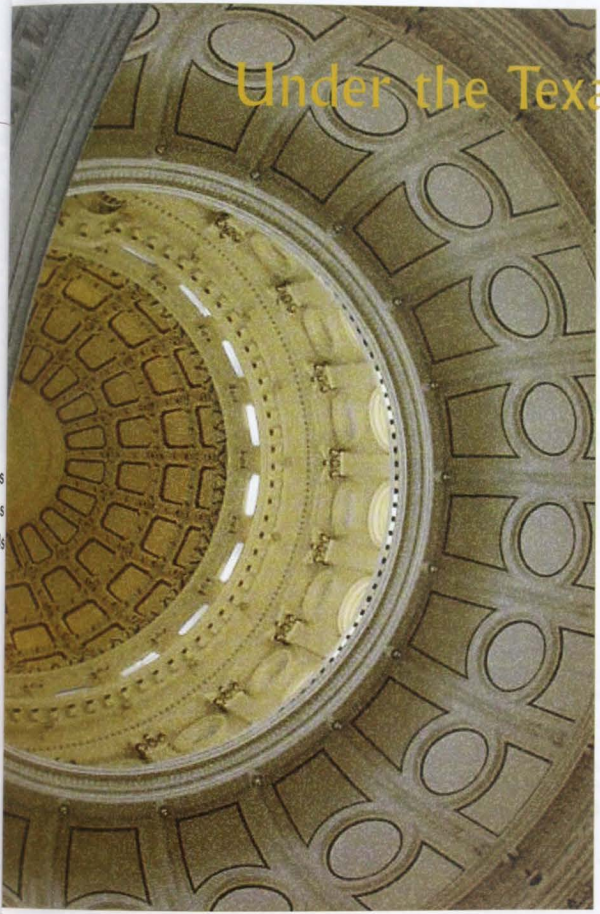
TEXAS D.O.
The Journal of the Texas Osteopathic Medical Association



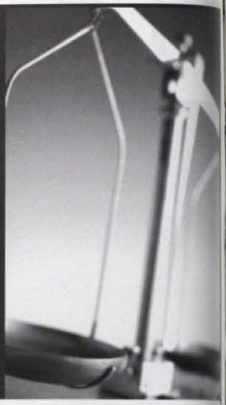
Under the Texas Dome

"All across Texas, doctors are abandoning the medical profession because of soaring malpractice rates and the plague of frivolous lawsuits... the medical malpractice crisis will do lasting damage to the practice of medicine in Texas..."

– Governor Rick Perry

Continuing Coverage of the 78th Legislative Session – page 9

Does Your Current Investment Advice Measure Up?



Our financial advice is based upon the integrity and objectivity that comes from not offering company-owned investment products. Together, we can create a portfolio that you can be sure has your best interests in mind. Would you have it any other way? Call today for more information or to schedule a consultation.

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

MARCH 2003

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Copy and Advertising deadline is the 10th of the month preceding publication.

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Under the Texas Dome

CALENDAR OF EVENTS

MARCH 26-30
"Annual Spring Conference"
Sponsored by Arkansas Society of ACOFP and Arkansas Osteopathic Medical Association
Location: Hot Springs, AR
Contact: Ed Bullington, E.D., Arkansas Society of ACOFP
501-374-8900; FAX 501-374-8959
osteomed@ipa.net or www.arkosteomed.org

APRIL 11-12
"15th Annual Spring Update for Family Practitioners"
Sponsored by the University of North Texas Health Science Center at Fort Worth
Location: Dallas Southwest Medical Center, Dallas, TX
CME: 13 hours category 1-A credits anticipated
Contact: UNTHSC Office of Professional & Continuing Education
800-987-2CME or 817-735-2539
www.hsc.unt.edu

MAY 2
"TOMA Board of Trustees Meeting"
Location: Austin Renaissance Hotel, Austin, TX
Contact: Lucy Gibbs, TOMA Associate Executive Director
800-444-8662; LucyG@txosteo.org

MAY 3
"58th Annual Meeting of the TOMA House of Delegates"
Location: Austin Renaissance Hotel, Austin, TX
Contact: Lucy Gibbs, TOMA Associate Executive Director
800-444-8662; LucyG@txosteo.org

JUNE 12-14
"AOA End-of-Life Care Workshop"
Sponsored by the American Osteopathic Association
Contact: Shelley Morrison, AOA Manager of Public Health
800-621-1773, Ext 8006; 312-202-8006
FAX 312-202-8306; smorrison@aoa-net.org

JUNE 18-22
"TOMA 104th Annual Convention & Scientific Seminar"
Sponsored by the Texas Osteopathic Medical Association
Location: Moody Gardens Resort, Galveston, TX
Contact: Sherry Dalton
800-444-8662 or 512-708-8662
Sherry@txosteo.org

JUNE 21
"TOMA Board of Trustees Meeting"
Location: Moody Gardens Resort, Galveston, TX
Contact: Lucy Gibbs, TOMA Associate Executive Director
800-444-8662

JUNE 25-29
"23rd Annual Primary Care Update"
Sponsored by the University of North Texas Health Science Center at Fort Worth
Location: Radisson Hotel, South Padre Island, TX
CME: 25 hours category 1-A credits anticipated
Contact: UNTHSC Office of Professional & Continuing Education
800-987-2CME or 817-735-2539
www.hsc.unt.edu

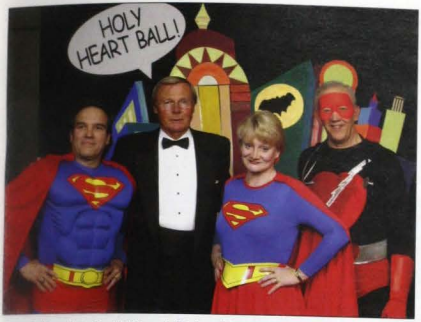
JULY 18-20
"American Osteopathic Association House of Delegates"
Location: Fairmont Hotel, Chicago, IL
Contact: Ann M. Wittner
800-621-1773, Ext 8013; 312-202-8013
FAX 312-202-8212; awittner@aoa-net.org.

SEPTEMBER 5-7
"14th Annual Leadership Conference on Osteopathic Medical Education"
Sponsored by the American Osteopathic Association and the American Association of Colleges of Osteopathic Medicine
Location: Chicago, IL
Contact: Joyce Ratliff, AOA OME Conference Coordinator
800-621-1773, Ext 8080; 312-202-8080
FAX 312-202-8202; jratliff@aoa-net.org

SEPTEMBER 13
"TOMA Board of Trustees Meeting"
Location: TOMA Office, Austin, TX
Contact: Lucy Gibbs, TOMA Associate Executive Director
800-444-8662; LucyG@txosteo.org

OCTOBER 12-16
"108 Annual AOA Convention & Scientific Seminar"
Sponsored by the American Osteopathic Association
Location: New Orleans, LA
Contact: AOA at 800-621-1773

DECEMBER 13
"TOMA Board of Trustees Meeting"
Location: TOMA Office, Austin, TX
Contact: Lucy Gibbs, TOMA Associate Executive Director
800-444-8662; LucyG@txosteo.org



Heart Ball co-chair, Dr. Al O-Yurvati (L) shared the stage with other super heros.

AOA Speaker of the House and Past TOMA President, Dr. Mark Baker and his wife, Rita, enjoyed the gala fund raiser.

Adam West, Donna Blanck and "Heartman" (aka Dr. Ronald Blanck)

POW! ZOK!

Super Heroes Fight Nation's No. 1 Villain

Over 350 super heroes joined forces with Gotham City's Adam "Batman" West in the fight against the nation's No. 1 villain – heart disease – at the American Heart Association's 2003 Super Hero Heart Ball. Held Saturday, February 8 at the Speedway Club at Texas Motor Speedway, the evening featured a super hero theme and honored Ronald Blanck, D.O., president of the University of North Texas Health Science Center, and his wife, Donna, for their contributions to the medical community.

West, who has starred in five television series including the classic *Batman*, served as emcee of the evening. He shared the stage with "Heartman", Fort Worth's caped crusader with the single mission of stamping out heart disease.

Mr. West and Dr. Blanck (who served as Heartman's alter ego) led the live auction, which included such items as Gregory Beck's bronze sculpture, "The Dancers", a trip to Kapaula, Hawaii, a trip to Key Largo, Florida and Stan Briney's western bronze, "Time for Decisions."

"Our volunteers and supporters are the real super heroes," said event co-chair Al O-Yurvati, D.O., associate professor of surgery at UNT Health Science Center. Super hero sponsors of the Super Hero Heart Ball included the University of North Texas Health Science Center, American Airlines, La Buena Vida Vineyards and Bank One.

The American Heart Association spent more than $382 million during fiscal year 2001-2002 on research support, public and professional education, and community programs. Nationwide, our organization has grown to include more than 22.5 million volunteers and supporters who carry out or mission in communities across the country. The association is the largest voluntary health organization fighting heart disease, stroke and other cardiovascular diseases, which annually kill about 950,000 Americans.

The gala, a major fund-raiser for the American Heart Association Fort Worth Division, raised $125,000 for life-saving research and educational outreach programs.

Osteopathic Medicine Day with the Texas Legislature

TOMA's first D.O.M.E. Day, (D.O.'s for Medical Excellence), held on January 29, 2003, was a great success. The surge of osteopathic legislative interest was at a peak as the osteopathic participation came from all corners of the state of Texas to address medical tort reform.

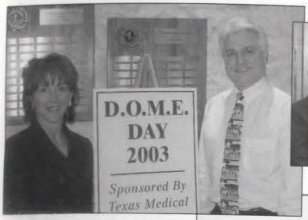
The day long event, coordinated at the TOMA offices in Austin, began with registration staffed by members of the Auxiliary to the Texas Osteopathic Medical Association (ATOMA), Shirley Bayles (the event co-chair), Pam Adams and Beth Beckwith. Over 90 participants were given D.O.M.E. Day bags with a legislative folder that contained extensive information on pertinent bills, capitol and legislative facts, capitol etiquette and capitol complex maps.

