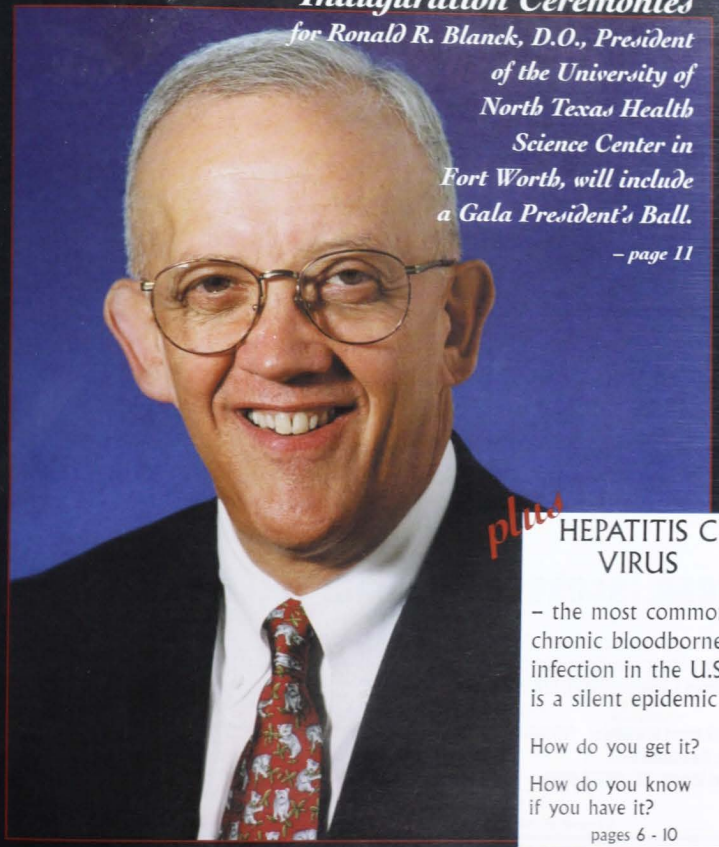
TEXAS D.O.

The Journal of the Texas Osteopathic Medical Association

Inauguration Ceremonies

for Ronald R. Blanck, D.O., President of the University of North Texas Health Science Center in Fort Worth, will include a Gala President's Ball.

– page 11



plus

HEPATITIS C VIRUS

– the most common chronic bloodborne infection in the U.S. is a silent epidemic –

How do you get it?

How do you know if you have it?

pages 6 - 10

Volume LVIII, No. 3 March 2001

TEXAS D.O.
The Journal of the Texas Osteopathic Medical Association

MARCH 2001

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INSIDE THIS ISSUE

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CALENDAR OF EVENTS

MARCH 28 – APRIL 1
"ACOFP 38th Annual Convention & Exhibition"
Sponsored by the American College of Osteopathic Family Physicians
Location: Philadelphia Marriott, Philadelphia, PA
CME: 47 hours Category 1-A credits
Contact: ACOFP, 800-323-0794;
FAX 847-228-9755; www.acofp.org

APRIL 17 – 21
"AROC 2001: NJAOPS Centennial"
Sponsored by the New Jersey Association of Osteopathic Physicians & Surgeons and the NJOEF
Location: Tropicana Casino & Resort
Atlantic City, NJ
Contact: 732-940-9000
Fax: 732-940-8899

APRIL 19 – 22
"32nd Annual Medical-Scientific Conference"
Sponsored by the American Society of Addiction Medicine
Location: Century Plaza Hotel & Spa, Los Angeles, CA
Contact: ASAM, 4601 North Park Ave., Suite 101
Chevy Chase, MD 20815
301-656-3920; Fax: 301-656-3815
E-mail: email@asam.org
Web: www.asam.org

APRIL 26 – 29
"Left-Brained Cranial Manipulation"
Sponsored by The Cranial Academy
Location: Rosemont (Chicago), IL
CME: 32 hours Category1-A credits anticipated
Contact: The Cranial Academy, 317-594-0411
FAX 317-594-9299
E-mail: CranAcad@aol.com

APRIL 19
"National D.O. Day 2001"
Sponsored by the American Osteopathic Association
Contact: www.aoa-net.org

MAY 3 – 6
"104th Annual Convention"
Sponsored by the Indiana Osteopathic Association (IOA)
Location: Marriott Hotel/Century Center, South Bend, IN
CME: 30 hours Category 1-A credits anticipated
Contact: IOA, 800-942-0501 or 317-926-3009

MAY 12
"56th Annual Meeting of the TOMA House of Delegates"
Sponsored by the Texas Osteopathic Medical Association
Location: DoubleTree Guest Suites
Austin, TX
Contact: Paula Yeamans, TOMA, 800-444-8662

JUNE 6 – 10
"102nd Annual Convention and Scientific Seminar"
Sponsored by the Texas Osteopathic Medical Association
Location: Arlington Convention Center, Arlington, TX
Contact: Jill Weir, CAE, Projects Coordinator
800-444-TOMA or 512-708-TOMA
FAX: 512-708-1415

JUNE 16 – 20
"Basic Course: Osteopathy in the Cranial Field"
Scholarship Information
Sponsored by The Cranial Academy
Location: The Westin Mission Hills Resort
Rancho Mirage, CA
CME: 40 hours Category1-A credits anticipated
Tuition: Program Director: Judith L. Lewis, D.O., FCA
$1,150 (nonmembers)
Scholarship: $575 (nonmembers)
Contact: The Cranial Academy
317-594-0411
FAX 317-594-9299
E-mail: CranAcad@aol.com

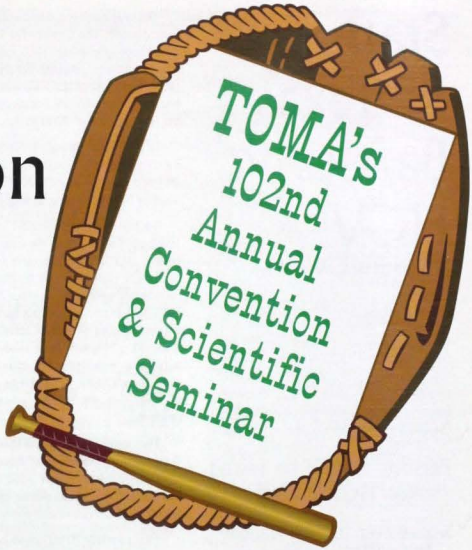
JUNE 21 – 24
"99th Annual Convention & Scientific Exhibition"
Sponsored by the Georgia Osteopathic Medical Association
Location: Amelia Island Plantation, Amelia Island, FL
Contact: GOMA, 2160 Idlewood Road, Tucker, GA 30084
770-493-9278
E-mail: GOMA@mindspring.com
Web: www.goma.org

JULY 13 – 15
"AOA House of Delegates Meeting"
Sponsored by the American Osteopathic Association
Location: Fairmont Hotel, Chicago, IL
Contact: Ann M. Wittner, AOA Director of Administration
800-621-1773; E-mail: awittner@aoa-net.org

OCTOBER 21 – 15
"106th Annual Convention and Scientific Seminar"
Sponsored by the American Osteopathic Association
Location: San Diego Convention Center, San Diego, CA
Contact: Ann Wittner, 800-621-1773
E-mail: mthompson@aoa-net.org

The New Age Health Connection

George N. Smith, D.O.
Program Chair



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Arlington Convention Center & Wyndham Arlington Hotel Arlington, Texas

For more information, contact Jill Wier, CAE, TOMA Projects Coordinator
800-444-8662 or 512-708-8662

State of Texas Battles HCV

(Hepatitis C Virus)

by
Alma Lydia Thompson, Program Specialist
Infectious Disease, Epidemiology & Surveillance Division, Texas Department of Health

Gary Heseltine, MD, MPH, Senior Epidemiologist
Infectious Disease, Epidemiology & Surveillance Division, Texas Department of Health

Persons should be tested for HCV if they:

- ✓ have ever injected illegal drugs—even once.
- ✓ received a blood transfusion or solid organ transplant before July 1992.
- ✓ received a blood product for clotting problems before 1987.
- ✓ have ever been on long-term kidney dialysis.
- ✓ have ever been pricked with a needle with infected blood or mucosal exposure to HCV positive blood.
- ✓ were born to a mother with Hepatitis C.

Texas is facing a silent epidemic of hepatitis C (HCV), which is a leading cause of liver disease. The Centers for Disease Control and Prevention (CDC) estimates 8,000 to 10,000 people in the U.S. die each year from a hepatitis C-related liver disease. Approximately 300,000 Texans (about 1.5 percent of the population) are infected with HCV, and most of them do not know it. Late in 2000, all "newly diagnosed" HCV cases became reportable in Texas. About 5,000 newly diagnosed cases were reported during the first quarter of 2000 in Texas.

HCV is transmitted through contact with infected blood. Although most (85%) HCV infections are chronic, the majority of people are asymptomatic. Over a period of about 20 years, approximately 20 percent of those infected with HCV develop cirrhosis, with another 5 percent progressing to liver failure, and hepatocellular carcinoma.

To begin addressing this epidemic, the 76th Texas Legislature passed House Bill 1652, an Act known as the Education and Prevention Program for hepatitis C, and appropriated more than $3 million for the biennium. The Act required the Texas Department of Health (TDH) to conduct seroprevalence studies to estimate the current and future impact of hepatitis C on the state, offer HCV counseling and testing services, provide HCV training to counselors and health care professionals, and conduct public awareness, education, and outreach activities. Texas is the first state in the nation to conduct a statewide seroprevalence study. Many states are following Texas' lead in establishing legislation to address hepatitis C. They are using TDH education and prevention materials as well as the Act itself as a basis for their efforts. Through this legislation, the State of Texas has established a leadership position in addressing the ongoing hepatitis C epidemic.

The state has been working on several blinded seroprevalence studies using blood samples from laboratories and clinics. The state expects to complete the studies and data analysis in the spring of 2001. Once these studies are finished, the data will help guide the health education, public awareness, and community outreach activities to inform health care providers and the public about hepatitis C.

This past fall, TDH began offering HCV counseling and targeted testing for hepatitis C through 20 existing HIV/STD testing sites. Through December 31, 2000, approximately 2,500 clients were counseled for HCV. About 2,200 of these clients were subsequently tested for anti-HCV antibodies, with 38 percent being positive.

TDH training staff developed and delivered a client-centered training course that helped counselors integrate HCV messages into existing HIV/STD prevention counseling. The curriculum provides information relating to transmission, risk reduction, treatment, the importance of early intervention, the special needs of persons with hepatitis C, and the psychosocial impact of the disease.

TDH was also mandated to provide training to public health clinic staff and health care providers. This past summer, 86 participants attended a didactic course at the University of Texas Southwestern Medical Center (UTSWMC). More than 150 participants attended a second course in November. Both courses covered hepatitis C epidemiology, diagnosis, and treatment. Another didactic course has been scheduled for May 19, 2001 at the UTSWMC.

A number of public awareness and educational activities are ongoing. These efforts are guided by the hepatitis C State Workgroup, which is a group comprising different stakeholders. The workgroup meets quarterly to keep its members abreast of one another's activities, thereby reducing duplication and maximizing resources. Two subcommittees comment on informational materials and activities for professional and general public education. TDH has produced brochures, posters, press releases, public service announcements, and Web pages. TDH is also working on educational campaigns scheduled for later this year.

