion in communities".

Becoming an Organ Donor

Any person potentially can be an organ donor. The medical condition of a donor at time of death determines the organs and tissues that can be given. Once a person decides to become a donor, he or she should share that choice with family members. A person 18 or older may sign a Uniform Donor Card. For people under 18, a parent or guardian must consent. A family member should witness the decision on the donor card.

Legislative Action

The 76th Texas Legislature in 1999 worked on several transplant-related issues. Two bills became laws. Senate Bill 673 by Senator Mike Moncrief created an Anatomical Gift Education Program to be funded by a $1 voluntary check-off fee on Texas driver's license renewals. These funds will be used to educate resid about laws governing anatomical g procedures for becoming an organ, ey tissue donor or recipient; and benefit such gifts. The Texas Department Public Safety will collect funds, and Texas Department of Health will deve educational programs, with broad-ba input from interested groups. Senate 862 by Senator Mario Gallegos create 13-member Task Force to examine curr organ allocation policy in Texas develop and implement an optim policy for the state. This Task Fo includes leaders of Texas' three or procurement organizations, six physici (transplant surgeons), three patient rep sentatives, and one non-voting mem representing UNOS.

The group is examining federal gui lines established by UNOS and is look at such issues as types of organs recover patient survival rates, retransplantati rates, transportation issues, medi urgency; the efficiency of each org procurement region; waiting times at tra plant centers, standardized listing crite for transplant candidates and the need encourage organ sharing within ea region of the state. This bill also calls fo "Texas-first" policy, intending for orga donated in Texas to stay in the state, exce for organs that fall under certain pri sharing arrangements." I am quite excit about the challenge our Task Force h been presented to implement a model all cation policy for organs for the State Texas," said Dr. Phil Berry, Chair of t Senate Bill 862 Task Force. "We a working diligently to make recommend tions this summer that will refine t current system. Our Task Force unde stands that the charge before us is completely consider all factors that w produce an allocation system fair to all o citizens, one that will equalize waiti times, and to give patients the informati they need to make good decisio concerning their surgical needs. We al will make recommendations that we ho will increase the consent rate for orga donation in our state."

Approaching a Discussion on Organ Donation

Talking with patients and famil members about organ donation ma

:m difficult, especially under stressful
:uations. There are some steps physi-
ins can take to improve the experience
: families contemplating decisions about
nation.

Speak with patients about the critical shortages in organ donation and ask them to discuss organ donation with family.

Tell patients that one person can help more than 50 others, improving or even saving the lives of those suffering from organ failure, bone defects, burns or blindness.

Explain that people of all ages, races and economic backgrounds are waiting for organ transplants.

Make organ donation brochures available in your office. If requested, provide patients with additional information or resources. Designate a staff member to be the source for information.

Know your patient and be sensitive to his or her health conditions.

Assure patients and family that the quality of medical care does not change for organ donors. Let them know that organ donation is not even considered until all possible efforts to save a patient's life have failed. And assure them that the determination of death must be made by doctors who are not involved in organ transplantation.

Don't pressure patients to sign a card. If they do sign a card, however, remind them how important it is to share their decision with their family.

'ormation in this article is provided by the Texas partment of Health. Other sources for informa-n include the Texas Medical Association, Texas nsplantation Society and the Coalition on nation. For more information, contact Susan ine, TDH Bureau of Kidney Health Care, at 512-1-3126; or Emily Palmer, TDH Communications ision, at 512-458-7400.)

Why Should You "Share Your Life"?

By Ronald N. Ehrle, RN, BSN, CPTC

It is hard to believe that it has been 45 years since the first successful kidney transplant was performed in Boston, Massachusetts. Much has gone on in the world of transplants since this monumental event. Transplants of kidneys, hearts, livers, lungs, pancreases, intestines, corneas, bone, and skin are now considered an accepted part of medical treatment. Unfortunately, the need for organ and tissue transplants continues to exceed the supply.

The lack of organ and tissue donors is a national health crisis with a simple cure. The solution has nothing to do with money or legislation - it has everything to do with people. Today, more than 67,000 people in the Unites States are waiting for a life-saving organ transplant. More than 3,000 live in Texas. Every 16 minutes, another name is added to the transplant waiting list. Every 24 hours, eight people die because suitable organs are not available. Thousands will die this year due to the lack of donors. Transplantation is the only hope for these people suffering from organ failure.

Of the 2.3 million deaths that occur each year in this country, only 10,000 – 15,000 are eligible to donate organs (kidneys, heart, liver, etc.). Unfortunately, only about half of the patients who are eligible to donate organs actually do so. The primary reason more people do not donate is that their family says no when asked to donate. Surveys have shown that if family members know that their loved ones wanted to be a donor, they would follow their wishes. However, many have never thought about or talked about donation with their family.

There are many myths surrounding donation that also influence how one feels about being a donor. Some of the more common myths and the facts are outlined below.

Myth	Fact
If I am in an accident and the hospital knows that I want to be a donor, the doctors will not try to save my life.	Donation takes place only after all efforts to save your life have been exhausted and death has been declared. The medical team treating you is completely separate from the transplant team. The transplant team is not notified until your family has consented to donation.
My religion does not support donation.	All mainstream organized religions approve of organ and tissue donation and consider it an act of charity.
My family will be charged for donating my organs.	Donation costs nothing to the donor's family or estate.
Donation will mutilate my body.	Donated organs and tissues are removed surgically, in an operation similar to gallbladder or appendix removal. The donation operation does not prevent an open casket funeral.
I don't need to tell my family that I want to be a donor because I carry a donor card.	The best way to ensure that your wishes are carried out is to tell your family.

continued on next page

It is sad to think that someone might have said no to donation because of a myth. In fact, one study showed that approximately 30% of the families who said no to donation would say yes today if given another chance.

The hospital and medical community have also become more aware of their responsibility in working to help alleviate the shortage of organs for transplant. A program called Live & Then Give was created by the Texas Medical Association. It was designed to first encourage Texas physicians to become donors and tell their family. Second, it challenged Texas physicians to talk about and encourage their patients to become organ and tissue donors. National and other state medical associations have adopted this creative program. Take the opportunity to discuss donation with your patients.

The nation as a whole has also realized its responsibility in working to alleviate the shortage of organs for transplant through the National Organ and Tissue Donation Initiative. This program is designed with input from all areas of society with the hope that donation will increase 20% in a two-year period. What this means is an additional 7,500 – 9,000 people and their families will be given a second chance at life.

This initiative further strengthens the relationship between hospitals and the nation's not-for-profit Organ Procurement Organizations (OPOs). First, a hospital is now required to notify the OPO in their area any time a death occurs. This will allow the OPO to evaluate each and every death for the potential to donate. Historically, thousands of potential organ and tissue donors were missed each year because hospitals did not realize that a patient was a potential donor. Second, the patient is a suitable donor, this initiative requires that only individuals who have received extensive training in loss, grief and end-of-life decisions offer the option of donation to family members. It has been demonstrated that when families are offered the option of donation by individuals who are well informed about the what, where and why of donation, the families feel more comfortable and are more inclined to say yes to donation.

Share your life by deciding to become an organ donor – and, don't forget to share your wishes with your family.

Ronald Ehrle is the managing director of the North Texas office of the LifeGift Organ Donation Center, 1701 River Run, Suite 300, Fort Worth, Texas, and can be reached at 817-870-0060.

Why Do Families Refuse to Donate Organs?

A STUDY

Every 40 minutes, in a hospital somewhere in the U.S., a
eving family whose loved one has died unexpectedly from a
ain injury faces a decision about organ donation. Half of the
ne, this family will say no, even though most Americans say
y are in favor of organ donation. Massive public education
mpaigns have been launched to convince more families to con-
nt to donation, but new research reveals that families' experi-
ces in the hospital strongly influences their decision about
nation.

A unique study published in 1998 in the "American Journal
Critical Care" revealed major differences in the hospital expe-
nces of families who consent to donation and those who
use. The Partnership for Organ Donation and the Harvard
hool of Public Health asked the immediate next of kin of 164
tential organ donors, including 62 who had refused to donate,
out their experiences with this decision. The first to reach sig-
icant numbers of families who declined donation, this study
owed a direct correlation between the families' satisfaction
th the care their loves one received and their willingness to
nsent to donation.