Before meeting with their legislators, participants were given a detailed briefing on Professional Liability Insurance (PLI) from Dr. Kenneth Bayles, co-chair of D.O.M.E. Day. Then former House of Representatives Keith Oakley spoke on "How to Effectively Talk to Your State Legislator," and Marsha Jones, Lobbyist for the Texas Alliance for Patient Access, reviewed and discussed the talking points behind PLI Reform.

Physicians, spouses, UNTHSC/TCOM students and legislative advocates were matched with State senators and legislators and sent off to the capitol to discuss the effects of the Professional Liability Insurance crisis and the need for reform in patient access to medical care. TOMA provided each participant with a camera to get candid photos of their D.O.M.E. Day experience, plus brochures, bookmarks and D.O.M.E. Day t-shirts to give to their representatives. The day ended with a debriefing at the TOMA headquarters where experiences were shared and "thank you" notes were written.

The osteopathic participants were well received at the capitol during this exciting day. Many doctors continue to receive follow up calls appealing for support and an increase of understanding from legislators on these critical issues.

Many thanks to Dr. Kenneth Bayles and his wife, Shirley, for their countless hours of hard work and their commitment to bringing osteopathic health care issues to the attention of our legislative representatives.


D.O.M.E.
DAY
2003
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TOMA Board Member Takes to the Airwaves

L to R: Peter Stulting, Sam Tesson, Daniel Saylak, D.O. and Terry Boucher at the TOMA building in Austin, Texas.

On January 25, 2003, the offices of the Texas Osteopathic Medical Association in Austin, Texas were transformed into a radio studio as a pilot program for an upcoming statewide radio program was created. The hosts, Daniel W. Saylak, D.O., an osteopathic family physician and emergency medicine specialist from College Station, as well as a TOMA board member, and Peter Stulting, a regional radio personality and interviewer, conducted interviews with Terry Boucher, Executive Director of the Texas Osteopathic Medical Association, and Sam Tesson, Executive Director of the State Office of Rural and Community Affairs. The program focused on patient access to physicians across the state of Texas, medical liability reforms and the special problems that rural and urban citizens face in developing a relationship with their physician.

Dr. Saylak was originally approached by radio industry leaders in November of 2002 to host a program that dealt with all aspects of the medical sciences. He has been a guest and occasional co-host on broadcasts of *Doctor's House Call*, a regional program originating in the Bryan-College Station area.

Initially, the program will be marketed to the 6 major radio markets in Texas: Dallas, Houston, Austin, Lubbock, Corpus Christi and El Paso. The pilot is currently in the production phase and will be ready for distribution soon. Dr. Saylak also hopes to gain recognition of the program from one of the state's health science centers. "This collaboration will help the program gain instant voracity with the public and potential advertisers," said Saylak. It is anticipated that the program will become interactive, allowing the public to phone in or communicate through the internet with the hosts.

"We hope to cover many different aspects of medicine and medical care", Saylak stated. We do not view this as a means of physician advocacy, but rather an opportunity to answer our listeners' questions about medicine, in an open forum, to explore the things that people care about, not what just interests our hosts."

On January 24, 2003, Texas Gov. Rick Perry officially designated medical malpractice and insurance reform as emergency issues for the 78th Texas Legislature. The designation allows state lawmakers to begin work on these issues within the session's first 60 days.

His message to the Texas Legislature designating medical malpractice reform as an emergency issue is as follows:

January 23, 2003
TO THE SENATE AND HOUSE OF REPRESENTATIVES OF THE SEVENTY-EIGHTH TEXAS LEGISLATURE, REGULAR SESSION:

All across Texas, doctors are abandoning the medical profession because of soaring malpractice rates and the plague of frivolous lawsuits. If this issue is not addressed soon, the medical malpractice crisis will do lasting damage to the practice of medicine in Texas and undermine the access Texans have to the quality, affordable health care they need.

NOW, THEREFORE, I, RICK PERRY, Governor of the State of Texas, pursuant to Article III, Section 5, of the Texas Constitution and by this special message, submit the following emergency matters for immediate consideration to the 78th Legislature, now convened:

Legislation that makes meaningful tort reform for the health care profession including but not limited to capping non-economic losses to plaintiffs at $250,000 and limiting plaintiffs' attorney fees to a prescribed schedule based on the size of the award.

Legislation that creates special courts or designates special judges to hear medical malpractice claims. These judges would have expertise in malpractice issues and would be better able to toss out frivolous lawsuits. This legislation should encourage these special courts or special judges to sanction lawyers and award litigation costs in frivolous cases.

Legislation that improves the Board of Medical Examiners' ability to police the medical profession and safeguard patient care through enforcement of licensing laws and consistent disciplinary enforcement actions.

Legislation that develops a process by which doctors and hospitals around the state can agree upon a clear set of procedures for reducing medical errors, and for clear and swift disciplinary actions against the relatively few bad doctors.

Legislation that extends tort immunity to health care providers who treat low-income patients.

Legislation that provides for a form of temporary, emergency liability insurance coverage for doctors who have been denied coverage solely for economic reasons.

Legislation that expands the Texas Department of Insurance and the Commissioner's exclusive ability to review insurance companies' rates and ensure that medical malpractice premiums are commensurate with losses.

Respectfully submitted,
Rick Perry, Texas Governor

78th Texas Legislative Session UPDATE

Current Bills In the Texas Legislature

HB 6 – Rep. Ray Allen - Relating to the regulation and enforcement of the practice of medicine by the Texas State Board of Medical Examiners. This legislation authorizes the board to establish a physician education and assistance program to ensure that physicians have sufficient knowledge regarding current medical technology and other developments in the practice of medicine. Part of the program would involve the development of procedures to identify and provide assistance to physicians who may be at risk of committing medical errors. In addition, the Occupations Code would be amended to add that the board shall suspend a physician's license on proof that the physician has been initially convicted of "any other offense that is a violent crime." No later than January 1, 2004, the board must adopt rules that prescribe the offenses that constitute a violent crime.

HB 566 – Rep. Leo Berman - Relating to the pursuit of a private claim against a workers' compensation claimant by a health care provider. Under this legislation, a health care provider could pursue a private claim against an injured employee or the employee's insurance carrier if the employee does not contest the denial of benefits by the insurance carrier within 45 days. If, however, the employee contests, he or she must provide written notice to the health care provider who would then be required to stop the pursuit of a private claim until the employee's injury is adjudicated not compensable. Health care providers would be entitled to become a party to the employee's claim and to receive information from the commission and the employee regarding the adjudication of the employee's claim. A health care provider that receives written notice from an injured employee but continues to actively pursue the private claim before the employee 's injury is finally adjudicated, may not recover any portion of any benefits awarded to the employee by the commission.

HB 570 – Rep. Fred Brown - Relating to limiting the liability of certain employers who do not provide workers' compensation insurance coverage. In the absence of intentional act or gross negligence of an employer, the liability of certain employers subject to claims for damages for work-related injuries or death would be capped at $250,000.

HB 579 – Rep. Rob Eissler – Relating to limiting liability of physicians and health care providers for charitable care. In an

action on a health care liability claim, physicians would be exempt from damages, and a hospital's liability would be limited to $500,000, if the care is provided in good faith; provided without compensation; and the patient or guardian signs a statement acknowledging: 1) the care is provided free and 2) limitations on the recovery of damages from the physician in exchange for receiving the care.

HB 627 – Rep. Elvira Reyna - Relating to an area quarantine in response to a bioterrorist attack; imposing a criminal penalty. This legislation would provide for the establishment of an area quarantine, to be determined by the commissioner of public health, in the event of a bioterrorist attack utilizing hazardous substances. Criminal penalties would apply to a person who failed or refused to follow instructions in such an event.

HB 648 – Rep. Toby Goodman - Relating to standard physician contract forms for use in managed care plans. This legislation would establish the Contract Advisory Panel to advise and make recommendation to the commissioner regarding the adoption of standard contract forms to be used by managed care entities when entering into contracts with physicians.

HB 690 – Rep. Garnet Coleman - Relating to health benefit plan coverage for certain physical injuries that are self-inflicted by a minor. Regardless of whether a health benefit plan provides mental health coverage, a plan would be required to provide coverage for an enrollee, from birth through 18 years of age, for a physical injury to the enrollee that is self-inflicted in an attempt to commit suicide; or by an enrollee with a serious mental illness.

HB 759 – Rep. Ron Wilson – Relating to a transportation service to facilitate the purchase of medications near the state border with the United Mexican States. The department would be authorized to provide transportation services for elderly individuals and other residents of Texas traveling to the United Mexican States near the border to purchase medications. Passengers would be charged a small fee for the transportation service.

HB 833 – Rep. Scott Hochberg - Relating to certain pharmaceutical services for an injured employee receiving workers' compensation medical benefits. Employees would be allowed to purchase brand name drugs if prescribed by the prescribing physician, but would be responsible for the cost difference between a brand name drug and a generic drug.

SB 208 – Sen. Chris Harris - Relating to the contents of physician profiles created by the Texas State Board of Medical Examiners. Certain information required in physician profiles would be deleted, including description of a felony conviction, a Class A or Class B misdemeanor, or a Class C misdemeanor involving moral turpitude during the past 10 years, and description of any charges reported to the board during the past 10 years to which the physician has pleaded no contest for which the physician is the subject of deferred adjudication or pretrial diversion, or in which sufficient facts of guilt were found and the matter was continued by a court. Instead, the bill would require a description of any "final" disciplinary action against the physician by the board during the 10-year period preceding the date of the profile including any final disciplinary action taken by the board on medical malpractice claims or complaints required to be reviewed by the board.

SB 229 – Sen. Rodney Ellis - Relating to the establishment of an interagency task force to study health literacy. This legislation would instruct the commissioner of public health to establish the Interagency Task Force on Health Literacy to assist the Texas Department of Health and appropriate agencies in studying health literacy and developing recommendations for improving health literacy in Texas. The task force would : (1) examine the ability of residents to access available health services and communicate with health care providers; (2) identify barriers that prevent residents with low health literacy from receiving health care; (3) identify groups at risk for low health literacy; (4) examine whether providing appropriate health information to and increasing the health literacy of the beneficiaries of public health insurance programs would increase the efficiency of health care providers and decrease expenditures; and (5) examine the impact on health literacy.