Most of the state's public education effort focuses on raising public awareness of hepatitis C risk factors, modes of transmission, prevention, and the value of early detection. TDH is working on educating persons about risk factors before they are exposed. Plans include radio campaigns and a hepatitis hotline scheduled to begin this spring; a

Hepatitis C Virus is not transmitted by shaking hands, hugging, kissing, or sitting next to an infected person.

video lending library planned for this summer; school curricula to be introduced next year; and booths to be displayed at professional conferences year-round.

Based on national data, most individuals chronically infected with HCV are between 29 and 59 years of age, with males outnumbering females. New cases occur primarily in 20-39 year-olds. African-Americans have the highest prevalence of the disease.

Those at highest risk—people who received a blood transfusion or solid organ transplant before July 1992 and those who have injected illegal drugs, even once—are encouraged to discuss their risks with their doctor. For those clients without private health insurance, TDH offers targeted HCV prevention counseling and testing, including available referrals, at 20 sites across the state. People on long-term kidney dialysis, and others—mainly hemophiliacs—who received anti-coagulant blood products before 1987 are also at risk.

The media campaigns are designed to inform the public about hepatitis C risk factors and the reasons early detection is important, thus countering misinformation about who is at risk. Recent radio ads by an advocacy group claimed that surgical procedures, ear piercing, and dental procedures put a person at risk for hepatitis C. This is false information. The ads also incorrectly asserted that individuals who were or had been in the armed forces, health care, law enforcement, and emergency medical services are at increased risk for infection. Misleading information such as this causes unnecessary public alarm and demands for testing that diverts resources from those truly at risk. Information from the CDC (MMWR October 16, 1998, MMWR July 28, 2000) indicates the prevalence of infection for these groups is similar to that of age and gender matched controls in the general population.

Health care providers can contact the TDH Infectious Disease, Epidemiology and Surveillance Division at 512-458-7676 for patient brochures, posters, videos, and patient resource information.

For more information on hepatitis C virus, visit the TDH Web site at <www.tdh.state.tx.us/ideas/factsht/factsht.htm> or the CDC Web site at <www.cdc.gov/hepatitis>.

Bills in the Texas Legislature Relating to Hepatitis C

HB 767 – Rep. Glen Maxey – Relating to training concerning HIV, hepatitis C, and sexually transmitted diseases for licensed chemical dependency counselors. CME requirements for licensed chemical dependency counselors would be amended to include six hours of training during each two-year licensing period relating to HIV, hepatitis C, and sexually transmitted diseases.

HB 768 – Rep. Glen Maxey – Relating to an interagency coordinating council for HIV and hepatitis. The HIV/AIDS Interagency Coordinating Council, to be renamed the Interagency Coordinating Council for HIV and Hepatitis, would add hepatitis to any communication facilitated between state agencies concerning policies relating to AIDS, HIV and hepatitis.

SB 338 – Sen. Frank Madla – Relating to a state plan for the prevention and treatment of hepatitis C. The TDH is directed to develop a state plan for prevention and treatment of hepatitis C. The plan must include strategies for prevention and treatment in specific demographic groups that are disproportionately affected by hepatitis C, including persons infected with HIV, veterans, racial or ethnic minorities that suffer a higher incidence, and persons who engage in high risk behavior, such as intravenous drug use.

Little Known Facts about Hepatitis C

Scientists isolated and sequenced the Hepatitis C virus genome 10 years ago, which led to the development of diagnostic tests to identify people infected with HCV.[1]

Almost 4 million people in the U. S., or 1.8 percent, are persistently infected, and the Institute of Medicine now includes HCV in its list of emerging infectious diseases. Those with the greatest risk of infection are individuals who ever experimented with injection drugs, even once or twice in the distant past, had multiple sexual partners, or received blood or blood products, for example, a transfusion prior to 1992.[1]

Without more effective therapies that produce recovery, the CDC predicts that deaths due to HCV will double or triple in the next 15 to 20 years due to the length of time most people in the U. S. have been infected.[1]

HCV is not spread by sneezing, hugging, coughing, food or water, sharing eating utensils or drinking glasses, or casual contact. Persons should not be excluded from work, school, play, child-care or other settings on the basis of their HCV infection status.[2]

Some estimates say the number of HCV-infected people may be four times the number of those infected with the AIDS virus. "One of the main differences is that Hepatitis C doesn't kill as quickly as AIDS," says Jay Hoofnagle, M.D., director of digestive diseases and nutrition at the National Institute of Diabetes and Digestive and Kidney Diseases.[3]

1. NIAID, NIH - "What You Should Know About Hepatitis C" <www.niaid.nih.gov/dmid/hepatitis/hepcfacts.htm>.

2. CDC, National Center for Infectious Diseases – "Viral Hepatitis C – Frequently Asked Questions"<www.cdc.gov/ncidod/diseases/hepatitis/cfaq.htm>.

3. FDA Consumer Magazine, March-April, 1999 <www.fda.gov/fdac/features/1999/299_hepc.html>.

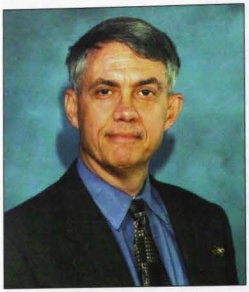
Hepatitis C: An Emerging Problem

by Monte Troutman, D.O.

The United States is currently suffering from an epidemic of startling proportions. This epidemic is caused by the hepatitis C virus (HCV). The current impact on our healthcare dollar is staggering with further healthcare costs to increase. Without effective treatment by the year 2020, these healthcare costs may increase to greater than $26 billion a year. The future healthcare burden is expected to increase due to decompensated cirrhosis, hepatocellular carcinoma (HCC), liver transplant demand and liver related deaths. Timely diagnosis and effective treatment of appropriate candidates are cost effective, because they can reduce future complications of this disease.

Four million to 10 million Americans are infected with HCV and represent nearly 2% of our population. HCV accounts for 20% of acute viral hepatitis in the United States, but 60-70% of chronic hepatitis and 30% of all cirrhosis. Eight thousand to 10,000 Americans die due to HCC caused by HCV in the United States, and it is estimated that this number will triple by 2010. Chronic HCV related disease is responsible for greater than 30% of liver transplants in the United States. Unfortunately, some portions of our population have an increased incidence of HCV. The incarcerated and immigrant population may have as many as 40-60 patients per 100 that are infected. Conservatively speaking, greater than 360,000 Texans are infected. Nationally less than 200,000 infected individuals are receiving treatment.

This RNA virus has a major characteristic in its tendency to cause chronic liver disease. At least 75% and possibly more of patients with acute HCV will ultimately develop chronic infection, and most of these will have chronic liver disease. About 20% of patients with chronic disease develop cirrhosis within 20 years of infection. About 20% of cirrhotics develop liver failure or HCC over another 10-20 year time frame. However, chronic HCV varies greatly in its course and outcomes. The 20-30 year window course of the disease can be shortened by several factors including age of onset, alcohol use, toxic medication (for



example acetaminophen) and concomitant liver disease from other causes.

Contact with blood and blood products is a major cause of HCV spread. The main causes of HCV spread are from blood transfusion and use of shared and poorly or unsterilized needles and syringes. Since mid-1992 effective routine blood screening for HCV antibiotics has nearly eliminated blood transfusion related hepatitis C. Some patients can acquire HCV with no known or admitted intravenous drug use or blood exposure. Other potential risk factors include body piercing, tattoos, healthcare work, frequent exposure to blood products (hemophilia, dialysis), nasal cocaine use with shared equipment, risky sexual behavior (multiple sex partners or history of sexually transmitted disease), and maternal infant transmission during childbirth (less than 5%). Immunocompromised patients, such as HIV, seemed to have increased incidence most likely from increased risk factors.

Many HCV infected people have no or minimal symptoms of liver disease. The most common minimal or nonspecific symptoms include fatigue, mild right upper quadrant pain, nausea, poor appetite, arthralgias, and myalgias. Likewise, the physical examination is frequently normal.

If symptoms or physical findings do occur, they usually present when the disease has progressed to an advanced irreversible state. These signs and symptoms include, jaundice, ascites, hepatomegaly, splenomegaly, muscle wasting, edema, pruritis, darkening of the urine, bruising and vascular spiders. In addition, HCV infected persons may demonstrate extrahepatic manifestations such as arthropathies, renal disease (glomerulonephritis), neuropathies, cryoglobulinemia, and lichen planus.

The diagnosis of chronic HCV requires clinical suspicion, liver enzyme testing, serologic testing, and liver biopsy. Clinical suspicion demands adequate risk factor assessment and pursuit of minimally abnormal liver function tests (LFT's) even if intermittent. Risk profile questionnaires for patients are readily available from multiple sources. Persons with risk factors and or chronically elevated LFT's, especially for greater than 6 months duration, should undergo serologic testing for hepatitis B and C.

The hallmark of screening is the enzyme immuno-assay for antibiotics known as anti-HCV. Third generation testing is now available and is sensitive and specific. False positives do occur but are infrequent. The recombinant immunoblot assay (RIBA) is now rarely used but can confirm a suspected false positive anti-HCV. Polymerase chain reaction (PCR) can detect low levels of HCV RNA in serum and is a most reliable way to demonstrate if HCV infection is present. Several methods are available including quantative PCR and branch chain DNA tests. Their major use is to detect current virus infection and likelihood of response to antiviral therapy. These PCR tests are not FDA approved, and suffer from lack of standardization. Another serologic test useful in treatment decisions is genotyping and serotyping of HCV. There are 6 genotypes and more than 50 subtypes of HCV. Genotype 1 is most common in the United States and the most treatment resistant. Despite these negative factors, HCV RNA titers are routinely used for confirmation of infection, for response to therapy, and for establishing sustained response to therapy.

Liver biopsy is not necessary for diagnosis but helpful in treatment decisions. Histologic evaluation can grade disease severity and stage the degree of fibrosis. Scoring systems have been developed to assist in severity assessment. A lack of liver biopsy should not eliminate treatment consideration, and some experts do not feel that it is necessary to do a liver biopsy to offer treatment. Most physicians do depend on liver biopsy results, as the NIH guidelines recommend that bridging fibrosis and at least moderate parenchymal inflammation be present to qualify for treatment.

Treatment of HCV has improved significantly over the past decade. In the United States, two regimens have been approved for treatment; (1) Monotherapy with alpha interferon (IFN), and (2) Combination treatment with IFN and ribavirin. Currently, combination therapy is preferred because of higher rates of sustained response. This form of therapy is more expensive, but is the standard of care for treatment in treatment naïve, relapsers and non-responders to monotherapy. Monotherapy should be reserved for patients who have contraindications to ribavirin. Several forms of IFN are available and are currently given by subcutaneous injection. Ribavirin is an oral antiviral agent. In late January 2001, the FDA approved a new form of IFN called PEG IFN. This is IFN, and it is a form of drug that can be given once per week. The IFN is bound to an inert substance (PEG) that allows sustained release.

Soon, PEG IFN will be available for treatment in combination with ribavirin. This combination therapy has increased response with no significant change in side effect profile. This new combination therapy is given on weight based dosing, and therefore, doses are different from previous therapy amounts. Therapy is either 6 or 11 months in duration dependent on independent predictors of sustained response. Genotype other than 1 is a positive predictor, and in certain individuals is an indication for only 6 months of therapy. Other positive predictors are low viral load (less than 2 million copies), age less than 40 years, female sex, or no fibrosis on liver biopsy.