"If we're serious about increasing donation, we have to be
ious about responding to the needs of these families. Many
milies are having unsatisfactory experiences in hospitals when
ing to make a choice about donation," said principal authors
illiam DeJong, Ph.D., Harvard School of Public Health, and
olly G. Franz, BSN, The Partnership for Organ Donation. The
dy revealed major differences in the hospital experiences of
nor and non-donor families, including their levels of satisfac-
n with the overall hospital experience, understanding of brain
ath and the way the donation request was handled.

For the study, next of kin of both donor and non-donor fami-
s were questioned in 30 to 60 minute structured telephone
erviews four to six months after the death of their relative.
estions addressed family characteristics, beliefs and attitudes,
derstanding of brain death, key events during the hospitaliza-
n, and contacts with staff from the hospital and the regional
gan procurement organization (OPO).

The study revealed that certain modifiable factors in the way
hospital handles donation are associated with family consent:
family's satisfaction with the overall hospital care that their relative received, specific aspects of the donation-request process, and the family's understanding of brain death. Non-donor respondents more often stated that hospital staff provided inadequate or insensitive care and that the organ donation request had been handled poorly.

Compared to the respondents who had consented to donation, non-donor respondents were significantly less likely to say that the subject of organ donation was brought up at the right time, that they were given enough time to talk about donation and make sure they were making the right decision, or that they were asked in a private setting. While 94 percent of the donor respondents said they would make the same decision today as they did when their relative died, one-third of the non-donors said they would not make the same decision or they were unsure.

"Non-donor families often had problems with the quality of care that was provided and with how the donation request was made. These are things that can be improved by healthcare providers," said DeJong.

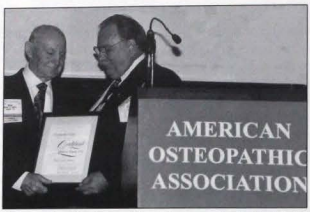
The study also found differences between donor and non-donor families in their beliefs and attitudes about organ donation and transplantation, their knowledge of the deceased's wishes about donation, and demographic characteristics of the patient and family. There were donors in all demographic categories, though non-donor respondents were more likely to be members of racial or ethnic minorities, to be born outside the U. S. and to report an annual household income of less than $35,000.

"Although families with certain demographic characteristics more often deny consent to donation, that finding cannot become an excuse to exclude families from the donation option," said Franz. "Ideally, no matter what a family's characteristics are, healthcare providers should approach the family with the belief that a donation is possible. In our study, even families who declined donation felt it was right to ask them and valued being able to make the decision. The key is treating every family with respect and care."

The Partnership for Organ donation is an independent, non-profit organization dedicated to solving the organ donor shortage through research and in-hospital projects.

Source: News release – The Partnership for Organ Donation

Elmer Baum, D.O.
Recipient of AOA's Distinguished Service Certificate



AOA President Dr. Eugene Oliver (R) presents the Distinguished Service Certificate to Dr. Baum.

Elmer C. Baum, D.O., of Austin, was awarded the American Osteopathic Association's highest honor during the AOA Annual Convention and Scientific Seminar, held in late October, 1999 in San Francisco. The AOA's Distinguished Service Certificate was presented to Dr. Baum in recognition of his outstanding contributions to the osteopathic profession.

Dr. Baum's accomplishments are lengthy and impressive. On the national level, he has served the AOA as a member of the Bureau of Insurance, chairman of the Council on Federal Health Programs, member of the Board of Trustees, vice president, and chairman of the AOA Osteopathic Political Action Committee. Additionally, Dr. Baum has served as a member of the White House Conference on Health, and as chairman of the Bureau of Public Education on Health.

On the state level, Dr. Baum was a member of the Texas State Board of Health for over 18 years. He also served the state as a member of the Regional Advisory Committee for the Regional Programs of Heart, Cancer and Stroke and as a member of the Medical Care Advisory Committee to the State Department of Public Welfare.

An active member of the Texas Osteopathic Medical Association since 1944, he served as TOMA president from 1952-53 and is currently a Life Member. He has combined his medical practice with serving as an active political voice in Austin for almost 50 years. He served as chairman of the state's Democratic Party from 1968-1971 and has osteopathically treated five Texas Governors. In addition, Dr. Baum treated all five Texas Lt. Governors from 1950 until 1994, and all Speakers of the Texas House of Representatives from 1949 to 1973.

Dr. Baum's influence in Austin led to obtaining private scholarships for osteopathic medical students in Texas, and he was instrumental in securing general appropriations for the Texas College of Osteopathic Medicine. These steps culminated with TCOM becoming a Texas state college for funding purposes.

In the 1950's, during Dwight D. Eisenhower's tenure as U.S. president, Dr. Baum's influence spread nationally when he, along with several other individuals including a senator from the State of Missouri, were able to obtain recognition of osteopathic physicians as officers in the draft. His presence and influence was such that he was twice a guest at the White House, per request of President Lyndon B. Johnson.

Dr. Baum has been honored with numerous awards, including the General Practitioner of the Year in 1958 from TOMA; Honorary Membership in the American Osteopathic College of Preventive Medicine in 1970; and the Distinguished Service Award in 1994 from TOMA.

In nominating Dr. Baum for the AOA Distinguished Service Award, TOMA noted the following on the application form: "Dr. Baum exemplifies everything that is good about the health care profession. Devoted to the principles of osteopathic medicine, he has distinguished himself as not only a man of vision, but as a true humanitarian. Dr. Baum has built bridges to allow future generations of osteopathic physicians to practice in Texas and in the nation."

The Texas Osteopathic Medical Association takes pride in congratulating Dr. Baum on receiving this prestigious award.

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w is the Time to ok at your ancial Plan for 00

in February, a famous furry stinator pokes its head out ole in the ground to assess rroundings. According to re, if the creature sees its w, it will burrow back rground for six more weeks.

ly, the groundhog is no role l for those looking to assess financial situations.

nyone who hasn't done so dy, February is an ideal h to examine one's finances. ng a plan for the year ahead rucial step to help you reach financial goals. Here are steps to help you get started.

Set specific goals. The step in this plan is to identify financial objectives. her that means saving for r purchase or setting aside for retirement, the goal d have a specific timeline avings plan, including ifiable benchmarks.

nay find that your priorities changed significantly since ast time you sat down to ate your finances, resulting changes in you and your y's circumstances.

3/00

2. Identify your resources and learn where your money is going. To do this, you'll need to track what you spend. A good start is to list your monthly fixed expenses and then estimate what you believe to be your other monthly expenses, such as entertainment, meals and clothing. Then, keep a notebook of what you actually do spend. You may be surprised to see a variance in what you think you spend versus what you actually do.

After you've gained a clearer picture of your spending, you should also calculate your net worth – your current assets minus your debt. It's a good idea to update this information yearly.

3. Set a budget and stick to it. Keeping your goals and expenses in mind, the next step is to create a budget. If your monthly income is not sufficient to meet your monthly expenses and your savings goals identified in steps one and two, then you will need to identify ways in which to increase your income or reduce your expenses.

This may involve looking for ways to reduce your taxes or consolidating debt into a low-interest loan, such as a home-equity loan. It may also mean altering your spending habits and scaling back on some luxuries to which you have grown accustomed. The ultimate objective is to free up money to apply toward your financial goals.

4. Evaluate your progress. Once your plan is in place, you should monitor your progress on a periodic basis, at least annually. Annual reviews will allow you to determine whether you are ahead or behind in achieving your benchmarks, and then adjust your plan accordingly. It's always possible to reset these goals at a later time.

There are numerous resources you can use in setting up a financial plan. Information is readily available on the Web, and you can consult a financial planning professional for further assistance in setting and achieving your financial objectives. Rest assured that the only advice you won't see recommended anywhere is burrowing under ground for six more weeks of winter.