SB 247 – Sen. Judith Zaffirini - Relating to a lifetime care task force for certain persons with disabilities. This bill would establish a Lifetime Care Task Force to develop a methodology for analyzing quality of life issues and economic issues relevant to persons with a disability who receive long-term care services or assistance from the state. Basically, the task force would develop a lifetime care plan that would include a list of the long-term care services and forms of assistance that are critical in preventing complications associated with the person's disability, and an estimate of monthly expenses for necessary care and commonly associated co-morbidities.

SB 248 – Sen. Kyle Janek - Relating to the composition and functions of the Texas State Board of Medical Examiners. This bill would change the makeup of the TSBME from 18 to 21 members, to consist of 13 physicians (up from 12 to allow for an additional M.D.); and increases the number of members who represent the public from six to eight. The bill also calls for an additional $15 surcharge for the first annual registration permit and for renewal of annual registration permit. The surcharge would be deposited into the public assurance account to be used to pay the costs incurred by the attorney general in prosecuting complaints filed with the board.

SB 327 – Sen. Kyle Janek - Relating to disease management programs for certain Medicaid recipients. Contract proposals would be requested from providers of disease management programs to provide services to Medicaid patients, who have a disease or other chronic health condition and are not eligible to receive these services under a Medicaid managed care plan. A disease management program would have to include a written guarantee of state savings on expenditures for recipients covered by such a program.

SB 355 – Sen. Kyle Janek - Relating to public health preparedness; providing criminal penalties. This bill basically amends

steps to be taken in a public health emergency to reflect the increasing threat of bioterrorism by biological or other means.

SB 438 – Sen. Jon Lindsay - Relating to disease control programs to reduce the risk of certain communicable diseases. This bill would basically authorize the establishment of disease control programs to combat the spread of infectious and communicable diseases, including HIV, hepatitis B, and hepatitis C. Local health authorities or organizations that contract with a local governmental entity could establish a disease control program that provides for the anonymous exchange of used hypodermic needles and syringes, offers education on disease transmission and prevention, and assists program participants in obtaining health-related services.

SB 462 – Sen. Eliot Shapleigh - Relating to the establishment of an asthma research center at the Texas Tech University campus in El Paso. The Texas Tech Asthma Research Center would be established, in collaboration with The University of Texas at El Paso and the Texas Commission on Environmental Quality. The center shall conduct research related to asthma, and conditions associated with asthma, including health problems associated with industrial pollution and other environmental contaminations in Texas in the region adjacent to the United Mexican States.

Concurrent Resolution Urging Support of Medicare Fix is Filed in Texas Legislature

HJR 3, introduced in the 108th U.S. Congress by Rep. Bill Thomas (R-CA), would freeze physician payments at 2002 rates for one year, and stop the implementation of the final fee schedule rule.

On February 10, HCR 44 by Rep. Robert "Robby" Cook was filed, urging Congress to recognize the impact of proposed Medicare fee reductions by passing HJR 3 and to update the physician Medicare payment formula. HCR 44 is as follows:

CONCURRENT RESOLUTION

WHEREAS, In 2001, nearly 2.3 million Texans were enrolled in Medicare, the federal health insurance program for individuals age 65 and older, and that number is expected to reach approximately 2.7 million by the end of this decade; with so many Texans reliant on Medicare for health insurance coverage, the program accounts for more than 20 percent of all personal health care spending in the state; and

WHEREAS, Despite its vital importance to so many seniors, regulations issued by the Centers for Medicare and Medicaid Services (CMS) in December 2002 would further reduce the amount doctors are paid for treating Medicare patients; this reduction compounds the effect of a similar reduction in the physician fee schedule made during the preceding year; and

WHEREAS, These cuts have had, and will continue to have, adverse effects on health care in Texas and nationwide; an American Medical Association survey conducted in 2002 found that one in four physicians has either restricted or plans to restrict the number or type of Medicare patients treated and one in three has stopped or intends to stop delivering certain services to Medicare beneficiaries; in fact, industry surveys indicate 21.7 percent of physicians no longer accept Medicare patients; and

WHEREAS, Access to health care is already a problem for Medicare patients; the Center for Studying Health System Change indicates that 11 percent of Medicare beneficiaries delayed or did not receive needed care because of problems getting doctor appointments; and

WHEREAS, Recognizing the Medicare crisis, the U.S. House of Representatives approved a bill last year that would have increased doctor payments for Medicare treatment by 1.9 percent in 2003, but the measure did not pass the Senate before the congressional session ended; instead, after weathering the payment rate cut of 5.4 percent in 2002, which cost Texas doctors a total of $139.4 million, further reductions are in store; and

WHEREAS, Under the new CMS regulations, which are based on a calculation methodology specified by federal law, additional cuts scheduled for the next three years will reduce Medicare physician payments by an additional 12 percent resulting in $695 million in losses for Texas doctors, or $17,841 per physician—the fourth largest loss in the country; and

WHEREAS, Texas physicians, also facing steep increases in medical liability premiums and low Medicaid reimbursement rates, are being driven into early retirement or from practicing in certain communities altogether; the increased loss of access to medical care is of particular concern to rural communities where managed care, which represents the primary source for Medicare treatment, has all but disappeared; and

WHEREAS, Legislation currently before Congress would freeze physician 2payment rates at their 2002 level for one year; House Joint Resolution 3, introduced by U.S. Representative Bill Thomas, would halt implementation of the physician payment regulation and prevent the cut in Medicare payments to doctors; now, therefore, be it

RESOLVED, That the 78th Legislature of the State of Texas hereby respectfully urge the Congress of the United States to recognize the impact of proposed Medicare fee reductions by passing House Joint Resolution 3 and to update the physician Medicare payment formula to avoid fee reductions currently scheduled through 2005; and, be it further

RESOLVED, That the Texas secretary of state forward official copies of this resolution to the president of the United States, to the speaker of the house of representatives and the president of the senate of the United States Congress, and to all the members of the Texas delegation to the congress with the request that this resolution be officially entered in the Congressional Record as a memorial to the Congress of the United States of America.

Lieutenant Governor David Dewhurst Announces Senate Committees

The Texas Senate is operating with 15 committees during the 78th regular legislative session, two more than in the previous biennium, according to Lt. Gov. David Dewhurst. Nine committees are headed by republicans, and six by democrats, continuing the Senate's tradition of bipartisanship, Dewhurst noted.

The two new committees are Infrastructure Development and Security, under Chair Steve Odgen and Vice Chair Gonzalo Barrientos; and Government Organization, under Chair Rodney Ellis and Vice Chair Jeff Wentworth.

continued on next page

Additionally, International Relations and Trade, previously the Border Affairs Subcommittee under Business and Commerce, has been elevated to full committee status. It is headed by Chair Eddie Lucio and Vice Chair Eliot Shapleigh. The Redistricting Committee has been combined into Jurisprudence, and one committee, General Investigations, will not be used in this session.

Dewhurst noted that he was particularly impressed, as he has held extended discussions with all 31 senators, with the wealth of experience among the Senate's first termers. Some have extensive legislative records of accomplishment in the Texas House of Representatives, and others have valuable background in health care and business. "We have an extremely talented Senate, enriched by diverse experiences and backgrounds," Dewhurst said.

"Everyone is determined to address the serious issues we face in a spirit of bipartisanship, cooperation and mutual respect," Dewhurst said. "As a body, the Texas Senate is well positioned to handle this year's budget problems and to make Texas an even better place to live and work."

Committees of Texas Senate, 78th Regular Session

Administration Committee has jurisdiction over all operational and administrative matters of the Texas Senate and sets the Senate local and uncontested calendar.
Chair: Senator Chris Harris
Vice Chair: Senator Juan Hinojosa
Members: Senators Mike Jackson, Kyle Janek, Leticia Van De Putte, Jeff Wentworth, John Whitmire

Business and Commerce Committee oversees all matters relating to the general business climate of Texas, including economic development.
Chair: Senator Troy Fraser
Vice Chair: Senator Kip Averitt
Members: Senators Kenneth Armbrister, Kim Brimer, Craig Estes, Mike Jackson, Eddie Lucio, Leticia Van de Putte and Tommy Williams

Criminal Justice Committee controls all matters relating to the penal code and the Texas prison system.
Chair: Senator John Whitmire
Vice Chair: Senator Tommy Williams
Members: Senators John Carona, Rodney Ellis, Juan Hinojosa, Steve Ogden and Bill Ratliff

Education Committee oversees all matters concerning public education and institutions of higher education.
Chair: Senator Florence Shapiro
Vice Chair: Senator Royce West
Members: Senators Kip Averitt, Kyle Janek, Steve Ogden, Todd Staples, Leticia Van de Putte, Tommy Williams and Judith Zaffirini
Note: Education has a Higher Education Subcommittee chaired by Senator West and includes Senators Averitt, Janek, Staples and Van de Putte

Finance Committee oversees all state budget and revenue matters.
Chair: Senator Teel Bivins
Vice Chair: Senator Judith Zaffirini
Members: Senators Kip Averitt, Gonzalo Barrientos, Kim Brimer, Robert Duncan, Kyle Janek, Jane Nelson, Steve Ogden, Florence Shapiro, Eliot Shapleigh, Todd Staples, Royce West, John Whitmire and Tommy Williams

Government Organization Committee will examine the organization of state government in an effort to improve efficiency.
Chair: Senator Rodney Ellis
Vice Chair: Senator Jeff Wentworth
Members: Senators Kenneth Armbrister, Teel Bivins, Kim Brimer, Bill Ratliff and John Whitmire

Health and Human Services Committee provides oversight on all matters concerning public health and welfare.
Chair: Senator Jane Nelson
Vice Chair: Kyle Janek
Members: Senators John Carona, Bob Deuell, Mario Gallegos, Jon Lindsay, Bill Ratliff, Royce West, and Judith