Candidates for treatment are those with a positive anti-HCV, elevated AST or ALT and evidence of chronic hepatitis on liver biopsy. Patients with decompensated cirrhosis, age over 60 years should be evaluated for treatment on an individual basis. Current indications are that a patient under the age of 18 is not a candidate for therapy, especially with ribavirin. Recommendations are not to treat patients with normal liver function tests; however, some controversy has surfaced concerning evaluation and treatment of patients with normal liver function tests with evidence of virus. Doses for the treatment with combination therapy are IFN 3 million units subcutaneously 3 times per week in combination with ribavirin at 1-1.2 gms per day. However, within the next several months, dosing will be changed with weight based dosing for PEG IFN and ribavirin.

Eliminating the virus is the goal of therapy. A secondary goal accomplished by the elimination of the virus is to decrease or prevent the development of cirrhosis or HCC. A response is called a sustained viral response when there is a negative RNA PCR viral test 6 months after the completion of therapy. The advancement and improvement of therapy now has increased response from 15% to greater than 60%.

Side effects accompany therapy in most patients. Compliance with therapy can be improved with close monitoring and support. Side effect symptoms are usually most intense in the first several weeks of therapy. Close monitoring and support are essential to ensure compliance with the therapy. When 80% of drugs are taken 80% of the time, clinically published eradication rates can be achieved. Common side effects from IFN are fatigue, headaches, arthralgias, myalgias, nausea, vomiting, fever, depression, suicide ideation, insomnia, hair loss, and bone marrow suppression. Side effects from ribavirin are anemia, fatigue, pruritis, rash, and cough. Multiple, less common side effects exist. Rarely is treatment discontinued due to side effects, but dosing may be altered or reduced to alleviate side effects. The anemia induced by ribavirin is usually within the first month of therapy, and does cause concern in patients with significant cardiovascular disease or pulmonary disease. Patients with advanced cardiovascular or pulmonary disease should probably not receive ribavirin therapy.

Other significant factors for successful treatment are support, both medical and emotional. Support groups have been established in major cities throughout the United States. Patient education information is available from multiple societies, organizations, and over the Internet. The most reliable source of information for patients and physicians is the NIH web site <www.niddk.nih.gov/health/digest/pubs/chrnhepc/chrnhepc.htm>. Patients should be instructed on mechanisms to avoid the spread of the disease. This includes discontinuation of risky behavior, such as IV drug use or multiple sex partners.

"Liver biopsy is not necessary for diagnosis but helpful in treatment decisions."

Also, members should be instructed not to share common household hygiene objects, such as toothbrushes, razors, or manicure equipment. Patients should be given further instruction on methods to prevent further damage to their liver, such as discontinuation of alcohol or hepatotoxic drugs, and refraining from raw seafood ingestion. All chronic hepatitis C patients should receive hepatitis A and hepatitis B vaccine. Unfortunately, no vaccine for hepatitis C exists. The only current prophylaxis for HCV is by prevention of spread.

Maintenance therapy should be reserved for those clinicians with experience in the treatment of patients with chronic hepatitis C. New treatments are currently in basic research, and no new therapies are currently on the horizon for implementation soon.

HCV is a major healthcare problem in the United States today. It lacks the high profile status that is given to other health-

care problems, such as HIV, breast cancer, prostate cancer, and Alzheimer's disease. Unfortunately, this lack of notoriety unless aggressively addressed may lead to an increased healthcare burden in the near future. Only with aggressive educational and informational campaigns to the lay public and to primary care physicians can this problem be adequately addressed. Appropriate screening, diagnosis, and treatment can be cost-effective and can decrease this healthcare burden.

Dr. Troutman is board certified in Internal Medicine and Gastroenterology. He is currently an Associate Professor of Medicine at the University of North Texas Health Science Center at Fort Worth.

Uncommon HCV Transmissions

Maternal-Infant Transmission

Maternal-infant transmission is not common. In most studies, only 5 percent of infants born to infected women become infected. The disease in newborns is usually mild and free of symptoms. The risk of maternal-infant spread rises with the amount of virus in the mother's blood. Breast-feeding has not been linked to HCV's spread.

Sexual Transmission

Sexual transmission of hepatitis C between monogamous partners appears to be uncommon. Whether hepatitis C is spread by sexual contact has not been conclusively proven, and studies have been contradictory. Surveys of spouses and monogamous sexual partners of patients with hepatitis C show that less than 5 percent are infected with HCV, and many of these have other risk factors for this infection. For this reason, changes in sexual practices are not recommended for monogamous patients. Testing sexual partners for anti-HCV can help with patient counseling. People with multiple sex partners should be advised to follow safe sex practices, which should protect against hepatitis C as well as hepatitis B and HIV.

Sporadic Transmission

Sporadic transmission, when the source of infection is unknown, occurs in about 10 percent of acute hepatitis C cases and in 30 percent of chronic hepatitis C cases. These cases are also referred to as sporadic or community-acquired infections. These infections may have come from exposure to the virus from cuts, wounds, or medical injections or procedures. However, the source can not be definitely located or traced.

Source: National Institute of Diabetes and Digestive and Kidney Diseases – "Chronic Hepatitis C: Current Disease Management" – < www.niddk.nih.gov/health/digest/pubs/chrnhepc/chrnhepc.htm>.

Hepatitis C Virus Federal Education Campaign

On July 27, 2000, U.S. Surgeon General David Satcher announced a new effort to help the American public become more aware of who is at risk for hepatitis C infection, and what action they should take if they believe themselves to be at risk Members of Congress joined with the Office of the Surgeon General to help distribute a letter to their constituents. The letter is as follows:

Dear Citizen:

Our country is facing a silent epidemic in the form of hepatitis C, a liver disease caused by the Hepatitis C Virus (HCV). An estimated 4 million Americans have been infected with HCV, and a majority of them probably are not aware that they are infected. With that in mind, members of Congress have joined with the Office of the Surgeon General to distribute this letter so you can take the appropriate action for yourself and your family.

Hepatitis C spreads by contact with an infected person's blood. You should get tested for hepatitis C if you:

- Have ever injected illegal drugs, even if you experimented a few times many years ago;
- Received a blood transfusion or solid organ transplant before July, 1992;
- Received a blood product for clotting problems produced before 1987;
- Have ever been on long-term kidney dialysis;
- Have ever been pricked with a needle that has infected blood on it; or
- Were born to a mother with hepatitis C.

In rare cases, you can get hepatitis C by having sex with an infected person, especially if you or your partner have other sexually transmitted diseases. You can NOT get hepatitis C by shaking hands with an infected person, hugging an infected person, kissing an infected person, or sitting next to an infected person.

While some people with hepatitis C experience flu-like symptoms, many don't have any symptoms. If you think you might have been exposed to hepatitis C, go to a doctor. The doctor will test your blood. For many people, hepatitis C is treatable with a drug called interferon, taken either alone or in combination with the drug ribavirin.

It is important to get help, because over time, hepatitis C can cause your liver to stop working. For more information, please contact the Centers for Disease Control and Prevention's Hepatitis C Hotline at 888-443-7232 or check the following web sites: <www.cdc.gov/ncidod/diseases/hepatitis/c/index/htm> and <www.niaid.nih.gov/information/search.htm>.

Sincerely,

David Satcher, M.D., Ph.D.
Assistant Secretary for Health and Surgeon General

News
from the University of North Texas Health Science Center at Fort Worth

– Osteopathic Physicians Invited to Dr. Blanck's Inauguration – UNT Health Science Center Festivities to Include First-ever President's Ball

Osteopathic physicians from around the country will convene in Fort Worth in April to celebrate the inauguration of Ronald R. Blanck, D.O., as the new president of the University of North Texas Health Science Center. UNT Health Science Center is home of the Texas College of Osteopathic Medicine, the state's only osteopathic medical school.

Inauguration ceremonies for Dr. Blanck are scheduled for April 7 at the Nancy Lee & Perry R. Bass Performance Hall in downtown Fort Worth. The ceremony will begin at 1 p.m.

As part of the festivities, the UNT Health Science Center will host its first community fundraising gala since The Rhapsody in Silver 25th Anniversary Ball in 1996. The 2001 President's Ball will be held the evening of the inauguration at The Renaissance Worthington in downtown Fort Worth. The students and faculty of the world-renown UNT College of Music will entertain guests throughout the evening with hot jazz, cool swing, big band favorites and Broadway show-stoppers.

President's Ball table sponsorships range from $3,000 to $25,000. Individual tickets are $300 to $2,500. Top-level underwriters will be invited to a private reception with UNT System Chancellor Alfred F. Hurley and the Inauguration Host Committee before the ball. For information, call 817-735-5493.

A veritable Who's Who from government, medicine, and business are serving as the host committee for the inauguration. The 16 committee members share at least two characteristics: admiration for Dr. Blanck's many achievements in medicine, in both academic and government circles, and support for the UNT Health Science Center's work in education, research, and patient care.

Serving on the committee are:

• Dr. William G. Anderson, associate dean of the Kirksville College of Osteopathic Medicine Michigan region and a past president of the American Osteopathic Association

• Kenneth Barr, mayor of Fort Worth

• Edward Bass, a longtime supporter of the health science center, is chairman and CEO of Fine Line, Inc. and president of the Sid Richardson Foundation

• Dr. Robert Bernstein, former Commissioner of Health for the state of Texas and past president of the Texas Public Health Association

• Robert I. Fernandez, president of a Fort Worth accounting firm who has been honored for his community involvement

• Kay Granger, U.S. Representative and former Fort Worth mayor

• Kay Bailey Hutchison, U.S. Senator from Texas

• Former U.S. Surgeon General C. Everett Koop, an internationally respected pediatric surgeon and a personal friend of Dr. Blanck for more than 15 years

• Dr. J. L. LaManna, chair of the board of Dallas Southwest Osteopathic Physicians and a recipient of the prestigious Founders' Medal from the health science center

• Gib Lewis, former Speaker of the Texas House of Representatives who is the namesake for the Lewis Library at UNT Health Science Center and a Founders' Medal recipient

• Mike Moncrief, Texas State Senator and another recipient of the Founders' Medal

• Lucille "Lupe" Murchison, former member of the Board of Regents for the UNT System

• Ross Perot, chair of the board for Perot Systems Corporation who has worked with Dr. Blanck on veteran's health issues since the Gulf War

• Bobby Ray, chair of the UNT Board of Regents who is also the COO of Goodman Homes Inc. and president of Diamond Ventures Corp.

• Tim Sear, president and CEO of Alcon, the global leader in ophthalmic pharmaceuticals, surgical instruments and accessories, and consumer vision care products

• Wayne O. Stockseth, a past chair of the UNT Board of Regents, Founders' Medal recipient, and president of the Corpus Christi-based Parts Distributing Co.

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Dr. Blanck, 59, most recently served as the Surgeon General of the United States Army and commander of the U.S. Army Medical Command -- with more than 46,000 military personnel and 26,000 civilian employees throughout the world. He retired from the Army as a lieutenant general in July 2000.

As president, Dr. Blanck oversees a growing academic medical center that includes the Texas College of Osteopathic Medicine, Graduate School of Biomedical Sciences, and School of Public Health. More than 190 full-time faculty and 300 volunteer community physicians work with 753 students who are training to be osteopathic physicians, researchers, public health professionals, physician assistants, and other health professionals.

The University of North Texas Health Science Center is composed of the Texas College of Osteopathic Medicine, the School of Public Health, and the Graduate School of Biomedical Sciences. The center's six Institutes for Discovery conduct leading-edge research on select health issues, including vision, aging, cancer, heart disease, physical medicine, and public health. A 110-member physician group practice, The Physicians & Surgeons Medical Group, manages 188,000 Fort Worth-area patient visits yearly. The institution injects some $244.3 million into Tarrant County and Texas' economies annually.