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800-321-0246

Texas ACOFP Update

ACOFP Fellow Award

The Fellow Award is in recognition of outstanding contributions through teaching, authorship, research, or professional leadership at the state or national level. Any Fellow in the College can nominate only one qualified ACOFP member for the Award of Fellow each year. The nominees are reviewed and approved by the Awards Committee and by a majority vote of the ACOFP Board of Governors.

Additional requirements are: a minimum of six consecutive years of dues paying membership on ACOFP and attendance at 50% or more of the AOA Scientific Seminars (registered as a family physician), and the ACOFP Annual Conventions over the last six years. You are encouraged to speak with a Fellow about sponsorship and the requirements to become a nominee.

The following physicians are TxAOCP members and Fellows:

Richard Anderson, D.O. Mesquite
David Armbruster, D.O., Pearland
Elmer Baum, D.O., Austin
John Bowling, D.O., Fort Worth
John Carter, Jr., D.O., Fort Worth
John Cegelski, Jr., D.O., San Antonio
Samuel Coleridge, D.O., Fort Worth
Marion Coy, D.O., Joshua
Robert Finch, D.O., Dallas
Gerald Flanagan, D.O., Argyle
Samuel Ganz, D.O., Corpus Christi
Richard Hall, D.O., Eden
Royce Keilers, D.O., La Grange
Arthur Katz, D.O., Dallas
Harold Lewis, D.O., Austin
R. Greg Maul, D.O., Rowlett
Robert Maul, D.O., Lubbock
L. N. McAnally, D.O., Granbury
Jack McCarty, D.O., Lubbock
William Mosheim, D.O., San Antonio
Robert Peters, Jr., D.O., Round Rock
Donald Peterson, D.O., Mesquite
Irvine Prather, D.O., Fort Worth
Harvey Randolph, Jr., D.O., Port Arthur
Phillip Saperstein D.O., Fort Worth
T. Robert Sharp, D.O., Mesquite
Stephen Urban, Jr., D.O., Fort Worth
John Walton, D.O., El Paso
Craig Whiting, D.O., Fort Worth
Rodney Wiseman, D.O., Tyler
Andrew Roland Young, D.O., Maypearl
Capt. Ben Young, D.O., Lubbock
T. Eugene Zachary, D.O., Fort Worth.

The Award strengthens you both as a physician and as a leader in your profession. Contact the TxACOFP Headquarters at 888-892-2637 for additional information.

ACOFP Convention in Las Vegas

You should have received registration materials for the ACOFP Annual Convention to be held March 27 – 31, 2000, in Las Vegas. If you are planning to attend this meeting, please consider serving as a Texas Delegate to the Congress of Delegates. We are still in need of delegates and would appreciate your support. Please contact Janet Dunkle at 888-892-2637 for more information.

OMT Review for Those Taking ABOFP Certification Exam.

The Texas ACOFP and UNTHSC at Fort Worth, Department of CME, is offering a 10 hour OMT Review for those registered to take the ABOFP Certification Exam in Las Vegas. The OMT Review, historically held the evening prior to this exam, has been eliminated and Texas is offering those who need their skills sharpened an opportunity to receive instruction.

The review will be held March 11 – 12, 2000, at the TOMA/TxACOFP headquarters in Austin, Texas. The fee is $150 and includes breakfast and lunch.

While registering for this review will not guaranteed passing the OMT performance evaluation, it will provide those who have not received recent OMT training the skills to effectively diagnose case history and demonstrate the appropriate OMT treatment. For registration information, contact TxACOFP at 888-892-2637.

TxACOFP Annual Clinical Seminar Held During TCOM Alumni Weekend

The 43rd TxACOFP Annual Clinical Seminar will be held July 27 – 30, 2000 at the Arlington Hilton Hotel. This year the TCOM Alumni Weekend activities will be held in conjunction with this seminar. As family practice encompasses all specialties, alumni will have the opportunity to also earn CME while attending the alumni weekend.

This year's seminar will offer 27 hours of Category 1-A CME. Areas of topics include Internal Medicine, Pediatrics, OBGYN, and Cardiovascular. Of course, Sunday will be devoted to OMT, beginning with a Medical Ethics Program.

Family Fun Night will be dinner and a baseball game at the Ballpark at Arlington (Texas vs. Detroit) or participation in the TCOM Alumni Golf Tournament. Due to last year's huge success, our President's Dinner will be followed by Casino Night with a few new surprises.

Mark your calendars and plan on attending this quality CME event. Registration forms will be mailed the first of May. For more information, contact TxACOFP at 888-892-2637.

Dallas Osteopathic Family Practice Meeting

The TxACOFP will hold a meeting for Dallas members on Thursday, March 16, 2000, at 7:00 PM at Dave and Buster's on Central Expressway and Walnut Hill Road.

Members and their spouses are invited to dinner and a lecture on Pediatric Allergies as well as a Power Card for games following the lecture. An OMT demonstration on "OMT in 10 Minutes" will also be offered.

This is a great opportunity to get to know the family practice D.O.s in your community. Invitations will be mailed to members with additional information.

The AOA Unity Campaign – How You Can Help

The Campaign for Osteopathic Unity became official in July 1998, when the American Osteopathic Association House of Delegates approved six resolutions to correspond with the following goals:

- crease awareness of osteopathic medi-ine and the AOA as the source of infor-ation on osteopathic medicine;
- centuate the distinctiveness of osteo-thic physicians; and
- lp unify the "family" of osteopathic edicine.

Basically, the campaign seeks to ntuate the distinctiveness of osteo-ic physicians, and to make D.O. a shold word throughout America.

Last year, BSMG Worldwide issued a l report on the AOA's image market-campaign, which was printed in the 1999 issue of the *Texas D.O.* As you recall, the public's perception of .s reflected the fact that there is limit-knowledge of the profession, even ng patients of osteopathic physicians.

The following are suggestions physi-s may utilize in order to help promote campaign:

- dd the tag line *"D.O.s: Physicians eating people, not just symptoms"* to ur letters and CME promotions.
- py the "Wellness Watch" from the OA Web site (www.AOA-net.org) and mail it to your local health reporters th an invitation to use it as filler.
- ace a Unity story in your newspaper. hese are ready-to-use stories located the Unity section under campaign date on the AOA Web site.)
- ace D.O. definition posters at each at during CME conferences.
- ace a Unity logo and link on your Web e. (Instructions are included in the AOA ity portion of the AOA Web site.)
- fer political and health writers your search and testimony on issues you e working on.
- nd a copy of your CME program to e local health writer wherever you are eeting, and invite them to attend to get ckground information.

f every D.O. did just one of the ve, think about how many people e efforts would reach.

The Texas Vaccines for Children Program

By Cathryn Gleasman, Physician Recruiter

Since its inception in 1994, Texas has participated in the Federal Vaccines for Children (VFC) Program. Our version is called the Texas Vaccines for Children Program, or TVFC. The Program was initiated by the passage of the Omnibus Budget Reconciliation Act of 1993. This legislation guaranteed that vaccines would be available at no cost to providers, in order to immunize children who meet the eligibility requirements.

Today, there are more than 6000 Texas providers enrolled. However, this is not enough. Texas leads the nation in the number of uninsured and underinsured children. We also have over a million children on Medicaid (Federal Fiscal Year 1998 data). Many of these children are not receiving the full set of immunizations required to protect them from vaccine-preventable disease. Under the TVFC, the following groups of children should be receiving their vaccines for free:

- Uninsured or underinsured children,
- children who are of Native American or Native Alaskan heritage and
- children on Medicaid.

In order to ensure the health and future of the children of Texas, we need your help. If you are not enrolled in the TVFC, please consider enrolling. It is a simple process:

- Fill out Provider Enrollment and Provider Profile forms,
- agree to screen for eligibility and
- agree to maintain records of the screenings.

Vaccine is ordered through regional and local health departments. A TVFC provider may not charge for the vaccine itself, but is permitted to charge a reasonable administration fee.