Infrastructure Development and Security Committee oversees state transportation issues as well as homeland security.
Chair: Senator Steve Ogden
Vice Chair: Senator Gonzalo Barrientos
Members: Senators Bob Deuell, Rodney Ellis, Jon Lindsay; Frank Madla, Florence Shapiro, Eliot Shapleigh, and Jeff Wentworth

Intergovernmental Relations Committee oversees all affairs between state and local governments.
Chair: Senator Frank Madla
Vice Chair: Senator Kim Brimer
Members: Senators Bob Deuell, Mario Gallegos and Jeff Wentworth

International Relations and Trade Committee oversees all matters concerning trade relations with foreign countries.
Chair: Senator Eddie Lucio
Vice Chair: Senator Eliot Shapleigh
Members: Senators Teel Bivins, John Carona, Craig Estes, Jane Nelson and Judith Zaffirini

Jurisprudence Committee oversees matters pertaining to the court system and all areas of law except penal law.
Chair: Senator Robert Duncan
Vice Chair: Senator Mario Gallegos
Members: Senators Kip Averitt, Teel Bivins, Chris Harris, Eddie Lucio and Royce West

Natural Resources Committee has jurisdiction on all matters concerning the conservation of natural resources and the control of land and water development.
Chair: Senator Kenneth Armbrister
Vice Chair: Mike Jackson
Members: Senators Gonzalo Barrientos, Robert Duncan, Craig Estes, Troy Fraser, Juan Hinojosa, Eddie Lucio, Jon Lindsay, Florence Shapiro and Todd Staples
Note: Natural Resources has an Agriculture Subcommittee chaired by Senator Duncan and including Senators Lucio and Estes

Nominations Committee considers all gubernatorial appointments to facilitate the constitutional duty of the Senate to advise and consent.
Chair: Senator Jon Lindsay

Vice Chair: Senator Bob Deuell
Members: Senators Gonzalo Barrientos, John Carona, Chris Harris, Juan Hinojosa and Mike Jackson

State Affairs Committee oversees all matters concerning state policy and the general administration of state government.
Chair: Senator Bill Ratliff
Vice Chair: Senator Todd Staples
Members: Senators Kenneth Armbrister, Robert Duncan, Rodney Ellis, Troy Fraser, Chris Harris, Frank Madla and Jane Nelson

Veterans Affairs and Military Installations Committee oversee issues facing veterans and matters concerning military base closures.
Chair: Senator Leticia Van de Putte
Vice Chair: Senator Craig Estes
Members: Senators Troy Fraser, Frank Madla and Eliot Shapleigh
Note: Veterans Affairs has a Base Realignment and Closure Subcommittee chaired by Senator Shapleigh and including Senators Fraser and Madla

An Invitation
to the 3rd Annual President's Ball

All osteopathic physicians in Texas are invited to join UNT Health Science Center President Ron Blanck, D.O., at the elegant City Club of Fort Worth on April 12, 2003, for the 3rd Annual President's Ball, "Steppin' Out in the Roaring 20s."

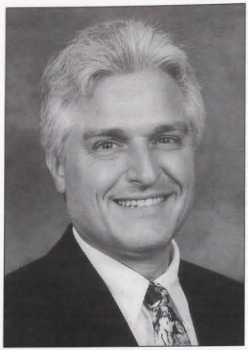
This fundraising gala will feature authentic ballroom, Broadway, blues, jazz and popular tunes from the 1920s, dance and costume contests. A silent auction featuring antiques, gourmet meals, fine jewelry and vacation getaways to destinations such as Cancun, Niagra Falls, Santa Fe and the Delaware coast will also take place. It's a black tie and period costume affair, so there's also the chance you could find yourself dining and dancing with a Ziegfeld Follies beauty, Charlie Chaplin, Rudolph Valentino, Mae West, Al Capone or a character out of an Agatha Christie mystery!

Sponsorships are available at the $10,000, $5,000, $3,000 and $500 levels, and are tax-deductible. Donor benefits range from a dinner for 10 hosted by the Blancks at their home to VIP campus tours and receptions with the president.

TOMA Auxiliary President Pam Adams, who chairs the ball's Silent Auction Committee, says that this annual event isn't just a great party, but the primary method of growing an increasingly important financial resource for Texas' only osteopathic medical school and the health science center as a whole. Adams explained that net proceeds from the ball go into the President's Progress Fund, "which helps our school achieve what state allocations cannot." Some examples of how donations are used, she said, include alumni activities at state and national conferences, financial assistance for student organizations, seed money for clinical and research initiatives, and the ability for President Blanck, his staff and faculty members to go "on the road" to cultivate donors and gain greater awareness of the school's educational, research and patient care capabilities and accomplishments.

Acquiring donations to the President's Progress Fund are more important than ever, Adams said, in light of the State of Texas' budget crisis and its severe impact on state agencies such as the health science center. On the Fort Worth campus there has been a hiring and wage freeze, more than a dozen layoffs and a reduction in some services - a $3.1 million total cutback. Further reductions are possible next fiscal year as well.

Information on sponsorships, individual tickets and how to donate items and services to the silent auction is available by calling the health science center's Office of Institutional Advancement at 817-735-5493. The ball is organized by Institutional Advancement and an all-volunteer President's Ball Planning Committee. Joining Adams on the committee are Betty Barnett, Donna Blanck, Ann Brooks, Marie Lansford, Sandra Lewis, Susan Motheral, PhD, Susan Selman and Kay Day, who serves as chair.



What Good Doctors "D.O."

by James E. Froelich, III, D.O., TOMA President

In January, I read an excellent article by Clifford Burross, M.D., the president of the Texas Medical Foundation (TMF) Board. His article, "What Good Doctors Do" was a response to and commentary on the poor performance by Texas in the most recent quality indicators measured by the Centers for Medicare and Medicaid Services (CMS). These indicators showed that Texas physicians are generally improving in our professional clinical performance but not as rapidly as most other states.

This puts us in a precarious position concerning the perception of the quality of healthcare and healthcare providers in Texas. Medicare asserts that their quality indicators are statistically valid and verify the quality of practices in all states. Texas is generally at the bottom of most categories. Hey, that's us they are talking about!

Not only are we being judged by CMS (Medicare/Medicaid), but these rankings are also on the Internet – public records now, y'all! Things were so bad in Texas that TMF formed a special task force to consider what we can do to improve our dismal national rankings.

The task force, called the Coalition for Medical Quality (CMQ), is exploring all of the reasons, failures and excuses that surround the report. We all agreed that the measurement methodology (and therefore our federal ranking) could be flawed. We also agreed, however, that these are the standards by which CMS is going to hold and judge us. Like it or not, we are going to have to do better.

In discussing the data, the committee had widely varying opinions but the resolution to the problem always went back to one thing: We, the physicians, are the solution. Not only that, but we become the solution doing what we know is best for our patients. Simply stated: It's what good doctors do. It's the way we all mean to practice but somehow it's not written down, not followed up, not documented well enough, or it just slipped our mind because we are all just so darn busy. As it turns out, the quality indicators measure the things that most of us mean to do 100% of the time anyway. It's what good doctors do and we are good doctors.

We know that most of our Medicare patients should be immunized against flu and pneumonia and we have tried to tell them. We have told them to be on aspirin, get off of cigarettes, have biennial mammograms, and have annual lipid profiles (especially our diabetics). Despite our efforts, we continue to fall behind the rest of the nation statistically. We can do better because it's what good doctors do.

Looking at the 22 quality indicators studied by CMS in the "sixth scope of work" (Quality Indicators, figure 1), I find that they can be broken down into three categories: Malpractice/liability potential, What good doctors do, and What good doctors do in hospitals. The Medicare quality indicator summary is organized by these three categories.

First, there are quality of care issues measured by the CMS quality indicators that can potentially generate allegations of malpractice if done or not done. These include the use of sublingual nifedipine in acute CVA, failure to place chronic a-fib patients on warfarin, timely reperfusion post -MI, or failing to place CVA patients on proper antithrombotics at discharge. Other indicators that could potentially be in this category are failure to place AMI patients on beta-blockers and aspirin at discharge, and not ordering biennial mammograms. These really should fall under "Other good practices" but in Texas with our present tort system – watch out. These are potential lawsuits.

The next category would be "What good doctors do." You know… flu shots, pneumonia vaccines, annual HgbA1C's and lipid profiles in diabetics, dilated retinal exams in diabetics, appropriate ACE therapy as well as the mammograms, aspirin therapy and beta-blockers mentioned above. We all do these things don't we? Well, I thought so too, but look at the table of Quality Indicators. We appear to be failing our patients on these simple things, or at least we are failing to document our good practices.

Then there is the category, "What good doctors do in hospitals." Sure, there are variations in practice styles and opinions, but generally most of us mean to give aspirin and beta-blockers within 24 hours of an AMI admitted to the hospital. We mean to send those people home on aspirin, beta-blockers and usually an ACE inhibitor. In our hospitalized pneumonia patients, we mean to get blood cultures and sputum cultures prior to antibiotics and to administer the most appropriate antibiotics just as soon as possible - but other things get in the way. Intrinsic to this set of indicators are hospital systems, practices, and personnel. Consequently, hospital systems and practices are going to have to be analyzed, tweaked, and revamped as a part of the solution to improving. This is where TMF can really help physicians and hospitals.