New Guide Helps Break Down Cultural Barriers in Providing Health Care to Hispanics

A new guide book has been released to help health care professionals understand and respond more effectively to the unique needs of more than 32 million Hispanics in the U. S. titled, *Quality Health Services for Hispanics: The Cultural Competency Component*, the guide emphasizes the central role of cultural competence in providing quality primary and preventive health care to Hispanics. The authors define cultural competence as the set of behaviors, attitudes, skills and policies that help organizations and staff work effectively with people of different cultures. The guide is the product of a partnership among HRSA's Bureau of Primary Health Care, the Department of Health and Human Services' Substance Abuse and Mental Health Services Administration and Office of Minority Health, and the nonprofit National Alliance for Hispanic Health. Copies of *Quality Health Services for Hispanics: The Cultural Competency Component* are available by calling the HRSA Information Center at 1-888-Ask-HRSA or visiting its web site at: <www.ask.hrsa.gov>.

HRSA is the lead HHS agency responsible for improving access to health care for all Americans.

Potomac Institute for Policy Studies Names Ronald R. Blanck, D.O., to Board of Regents

The Potomac Institute for Policy Studies, a policy research institute that provides nonpartisan analysis of technology and technology policy, has appointed University of North Texas Health Science Center president Ronald R. Blanck, D.O., to its board of regents. In this capacity, he will advise the chair and board of directors on the strategic direction of the institute. The Institute has conducted studies on a wide range of technology and technology policy topics, including defense acquisition reform, dual use technology, space commercialization, cyberterrorism and biological terrorism.

"It is a privilege to welcome Dr. Blanck to our board of regents," said Michael Swetnam, president and chairman of the board of the Potomac Institute for Policy Studies. "Dr. Blanck brings proven leadership abilities and a wealth of experience in military medicine and national policy. His continued commitment to education, whether it be in a university or public policy arena, is a tremendous asset to the institute."

"The Potomac Institute is well-known for its on-target examination of policy issues," said Dr. Blanck. "I became familiar with its work during my Army days, and now I look forward to working with the Institute as the president of one of its academic partners and a member of its board of regents."

Dr. Blanck is president of the UNT Health Science Center. He joined the health science center after a 31-year military career. During his career, Dr. Blanck served as Surgeon General of the Army and commander of the U.S. Army Medical Command, with more than 46,000 military personnel and 26,000 civilian employees throughout the world. Dr. Blanck first entered the military as a medical officer in Vietnam following his graduation from the Philadelphia College of Osteopathic Medicine. He also has served as assistant chief of the General Medicine Service in the Department of Medicine at Walter Reed, assistant dean of student affairs at the Uniformed Services University School of Medicine and chief of the Department of Medicine at Brooke Army Medical Center. He had held adjunct teaching positions at Georgetown University, George Washington University, Howard University School of Medicine and the University of Texas Health Science Center at San Antonio.

Dr. Blanck is a fellow and past governor of the American College of Physicians. He most recently was named a recipient of Mastership in the American College of Physicians at American Society of Internal Medicine. He also is an active member of the Association of Military Surgeons of the United States, the American Osteopathic Association, the Texas Osteopathic Medical Association, the Association of Military Osteopathic Physicians and Surgeons, and the American Medical Association. His military honors include the Distinguished Service Medal, the Defense Superior Service Medal, the Legion of Merit, the Bronze Star and Meritorious Service and Army Commendation Medals.

Texas ACOFP Update

by Janet Dunkle, Executive Director

"Sailing into Women's Health" CME Cruise Big Success

The Carnival Cruise Ship "Celebration" was the setting for the Sailing Into Women's Health program held January 19 – 25, 2001. Forty-two physicians participated in this event with CME topics which included Osteoporosis and Osteoarthritis, Smoking Cessation, Cardiovascular Disease in Women, and plenty of OMT. (Yes, we dragged the manipulation tables with us!) This program provided the attendees and their families with the opportunity to visit with speakers, pharmaceutical representatives, and colleagues on an informal basis.

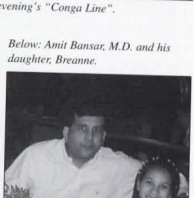
We gratefully acknowledge Bayer, Pharmacia, Wyeth-Ayerst, and the AOA for their support in providing all of the speakers and making this program a success.

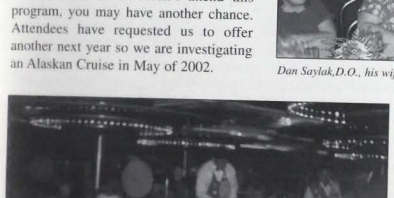
For those who couldn't attend this program, you may have another chance. Attendees have requested us to offer another next year so we are investigating an Alaskan Cruise in May of 2002.

Former Texans, Jayne Knight, D.O. and Brian Knight, D.O. join the evening's "Conga Line".

Dan Saylak,D.O., his wife, Amy and their daughter, Suzanne.

Below: Amit Bansar, M.D. and his daughter, Breanne.





Right: Russell Bell, D.O. and his new daughter, Brittney.

Left: Pharmacia sponsor Mike Parks and his family.

Debbie Sloan (L) and Ronda Beene, D.O.

Jack McCarty, D.O. and his wife, Cindy.

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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.

The deadline for submitting an application for the Fall 2001 award is May 15, 2001. You are encouraged to speak with a Fellow about sponsorship and the requirements to become a nominee. The following physicians are TxACOFP 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
Joseph Dubin, D.O.	Dallas
Robert Finch, D.O.	Dallas
Gerald Flanagan, D.O.	Argyle
Samuel Ganz, D.O.	Corpus Christi
Richard Hall, D.O.	Eden
Armin Karbach, D.O.	Arlington
Royce Keilers, D.O.	La Grange
Arthur Kratz, 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
David Richards, D.O.	Powell, Ohio
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 is one that strengthens you as a physician and as leader in your profession. Contact the TxACOFP Headquarters at 888-892-2637 for additional information.

ACOFP Convention in Philadelphia

You should have received registration materials for the ACOFP Annual Convention to be held March 27 – April 1, 2001 in Philadelphia. 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.

TxACOFP Annual Clinical Seminar Held During TCOM Alumni Weekend in Fort Worth

The 44th TxACOFP Annual Clinical Seminar will be held July 26 – 29, 2001 at the Raddison Plaza Hotel in Fort Worth. Again we will hold this seminar in conjunction with the UNTHSC's Alumni Weekend with special activities held for TCOM alumni. 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 28 hours of Category 1-A CME. Areas of topic include Geriatrics, Women's and Men's Health, and an Obesity Workshop. Hand's on workshops on joint injection, foot problems, and OMT will be included as well as a panel discussion led by members who have successfully been able to stay in private practice.

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.

Settlement Reached for Medicaid Overcharging

The Texas attorney general's office has reached a $1 million settlement with Bayer Corp. to resolve charges that Bayer overcharged the Texas Medicaid program by inflating the prices used to set reimbursement rates. Texas joined 45 other states and the federal government in the agreement, which requires that Bayer pay $14 million for allegedly overcharging Medicaid for intravenous biological fluids used in treating hemophilia and immune deficiency diseases.

(Fort Worth Star-Telegram, 1-24-2001)

Call for Committee Members

A Message from TOMA President-elect Mark A. Baker, D.O.

Dear TOMA Members;

During the past year, the osteopathic profession experienced both great excitement and uncertainty. While D.O. recognition is increasing, osteopathic physicians have had to continue to fight D.O. discrimination on several other fronts.

Our challenges for the year and the future will include managed care reform, workers' compensation, medical errors, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Changes seem to be occurring in the medical profession on a daily basis. That's why it is so important that we keep our state association strong and unified. One way you can help to ensure that sense of unity is to become active in TOMA committees.

Your participation on a committee will keep you in contact with your peers from all around the state. **Your input** can help to solve existing problems and prevent others from forming.

You make up the osteopathic profession. **You** are responsible for its future. **You** must do the work if ***you*** expect to reap the benefits. So, take a moment to read over the list of TOMA committees below. Mark the committees on which you would like to serve in 2001 and 2002. (If you check more than one, please indicate order of preference.) Then mail the form, by March 31, 2001, to TOMA, Attention: Terry Boucher, Executive Director, 1415 Lavaca Street, Austin, Texas, 78701 or FAX: 512-708-1415.

I will do my best to accommodate your requests. **Thank you!**

TOMA Committees

___ Awards and Scholarship
___ Constitution, Bylaws & Documents
___ Environmental Health & Preventive Medicine
___ Ethics
___ Governmental Relations
___ Membership, Services & Professional Development
___ Military Affairs
___ Osteopathic Principles & Practice
___ Physicians Health & Rehabilitation
___ Professional Liability Insurance
___ Public Information & Publications
___ Socioeconomics
___ Strategic Planning
___ Student/Postdoctoral Affairs

Name (please print)
_____

Address (please print)
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Phone (_____) _____

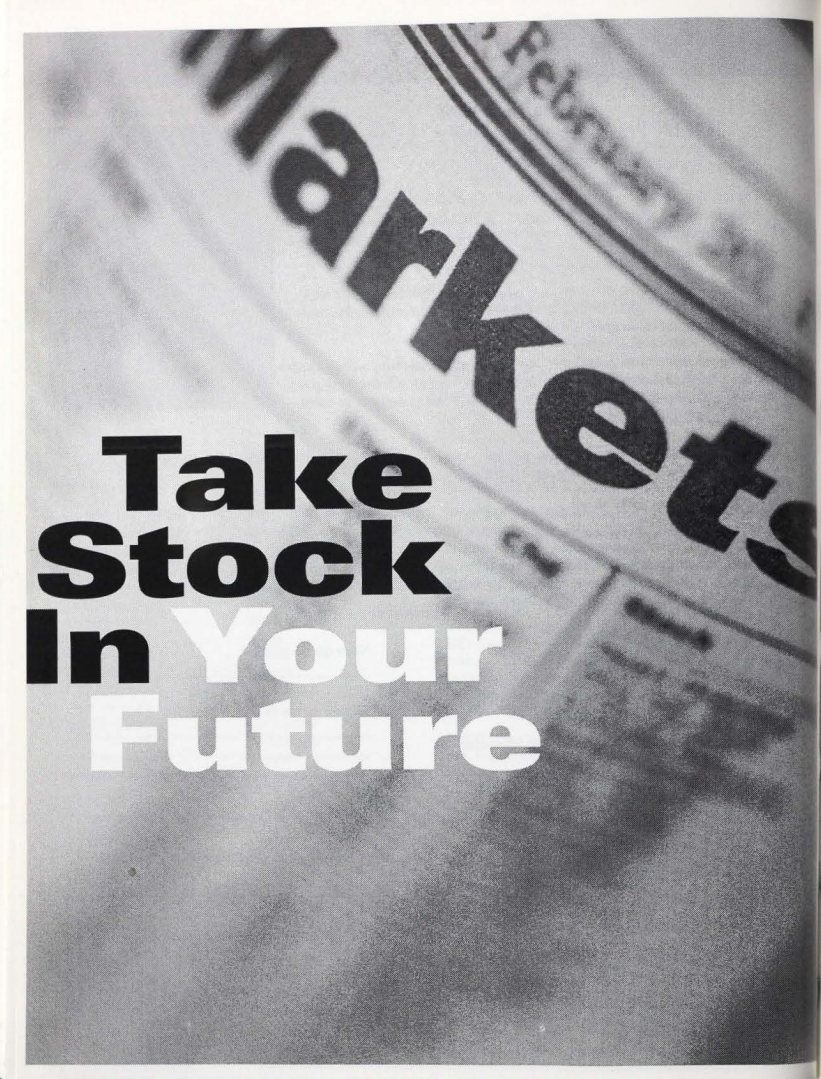
FAX (_____) _____

E-mail _____

AOA Number _____

Specialty _____

Signature
_____


Markets
Take
Stock
In Your
Future

No one can predict the future.
But that doesn't mean you can't plan for it.
Our financial advice is based upon helping you create an investment portfolio to meet your goals, whether it's saving for retirement, a college education or buying a home.