There are innumerable benefits to being a TVFC provider: to you, to the families in your practice, and to the people of Texas. Some of the most important are related to removing barriers to immunization. For instance, no longer will you have to refer an uninsured child to a public health center for immunization, and hope the parent has the means to get them there and will do so. The TVFC removes the worry of the financial cost of vaccination, thereby removing the reason for the referral. The child is then kept in her 'medical home', which is beneficial to you, the provider, and to the child.

The people of Texas benefit as taxpayers, as vaccinating versus treatment for disease saves an enormous amount of money. For example, for every dollar spent on DTaP, $23.40 is saved in direct and indirect costs. Also, because the vaccine contracts are negotiated at a federal level, the lowest possible price and a standardized cost are ensured. Of course, we also benefit by maintaining a high level of immunity in our communities. Your practice benefits as well, since vaccine is provided at no cost to providers. As many families who are currently paying for vaccinations will be TVFC eligible, you will receive their vaccine with no out-of-pocket expense on your part.

No one tells Program providers whom they must see, or dictates that they accept Medicaid clients. Providers continue to serve the same populations they have always served. Except now, through enrollment in the TVFC, more children will be receiving their full complement of vaccines. The Program automatically covers all vaccines recommended by the Advisory Committee on Immunization Practices (ACIP) and approved by the Centers for Disease Control and Prevention (CDC).

A fully immunized society is necessary to reach optimum eradication of vaccine-preventable infectious disease. With your help, we can reach those goals, leading to a happier, healthier, Texas. Please feel free to contact Cathy Gleasman, Physician Recruiter, Texas Department of Health, Immunizations Project with any questions or comments or for information on enrolling. We can be reached at 800-252-9152 or 512-458-7284.

In Memoriam

Bob E. Jones
Former Executive Director of the Oklahoma Osteopathic Association

Bob E. Jones of Oklahoma City, Oklahoma, passed away on February 3rd. He was 63. Services were held February 8 at New Covenant Christian Church in Oklahoma City.

Mr. Jones received a Bachelor of Arts and a Bachelor of Divinity degree from Phillips University and Graduate Seminary in Enid, Oklahoma. He was ordained in the clergy in 1961 and served as associate minister until 1963 at the First Christian Church in Lawton. Following his ministry, he was selected as executive director of the Oklahoma Osteopathic Association, a position he served for 30 years, retiring in December 1999.

His love for the osteopathic profession and dedication to its growth was evidenced through his influence in the establishment of the Oklahoma State University College of Osteopathic Medicine in 1972. Mr. Jones counseled hundreds of students who are now osteopathic physicians serving throughout Oklahoma. He is the author of the books, "The Difference a D.O. Makes," and "Osteopathic Medicines; The Premier Profession."

Mr. Jones served on numerous boards and agencies throughout his career, including board of trustees of the Donna Nigh Foundation for the Developmentally Disabled; governor of the Oklahoma State University Foundation; as advisor to the American Osteopathic Association Council on Federal Health Programs and member of the Association of Osteopathic State Executive Directors. In addition, Mr. Jones was a member of New Covenant Christian Church and an original member of the "OK-4" Barbershop Quartet.

Honors and awards include the AOA's Distinguished Service Certificate; Outstanding and Distinguished Service Award from the Oklahoma State University College of Osteopathic Medicine; Distinguished Service Award from the American College of Osteopathic Family Physicians; Outstanding and Distinguished Service Award from the Oklahoma Osteopathic Association; Outstanding and Distinguished Service Award from the Arkansas Osteopathic Medical Association; the George Nigh Association Executive of the Year Award; 1999-2000 Millennium Award from the Auxiliary to the AOA; and Award of Appreciation from the USO for public service and entertaining armed forces in military hospitals in the Pacific in '69-70.

Survivors include his wife, Gayle Jones; daughters Jennifer and son-in-law Brian Cain, and Julie and son-in-law Matthew Atyia, all of Edmond; three grandchildren, Allyson and Carter Cain and Justin Atyia; sisters Carol Briggs and husband John of Ripley, Betty Beall of Kingfisher, and Sherry Martin and husband Jay of Moore; and many loving nieces and nephews and thousands of friends.

Contributions can be made to the OEFOM Bob E. Jones Scholarship Fund, 4848 North Lincoln Blvd., Oklahoma City, Oklahoma 73105-3335.

Gertrude Rose Kuban

Gertrude Rose Kuban of Granbury passed away on January 25, 2000. She was 89. A Mass of Christian burial was held January 28 at St. George Catholic Church, with burial in Mount Olivet Cemetery.

Mrs. Kuban was born February 14, 1910, in Fort Worth. She was a member of St. George Catholic Church and the Altar Society of St. Joseph.

She was preceded in death by her husband, Louis William Kuban. Survivors include sons, Jimmy L. Kuban and his wife, Marilyn, of Fort Worth, and David L. Kuban, D.O., and his wife, Cathy, of Granbury; grandchildren, Ronnie Kuban, Mark Kuban, Eric Kuban and Steven Kuban; great-grandson, Cody Ki[illegible] brother, Lawrence Gabert of Euless; [illegible] nieces and nephews.

Memorials may be made in [illegible] Kuban's name to the Humane Societ[illegible] Texas.

Ralph Connell, D.O.

Dr. Ralph Connell of Dallas pa[illegible] away on December 19, 1999. He was Graveside services were held Decembe[illegible] at Restland Memorial Park, with meme[illegible] services following at Park Cities Ba[illegible] Church, Ellis Chapel in Dallas.

A 1935 graduate of Kirksville Col[illegible] of Osteopathic Medicine, Kirksv[illegible] Missouri, Dr. Connell served a reside[illegible] in ophthalmology and otolaryngolog[illegible] Kansas City Osteopathic Hospital. [illegible] practiced in Oklahoma before reloca[illegible] to Dallas, where he practiced for over[illegible] years. Dr. Connell was certified in b[illegible] ophthalmology and otorhinolaryngol[illegible] and was a fellow of the Osteopa[illegible] College of Ophthalmology [illegible] Otorhinolaryngology.

His honors and awards were nume[illegible] ous, and included president of [illegible] American College of Ophthalmology [illegible] Otolaryngology; member of the boar[illegible] directors and outstanding alumnus [illegible] Kirksville College of Osteopat[illegible] Medicine; life member of the Ameri[illegible] Osteopathic Association and the Te[illegible] Osteopathic Medical Association. ac[illegible] tion, Dr. Connell was a member of P[illegible] Cities Baptist Church.

Survivors include his wife of 60 ye[illegible] Pet Connell. Memorials may be made [illegible] Dr. Connell's name to Kirksville Coll[illegible] of Osteopathic Medicine; Shrine[illegible] Crippled Children; Presbyterian Villa[illegible] Park Cities Baptist Church; or the cha[illegible] of your choice.

TOMA President Elect Seeks Committee Appointees

Each year, the President Elect of the Texas Osteopathic dical Association must name TOMA members to the sociation's various committees when he or she assumes the ice of President. Strong committees are an essential part of Association's operations, and require dedicated and knowl- eable members.

Bill V. Way, D.O., of Duncanville, who will succeed Rodney Wiseman, D.O., as the Association's President during the 00 Annual Convention in Corpus Christi, would like all MA members interested in continuing to serve or desire to ve on a committee to write him as soon as possible so he can in to consider appointments. Dr. Way recently said, "I am king for a few good osteopathic physicians, men and women, serve on the various TOMA committees."

Simply note the TOMA committee or committees in which are interested, enclose a brief CV detailing your training, ctice and related experiences, and send your letter to Dr. Way, sident Elect, c/o Terry Boucher, Executive Director, Texas eopathic Medical Association, 1415 Lavaca St., Austin, TX 701-1634 or e-mail to <TerryB@txosteo.org>.

Re-appointments and new appointments will be made to the following committees: Awards and Scholarship; Constitution, Bylaws and Documents; Environmental Health & Preventive Medicine; Ethics; Governmental Relations; Membership, Services & Professional Development; Military Affairs; Osteopathic Principles and Practice; Physicians Health & Rehabilitation; Professional Liability Insurance; Socioeconomics; Strategic Planning; Student/Postdoctoral Affairs; and other appointed special committees.