The first part of the solution starts with educating and informing you. TMF is working on several multifaceted solutions that may include educational articles and speakers, prompters for the hospitals and "tool kits" for hospitals. TMF may develop

continued on page 3

Texas Medical Foundation
Texas Baseline Rates/Remeasurement Rates for the CMS National Medicare Quality Indicators

CLINICAL TOPICS AND QUALITY INDICATORS	BASELINE		REMEASUREMENT	
	Rank*	Rate	Rank*	Rate
INPATIENT	10/1/98 - 3/31/99			
Acute Myocardial Infarction			1/1/01 - 6/30/01	
Early administration of aspirin	45	78.0%	41	82.5%
Early administration of beta blockers	49	50.7%	41	64.7%
Timely reperfusion (median time)	20	39.7%	41	47.4%
Angiotensin converting enzyme inhibitors at discharge	44	62.9%	50	63.5%
Smoking cessation counseling during hospitalization	52	19.4%	37	37.0%
Aspirin at discharge	32	83.7%	50	74.9%
Beta blockers at discharge	48	58.1%	41	71.8%
Atrial Fibrillation			1/1/01 - 6/30/01	
Discharged on warfarin	49	44.5%	49	48.2%
Heart Failure			1/1/01 - 6/30/01	
Assessment and treatment of low LVEF	39	74.2%	43	75.6%
Pneumonia			10/1/00 - 3/31/01	
First antibiotics within 8 hours	44	80.4%	48	82.2%
First antibiotic consistent with recommendations	19	79.8%	30	84.4%
Blood culture before antibiotic	23	84.1%	32	81.1%
Inpatients screened for, or given, flu immunization	36	11.7%	45	16.6%
Inpatients screened for, or given, pneumococcal immunization	40	8.4%	42	17.4%
Stroke			1/1/01 - 6/30/01	
Antithrombotic at discharge	52	72.0%	46	79.5%
Avoid sublingual nifedipine rate	47	89.8%	41	97.5%
OUTPATIENT				
Breast Cancer	1/1/97 - 12/31/98		10/1/99 - 9/30/01	
Biennial mammography screening rate (age 50-67)	44	51.5%	42	56.2%
Diabetes	7/1/97 - 6/30/99		10/1/99 - 9/30/01	
Annual HbA1c rate	21	72.8%	37	75.3%
Biennial lipid profile rate	4	65.7%	10	77.0%
Dilated eye exam rate	31	68.3	40	64.9%
Pneumonia	BRFSS 1999		**	
Influenza immunization rate	18	68.0%	42	68.7%
Pneumococcal immunization rate	31	44.4%	39	61.6%

Out of 52 states/territories

****CMS survey conducted in 2002 to determine immunization rates**

continued from page 14

templates concerning pneumonia, AMI, and standing orders for smoking counseling. There may also be other pieces developed on how to appropriately charge for immunizations in doctors' offices and hospitals so that we get paid properly.

Success depends on one thing, the Texas physicians. If we fail to buy in, then TMF fails and our state will suffer the consequences. Phil Dunne, executive director of TMF cautions, "We are going to have to take this whole thing in bite-sized chunks so that we can digest it." Mr. Dunne voiced his concern that Texas has scored so poorly because, "we all know that good medicine is being practiced in Texas" but the new numbers do not reflect that quality. These numbers can be used against us. " We want to get started on the solutions right away," Mr. Dunne urged.

Mr. Dunne informed the committee that the initial thrust by TMF would be threefold: 1) smoking cessation counseling, 2) pneumonia and flu vaccinations, and 3) pre-op antibiotics being administered one hour prior to surgery. The committee felt that these items would be easy to improve upon and would make an immediate impact.

Wow, that seems easy! Let's see, a standing order or policy that mandates pre-op antibiotics be administered just prior to surgery (not to exceed 60 minutes) and nursing adherence to that policy. That seems simple. Why are our Texas hospitals not already performing to this standard?

How about if we institute a policy that offers automatic smoking counseling by respiratory therapy or nursing to all smokers who are admitted to our hospitals? All that we would need to do then would be to document it or document that they declined the service. A nurse could do that as a part of the initial nursing assessment. Surely we can improve and raise our Quality Indicator from a miserable 37.0%. The worst that could happen is that the patient could refuse the offer of counseling.

The pneumonia vaccine standard is my favorite. The indicator will be whether or not the hospitalized pneumonia patient was asked if he/she has received a pneumonia vaccine and a plan of action for those who have not. A tiny stamp or sticker placed on the nurses' physical assessment form and a trained nursing staff should get that indicator score up in the 80th or 90th percentile in a few months.

Let's face the facts. The CMS and their quality indicators are not going to go away. These are the indicators by which we will be judged in the future. We are going to have to do better this next time. We know that our Texas physicians practice the highest quality medicine. It will be TMF's job to help us bring that fact to light. Ultimately, regardless of TMF's efforts, we the physicians hold the key. The solution will be easy because it's what best doctors do and that's us.

ATOMA News

We thank and welcome all of you who joined ATOMA during our most recent membership campaign. You have chosen to become a part of a dynamic group of supptorters of the osteopathic profession both in Texas and around the nation!

For those of you who, for some reason may have put that applicatin aside, and forgotten about us, we are still graciously accepting applications! If you have lost that application you should e-mail Lucy Gibbs at the TOMA Office at <LucyG@txosteo.org>. with your name and mailing information. You can also e-mail me at <Bagalar1@aol.com> with questions or a request for an application. If you do not have e-mail, the TOMA office phone numbers are 512-708-8662 or 800-444-8662.

We hope that you are planning to attend TOMA's 104th annual convention in Galveston on June 18-22. ATOMA will have a booth in the Exhibit Hall. If you are a new member, please stop by the ATOMA Booth to get aquainted. We'd love to meet you! Plus, place bids on some of the wonderful items we will be auctioning off through our Silent Auction during the Presidents Banquet.

Self's Tips & Tidings

By Don Self

HIB Vaccine Codes

The Centers for Medicare and Medicaid Services (CMS) is changing its mind again concerning coding for hepatitis B vaccines for the next few months. They sent out a directive in November of 2002 that it would be deleting CPT codes 90740, 90743, 90744, 90746 and 90747, and replacing them with HCPCS codes Q3021, Q3022 and Q3023 starting on January 1st of this year. Now they are saying on April 1st they are reactivating the CPT codes.

The CMS announcement said, "Effective January 13, 2003, if a claim with a date of service January 1, 2003 through March 31, 2003 is received containing CPT codes 90740, 90743, 90744, 90746 or 90747 it will be returned to the provider." The problem is that CMS has also told the carriers to return any claims with the Q codes (Q3021, 22 or 23) to the provider. So, hold onto all claims for Hep B until April 1st, per CMS. If one of these codes appears on a claim with several other items, just pull out that one item and then submit the rest of the claim. If you file a claim for several items and one of them is one of the G codes shown above, don't be surprised if the whole claim is denied.

"This isn't at all unlike Medicare," states consultant Robyn Lee with Brooks Consulting in Chicago. And providers need to pay attention to this information, she said. If a provider sends in a claim containing one of these codes in addition to several others, "the whole claim would be denied. So you really do want to pull that one item off and not bill for it" until the time is right, she concludes.

Using Time to Determine Level of Office Visit

Let's say a Medicare patient, with dementia, whom you've been seeing for 10 years comes into the office with her grown daughter. After six minutes of reviewing the history, performing an exam and discussing drugs, you enter into a 20-minute discussion with the daughter about coordination of care in the home and coping with mom's dementia. If you don't take the 20-minute conversation into account and instead code only based on the limited encounter or limited history and exam, the visit may just be a 99212. But, since the 20 minutes you spent counseling and coordinating care with the family member made it a 26-minute visit and more than 50 percent of the visit, it automatically becomes a 99214. Although you may want to document the history/exam/mdm for the visit to remind yourself for next time, it's not necessary for coding purposes. Too often, physicians under-code their services..

Keep in mind that counseling for E/M services involves a discussion with the patient or family about one or more of the following: diagnostic results or recommended tests, prognosis, risks/benefits of treatment, instruction for management or follow-up, importance of compliance, or risk factor reduction/patient education. It does not include psychotherapy which requires the time-based psychotherapy codes (90804-90857).

Using Code 99058

When a patient presents at the physician's office and requires unscheduled emergency care, you should use code 99058 in addition to the other services provided, including office visit codes (use modifier 25 on the office visit). This is reported for those patients whose condition, in the clinical judgment of the physician, warrants the physician's interrupting his/her care of another patient to deal with the "emergency." You shouldn't use this code when the doctor's normal schedule has urgent care slots available in the schedule and patients are "worked into" the schedule.

Having Everyone Sign a B.A. or C.A.

While some may recommend you have everyone who has access in your practice (other than patients) sign a Business Associates agreement, several attorneys intimately familiar with HIPAA recommend otherwise. Apparently, the BA has contractual issues associated with it. Along the same lines, those most in tune with HIPAA say that a Confidentiality Agreement (CA) is not needed for pharmaceutical representatives since the only disclosure they would have to PHI (protected health information) would be "incidental," which goes for the janitorial staff as well. However, if your physician shows a patient's chart to a pharmaceutical representative to get their suggestions on dosage or something similar, then you would need a CA signed by the representative.

Which UPIN to Use?

If you're filing claims for yourself and you have a Medicare number, then you know your UPIN. But what if you add another physician or provider to your practice or you're doing a consultation requested by another physician? What UPIN do you provide in block 17 on the claim form? Here are the surrogate UPINs that Medicare wants you to use on the claim.

OTH000: Used when the ordering/referring physician has not yet been assigned and does not qualify for one of the other surrogate UPINs.

RES000: Used by physicians meeting the description of "intern," "resident," or "fellow."

VAD000: Used by physicians serving on active duty in the United States military and those employed by the Department of Veterans Affairs.

continued on next page

PHS000: Used by physicians serving in the Public Health Service, including the Indian Health Service.

RET000: Used by retired physicians who have not been issued a UPIN. (Retired physicians who have been assigned a UPIN must use the assigned UPIN.)

Can't Afford to Send Your Staff to a Seminar?

It does get to be a little expensive to send your entire staff to a seminar, so to make things easier for you (and them), check out the live audio seminars on my web site at <www.donself.com> on coding, E&M documentation, HIPAA and more. You can have a room full of folks listening for the same price as one.

G0001, 36415 & 36416 for 2003

For 2003, the CPT Editorial Panel revised specimen collection code 36415 to represent collection of venous blood by venipuncture and added code 36416, collection of capillary blood specimen (e.g., finger, heel, ear stick). However, CMS must undertake further efforts before implementing codes 36415 and 36416. For 2003, the clinical laboratory fee schedule will continue to include code G0001, routine venipuncture for collection of specimen(s) and laboratories should continue to bill code G0001 for Medicare payment of venous blood collection by venipuncture

HIPAA and Brown Paper Bags On Patients' Heads

The December 3, 2002, guidance from the Office for Civil Rights included the following clarifications:

The HIPAA privacy rule is not intended to impede "customary and essential communications practices," such as sign-in sheets, nursing station whiteboards, and confidential communications among providers that may be overheard by visitors. These incidental uses and disclosures are permitted when a covered entity puts in place reasonable safeguards and minimum necessary policies and procedures.