Contact us today for more information or to schedule a consultation.

Dean, Jacobson Financial Services, LLC

The only financial services company endorsed by TOMA

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P.O. Box 470185
Fort Worth, TX 76147-0185

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In Memoriam

Angeline Kate Patrick

Mrs. Angeline Kate Patrick, mother of George N. Smith, D.O., passed away January 13, 2001, in St. George, Utah, where she had been a resident since 1989. She was 87. She was born November 22, 1913 in Ozona, Texas; the third child of James Thomas Patrick and Nettie Louise (Phillips) Patrick.

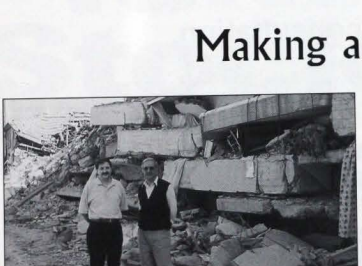
She married Weldon Arch "Smitty" Smith in 1935. They had three sons: Jimmy, of Alpine, Texas; Johnny, of Las Vegas, Nevada; and George, of West, Texas. Smitty passed away in 1973. Mrs. Patrick later met Harry Thomas Hill, with whom she was with for almost 28 years.

She was a waitress for many years before becoming a cashier at Luby's Cafeteria in El Paso, the position she held until retirement.

Mrs. Patrick loved people, animals, flowers, painting and gardening. She also enjoyed games, especially Rummy-Q. Her favorite food was anything chocolate.

She is survived by Harry Hill; her three sons and their wives; seven grandchildren; one step-granddaughter; and four great grandchildren.

Making a Difference



Editor's Note: The following communication is from Kamran Algilani, D.O., of Dallas (left in photo). Dr. Algilani is a 1990 graduate of the Oklahoma State University, College of Osteopathic Medicine. Board certified in family practice, he has been practicing in Texas since 1993.

"To my fellow D.O.s;

I practice family medicine in Dallas and am Medical Director of three clinics. I am also an active member of COPS of Parkland Hospital and Southwestern Medical School at Parkland. My clinic is open to refugees from all over the world, although most of my patients are from the Middle East.

"During the past year in our three clinics, we have spent over $200,000 offering independent care to refugees from Iran, Iraq, Turkey, Bosnia, Syria and Kurdistan. Unfortunately, financial assistance is minimal at best. It is even hard to get money from insurance providers.

"Last summer, I spent the month of July in Turkey, Iran, and Northern Iraq, offering my services to anyone in need. Most of this time was spent helping earthquake victims in Turkey. The town in the photo (Adapazari) had a population of 300,000. Fifty percent of the town was completely destroyed. The photo was taken 10 days after the earthquake. I spent the entire month treating earthquake victims (mostly Turks) free of charge .

"In my opinion, there is no difference among people who are desperate for health care. So, won't you please help? Regardless of who suffers from disease, I want to help and offer whatever services I can. My dream, joy and passion has always been to see people smile and be free of pain, disease and disasters. In my office, I practice medicine as well as meet emotional and daily needs of my patients, because refugees see their physician as their savior."

Physicians wishing to contribute medicines and/or monetary donations, can contact Dr. Algilani at: Kamran Algilani, D.O., 2829 West NW Highway, #500, Dallas, Texas 75220; 214-352-3000.

Update on the 77th Texas Legislative Session

As a follow-up to last month's article, the following are additional bills of interest that have been filed in the Texas Legislature as of press time. For your information, Friday, March 9, was the deadline for filing bills for this session.

HB 576 – Rep. Kyle Janek – Relating to the standardization of credentialing of physicians and providers. The Medical Practice Act would be amended to provide for the establishment of a single, mandatory credentials collection program for all physicians' and providers' core credentials data. (Providers are defined as any person other than a physician including a licensed doctor of chiropractic, advanced practice nurse, dentist, pharmacist, optometrist, registered optician, pharmacy, hospital, or other institution or organization or person that is licensed or otherwise authorized to provide a health care service in this state.) The Texas State Board of Medical Examiners, in consultation with the Advisory Board on Provider Credentialing Information, is directed to develop the standardized credentials verification program by contracting with one regionally based accredited credentials verification organization. Once in place, state agencies and health care entities would be prohibited from collecting duplicate core credentials data from a physician or provider for credentialing purposes if such information is already on file with the Designated Credentials Verification Organization.

HB 757 – Rep. Garnet Coleman – Relating to the establishment of a task force to eliminate health and health access disparities in Texas. The health disparities task force would be established to assist the department in eliminating health and health access disparities in Texas among multi-cultural, disadvantaged and regional populations, including reorienting all existing programs toward eliminating those disparities. Duties of the task force would be to investigate and develop short and long-term strategies to eliminate such disparities. An annual progress report would be submitted to the governor, lieutenant governor and speaker of the house.

HB 767 – Rep. Glen Maxey – Relating to training concerning HIV, hepatitis C, and sexually transmitted diseases for licensed chemical dependency counselors. CME requirements for licensed chemical dependency counselors would be amended to include six hours of training during each two-year licensing period relating to HIV, hepatitis C, and sexually transmitted diseases.

HB 768 – Rep. Glen Maxey – Relating to an interagency coordinating council for HIV and hepatitis. The HIV/AIDS Interagency Coordinating Council, to be renamed the Interagency Coordinating Council for HIV and Hepatitis, would add hepatitis to any communication facilitated between state agencies concerning policies relating to AIDS, HIV and hepatitis.

HB 781 – Rep. Dale Tillery – Relating to the qualification of a treating physician as an expert. This bill would add a new section to the Civil Practice and Remedies Code, to be titled, "Treating Physician Presumed Qualified as Expert." Basically, any physician licensed to practice medicine in the state would be presumed qualified to provide an expert opinion in a civil case concerning an individual to whom they are actively providing care. Such a presumption could be rebutted only by clear and convincing evidence that the physician is not qualified to provide an expert opinion.

HB 821 – Rep. Helen Giddings – Relating to cardiopulmonary resuscitation instruction for public school students and to cardiopulmonary resuscitation and first aid training of certain school district personnel. School districts that offer health as a required curriculum would add "specific instruction in the principles and techniques of cardiopulmonary resuscitation given at least once at the seventh grade level or above." In addition, school employees who serve as head coach or chief sponsor for an extracurricular athletic activity would be required to show proof of training in cardiopulmonary resuscitation and first aid, rather than certification.

HB 849 – Rep. Garnet Coleman – Relating to coverage of anorexia as a serious mental illness under certain group health benefit plans. Serious mental illness, as defined in Section 1(1), Article 3.51-14 of the Insurance Code, would be amended by adding anorexia and bulemia.

HB 895 – Rep. Garnet Coleman – Relating to a demonstration project to provide certain medications and related services through the medical assistance program. A five-year demonstration project would be established to provide psychotropic medications and related lab and physician services to persons through the medical assistance program. A person would be eligible to participate in the program if the person 1) has been diagnosed with schizophrenia or bipolar disorder; 2) is between 19 and 64 years of age; 3) has a net family income that is at or below 200 percent of the federal poverty level; 4) is not covered by a health benefits plan offering adequate coverage; and 5) is not otherwise eligible for medical assistance.

HB 896 – Rep. Garnet Coleman – Relating to a demonstration project to provide certain services and medications through the medical assistance program to persons with HIV infection or AIDS. A demonstration project would be established to provide services and medications through the medical assistance program to persons with HIV infection or AIDS. A person would be eligible to participate in the program if the person 1) has been diagnosed with HIV infection or AIDS by a physician; 2) is under 65; 3) has a net family income that is at or below 200 percent of the federal poverty level; 4) is a resident of a county included in the project or receiving medical care through a facility located in a county included in the project; 5) is not covered by a health benefits plan offering adequate coverage; and 6) is not otherwise eligible for medical assistance.

HB 910 – Rep. Roberto Gutierrez – Relating to the establishment of the Texas A&M University System Health Science Center South Texas Center for Rural Public Health. The Board of Regents of the Texas A&M University System is given authority to establish the South Texas Center for Rural Public Health, to be

under the management of the Texas A&M University System Health Science Center. The Center "shall develop and provide community-based instructional sites for the education of public health professionals and the delivery of health education outreach programs."

HB 951 – Rep. Domingo Garcia – Relating to comprehensive diagnostic tests and other care required to be provided as part of a basic health care plan offered by a health maintenance organization. This bill sets forth required diagnostic tests to be provided by HMOs as part of the basic health care plan. These include: annual tests for blood hemoglobin, blood pressure, blood glucose levels, blood cholesterol levels or low-density lipoprotein levels and blood high-density lipoprotein levels for enrollee 20 years and older; for each enrollee 35 or older, a glaucoma test performed every five years; for enrollees 40 or older, an annual exam for the presence of blood in the stool; for enrollees 45 or older, a left-sided colon exam of 35 to 60 centimeters, performed every five years; for females 20 or older, a pap smear, performed as frequently as recommended by the TDH; for females 40 or older, a mammogram, performed as frequently as recommended by the TDH; and for each adult, recommended immunizations, performed as frequently as recommended by the TDH. In addition, HMOs must provide to enrollees 20 or older an annual consultation with a physician or appropriate provider to discuss lifestyle behaviors, such as control of smoking and exercise plans.

HB 980 – Rep. Craig Eiland – Relating to workers' compensation lifetime income benefits for certain compensable injuries. The following is added to the list (Section 408.161(a), Labor Code) under which lifetime income benefits are paid until the death of the employee: "an injury resulting in a disabling neurological or psychiatric condition that substantially limits at least one major life activity of the employee."

HB 1018 – Rep. Rick Hardcastle – Relating to the processing of certain applications submitted to the Texas State Board of Medical Examiners. The TSBME would be directed to adopt rules for expediting an application for a license made by a person who is licensed to practice medicine in another state, and who submits an affidavit with the application that the applicant intends to practice in a rural community as determined by the Center for Rural Health Initiatives.

HB 1049 – Rep. Burt Solomons – Relating to eligibility to act as a designated doctor under the workers' compensation system. A new section entitled "Training and Certification Requirement for Designated Doctors" is added to the Labor Code. To be eligible to serve as a designated doctor, a doctor must complete required training and be certified by the commission as a certified workers' compensation medical examiner. The commission shall adopt a training program for certification that consists of 1) 16 hours of training on the impairment rating guidelines; 2) 12 hours of training on requirements and commission rules; and 3) 12 hours of training on relevant appeals panel decisions and other information the commission determines to be relevant. A physician who completes the training must pass an exam prescribed by the commission in order to be certified.

HB 1116 – Rep. Glen Maxey – Relating to establishing a maximum sales price for drugs sold to certain entities. A new section entitled "Maximum Sale Price" would be added to the Health and Safety Code stating that a person may not sell a drug to a public entity for more than the reimbursement rate for the drug under the Medicaid vendor drug program.

HB 1192 – Rep. Kim Brimer – Relating to a gateway physician pilot program for the provision of medical benefits to certain state employees who sustain compensable injuries. The office and the Research and Oversight Council on Workers' Compensation are directed to jointly develop and implement a pilot program under which medical benefits are provided to certain state employees who sustain compensable injuries through the use of a health care delivery network. The pilot program is to be established as a loss control program designed to determine whether the state may better control the costs associated with the state employee workers' compensation program by generating savings and more efficient delivery of health care services through contracts with health care delivery networks. A limited number of state agencies would be selected for participation in the pilot program.