If you are interested, or know of someone who is interested, in serving on a TOMA committee, check the bylaws beginning on page 109 of the 2000 TOMA Membership Directory for more details and information on the various appointed positions available, or contact the TOMA state office for specific committee charges.

TOMA members have an immense amount of talent. The Association's future depends on you and your willingness to become an active part of this great organization. Dr. Way looks forward to hearing from you by April 30.

SAA Update

by Ann Costello, SAA President

The Student Associate Auxiliary has been busy preparing to ve into the next century while planning another fantastic year. April 1, 1999 our new officers were elected and committee cers were appointed. May was the time to wish our seniors ll as they move into the next phase of medical training. We d our annual Senior Luncheon on May 15, 1999, and Mrs. rilyn Richards performed the officer installation. Also in May, udine Doyle was awarded the Donna Jones Moritsugu Award he Senior Banquet. This is an honor bestowed upon the spouse a graduating senior who best exemplifies the role of a profes- nal's partner, in being a person in his or her own right, while ng supportive of mate, family, and profession. ngratulations Claudine!

The month of June was spent attending the TOMA Annual vention and planning the calendar and budget for the upcom- year. Ann Costello, Melissa Smith, and Mandy Sutterer were e to be present at convention in Dallas and enjoyed meeting physicians and their spouses as well as learning more about MA and ATOMA.

SAA raised funds for our book covers and help with the OMA silent auction and T-shirt sales. After convention we set budget and scheduled our service, social, and educational nts for the year.

In July SAA was very busy ordering, counting, and sorting r 300 lab and clinic coats for the students at UNTHSC/TCOM. Other fundraising activities included organizing a raffle for a "Journey's End" trip to Dr. George and Linda Cole's lake home and making bell wreaths to sell at National Convention in San Francisco, October 25-29.

The first of August was spent participating in Orientation Week for the Incoming students at UNTHSC/TCOM. SAA began the week with our Welcome Wagon delivering bags of goodies to the homes of freshmen students and welcoming them to Fort Worth. We also distributed lab and clinic coats, sponsored a soda break, answered questions on a panel during Family Day, and hosted SAA's orientation night for the spouses and significant others of the incoming students. As our guest speaker at orientation night, Mrs. Pam Adams clarified the role that SAA, ATOMA, and AAOA play in the careers of physicians and their families. Also during August our book covers, which give a brief explanation of osteopathic medicine, were distributed to several high schools and middle schools throughout Texas. This is our NOM week project which we hope to continue each year.

Toward the end of August SAA was invited to the home of Dr. Mark and Rita Baker for the annual pool party honoring the incoming freshmen. The Bakers continually provide support to the Student Associate Auxiliary, and we appreciate everything they do.

In September SAA held the pizza party in the Founders' Activity Center at UNTHSC/TCOM for students, SAA members,

and their families. Also in September Nancy Zachary hosted the Freshman Brunch and District II provided the delicious food. These events are a great way to meet and get to know the new spouses and significant others.

October was another busy month for the Student Auxiliary beginning with the Hospital Dinner and Tour sponsored by the Osteopathic Health System of Texas. Later in the month Dr. Nelda Cunniff-Isenberg and Mr. Lewis Isenberg opened their home to SAA for a fish fry. We also had a successful bake sale and several members started a Fall Book Club.

In November the officers were treated to a dinner at the Fort Worth Club by Dr. David and Merilyn Richards. We were grateful to have this last dinner with the Richards before they left for Ohio. Dr. Jim and Dodi Speece welcomed SAA to their farm with a bon fire and hay ride, and everyone had a great time roasting hot dogs and making s'mores. We rounded out the month with NOM week and a progressive dinner.

SAA ended the millennium quietly with a Christmas party at the home of Dr. Robert and Pam Adams. We also helped to decorate the lobby and cafeteria of the Osteopathic Medical Center of Texas and sung carols to several patients there.

January 2000 brings us to the close of yet another a successful fund-raiser selling Passbooks. We are also planning the Lottery Panel for second year students and spouses/significant others and working on a slate for the officers in 2000-2001. We hope to help Rita Baker meet her goals, as AAOA President, in spreading the Yellow Ribbon Program throughout Texas and helping to educate the public on D.O.s, "physicians treating people, not just symptoms".

From the Texas Medical Foundation

Promoting Quality, Cost-Effective Health Care In the Sixth Scope of Work

The Health Care Financing Administration (HCFA) has launched a new contract w peer review organizations (PROs) nationwide that strives to improve the quality of hea care that Medicare beneficiaries receive and protect the Medicare Trust Fund. This si contract and its scope of work began in Texas on February 1, 2000, under the direction the Texas Medical Foundation (TMF). Nationwide, PROs will be working with the medi community in their state to fulfill the contract objectives and improve health care.

In the contract, TMF is charged with three major efforts – assuring quality hea care for Medicare beneficiaries, safeguarding Medicare funds, and providing bene ciary outreach and protection. These three goals will be accomplished in the 6SOW several facets.

First, in order to demonstrate that beneficiaries are afforded an optimum level of ca TMF must demonstrate statewide levels of improvement for six major disease top through the Health Care Quality Improvement Program (HCQIP). Chosen by HCFA their prevalence among the Medicare population, the national clinical project topics this contract are: acute myocardial infarction, congestive heart failure, stroke/transi ischemic attack/atrial fibrillation, pneumonia/influenza, diabetes, and brea cancer/mammography. Like TMF, all other PROs in the U.S. will address these sa clinical areas, while promoting the application of continuous quality improvement in t field of health care.

To protect the Medicare Trust Fund, TMF has implemented the Payment Err Prevention Program (PEPP) in inpatient PPS facilities. TMF will collaborate with the hospitals to identify potential sources of payment error and promote system changes th prevent future errors. The long-term goal of identifying these sources of error is prevent future incorrect payments.

The final mission of the contract is to protect Medicare beneficiaries through patient rights and preventive health education. This is achieved through mandatory case revie the dissemination of health information, and maintenance of a toll-free hotline. Throu mandatory case review, TMF acts as an impartial third party who can evaluate th concerns of beneficiaries about the quality of care that they receive. Additionally, TM promotes public awareness of the Medicare program and the six clinical topics throu seminars, public service announcements, brochures, and other outreach campaigns wi the goal of assimilating information into a comprehensive understanding of the Medica program. TMF's Medicare hotline also affords beneficiaries the opportunity to report c concerns related to quality of care.

For more information about TMF's activities, please contact one of the following sta members at 1-800-725-9216:

HCQIP – Carol McCauley, Director of Health Services Improvement
PEPP – Debbie Lovato, Director of Health Services Assessment
Beneficiary Protection – Rhonda Strange, Director of Communications

The Council of Student Council Presidents is an osteopathic student group sponsored by the American Association of the Colleges of Osteopathic Medicine. CSCP was created in 1974 to represent 100% of all osteopathic medical students nationally to the AOA and serves as an entity to voice student concerns and issues. We are currently conducting a fundraiser by offering a beautifully illustrated, full color "Embrace Osteopathic Medicine" poster (19" x 25", suitable for framing). The original illustration was created by Larry Slalob from NYCOM and depicts the tools of the osteopathic physician. Prints may be purchased for $22 (S/H included) by placing an order at 817-735-2421/2505. Please send checks to:

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Fort Worth, Texas 76107-2699

Thanks for your support!

elf's
ips & Tidings

By Don Self

A patient calls for an appointment: if 're like most offices, you advise the ent to arrive early for their appoint- t and bring their insurance card with n on the first visit. That's pretty much way most offices do it. We recom- d that you also advise the patient to g photo identification with them. ead of just the insurance card, we also gest you have the new patient bring r insurance policy with them. The rea- for this is simple - the card only has much information, while the policy sheet will usually show the ductible, dates of coverage, phone bers, fax numbers and policy exclu- s. Making a copy of this face sheet on first visit may save your staff some ble later on. Most offices that do not ire all new patients to present a photo tification have had some patients mis- resent their name, address, occupation, ne number and other pertinent data to id having to pay for services rendered. absolutely amazing how easy this is how often it happens. We recommend you make a copy of the photo identi- tion on all new patients.