The privacy rule does not require structural changes, such as soundproof or private rooms or system changes such as the encryption of emergency medical radio or telephone transmissions.Be careful where you get your HIPAA information. So far, more than half of the things repeated to me by people that have attended a HIPAA seminar has been incorrect. That is why we're doing HIPAA audio seminars now.

Screening DRE and PSA

Screening Digital Rectal Examinations - Screening digital rectal examinations (HCPCS code G0102) are covered at a frequency of once every 12 months for men who have attained age 50 (at least 11 months have passed following the month in which the last Medicare-covered screening digital rectal examination was performed).

Screening Prostate Specific Antigen Tests - Screening prostate specific antigen tests (code G0103) are covered at a frequency of once every 12 months for men who have attained age 50 (at least 11 months have passed following the month in which the last Medicare-covered screening prostate specific antigen test was performed).

HIPAA Certified Training

Be careful if someone calls you and says your employees must attend HIPAA certified training. This would be like someone calling you and saying you have to attend a mandatory Medicare seminar. Neither one exists. Yes, your staff does need to be trained on HIPAA, but there is no HIPAA certification required or mandated by the government. Anyone telling you this may be trying to sell you something.

Cardiac Monitor Billing Mistakes

If you are providing 30-day cardiac event monitors to your patients to monitor their arrhythmia, you should be aware of the proper and improper billing techniques. Some one may tell you that their company will do the billing for you, and even try to make you believe they can ge more money by doing the billing than you can, with some nonsense about profiles. My advice is that you never let any monitoring company bill for your services. You bill for yours and let them bill for theirs. Remember, if someone billing for you and the services you provide uses improper codes, it will be YOU that is held liable if you receive payments on those claims. Along those same lines, if someone tells you that it's okay to use 30 charges of code 93235 for a 30-day cardiac event monitor, be very careful. In my opinion (and that of every certified coder we have asked), that could get you into more trouble. We recommend you bill for your own services using code 93270 and 93272 for the hookup and interpretation and never use code 93235 with multiple units.

If you're not using cardiac event or holter monitors in your practice and want to talk to us about what company we recommend, please give us a call at 800 256-7045. When someone says that they are recommended by Don Self & Associates, give us a call and make sure they're telling you the truth.

Charging Initial Consultation Codes On Established Patients

You have to be careful where you get your information. Someone is telling offices that you cannot charge an initial consult code (99241 – 99255) on established patients and that is false. You are allowed to use these codes on new or established patients. The only requirement is that it is a consult requested by another health care professional. Also, you can charge a consult EVEN if you do initialize treatment on the patient at the time of the consultation. That has never been a problem, even with Medicare.

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Letters to the Editor

Dear Editor;

There is great concern regarding the increasing cost of prescription drugs and the inability of many patients who need them to afford them. The federal government will soon propose some method of subsidizing this expense for persons covered by Medicare, Medicaid, and other federal health programs at a cost of billions of dollars, which means increased taxes and deficit spending.

The price of these drugs is determined by the cost of development, production and distribution. One area where the biggest increase in cost has occurred is in marketing, where the emphasis has shifted from informing physicians regarding a new medication available for prescription to advertising in the media to create a patient demand for a particular brand name of that drug.

A few years ago, the promotion of a brand-name prescription drug through televised and printed advertisement was unheard of and even considered unethical. Now the phrase, "ask your doctor if such and such is right for you" is commonly seen and heard in televised and printed advertisements, which cost billions of dollars paid by pharmaceutical companies competing with a product of another company which may be prescribed to treat a disease or symptom.

This promotion does not increase or decrease the incidence of the disease or the success of its treatment. It does not even increase the amount of the drugs prescribed and sold to treat the disease. It only asks the individual to suggest what particular medication the physician should prescribe, hoping to increase the sale of that particular brand drug and decrease the sale of some equally effective medicine the physician might otherwise prescribe.

In view of the above, I believe that TOMA and the AOA should initiate an effort to focus the attention of both the medical profession and the federal government on this matter, and propose legislation to prohibit the advertisement to the general public of a brand-name prescription drug. This would not preclude advertisements to inform people about health problems or their treatment but would forbid the promotion of a particular brand-name product. Such legislation would result in decreased cost of prescription drugs and an increased use of those drugs that the physician believes is most efficacious and cost effective.

D. H. Hause, D.O.
Juriquilla, Mexico
(Editor's note: The author, a retired surgeon, served as TOMA president from 1980-1981.)

Dear Editor;

Since 1934, the National Board of Osteopathic Medical Examiners has provided the osteopathic profession with an instrument to assess the knowledge and skill required to gain licensure to practice osteopathic medicine.

In order to fully accomplish our mission, we must assure that the test items that provide the basis of the COMLEX-USA series are reflective of current principles and practices within the various disciplines of osteopathic medicine. It is most important that the items submitted mirror many aspects of practice including, but not limited to, geographic variance and the applicability of osteopathic techniques across all specialties. Likewise, the information in the test item should be referenced by a recognized text, journal or national meeting, whenever possible.

To broaden the scope and number of test items, it is important to involve as many qualified osteopathic practitioners from both the academic and private practice arenas to write test items for the

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NBOME. To this end, I am writing to you to encourage you and the members of the Texas Osteopathic Medical Association that are so inclined, to become active participants to help us and the profession help you maintain the uniqueness and distinctiveness of osteopathic profession. You can do this, regardless of your specialty, by accepting an assignment from the Level coordinator and writing a quality referenced test item incorporating subject matter from specialties as well as test items in OMM/OPP.

The contribution of each individual item writer is of critical importance to the process. If for example, 500 items are required for a discipline in the examination, nearly 750 items are required for the item review process as a percentage of the submitted items are typically rejected. From the item writer's pool , some 950 or so items are required to generate the reviewable test items based on the current rejection rates from the submitted item pool. Whenever one item writer fails to submit his/her assigned test items, an extraordinary burden is passed on to other items writers who willingly contribute or to the construction committee member's, who must prepare additional test items before the test items can be ultimately utilized.

You are reminded that your members will receive 1 hour of 2-A credits from the AOA, for each test item that is written. Ordinarily, it takes approximately 1 hour to construct a well designed, referenced test item in the format requested by the Level committee.

Please have interested society members contact Dr. Michael Warner. (Level 1) at <mjwarner@charter.net>, Dr. Deborah Pierce (Level 2) at <pierce-deborah@copperhealth.net>, Dr. Carman Ciervo (Level 3) at <ciervo@umdnj.edu> or Dr. Elaine Wallace (OMM/OPP) at <ewallace@nova.edu>, if your members are willing to donate their time and energy to assist us in maintaining the quality and currency or our licensing examination. Your efforts will benefit our students, the profession and yourself, while promoting osteopathic medicine for the future.

Sincerely,
Fredrick G. Meoli, D.O., FACOS
NBOME President

Blanck Named to New Biodefense Council for Academic Health Centers

The Association of Academic Health Centers has named Ronald R. Blanck, D.O., president of the University of North Texas Health Science Center at Fort Worth, to its new Biodefense Council.

Comprising 12 current and former chief executive officers of academic health centers nationwide, the council is examining how academic health centers are participating in the development and operation of defenses against bioterrorism and other defense-related threats.

"Academic health centers need to be in the forefront of preparing for the consequences of weapons of mass destruction and particularly biologic agents because of the expertise on our campuses," said Dr. Blanck, a retired lieutenant general and former Army Surgeon General. "We are uniquely positioned to facilitate the coordinated planning of the various organizations who have responsibilities in this area."

"I am pleased that so many academic health center leaders will be engaging in this strategic planning effort to address critical national concerns. Academic health center leaders bring a wide range of expertise and experience in emergency preparedness issues that will make an invaluable contribution to policies and practices that will affect the health and well being of the entire nation," said Roger J. Bulger, M.D., president of the AHC.

Heading the council is Gregory Eastwood, M.D., president of the State University of New York Upstate Medical University, and past chair of the AHC board of directors. Biodefense activities were initiated by Dr. Eastwood who took office as chairman of the board soon after the terrorist attacks of September 11, 2001.

"Biodefense is a priority issue for the board of directors; the council is an outgrowth of our post-September 11 actions and highlights our commitment to protecting the nation's health and well being in the many realms of academic health center responsibilities," Dr. Eastwood said.

The Association of Academic Health Centers is a national, nonprofit organization dedicated to improving the health of the people by advancing the leadership of academic health centers in health professions education, biomedical and health services research, and health care delivery. About 100 institutions are members of the national, non-profit association.

Health Science Center Seeks Volunteers for Diabetes Prevention Clinical Trial

At least 16 million Americans have a condition known as "pre-diabetes," where their blood sugar levels are higher than normal but not high enough to be diagnosed with diabetes. People with pre-diabetes are at risk of developing type 2 diabetes, a condition resulting from the body's inability to correctly use insulin.

As part of its efforts to learn more about pre-diabetes, the University of North Texas Health Science Center is seeking volunteers to participate in the largest clinical research trial studying the prevention of diabetes. The program spans 40 countries and will enroll more than 7,500 patients.

The clinical study will evaluate two medications currently approved for other uses by the Food and Drug Administration to determine whether they safely and effectively delay the onset of type 2 diabetes and reduce complications such as heart attack and stroke.

If you have some of the following risk factors, you may qualify to participate:

50 years of age or older
Family history of diabetes
High blood pressure
Heart disease including a heart attack or stroke
Current or former smokers
Overweight

Participants who qualify will receive study-related care, study medication, and diet and exercise counseling. For more information, call Enisa Arslanagic at 817-735-5159.