HB 1202 – Rep. Kim Brimer – Relating to the medical review of health care provided under the workers' compensation insurance system. The Commission shall develop a list of doctors who are approved to provide medical care and services. Each doctor licensed in Texas is eligible to be included on the list of approved doctors if they register with the commission in the prescribed manner and comply with commission requirements. Approved doctors would be issued a certificate of registration valid for four years and renewable upon application. Except for Commission-granted exemptions, each doctor performing such functions including required medical examinations and medical utilization review evaluations must hold a certificate of registration.

HB 1205 – Rep. Kim Brimer – Relating to changing the name of the Texas Workers' Compensation Commission to the Texas Department of Workers' Compensation, and to changing the powers and duties of the governing authority of that department. In addition to the other duties required of the Texas Department of Workers' Compensation, the department shall also 1) regulate the business of workers' compensation in this state; and 2) ensure that this title and other laws regarding workers' compensation are executed.

HB 1349 – Rep. Garnet Coleman – Relating to the mission, responsibilities, and duties of the Texas Department of Health to eliminate health and health access disparities in Texas. The Health and Safety Code would be amended by adding the term, "eliminating health and health access disparities" to the responsibilities of the TDH.

HB 1526 – Rep. Kevin Bailey – Relating to the selection of a doctor for workers' compensation benefits. The Labor Code would be amended to read that an injured employee is entitled to the employee's initial choice of a doctor. The initial choice of doctor is "the first doctor who provides health care to the employee after the injury occurs, other than: 1) a doctor salaried by the employer; 2) a doctor recommended by the insurance carrier or employer, unless the injured employee continues to receive treatment from the doctor for a period of more than 60 days after the date of receipt of written notice of the employee's right to change doctors; or 3) a doctor providing emergency care to the injured employee, unless the injured employee receives

treatment from the doctor that is unrelated to the emergency treatment for a period of more than 60 days after the date of receipt of written notice of the employee's right to change doctors." An employee would be allowed to change doctors one time by submitting to the commission in writing the reasons for the change. A third or subsequent doctor selected by the employee would be subject to the approval of the insurance carrier or the commission.

SB 282 – Sen. Jane Nelson – Relating to requiring the Texas Department of Health to promote the vaccines for children program to certain health care providers not currently enrolled in the program. Not later than October 1, 2001, the Texas Department of Health is directed to develop and distribute educational materials designed to promote and increase awareness of the vaccines for children program to each health care provider in this state, including a Medicaid provider who is not enrolled but is otherwise eligible to participate in the vaccines for children program.

SB 332 – Sen. Mike Moncrief – Relating to the provision of a pharmaceutical sample by a physician to certain indigent patients. The Occupations Code is amended to include "pharmaceutical samples provided by drug manufacturers for indigent pharmaceutical programs" to those pharmaceutical samples that a physician may supply to a patient free of charge.

SB 338 – Sen. Frank Madla – Relating to a state plan for the prevention and treatment of hepatitis C. The TDH is directed to develop a state plan for prevention and treatment of hepatitis C. The plan must include strategies for prevention and treatment in specific demographic groups that are disproportionately affected by hepatitis C, including persons infected with HIV, veterans, racial or ethnic minorities that suffer a higher incidence, and persons who engage in high risk behavior, such as intravenous drug use.

SB 424 – Sen. Eliot Shapleigh – Relating to a state strategic health plan. This legislation would direct the Texas Department of Health, with the assistance of the Health and Human Services Commission and the University of Texas School of Public Health at Houston, to study the health of Texas residents and develop a strategic health plan for the state. The plan must outline steps the state should take to address the health needs of Texans. The TDH is directed to develop the plan and file a written report no later than December 15, 2002.

SB 425 – Sen. Eliot Shapleigh – Relating to the qualifications for persons who review the necessity or appropriateness of health care services. The Insurance Code would be amended to stipulate that "utilization review conducted by a utilization review agent shall be under the direction of a physician licensed to practice medicine in this state," (rather than a state licensing agency in the U. S.). The same would hold true under the procedures for appeals.

SB 426 – Sen. Eduardo (Eddie) Lucio, Jr. – Relating to prescription drug coverage under the state Medicaid program. Under its rules and standards governing the vendor drug program, the department may not limit benefits for the number of medications prescribed to a recipient of prescription drug benefits under the medical assistance program.

SB 427 – Sen. Eduardo (Eddie) Lucio – Relating to health benefit plan coverage for the treatment of autism and pervasive developmental disorders. This legislation would amend the Insurance Code by requiring certain individual or group health benefit plans to provide coverage for any medically necessary treatment, equipment or therapy for the treatment of autism or a pervasive developmental disorders.

SB 442 – Sen. Troy Fraser – Relating to the establishment and operation of a task force to examine issues regarding expansion of the provision of health benefits to employees of small businesses. The small business health benefits task force would be established to make recommendations to the legislature with respect to improving the availability of group and individual health benefits coverage to employees of small businesses (defined as business entities that employ at least two but fewer than 50 employees) in Texas. Not later than December 1, 2002, a written report concerning the recommendations of the task force must be submitted to the governor, lieutenant governor and speaker of the house of representatives.

SB 516 – Sen. Frank Madla – Relating to creating the rural physician relief program. The Rural Physician Relief Program would be established to "provide affordable relief services to rural physicians practicing in the fields of general family medicine, general internal medicine, and general pediatrics to facilitate the ability of those physicians to take time away from their practice." Rural physicians wanting to participate in the program would pay fees and, these fees in turn, would be used to pay the physicians providing the relief.

SB 531 – Sen. Jane Nelson – Relating to requiring the Texas Department of Health, in consultation with the General Services Commission, to study the cost and feasibility of installing automated external defibrillators in state buildings. The TDH is directed to report the results of its study, along with any recommendations, to the governor and the presiding offices of each house of the legislature not later than November 2, 2001.

SB 594 – Sen. Chris Harris – Relating to retrospective reviews of health care services by utilization review agents. The Insurance Code would be amended by adding the following: "A utilization review agent may not, through a retrospective review, reduce or deny payment for health care services or reduce or deny the number of days of inpatient care for which a health insurance policy or health benefit plan provides benefits if the health care services or inpatient days received by the enrollee were preauthorized by the payor under the health insurance policy or health benefit plan." This would not apply if the enrollee's coverage was canceled for fraud, misrepresentation, or nonpayment of premiums; or if the preauthorization was based on a material omission or misrepresentation made by the treating health care provider regarding the enrollee's health condition.

SB 595 – Sen. Chris Harris – Relating to access to certain complaints filed with the Texas State Board of Medical Examiners. A new section entitled, "Complaint Confidentiality" would be added to the Occupations Code whereby the basis of and current status of any complaint under active investigation would be kept confidential.

SB 616 – Sen. Leticia Van de Putte – Relating to the establishment of a medical assistance pilot program for the management

Looking Back

"Celebrating 100 Years of Osteopathic Medicine in Texas"

Mollie Baldwin, D.O., was the first female osteopathic physician to practice in Texas. Research by Craig Elam, Associate Director, Technical Services, of the Gibson D. Lewis Health Sciences Library of the University of North Texas Health Science Center at Fort Worth, notes the following: From her hometown of Plevna, Missouri, she entered the American School of Osteopathy (ASO) in October 1895, graduating June 23, 1897. Dr. Baldwin opened a practice in Brookfield, Missouri, on June 23, 1897, bringing along a student to assist her. In November 1897, she left Missouri to relocate in Waco, Texas. As indicative of the following narratives, Dr. Baldwin was extremely involved in practicing and spreading the concepts and philosophy of osteopathic medicine.

The following appeared in the March 1898 issue of the *Journal of Osteopathy*, in the "Letters From Graduates" section.

"Since I left Missouri in November I have been among those who had never heard of Osteopathy. It is amusing to see people stop, pose and spell aloud from my sign.

"Am located at 828 Austin Avenue, next to the business center on the main car line. I have done business since the first day but not as extensively yet as I would like. I have refused offers in other states and expect to stay here until it gets too warm to work. It is very pleasant here now though we need a fire most of the time.

"My first case was one of paralysis of certain nerves of deglutition. The trouble has affected the patient's speech. The hyoid bone was held out of line by a contracture and this was the cause of the entire trouble. Under Osteopathic treatment the patient has about recovered.

"Next was Jas. B. Baker, a retired capitalist who has suffered for thirteen years from lightning stroke. He has improved from the first. He spent several months of the past year under treatment in New York and Boston.

"Mr. Phillips of Hico, Texas, a former patient of the Infirmary, sent me a friend who was visiting Texas from Bay City, Michigan. He was very much pleased as I relieved him of a severe prickling in his hands and feet which had incapacitated him for work.

"I have several other cases that promise a good recovery, and hope to report them later."

Mollie Baldwin, D.O.
Waco, Texas

The following appeared in the May 1898 *Journal of Osteopathy*, in the "Letters From Graduates" section.

"You never appreciate the Journal till you are too far to know its contents until it comes.

"We are making friends for Osteopathy. I took off a severe attack of neuralgia for a lady who thought she knew about Osteopathy, but she "did not know how to appreciate it until I gave her such wonderful relief."

"One case of painful menstruation (patient would "faint" and fall, cramps, etc.), was all right the first time in two years after two week's treatment. The seventh and eleventh dorsal affected particularly.

"In a case of epilepsy of some standing, and such violence as to have left scars where patient unconsciously tore her flesh. I have the satisfaction of seeing her look in vain for an attack for over five weeks, though she has so fully determined to be incurable that she dare hardly hope yet. Noted specialists told her they could give only temporary relief and were not doing that. Again the seventh and eleventh dorsal and upper cervical were involved."

Mollie Baldwin, D.O.
828 Austin St., Waco, Texas

The following appeared in the July 1898 *Journal of Osteopathy*, in the "Field Notes" section.

Mollie Baldwin, D.O., Waco, Texas - After quoting a number of cases she has under treatment says:

"If we did not forget from one summer to the next how hot the preceeding one was, I would say we are having very hot weather though they say it is comparatively pleasant now. The average Texan thinks he cannot live without his calomel and quinine and it seems even Missourians soon feel them a necessity, but I have existed in Texas six months without either.

"I wish more of my class especially would write to the Journal. I so much enjoy hearing from them."

"Legislative Session"...continued from previous page

of children's asthma. The Medicaid Disease Management Pilot Program for Children's Asthma would be established by the commission in counties, selected by the TDH, with a high incidence of children's asthma and a high rate of hospital emergency room care for the treatment of children's asthma. The pilot program is to provide continuous care, case management, and asthma education to Medicaid recipients younger than 19 who have been hospitalized or received emergency care services for asthma. Health care provider education will also be provided. A report examining the cost-effectiveness of the pilot program; evaluation of the effects of the program; and recommendations for changes in or expansion of the program, is to be submitted not later than December 1, 2004.

For more information, log on to <www.capitol.state.tx.us>.

TRICARE News and Other Related Military Issues

by Retired Army Lt. Gen. Ronald R. Blanck, D.O.
President, University of North Texas
Health Science Center at Fort Worth

Max Facts

Author's Note: Information and comments contained in "Max Facts" are my personal comments. They are not official, regulatory nor policy. They do not state nor imply a Department of Defense, Department of Army, ODCSPER, or Army Retirement Services office, position, policy, statement, or endorsement. "Max Facts" are intended solely for information purposes.