When to Collect the Co-Pay

There is no reason to wait until dicare pays the claim before you mpt to collect the patient's co-pay, if know what Medicare's allowed or roved amount is. We strongly recom- d that you collect the patient's co-pay or deductible at the time of service, n you are aware of Medicare's roved amount.

If the patient is part of a managed care n in which you participate, why not ect the co-pay PRIOR to the patient g seen. When the patient checks in, ect the co-pay then and avoid collec- and checkout slowdowns. In fact, we mmend that you post a sign in your e stating that as of a certain date your e will collect co-pay at the initiation of the visit "To speed up your check-out process." This is not only allowed, it is recommended.

Help Me Find a New Accounts Receivable System

At least once a month, I get a call from a Texas osteopathic physician asking me what system would be best for their office. Recently, after asking quite a few of my monthly retainer clients what system they use, what they like best about it and what problems they experience, I have started recommending the Easyway system. Not only does this system provide all of the reports, claims filing capabilities, accounts receivable management, and integrates with electronic patient statements, but it also is extremely easy to use and manage. The updates are priced reasonably and I like the ease in which data files can be imported into and out of the system. If you want more information on this system, give us a call.

Thank You

A special thanks to all of the members of the Texas Osteopathic Medical Association, with emphasis on all of the staff at the TOMA office in Austin, for their continued support and referrals. Due to the relationship we have enjoyed with TOMA, we now are working with several other state and national associations, including the Texas Podiatric Medical Association, American College of Family Physicians, Nevada Osteopathic Medical Association, Professional Association of Healthcare Office Managers and others. For the past 11 years, we have been honored to work with TOMA.

Regional Blocks

Modifier 47 is one of the least used and most commonly ignored modifiers by surgeons and this is costing surgeons quite a bit of money. Modifier 47 describes a regional or general anesthesia administered by the surgeon. It is not used for local anesthetics. As an example, a surgeon administering a total ankle block (regional anesthesia) without the presence of or the assistance of an anesthesiologist or anesthetist for a bunionectomy with osteotomy and the removal of a dorsal metatarsal cuneiform oxostosis right foot should list the procedure twice on the claim. The first time, the code should be listed without a modifier to denote the surgery and the second time, it should be listed with the 47 modifier to denote the regional anesthesia by the surgeon.

Are You Down-Coding Too Many Visits?

Invariably, at every single seminar at which we teach E&M documentation and at which physicians are present, we are told that the physician has been down coding too often. The documentation for a level four visit is not as comprehensive or time consuming as many physicians think. As an example, you see a patient complaining of cough in your office. Let's examine the following documentation requirements for a level 4 established patient office visit (99214):

1. Chief Complaint (we never recommend that the words follow-up be used in your documentation)
2. 4 history questions on an acute condition or 3 questions on a chronic condition
3. 2 Review of System questions: "Have you been around anything you are allergic to or has this cough been giving you headaches?"
4. 1 past/family/social history question: "Have you taken up smoking again?"
5. Exam of 2 body areas: head and chest would qualify

6. 12 elements of the examination: 2 of the elements are probably obtained by your nurse since any three constitutional items count as one element, such as temp, pulse, BP, height, weight, respiration. The other 10 elements are services you are looking at, such as external appearance of ear and nose; lips, gum & teeth; tonsils, effort of respiration, palpation, percussion, palpation of the cardiovascular, inspection of their skin, etc.

You're already asking these questions, but are you documenting the answers? Are you documenting the unremarkable portions of your exam? Remember in the 97 documentation guidelines as published by HCFA, you're allowed to count the negatives as long as you note the negatives. Sometimes, it's only a one-word difference in the level 3 visit to a level 4 visit. Don't give away thousands of dollars each month just because you don't know exactly what is required. If you want one of the E&M documentation sliderules, of which we have sold thousands, give us a call at 888 (NOT 800) DON-SELF.

Emergency Room Billing

When you are called to the ER to see a patient, you are allowed to use the ER codes 99281-99285, even though the ER doctor used them as well, since you are a different specialty than the ER doctor. If you give critical care services (treating the critical condition) to the patient in the ER, and you spend 30 minutes or longer working on the patient's case, it would be wisest to forego the billing of the ER visit code and bill for the critical care (99291) instead. Also, don't forget to inform your billing staff of any services you render in the ER, such as CPR, arterial line, repair, etc., as this does add up to quite a bit of money. If it is not a critical situation, but you see the patient in the ER and then decide to admit them, you would bill for the hospital admit and not bill for the ER visit as well, since the admit includes any related E&M services.

Nursing Facility Admit and Re-admit

There are three codes to use for ar al nursing home reassessment (99 99302 & 99303), but there is only code that should be used for admit readmit to the nursing facility (993 You are also allowed to bill for the ho tal discharge (99238 or 99239) on same day as an admit into a skilled n ing facility. There may be times when have a same day hospital admit as charge and then you readmit the pat into the SNF. In those cases, you w code for the hospital service as 992 99235 or 99236, plus the SNF admit. will have to file the services on two ferent claim forms since the place of s ice is different for both.

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10 Years Ago in the *Texas D.O.*

- Homer R. Goehrs, M.D., FACP, became the new executive director of the Texas State Board of Medical Examiners, replacing retiring G. V. Brindley, Jr., M.D.
- The Texas Medical Association broke ground at its new Austin location, at 15th and Gaudalupe Streets. The 120,000 square-foot building would more than double the space of the current location. The new structure was expected to be ready for occupancy in the summer of 1991.
- Robert G. Maul, D.O., who served as program chairman for the Annual Convention of the American College of General Practitioners in Osteopathic Medicine and Surgery, was elected to a one-year term on the Board of Governors of the National ACGP. In addition, T. Eugene Zachary, D.O., was re-elected to an eighth term as speaker of the ACGP's House of Delegates. Also serving as speaker of the TOMA House of Delegates and the AOA House of Delegates, Dr. Zachary was the first physician to serve as speaker of the three groups at the same time.
- Les T. Sandknop, D.O., was named chief of medical staff at Lake Pointe Medical Center.

TEXAS FYI

TDH Emergency Abortion for Minor and Third Trimester Abortion Forms

Senate Bill 30, passed during the 76th slative session, requires parental notition before an abortion may be formed on a minor. Two exceptions e created: the first is when an emercy exists and the second is when the or has received an order from a statu- court granting permission to the or for an abortion without parental fication. For more information on the guidelines, see Chapter 33 of the ily Code, or Senate Bill 30.

Physicians who perform emergency rtions on minors must report the cedure to the Texas Department of alth on the form approved by the partment: "Physician's Certification – formance of Emergency Abortion."

Similar reporting is also required for d trimester abortions, regardless of , and should be reported to the TDH in 30 days of the abortion. The form reporting third trimester abortions has n revised: "Third Trimester Abortion tification Form."

The new reporting forms went into ct January 1, 2000. Physicians should note the change in address for orting as indicated on each form. stions may be directed to Sara M. cia at 512-458-7111, ext. 2527; or at -458-7509, Bureau of Vital Statistics.

exas' Largest Nursing Home Provider to Seek Chapter 11 Bankruptcy Protection

Mariner Post-Acute Network, which ns 101 nursing facilities in Texas and is nation's second-largest nursing home n, reportedly had $1.5 billion lower ings than expected last fiscal year and s to declare bankruptcy. A bankruptcy g is not expected to result in patient placement, but would add to the 144 as nursing homes already in bankcy. (Dallas Morning News, 1-18-2000)

xas AG Appeals Order Could Block Expanded Licensing

A U.S. District Judge had blocked as onstitutional a new Texas law requiring licensure of physician offices that perform over 300 abortions per year and increasing criminal liability of violators. Texas Attorney General John Cornyn said that law, which took effect September 1, upholds public health interests by providing "additional, reasonable safeguards to protect women who choose to have an abortion in high-volume abortion facilities in Texas." (Houston Chronicle, 1-3-2000)