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From the U.S. Department of Health & Human Services

Project "BioShield"
New $6 Billion Effort to Protect Americans from Bioterror Attack

HHS, in cooperation with the Department of Homeland Security, will spearhead the development of Project BioShield. The project will bring together the resources of the United States government in an innovative effort to develop defenses against bioterror before they are ever needed. The project was announced by President George W. Bush in his State of the Union address on January 28. The project will have three major goals:

- Ensure resources to develop new "next-generation" countermeasures: BioShield would create a special secure spending authority to pay for the delivery of "next-generation" medical countermeasures. Over the next 10 years, almost $6 billion will be available to purchase new countermeasures for smallpox, anthrax, and botulinum toxin. Additional funds will be available to produce and purchase countermeasures for other dangerous agents, such as Ebola and plague, once safe and effective treatments are developed.
- Expand research and development: BioShield would expand the ability of the National Institutes of Health to speed research and development on medical countermeasures based on the most promising scientific discoveries.
- Make promising treatments available quickly for emergencies: Under Project BioShield, the Food and Drug Administration would have the ability to make new and promising treatments under development available quickly in emergency situations - potentially saving many more lives than treatments otherwise available today.

Proposed Medicaid Reforms

HHS Secretary Tommy G. Thompson announced that the President will propose a sweeping new plan to enable states to improve health insurance coverage for low-income Americans. The proposal, to be developed in full consultation with governors and Congress, would be optional for states. The President's proposal would accomplish several Medicaid reform goals.

First, it would invest more money immediately to protect recipients from losing health coverage and create opportunities for expanding coverage. To help states get through their budget crises, the proposal increases the federal share of the overall Medicaid budget by an estimated $3.25 billion in 2004 and $12.7 billion over five years. This investment will help prevent struggling states from reducing Medicaid coverage. In the past year, 38 states have either trimmed benefits, cut payments to providers or reduced eligibility. A total of 78,504 individuals have lost eligibility. This investment will help stem and reverse that trend.

Second, it will provide flexibility for states to develop innovative programs to expand coverage to more people. The proposal seeks to reduce rules and regulations so states can target funds to areas of greatest need and provide quality benefit packages that help more people. They can do so without seeking federal waivers. This will allow states to create programs to cover the mentally ill, the chronically ill, and specific populations such as those with HIV/AIDS, according to their needs. It will also facilitate tailored long-term care benefits to meet the unique needs of each senior citizen, providing seniors and their families a greater array of choices in services.

Third, it will emphasize covering entire families, children and parents. The President wants to promote family coverage and continuity of care so family members can see the same doctors and participate in same health plan. Often, low-income parents and children can be part of three or more health care plans, each with their own doctors and own rules. The proposal seeks to build on studies that show the best way to increase health coverage for children is to make coverage available to parents as well.

With 44.3 million Medicaid beneficiaries (22.7 million of them children), the Medicaid program is bigger and expanding more rapidly than Medicare. It is therefore crucial that effective, common sense reform is enacted for the health of the program.

HHS Extends Use of Rapid HIV Test to New Sites Nationwide

On January 31, 2003, HHS announced that it has extended the availability of a recently approved rapid HIV test from the current 38,000 laboratories to more than 100,000 sites, including physician offices and HIV counseling centers.

"Ensuring the widespread availability of a rapid HIV test to outreach services in communities where people are at high risk of HIV is vital to the public health," HHS Secretary Thompson said. "Without today's action, this test would be limited to use in laboratory settings where many high-risk people do not go for testing."

The OraQuick Rapid HIV-1 Antibody Test, manufactured by OraSure Technologies, Inc., of Bethlehem, Pa., provides results in as little as 20 minutes. It is performed on a fingerstick sample of blood. Studies show that the test has an accuracy of 99.6 percent. Unlike other antibody tests for HIV, this test can be stored at room temperature, requires no specialized equipment and can be used outside of traditional laboratory or clinical settings.

HHS' Food and Drug Administration (FDA) approved OraQuick last November for use in laboratories that perform moderate complexity testing. The expanded use to additional sites was granted by HHS under a Clinical Laboratory Improvement Amendments (CLIA) waiver.

Each year, 8,000 HIV-infected people who come to public clinics for HIV testing do not return a week later to receive their test results. With the new rapid HIV test, results are available on the spot in about 20 minutes.

continued on next page

As with all screening tests for HIV, if the OraQuick gives a reactive test result, that result must be confirmed with an additional specific test.

FDA approved the OraQuick test in November as a moderate complexity test. Moderate complexity tests must be performed in a CLIA-approved laboratory by CLIA-certified laboratory staff.

CMS Streamlines and Simplifies Quality and Personnel Rules for Clinical Laboratories

On January 23, The Centers for Medicare & Medicaid Services (CMS) issued new quality and personnel rules for laboratory services that are designed to enhance patient safety while making it easier for laboratories to understand and comply with these requirements. The changes are part of a broader effort across the Department of Health and Human Services to restore common sense to the regulatory process and promote higher-quality care.

The rules, which complete the implementation of the Clinical Laboratory Improvement Amendments of 1988 (CLIA), apply to laboratory testing in all settings, including commercial, hospital, and physician office laboratories. The requirements are tailored to the complexity of the testing. Currently about 176,000 laboratories are certified under CLIA. The new rules will have the greatest impact on the 38,000 labs that are authorized to perform high or moderate complexity testing.

"For the first time, CLIA requirements have been reorganized in a more logical fashion to parallel the flow of a patient specimen through the laboratory," CMS Administrator Tom Scully said. "This reorganization should help laboratories understand and apply the requirements more easily, and reduce laboratory errors."

The final rule reduces the frequency with which laboratories must perform quality control (QC) in most specialty and subspecialty areas and brings all non-waived testing under the same QC requirements. Personnel standards will continue to be based on test complexity.

As recommended by the Clinical Laboratory Improvement Advisory Committee (CLIAC), the rules now require laboratories to validate the accuracy of moderate as well as high complexity tests prior to the testing of patient specimens and the reporting of those results; however, requirements for routine QC will be more flexible. Guidelines will be available to laboratories to use to meet the federal requirements and will be posted on the CMS web site.

The final rule also "grandfathers" certain non-board certified individuals with a doctoral degree who have served or are currently serving as a director of a laboratory performing high complexity testing, allowing them to continue directing high complexity laboratories despite their lack of board certification. All new directors of high-complexity laboratories who have a doctorate, rather than a medical degree, will need to be board certified.

The final rule was published in the January 24 *Federal Register*. The grandfathering provision became effective February 24. For all other requirements, the effective date will be April 24, to allow time to educate laboratories about the new rules.

HHS Identifies Drugs for Pediatric Testing

HHS Secretary Tommy G. Thompson on January 21 named 12 commonly prescribed drugs that need to be tested for use in children. He said government-supported tests of the drugs will begin this year, with up to $25 million available to launch the tests in fiscal year 2003 and up to $50 million to be included in the President's FY 2004 budget proposal for the testing. An additional $18 million will also be provided for review by the Food and Drug Administration (FDA).

The testing is called for in the Best Pharmaceuticals for Children Act (BPCA), which was signed into law by President Bush last year. The law provides for HHS agencies to sponsor pediatric tests of certain drugs already approved for marketing but never tested specifically for their effects in children. The list identifies the dozen highest-priority drugs needing pediatric review.

The list of drugs was developed by the National Institute of Child Health and Human Development (NICHD), part of HHS' National Institutes of Health (NIH), in consultation with FDA and experts in pediatric research. The list will be updated each year.

Once a drug has been approved for a particular use, physicians may prescribe it for other uses, as they deem necessary. Many commonly available drugs, although approved for use in adults, have never been tested specifically for use in children. The 12 drugs on the list are currently prescribed for children, but their safety and effectiveness has been established only in adults:

Azithromycin-An antibiotic used to treat many different types of bacterial infection

Baclofen-A muscle relaxant used to relieve the spasms, cramping, and tightness of muscles caused by medical problems such as multiple sclerosis or certain injuries to the spine.

Bumetanide-Used to reduce the swelling and fluid retention caused by various medical problems, including heart or liver disease. It also is used to treat high blood pressure. It causes the kidneys to get rid of unneeded water and salt from the body into the urine.

Dobutamine-A heart stimulating drug.

Dopamine-Used to treat Parkinson's disease and Schizophrenia.

Furosemide-Used to treat swelling and water retention.

Heparin-Decrease the clotting ability of the blood and help prevent harmful clots from forming in the blood vessels

Lithium-Treatment for bipolar disorder.

Lorazepam-Treatment for anxiety.

Rifampin-Used in combination with other medications to treat tuberculosis, and to treat carriers of meningitis-causing bacteria.

Sodium Nitroprusside-A treatment for high blood pressure.

Spironolactone-A treatment for high blood pressure.

Each drug will undergo about two years of testing, followed by evaluation of test results by the FDA. NICHD will oversee the testing process, consulting closely with other NIH institutes and the FDA.

Slow Donations Forcing Greater Houston Area Chapter of the American Red Cross Lay Offs

A $1 million shortfall in its $11 million budget is forcing the chapter to lay off about 30 of the 200 employess and trim community programs such as transportation for the elderly, lifeguard training and CPR classes. However, the shortfall will not affect disaster response and services for military personnel. Like charitable organizations across the country, the Houston Red Cross is in a financial squeeze blamed on the weak economy and a drop in donations after an initial post-September 11 outpouring, while the Houston chapter is supported mainly by United Way money and individual contributions.

(Houston Chronicle, 1-21-03)

Military Veterans and Retirees No Longer to Receive Naval Hospital Services in South Texas

With 60 medical professionals who have deployed at the end of January, Naval Air Station Corpus Christi will first provide service to active duty members and their dependents, while normal service will resume if reservists are sent to fill the spots left open by those who left, or if those deployed come back. Only those with the TRICARE Prime health plan will be able to go to the hospital for services such as doctor visits, lab tests, X-rays and prescriptions, potentially affecting about 8,000 Veterans of Foreign Wars members from Corpus Christi to the Valley. Hospital officials said they will help those affected find medical and prescription services in town if they call for help.