TRICARE, like all health care in this country is at best, confusing for most and totally non-understandable for the remainder. One of the problems with trying to explain TRICARE is the difference in the program between active duty family members and retirees and their family members. There are subtle differences, and not always easy to track. In spite of all the problems TRICARE remains as the most important entitlement to military personnel, both active duty and retirees, and family members. It therefore behooves all of us to try to understand it to the best of our ability.

For military associations, the Army Family Action Plan, the Chief of Staff Army Retiree Council and the retiree councils of the other services, military health care has been the major issue for several years. With the passage of the FY 2001 National Defense Authorization Act (PL 106-398), many improvements in military healthcare became a reality. However, getting information to beneficiaries and getting beneficiaries to understand this information and their overall medical care benefits may be an even bigger task than getting Congress to pass the legislation. Therefore, I want to devote this last issue of **Max Facts** for 2001 to TRICARE.

The changes in TRICARE by PL 106-398 are the most significant changes in military health care since PL 89-614, which established the Civilian Health and Medical Program of the Uniformed Services (CHAMPUS) in 1966. PL 89-614 established CHAMPUS as a cost-sharing program. For outpatient care, after a $150 annual deductive per individual ($300 per family), retirees would be responsible for 25% of the allowable charge; for inpatient care, 25% of allowable charges. One of the problems with early CHAMPUS was the retiree was responsible for all charges over the allowable charge, unless the provider agreed to accept the CHAMPUS allowable as full payment. The other problem, and perhaps the most onerous to retirees as years went by, was the fact that CHAMPUS eligibility ended when the retiree became eligible for Medicare. Many associated this limitation with the advent of TRICARE by PL 103-160 in 1993, when factually it was in effect since the passage of PL 89-614 in 1966.

CHAMPUS was strictly a fee-for-service health care program and was only interim between active duty and Medicare. TRICARE, with its three types of care (fee-for-service, preferred provider and Health Maintenance Organization), coupled with its mail order pharmacy program and continuation after age 65, and the establishment of a so-called Retiree Health Care Trust Fund, makes it almost unrecognizable or comparable to CHAMPUS.

The basic components of TRICARE are Standard, Extra and Prime:

TRICARE Standard is a fee-for service program that permits the beneficiary the freedom of selecting any provider desired. TRICARE Standard, like other fee-for-service programs, entails deductibles, a percentage of the allowable charges and the possibility of filing claims.

TRICARE Extra is a Preferred Provider Organization (PPO) program that restricts beneficiaries' freedom in the selection of providers. A provider must agree to participate in TRICARE and thus accept the TRICARE allowable charge and payment as payment in full, as well as take care of the filing of claims.

TRICARE Prime is a Health Maintenance Organization (HMO) which also restricts the beneficiary freedom in selection of providers. Under TRICARE Prime, there is an annual premium and co-payments. However, the beneficiary does not have to worry about deductibles, co-payments, or filing of claims.

With that as a brief background, some of the PL 106-398 provisions that changed TRICARE are:

1. Effective April 1, 2001, the pharmacy benefit provides Medicare-eligible retirees of the uniformed services, their family members and survivors the same pharmacy benefit as retirees who are under age 65. It includes access to prescription drugs, not only at military treatment facilities, but also at retail pharmacies and through our national mail order service program. There are costs involved, depending upon which aspect of the pharmacy benefit is used. If prescription drugs are obtained at a military pharmacy, there is no cost involved. If prescription drugs are obtained from a TRICARE retail pharmacy, the cost for a 30-day supply is $3 for a generic drug and $9 for a brand name drug.

   If prescription drugs are obtained from a non-TRICARE retail pharmacy, the cost will be $9 or 20% for a 30-day supply after meeting the $150 annual deductible per person or $300 per family. If prescription drugs are obtained from the National Mail Order Pharmacy (NMOP) program, beneficiaries will pay $3 for generic and $9 for brand name for a 90-day supply. Because it has not been completely finalized, these costs could change between now and April 1, 2001, but if they do, I only suspect minor changes.

2. Eligibility for the pharmacy program is as follows:

   Beneficiaries who turned 65 prior to April 1, 2001, will automatically qualify for the benefit whether or not

they have purchased Medicare Part B. Beneficiaries who attain age 65 on or after April 1, 2001, must be enrolled in Medicare Part B.

3. Medicare-eligible military beneficiaries become eligible for all other TRICARE benefits effective October 1, 2001. The law requires that all Medicare-eligible beneficiaries, regardless of age, must be enrolled in Medicare Part B to receive this extension of TRICARE benefits. TRICARE Management Agency (TMA) tells me that OCONUS as well as CONUS retirees must enroll in Medicare Part B to receive TRICARE after age 65. Although this could change, this is how it currently stands. Enrollment in Part B for OCONUS retirees will not give them Medicare benefits, but it will give them TRICARE benefits after age 65. Enrollment in Part B will provide the following benefits or coverage:

   If the medical care received is a benefit of both Medicare and TRICARE, Medicare will pay the allowable amount for the care. TRICARE will pay the amount that is the Medicare cost share, as well as any Medicare deductible. Most, but not all, medical services are a benefit under both Medicare and TRICARE. However, if the medical care received is a benefit of Medicare, but NOT a benefit of TRICARE, Medicare will pay its normal amount and the beneficiary will be responsible only for the Medicare deductible and cost-share. An example of this type of care is certain types of Chiropractic care that are covered by Medicare. This is a factor that must be considered before cancellation of Medigap policies. I would recommend that those with Medigap policies not be too hasty in effecting cancellation. Best to look before you leap.

   If the medical care received is a benefit of TRICARE, but NOT a benefit of Medicare, Medicare pays nothing. TRICARE will pay the amount it pays for the same service received by a retiree under the age of 65. In this case, the beneficiary must pay the applicable TRICARE cost-share and deductibles. An example of this type of coverage is the prescription drug benefit.

4. The health care entitlement for Medicare-eligible beneficiaries will be funded, beginning in fiscal year 2003, through the Department of Defense Medicare-eligible Retiree Health Care Fund established by the Department of Treasury. This basically means that starting in fiscal year 2003, DOD must transfer a yet to be determined amount of money each year into the Health Care Trust Fund which will ensure continuation and funding for the program in the future. While this is a function of accounting and budgeting, it follows the pattern set in 1984 when military retired pay from pay-as-you-go appropriated annual funding to accrual funding.

5. The TRICARE Senior Prime demonstration program is extended through December 31, 2001. This program, AKA Medicare Subvention, provides the reimbursement to DOD facilities for medical care provided to military beneficiaries who are Medicare eligible.

6. Effective April 28, 2001, active duty family members enrolled in TRICARE Prime will no longer have co-payments for civilian health care services under TRICARE Prime (except prescription drugs).

7. Effective October 1, 2001, TRICARE Prime Remote (TPR) program will be expanded to active duty family members throughout CONUS. In the interim, the Department will implement a program to waive co-payments and deductibles of TRICARE Prime Remote active duty family members.

8. An Individual Case Management Program for Persons with Extraordinary Conditions (ICMP-PEC) was funded with a cap of $100 million. In appropriate cases, the program allows waiver of TRICARE limitations on health care coverage, including coverage of custodial care services for persons with exceptional conditions. I don't have full details on this program, but as I get additional information or implementing instructions I will pass them along. This really leaves me with a lot of as yet unanswered questions.

9. The annual TRICARE catastrophic cap for retirees was lowered from $7,500.00 to $3,000.00

10. The chiropractic health care demonstration became a permanent benefit for active duty personnel at designated Military Treatment Facilities worldwide. A five-year phased-in implementation will begin in 2001.

11. Eligibility requirements. These are important and retirees cannot afford to overlook them or to not become familiar with them. Retirees cannot expect to rely upon the excuse that "no one told them" when or if they are denied benefits or are required to pay additional costs. Retirees and family members must enroll in Medicare Part B. Beneficiaries who have already turned 65 and do not have Medicare Part B should purchase it if they would like additional health benefits through TRICARE. Medicare allows enrollment each year from January 1 through March 31. Coverage under Part B will be effective July 1 of the same year. Beneficiaries who have not enrolled may be required to pay a surcharge (adjusted for age) to join Part B. Beneficiaries with questions regarding Medicare and Part B can visit any Social Security Administration (SSA) office, call the Social Security Administration (SSA) toll-free number, 1-800-772-1213, or call the toll-free Medicare number, 800-633-4227. They also can find information on the Medicare web site at <www.medicare.gov>.

    It can not be repeated enough and it must be clearly understood that beneficiaries age 65 and over who do not have Medicare Part B, will NOT have the TRICARE benefit to help pay the cost of their doctor and hospital bills when the new benefit begins October 1, 2001. It does not take a rocket scientist to know that if one is already age 65, does not have Medicare Part B now, or does not enroll in the open enrollment period January 1 through March 31, 2001, they will not have coverage come October 1, 2001.

12. If someone is age 65 or older and doesn't know if they are enrolled in

Medicare Part B, they need only check the back of their Medicare Card. If they do not have a Medicare Card, the possibility exists that the individual is also not enrolled in Medicare Part A, or has lost the card. In either case they should check with a local Social Security office to have a new one issued.

13. What should you do about Medicare Supplemental (MEDIGAP) Policies. If anyone presently has a MEDIGAP policy, the word is to KEEP IT for now. Because of the delayed effective dates, any decision to drop a MEDIGAP based on the new law is premature. TRICARE is working with the Health Care Financing Administration (HCFA), The Military Coalition (TMC) and the National Military & Veterans Alliance (NMVA) to provide the most accurate information on what should be considered before any supplemental policy is dropped.

14. I've received no word yet on what is going to be done about the civilian medical care expiration date that shows up on the back side of our military ID cards. That date should be the date of the ID card holders 65th birthday.

15. Again, a reminder - UPDATE INFORMATION IN DEERS: Beneficiaries should have up-to-date information in the Defense Enrollment Eligibility Reporting System (DEERS). In the coming months, TRICARE will mail, using the DEERS addresses, information to beneficiaries who have received this new entitlement. To ensure that they are not overlooked, eligible beneficiaries must have the most accurate family and beneficiary data in DEERS. Eligible beneficiaries may update their addresses in DEERS in a number of ways:

* Visiting local personnel offices that have an ID card facility;
* Calling the Defense Manpower Data Center Support Office (DSO) Telephone Center at 1-800-538-9552. The best time to call the Telephone Center is Wednesday - Friday, between 9 - 3 (Pacific Time) to avoid delays;
* Faxing address changes to 1-831-655-8317;
* Mailing the change information to the DSO, Attn: COA, 400 Gigling Road, Seaside, CA 93955-6771, visiting a military treatment facility;
* E-mailing information to <addrinfo@osd.pentagon.mil> and include the following information:

1. Sponsor's Name and Social Security Number
2. Name(s) of other family members affected by the address change
3. Effective date of address information
4. Telephone number (to include area code), if available.

To change information other than address data, however, beneficiaries may only visit an ID card facility, mail or fax changes with appropriate documentation to the address/numbers provided above. To learn what documentation is required, call an ID card facility or the DSO toll-free number, 1-800-538-9552. The hours of operation for DSO are Monday-Friday (excluding Federal Holidays), 0600-1530 (Pacific Time).