Sale of Harris Methodist Health Plan Formally Approved

The transaction brings to PacifiCare nearly 300,000 commercial and Medicare members, boosting its HMO membership in Texas to nearly 500,000. The deal produced 150 Harris health plan managerial and staff layoffs, with many of the remaining 700 Harris employees slated for layoffs in three to 12 months. PacifiCare is reviewing ways to integrate the health plans' information systems, member services operations and marketing staffs. Former Harris owner Texas Health Resources will become solely a hospital company, operating the Harris Methodist and Presbyterian systems, as well as Arlington Memorial and St. Paul in Dallas. (Fort Worth Star-Telegram, 2-1-2000)

Charter Behavioral Health Systems to Close Hospitals

Closures include Charter Grapevine Behavioral Health System, Charter Haven Behavioral Health System in DeSoto and Compass Hospital of Dallas in DeSoto, all of which have stopped accepting patients and are expected to shut down within the next month as patients complete their treatments or are discharged. Also slated for closure is Charter Behavioral Health System of Corpus Christi. Charter is closing or consolidating a total of 33 of its facilities nationwide and will leave 37 operational. (Dallas Morning News, 2-1-2000; Corpus Christi Caller-Times, 1-28-2000)

Group of 450 Physicians Ending Contract with the Area's Largest HMO

Preferred Independent Physicians of America announced that it is terminating its contract with Humana Health Plan of Texas after failing to produce a new contract during a year of negotiations. The group's 11,000 Humana patients face having to switch insurance coverage or find new physicians who accept Humana if their current physician or clinic does not sign an independent contract to continue seeing Humana HMO patients. Humana said it would continue to pay the group's physicians for treatments through March 31, even without a contract. (Austin American-Statesman, 1-28-2000)

Texas Stands to Lose $72 Million and $104 million Due to Steep Decline in Cigarette Sales

A 14 percent statewide decline in tobacco consumption will affect the amount that Texas receives from its $17.3 billion multiyear settlement with the tobacco industry, which uses a formula that takes tobacco consumption into account. Health initiatives to be funded by the settlement money, such as a cancer center in San Antonio, would have to make up for the shortfall by using permanent endowment funds or interest earned by endowment funds, while some programs may have to be cut altogether, the San Antonio Express-News said, citing Texas Senator Royce West (D-Dallas). (San Antonio Express-News, 1-19-2000)

continued on next page

Thousands of Uninsured Children Eligible for Public Health Benefits

Over 680,000 uninsured children in Texas are currently eligible for public health benefits, including Medicaid and the Children's Health Insurance Program (CHIP). Citing the figure was the Urban Institute's "Assessing the New Federalism" study, which called for better coordination by governmental agencies to redress the problem. The study noted that formidable barriers to effective outreach programs include confidentiality requirements to protect the privacy of program enrollees, widespread confusion over eligibility and onerous application requirements. Eighteen percent fewer Texas children were enrolled in Medicaid in August 1999 than in January 1996, despite no corresponding reduction in Medicaid eligibility. (Houston Chronicle, 1-3-2000)

Bell Named TDH Executive Deputy Commissioner Texas Commissioner of Health

William R. Archer, M.D., announced that Charles E. Bell, M.D., has been named Executive Deputy Commissioner of the Texas Department of Health (TDH). Bell replaces Patti Patterson, M.D., who resigned in December to accept a position with Texas Tech University Health Sciences Center in Lubbock. Bell's appointment to the second highest TDH executive staff position was effective February 1. Since May 1998, Bell has served as director of TDH's public health regional office based in Lubbock and covering 41 counties in the Panhandle and High Plains areas of the state. From 1990 to 1998, Bell was chief of TDH's HIV and sexually transmitted diseases prevention bureau in Austin. A native of Port Arthur, Bell holds a medical degree from Southwestern Medical School, Dallas; a master's degree in health care administration from Trinity University, San Antonio; and a bachelor's degree in biology from the University of Dallas.

Two Hospitals to Stop Treating Aetna Members

Harris Methodist and Presbyterian Hospitals in North Texas will stop treating 65,000 Aetna U.S. Healthcare members if a contract dispute cannot be settled. The hospitals' parent company, Texas Health System, said that Aetna members whose primary care physicians are affiliated with Medical Select Management, a 1600-member physician organization in Tarrant County, will have to seek care at other hospitals in 90 days. Texas Health claimed that its 1997 letter of agreement with Aetna and Medical Select Management is illegal because it requires the hospital to assume some financial risk for physicians' treatments, while Aetna maintained that the letter was binding and legal. (Fort Worth Star-Telegram, 1-5-2000)

Hospitals Report Good Net Income as HMOs Report Losses

Most Texas hospitals reported a healthy net income for 1998, while HMOs reported mounting losses for the fourth straight year. According to an Allan Baumgarten annual report of the Texas health care market, Houston-area hospitals earned profits of $576.2 million, or 11.2 percent of total revenues, in 1998, while Dallas-Fort Worth-area hospitals reported profits of $455 million, or 8.1 percent of their total revenues. Overall, the report noted, hospitals broke even on their operations but had significant revenues from other sources, including investments, philanthropy and government subsidies. Texas HMOs lost more than $345 million in 1998, almost all from commercial plans, and lost $102 million in the first half of 1999. (Allan Baumgarten, 1-7-2000)

Fort Worth Hospital to Build $4.5 Million Cardiac Care Unit

All Saints Episcopla Hospital in Fort Worth has annnouced plans for a new 28-bed unit that will replace an older unit at the Medical District campus. It is expected to open in late 2001. All Saints has reportedly raised over $2.7 million for the unit and hopes to complete fund raising next October before beginning the unit's construction. (Fort Worth Star-Telegram, 12-16-99)

Ennis Hospital Saved from Closure

On the heels of an announcement by Baylor Health Care System in December to close Ennis Hospital at the end of January, the city council has voted to
Province Healthcare of Brentw
Tennessee, to take over operati
Province agreed to pay the city of E
which owns the hospital building
million in advance for a 30-year l
agreement. The agreement also has t
10-year renewal options, giving Prov
a potential 60-year agreement. The
has agreed to refund the hospital's ta
with a guarantee from Province that
money will be invested in the hosp
(Fort Worth Star-Telegram, 1-20-2000

Private Health Insurers Pledge to Help Medicaid Program Recoup Funds

After reports that the Texas Medic
program may have paid as much as
billion for treatment that should have b
covered by private insurers or ot
parties, private insurers in the state s
they are willing to share with Medic
their billing and collection procedures
recovering money owed them by ot
insurers or parties, reported the Hous
Chronicle. "There are lessons to
learned from the private insurance sect
and we would welcome the opportunity
work with Medicaid to possibly impro
their collections," the Chronicle add
citing Jerry Johns, president
Southwestern Insurance Informati
Service. (Houston Chronicle, 12-13-99

Columbia HCA Selling Three Texas Hospitals to Atlanta-Based American MedTrust, Inc.

Columbia signed a letter of intent
sell the 221-bed Bellaire Medical Center
southwest Houston to American MedTru
a transaction expected to close by April 3
and is also selling its 90-bed Medic
Center of Lancaster near Dallas and Nor
Bay Hospital in Aransas Pass. MedTrust,
privately held company, owns or operat
130 hospitals nationwide. (Houst
Business Journal, 1-24-2000)

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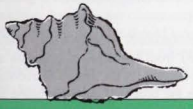

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AOA Eye on Federal Agencies

HHS Releases Proposed Privacy Regulations to Protect Patient Information

The AOA called on President Clinton and HHS Secretary Donna Shalala to extend the comments period for the proposed privacy regulations. HHS announced December 13 that it had extended the January 3 deadline for comments to February 17. The proposal outlines the privacy standards providers, plans and health care clearinghouses would have to meet to protect patient information. This proposal attempts to address growing public concerns that advances in electronic technology in the health care industry may erode privacy surrounding individuals' health information. Here are a few highlights of what you can expect if the proposal is finalized.

- Physician practices would have to designate an employee or other person to serve as a privacy compliance officer responsible for developing policies and procedures for use and disclosure of protected health information.
- A practice also must designate a contact person or office to receive complaints and provide information about the matters covered by the practice's notice on privacy.
- The practice must train all employees who are likely to have contact with protected health information about the privacy policies and procedures.
- Physician practices would be required to ensure that their business partners (anyone who carries out, or assists with, a function for the practice) with whom they share protected health information understand – through a written contract – that they are subject to standards regarding use and disclosure of protected information.
- Practices would have to document their policies and procedures for complying with the applicable administrative requirements.
- Patients would have the right to review and request corrections and amendments to their medical records.
- Anyone in the practice who has regular contact with protected health information would be subject to sanctions, as would the practice's business partners. Sanctions range from a warning to termination.
- Anyone failing to comply with the requirements could face civil money penalties capped at $25,000 for each calendar year for each provision that is violated.

From the AOA

The AOA wants its members to know that HCFA offers fr Medicare online training that covers ICD-9-CM coding, fraud a abuse, home health agencies, HCFA 1500 and 1450 forms, a Medicare Secondary Payer issues. Check out <www.medica training.com>. It's a good source of free information.

News on Nominations

AOA has nominated Angelyn K. Moultrie-Lizana, D.C M.S., of San Pedro, California, and Ian Robert Levenson, D.C of Greenwood Village, Colorado, for the Practicing Physici Advisory Council. Dr. Moultrie currently practices at t Mullikin Medical Center in Artesia, California, and is on acti status with the U.S. Navy Reserves at Camp Pendleton. D Levenson is board certified in family medicine and has served both vice president and president of the Colorado Society Osteopathic Medicine. Both are members of the AOA an ACOFP. The AOA has also nominated William Anderson, D.O of Southfield, Michigan, for the Committee on Minority Healt He is associate dean at Kirksville College of Osteopathi Medicine. The purpose of the committee is to advise and mak recommendations on improving minority health.

Final Physician Fee Schedule for 2000

The 2000 Medicare physician fee schedule conversion facto is $36.6137. Of the 35 major payment specialties, 15 are esti mated to experience payment increases such as emergency medi cine and nephrology. Nineteen specialties will experienc payment decreases, such as cardiac surgery, orthopedic surger and thoracic surgery.

HCFA changed all professional liability relative value units which were charge-based from Medicare claims data accumu lated in 1989, to resource-based RVUs. The AOA recommende that HCFA should make the proposed resource-based malprac tice RVUs interim until more current and accurate data can b used. HCFA agreed that the RVUs should be considered interim until they can be verified by more recent data.

HCFA also removed the physicians' clinical staff time in the facility setting from the raw CPEP data used in calculating the practice expense payment for any service. The AOA agreed that Medicare should not pay twice for a service, but noted further study may be necessary to resolve the issue of practice expense payment for the physicians' clinical staff time in a facility setting. HCFA has not seen sufficient data to convince the agency that the use of the physician's clinical staff in the facility setting is a typical practice.

Regarding site of service, HCFA clarified that when practi tioners provide a service in a mixed facility (a combination of nursing home and SNF patients), practitioners should designate their service as a facility service, unless they can verify that no

t A claim will be made for the service, which case the no-facility designation be used. The AOA opposed this posal, contending the physician should have to prove that no other party has in a claim for that service. However, FA said it "does not believe that it uld be an onerous task for the physi- to determine at the time of service ether the patient is a SNF or nursing e patient. This information is needed ay the bill correctly and the physician the best position to obtain this infor- ion quickly."

HCFA will not require the routine use modifier –25 with all the procedures ing a global indicator of XXX. HCFA identify specific codes with which E/M service furnished would need to ne that is documented as being signif- nt and separately identifiable, and uld be reported with Modifier –25. FA will seek review of these codes n physician specialty societies and -physician practitioners who are norized to bill Medicare on their own. ese specific codes will be included as s in the Correct Coding Initiative and l be implemented no earlier than ober 1, 2000.

HCFA has modified its nurse practi- ner (NP) qualifications for Medicare t B coverage of services, grandfa- ing in NPs who don't have a master's ree and extending the time required possessing a master's degree, despite ections from the physician community. AOA contended that NPs should have aster's degree and to lower the educa- standard to grandfather currently cticing nurse practitioners lacking a ster's degree will not benefit the dicare patient.

HCFA also adopted as final the posed exception to the supervision of gnostic tests which specified that no sician supervision is required for gnostic tests performed by NPs and ical Nurse Specialists (CNS) when are authorized by the state to perform se tests. In addition, physician assis- s legally authorized to perform diag- tic tests under state law would require eneral level of physician supervision. AOA contended that it is inappro- te for CNSs and NPs to order diag- ic tests without at the least general physician supervision. Diagnostic tests require medical judgment by a physician, both in their necessity to be ordered, and in their interpretation.

HIPDB Up and Running

As of November 22, 19999, the Healthcare Integrity and Protection Data Bank became operational. Health care practitioners, providers and suppliers who request information about themselves are required to pay a $10 fee. This database will contain 1) civil judgments against a health care provider, supplier or practitioner in federal or state court related to the delivery of a health care item or service; 2) federal or state criminal convictions against a health care provider, supplier or practitioner related to the delivery of a health care item or service; 3) actions by federal and state agencies responsible for the licensing and certification of health care providers, suppliers or practitioners; 4) exclusion of a health care provider, supplier or practitioner from participation in federal or state health care programs; and 5) any other adjudicated actions or decisions that the HHS Secretary establishes by regulation. The OIG modified its regulations to exclude administrative fines or citation, corrective action plans and other personnel actions unless they are 1) connected to the billing, provision or delivery of health care services; and 2) taken in conjunction with other licensure or certification actions such as revocation, suspension, censure, reprimand, probation or surrender. In addition to the self-queries, only state and federal government agencies and health plans have access to this new data bank. HIPDB is directed at combating fraud and abuse in a broader scope. Those reported to the data bank may dispute the accuracy of the data bank report within 60 calendar days of receipt of the report. For more information, check out the Web site at <www.npdb-hipdb.com>.

AOA Gives Compliance Guidance Recommendations to the OIG

Flexibility is key to establishing compliance guidance for individual and small group physician practices, the AOA emphasized in its comments to the HHS Office of the Inspector General. The OIG requested recommendations from interested parties as it considers developing a compliance guidance program for physician practices, especially those serving Medicare and other federal health care program beneficiaries.

The purpose of the guidelines is to help physicians submit clean and accurate claims and to curb fraud and abuse. These guidelines would not be mandatory. The OIG anticipates that the physician guidance will contain seven elements that the OIG considers necessary for a comprehensive compliance program. These seven elements include:

1) The development of written policies and procedures; 2) The designation of a compliance officer and other appropriate bodies; 3) The development and implementation of effective training and education programs; 4) The development and maintenance of effective lines of communication; 5) The enforcement of standards through well-publicized disciplinary guidelines; 6) The use of audits and other evaluation techniques to monitor compliance; and 7) The development of procedures to respond to detected offenses and to initiate corrective action.

The AOA emphasized that the vast majority of physicians code correctly and don't have significant billing errors. The AOA does not believe it would be appropriate to expect individual physicians and small group practices to follow a cumbersome system solely to show that they are honest in their dealings with the government.

The OIG must keep in mind the limited resources and small number of employees in a solo practice and small group practices when developing compliance guidelines, according to the AOA. The size of the practice and experience with regulatory problems in the past should govern the complexity of the compliance program.

Finally, the AOA believes the guidelines should not require small practices to hire a multitude of consultants. The OIG must recognize that any compliance plan will require an expenditure of time and funds, which could be prohibitive depending on the requirements of the guidelines. The OIG's office should allow the practice to implement a compliance program on an incremental basis.

NEW TEXAS STARS

The following people have made pledges or have contributed to TOMA's Building Fund Campaign since the start of the new year. These people are now known as "Texas Stars" because of their commitment to the osteopathic profession.

Alan C. Baum, M.D.
BMS, Stefani Cunningham
Cindy Boucher
Howard Galarneau, D.O.
GM Pharmaceuticals
John P. Hood, D.O.
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Novartis Pharmaceuticals Corp.
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Charles H. Wheeler, D.O.
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