16. Information on TRICARE and help are available at the following sites:

TRICARE related questions: <TRICARE_HELP@AMEDD.ARMY.MIL> or QUESTIONS@TMA.OSD.MIL>

TRICARE web page: <www.tricare.osd.mil>

TRICARE Beneficiary Discussion Forum: <www.tricare.osd.mil/forums/index.cfm?CFApp=7&>

TRICARE regions map and directory of TRICARE Service Centers: <www.tricare.osd.mil/tricareservice-centers/default.cfm>

TRICARE Claims Forms: <www.tricare.osd.mil/ClaimForms/>

DEERS address change: <www.tricare.osd.mil/DEERSAddress/>

17. There are millions of beneficiaries out there. Will all of them receive the information? No, probably not, but between the efforts of TRICARE, the military associations, and you, we can reduce the number that don't get the word. Never, never, can all of these efforts absolve anyone from their personal responsibility in obtaining information on THEIR benefits and entitlements.

18. Have I missed something? Probably. PL 106-398 made a lot of changes and it will take time to get them explained and understood. Future articles on TRICARE will be shorter and target one specific issue but for now, I thought it important to provide a more comprehensive review so that people know what to focus on in the future.

19. Again, I urge all beneficiaries to take advantage of the periodic briefings presented at military installations by TRICARE and regional contractors.

Self's Tips & Tidings

By Don Self

Carriers Bundling Services

The next time a private or managed care plan incorrectly bundles a service (like an office visit) into a procedure when you correctly used the 25 modifier on the visit, try sending the CEO of the insurance plan a letter stating that you are now sending the following letter to your patients in those instances. Tell them that you no longer will continue with the appeals, since you filed the claims correctly.

Here's a letter to include to the CEO. Then, after checking with your attorney, send this letter to the patient, too. However, beware - if you signed a contract that says you cannot bill the patient even for non-covered services, you are stuck. My advice is to read the contracts before signing and, if they contain garbage like that, either change them or don't sign them.

"Dear Patient,

We have billed your insurance company on your behalf for the recent office visit and cerumen impaction removal. Almost every insurance carrier we have had to deal with in the past has paid this without question, including Medicare and Medicaid. This is important since you know that Medicaid and Medicare are two of the most restrictive plans for payments. Your plan has denied it, even though they claim to use the standards of the industry. Since we billed them, strictly as a courtesy to you, it is your final responsibility to pay for the services you received. We are more than happy to provide you with a complaint form for the state board of insurance and a copy of the denial from your carrier so that you may present it to your employer. We believe it is very beneficial for the employer who is choosing the insurance to know when a carrier is not paying for services that are medically necessary. Those two forms are attached.

Please pay the enclosed statement and let us know if we may assist you in filing a complaint with the state board against your insurance carrier"

There is Life After HMOs

Almost every week, I talk with someone via e-mail or phone who tells me their practice is different and they cannot survive without belonging to every HMO, PPO and every managed care plan that presents to them. What does it take to convince people that they do not have to see 40 patients a day at $40 per patient if they can see 20 patients a day not in managed care and be paid $80 per patient? In other words - you can survive without being at the mercy of every managed care plan out there if you work smart. This may mean that you have to actually be at work 40 hours a week for awhile until you get your patient flow back up, after dropping out of some of the garbage contracts you signed. But what is your self-esteem worth? I apologize if I am offending anyone, but this concept and notion that you have to belong to all of these plans or you will not see any patients or make any money is hogwash. Before you call me and say that I don't know Austin, Texas - be aware that I can name doctors there that belong to no managed care plans and they make more net profits than 90% of the practices signed up with managed care. The same thing applies in Houston, Chicago, Lubbock, New York, etc. Yes, you can survive without managed care, but you're going to have to give service to the patients. You're going to have to not make the patients wait an hour while you're running late before seeing them. You're going to have to give better service to the patients than they get at the clinic that herds them in and out like cattle. If you're willing to do that - you can not only survive - but you'll probably increase your net income to yourself, your clinic and be able to pay your employees a very fair wage.

Your Computer as a Resource

I'm teaching between 40 to 50 seminars a year now. At every seminar, I ask one question in particular: How many of you have internet access at work? Usually, less than half of the hands go up. If I ask how many have a phone, fax or computer, every hand goes up. You wouldn't think about operating a medical business today without a fax, so why are you doing so without the internet as a resource? What can you get off the net? How about: Medicare fee schedules for every location in the country, 2001 CPT codes, Medicare Utilization tables showing if you are using certain codes more often than your colleagues in your specialty, New patient forms, Review of System forms, documentation guidelines, collection courses, etc. Every one of those are on my site at <www.donself.com>. You can talk to other people doing exactly your job and get advice or give advice, via e-mail or live chat. TOMA has an excellent Web site with information, listing of members, legislative affairs, and more. HCFA has their rules, regulations and codes on the net, and the AMA even has the CPT codes on a page. You want legal advice on HIPAA, Stark, False Claims Act, Qui Tam or other issues?

It's on the web. I'm a member of 9 different e-mail listserves. A listserve is a way for thousands of people to forward e-mails to others. When I post a question to a listserve, it goes out to all members immediately, via e-mail. If someone answers, the answer is sent out via e-mail to all members immediately. I get more than 300 e-mails a day via the listserves. The nice part is that you can't ask me a question that I cannot find an answer to. So get online and visit <www.txosteo.org>, my site, HCFA's site and others.

CCI Edits Suspended

If you got frustrated because all of the carriers started including the office visit in with the cerumen removal or they included the x-ray with the office visit and didn't pay for both, here is some good news. On

January 29, 2001, HCFA put all new CCI edits, including the version 6.3, on suspend. While this means that the carriers should not require the 25 modifier on the visit codes in order to pay for the office visit, and they should pay for the x-ray in addition to the office visit, be aware that some carriers are quick to change to things that will restrict payments and slow to change to things that will increase payments. So, watch your payments claims closely and be quick to appeal if they keep denying.

Prolonged Service Code 99354

If I walked into your practice and handed you $100 twice a week, you'd pay attention to what I was doing. I'm telling you that you're missing that much on a regular weekly basis and maybe even more than that in the area of prolonged service. Code 99354 is an adjunct or add-on code that should be used in addition to any other office visit code. If you want to bill for it, you have to document the time (I personally require my clients note start-stop times) and the reason why this normal visit is taking 30 minutes or longer. Medicare's allowed amount is around $100 and private carriers normally pay $150 to $200 for it, in addition to the office visit. If you have any questions on its usage - call me at 800 256-7045 and we'll try to help you.

Clarification from November's Issue

In November's issue, I explained the program that I have doctors all over the country using with cardiac event monitors and 24 hour holter monitors. Apparently, I did not clarify myself enough as I've had several physicians contact me since then asking how much it costs. It does not COST the physician anything. There is no investment, no purchase, no rent and no lease. Yes, the practice makes money and lots of it and the patient is helped, but it does not cost the practice, the clinic or the physician any money. The company I'm working with makes their money from the carriers and the carriers are glad to pay since it saves them money in the long run. Oh, remember above where I said I was walking in and handing you $100 twice a week? Picture that as $100 every day of the week with this service.

Medicare Filing Deadlines

There is a lot of confusion and misunderstanding in this area. Today, you can file your Medicare claims dating back to October 1, 1999. Anything 12 months or longer will be penalized 10% by Medicare, but 90% is still better than nothing. So, if you're in one of my seminars and you learn that you can bill for this trigger point or that venipuncture or this injectable or whatever - consider going back and refiling it to the carrier. If it's over 95 days with Medicaid, don't give up on it completely. Sometimes, all it takes is one simple letter from your state representative (elected official that works for you). I was able to get one office $62,000 one time with a simple letter from a Texas Congressman. All it took was one small supper at a restaurant and my client got the check from Medicaid. Never give up.

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ATOMA News

Dear TOMA Supporter;

It's time to get ready for TOMA's 102nd Annual Convention and Scientific Seminar in Arlington, Texas, June 6 through 10, 2001.

Here's your opportunity to support the Texas Osteopathic Medical Association's Auxiliary at their Annual Golf Tournament and have lots of fun too! Proceeds received from the event are used by the auxiliary to provide scholarships to TCOM students, support the Educational Endowment Fund and the National Ad Campaign.

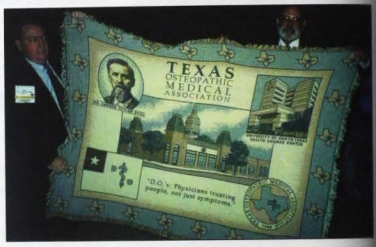
ATOMA is accepting sponsorships for TEE Signs at each hole as well as other great promotional opportunities for your company. Sponsorships are available for $100 to $750.

For more information, e-mail Linda Cole, ATOMA Golf Tournament Chair at <lmcole@amaonline.com>.

ATOMA's

"D.O.'s: Physicians treating people, not just symptoms." blanket/throw

On sale for $65 plus $5 shipping and handling.
For more information, e-mail Joyce Hanstrom-Parlin at <kjparlin@hotmail.com>.



WANTED!

Donations for the Arlington's Women's Shelter
(for Abused Women and Children)

If you plan to attend the 102nd Annual Convention and Scientific Seminar in Arlington, please bring any of the following items to the ATOMA President's Installation Breakfast on Thursday, June 8th:

bath and toiletry items (like the ones we all collect from hotel visits), new or gently used toys, cotton sweat shirts and pants, socks, sweaters, jackets; all to be donated to the Women's Shelter.

Remember: Most families arrive at the shelter with only the clothes on their backs, leaving behind even the most basic necessities, in order escape their violent environment.

Claim management at its best.

Teresa Canant-Finch is a fighter. An experienced fighter. As a senior litigation supervisor for TMLT, Teresa has managed malpractice claims for physicians for sixteen years. She is good at what she does, but is the first to say she doesn't achieve her success alone.

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FOR SALE – Family Practice, Dallas, Texas. No hospital. Will work with new owner during transition period. Established practice 40 years-plus. Call TOMA at 800-444-8662. (23)

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FOR SALE – FAMILY PRACTICE, AUSTIN, TEXAS. Net $200,000/no hospital. Will finance. Will work with new associate/owner during transition period. Contact TOMA at 800-444-8662. (09)

MISCELLANEOUS

FOR SALE – Late model MA X-ray and processor with view box and accessories; hydraulic stretcher; transport stretchers; Coulter counter and diluter; storage cabinets; office desk; assorted other items - very good condition. Contact: Dr. Glen Dow or Office Manager, 817-485-4711. (48)

CLASSIFIED ADVERTISING RATES

TOMA Members - $25 per insertion up to 85 words. $1.00 per each additional word after 85.

Non-Members - $2.00 per word (25 word minimum)

For more information call TOMA at 512-708-8662 or 800-444-8662

www.txosteo.org

ON THE WEB in March

ON 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**
- **Texas FYI**
- **Washington Update**
- **AOA Eye on Federal Agencies**
- **News from the AOA**

- **Texas Stars and Heritage Campaign Members**
  A Listing.

People who have made pledges or have contributed to TOMA's Building Fund Campaign are known to TOMA as "Texas Stars" and "Heritage Campaign Members" 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.

2001 TOMA HOUSE OF DELEGATES

The 56th Annual Meeting of the TOMA House of Delegates will be held on

SATURDAY, MAY 12, 2001

DoubleTree Guest Suites • Austin, Texas
— Across the street from the TOMA office —
For room reservations at the TOMA rate of $139 per night, call the hotel directly at 512-478-7000.
Be sure to mention that you want the "TOMA Room Rate".

This serves as a reminder that any member or district planning to present resolutions to the TOMA House of Delegates' meeting, May 12, 2001, in Austin, must submit such resolution(s) to the TOMA office ***prior to March 15.***

No resolutions will be voted on in the House of Delegates' meeting unless they have been received in the TOMA office prior to the above date. If you have any questions regarding resolutions, please call Paula Yeamans at the TOMA office at 800-444-8662.

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