(Corpus Christi Caller-Times, 1-31-03)

Texas HMO Report Now Available

The Office of Public Insurance Counsel (OPIC) has released its fifth annual HMO report, which allows consumers to compare the quality of care delivered by Texas HMOs.

OPIC's report, "Comparing Texas HMOs 2002," focuses on the satisfaction of members with their HMOs. The report includes the results of a survey of HMO members, information on the results of

Independent Review Organization appeals and an analysis of complaint data collected by the Texas Department of Insurance.

The report (including the Spanish translation, "Comparacion de los HMOs en Texas 2002") is available from the agency's web site at <www.opic.state.tx.us> or call 512-322-4143 to order a copy of the report. The agency has also made available a questionnaire at <www.opic.state.tx.us> for comments and/or suggestions.

Texas Cancer Care Relocates Fort Worth Clinic-Begins Plan for New Vision

Texas Cancer Care (TCC) is moving its central Fort Worth clinic from within Moncrief Radiation Center, at 1450 Eighth Avenue, to its newest independent clinical site at 750 Eighth Avenue. TCC physicians will begin seeing patients at the new location on Monday, March 3.

"We anticipate a smooth, seamless transition as we move just a few blocks north of our current location," said TCC President Dr. Bill Jordan. "Most importantly, our patient care will continue without interruption."

The layout of new clinic has been designed to better accommodate patients' needs, with larger exam rooms, a more comfortable chemotherapy suite and dedicated patient teaching areas. The location offers convenient surface parking and easy elevator access to all of TCC's services on the second floor.

This move also signifies the first implementation phase of TCC's ultimate plans to provide the "next generation of cancer care" for the North Texas region. Since the early 1990s, TCC physicians and staff have embraced a vision of a truly integrated cancer center for this community. In November, the Texas Cancer Care Board finalized plans for the evolution of the TCC organization within the changing landscape of complex cancer management. The Board directed Texas Cancer Care to maintain a clear focus on creating its vision for the next generation of cancer care - a comprehensive continuum of care where cancer patients and their families can access all of the services and resources they need in one community-based center of excellence.

"In December, we met with UT Southwestern-Moncrief to discuss the merits of our vision and the idea of pursuing it together," Dr. Jordan said. "UT Southwestern's business managers shared that they were 'going in a different direction,' so we agreed that TCC would pursue its long-standing vision independently. Although the relationship that we have had with UT Southwestern-Moncrief has been meaningful and instructive, this move - to an institutionally neutral paradigm - presents a uniquely positive and adaptable opportunity for us to better serve patients in this very difficult specialty," Dr. Jordan said. "We will now be able to be inclusive of all organizations, institutions and physicians who would like to work with us to powerfully impact cancer care for our community throughout North Texas."

Texas Cancer Care is a multi-clinic physician's group utilizing advanced information technology and high-quality research to provide patient-centered care for the treatment of cancer and blood disorders, in the North Texas region. TCC specializes in medical oncology and hematology, while coordinating chemotherapy, radiation therapy, surgical therapy, diagnostics, genetic risk counseling, nutritional therapy, patient and family support groups, and pastoral care for patients. Through multiple full-service clinical locations in Tarrant, Johnson, Parker and Palo Pinto counties, TCC's physicians, oncology nurse practitioners and a staff of more than 100 individuals provide high-quality cancer care for nearly 7,500 patients each year. For more information about Texas Cancer Care, visit <www.texascancer-care.com>.

GlaxoSmithKline May Stop Sales to Canada in Response to Purchases by U.S. Consumers

Responding to the growing popularity of cheaper Canadian drugs among U.S. consumers, GlaxoSmithKline threatened to stop supplying wholesalers and retailers in that country unless they ceased their cross-border sales by Jan. 21. In a letter sent in January to wholesalers and some pharmacies, Glaxo said it feared drugs could be harmed in the shipping process and that Americans buying drugs in Canada weren't being properly supervised by doctors.
(Associated Press, 2-11-03)

Federal Centers for Medicare and Medicaid ServicesWeb Site to Publish Data on Hospitals' Rates of Compliance with 10 "Best Practices" Medical Procedures

The hospitals will participate voluntarily and the data gathering will be overseen by the government, while the site will also carry data gleaned from patients' responses to a standardized "experience of care" questionnaire. The measures of quality do not directly evaluate patient outcomes, partly because of hospitals' contention that raw outcome data, if not risk-adjusted for the health of the patient population and other factors, do not accurately reflect quality of care.
(Washington Post, 1-21-03)

Bush Administration Rescinded Announcement that States May Limit Visits to Emergency Rooms by Medicaid Managed Care Patients

While the administration initially defended the change, saying it was simply letting states put the same limits on its managed care patients as they did on others in Medicaid, Tom Scully, administrator of the Centers for Medicare and Medicaid Services, said in a letter that the change was being rescinded because "We heard concerns...that the policy, while well-intentioned, may have some unintended consequences and could potentially result in some restriction of payment for true emergency care for Medicaid beneficiaries." Scully's letter was addressed to Sens. Charles Grassley (R-Iowa) and Max Baucus (D-Mont.), the chair and top Democrat on the Senate Finance Committee.
(Associated Press, 2-22-03)

Commercial Companies Offer Help with Internet Health Information

For about $150 to $500, the companies gather information, hunt for clinical trials and deliver a docket of information in a week, while in some cases, the services interview the investigators or try to secure a spot in an experimental study for the customer. The services say they do not aim to replace medical consultations, but rather intend to provide easy-to-digest information that patients might expect from a long chat with a physician, while some of the companies say that some of their clients are doctors.
(New York Times, 1-28-03)

Bush Administration Loses Another Round to promote Discount Pharmacy Cards to Medicare Recipients

After the government's second attempt at implementing a discount pharmacy card for Medicare recipients program, U.S. District Judge Paul L. Friedman said it was "mind-boggling" that the government would try to implement the program without having statutory authority, while representatives of drug stores and pharmacist groups said the decision has effectively killed the idea in its current form. Medicare administrator Tom Scully said the administration was still determined to implement the program and suggested that it may do so legislatively by seeking help from Congress.
(Associated Press, 1-30-03)

CDC Begins Shipping Smallpox Vaccine to the States

The Centers for Disease Control and Prevention (CDC) announced January 22 that the agency has begun distributing smallpox vaccine to state and local governments that will coordinate the vaccination of smallpox response teams. The teams are part of the nation's voluntary vaccination program to protect Americans from the potential threat of a terrorist attack involving the release of the smallpox virus.

"At this time, our highest priority is to vaccinate members of smallpox response teams in the states," said Dr. Julie Gerberding, director, CDC. "Several months of detailed planning and training, and the development of scientifically sound and informative educational materials have prepared us for the safe and rapid implementation of the plan to vaccinate those healthcare professionals who would be on the front lines in the event of a smallpox attack."

Thus far CDC delivered kits with enough vaccine and needles for 21,600 public health and healthcare workers to Connecticut, Nebraska, Vermont and Los Angeles County. As of January 22, 20 states (including 1 county) have requested nearly 100,000 doses of vaccine.

This is the first shipment of vaccine to state and local governments under the President's plan to protect the American people from an intentional release of the smallpox virus. Under the program, smallpox vaccine is being offered to those most likely to respond to a potential outbreak of the disease. By preparing these smallpox response teams, the government will be able to protect the American people in the event of a smallpox release.

In all states, smallpox vaccination is voluntary. Each state notifies CDC when it is ready to receive its shipment of smallpox vaccine to begin pre-event vaccination of public health and healthcare workers.

Once CDC receives a request for smallpox vaccine from a state, the order is forwarded to the National Pharmaceutical Stockpile for processing and shipment.

Smallpox vaccine is not given with a hypodermic needle. The vaccine is administered using a bifurcated (two-pronged) needle that is dipped into the vaccine solution. The needle is used to prick the skin, usually the upper arm, several times in a few seconds. Each shipment of vaccine includes bifurcated needles.

Many Physicians View Treatment Guidelines Positively

Sometimes dismissed as "cookie-cutter" medicine, treatment guidelines for specific medical conditions influenced more than half of all U.S. physicians in 2001, and nearly two-thirds of affected physicians viewed guidelines positively, according to a national study released January 30 by the Center for Studying Health System Change (HSC). The study found similar positive results for patient satisfaction surveys and practice profiling, where individual physicians' treatment patterns and use of medical resources are compared with other physicians.

In 2001, 62 percent of physicians said patient satisfaction surveys had a moderate, large or very large effect on their practice of medicine, with 77 percent of affected physicians rating the use of patient surveys positively. Practice profiling was less widespread – only 34 percent of physicians reported profiling affected their practice of medicine, and half of those affected reported a positive effect.

"With medicine rapidly changing and increasingly complex, care management tools—such as treatment guidelines—offer the potential to help physicians practice more effectively, so it's encouraging that most physicians view these tools positively," said Paul B. Ginsburg, Ph.D., president of HSC, a nonpartisan policy research organization funded exclusively by The Robert Wood Johnson Foundation.

The study also found that physicians in practices with more revenue from managed care were somewhat more likely to report that care management tools had affected their practice of medicine, but managed care participation had little effect on whether physicians viewed the tools positively. Researchers did find that physicians who completed their medical training within the five years prior to the survey were more likely to report that care management tools both influenced their practice and had a positive effect than physicians who completed their training earlier.

"Newer physicians may be more familiar and comfortable with evidence-based medicine and the use of care management tools because they were trained in the era of managed care," said HSC Health Research Analyst Marie Reed, M.H.S, who co-authored the study with HSC Researcher Kelly Devers, Ph.D., and Bruce Landon, M.D., of Harvard Medical School.

The study also examined the use of financial incentives tied to practice profiling and patient satisfaction surveys. Physicians who received financial incentives based on profiling were more than twice as likely to indicate that profiling affected their practice of medicine than physicians without such incentives—62 percent vs. 30 percent. Similarly, 84 percent of physicians receiving financial incentives tied to patient satisfaction surveys indicated the surveys affected their practice of medicine, compared with 59 percent of physicians without such incentives.

"If care management tools are going to improve the quality of care, physicians must perceive them as valid, useful and fair," Reed said.

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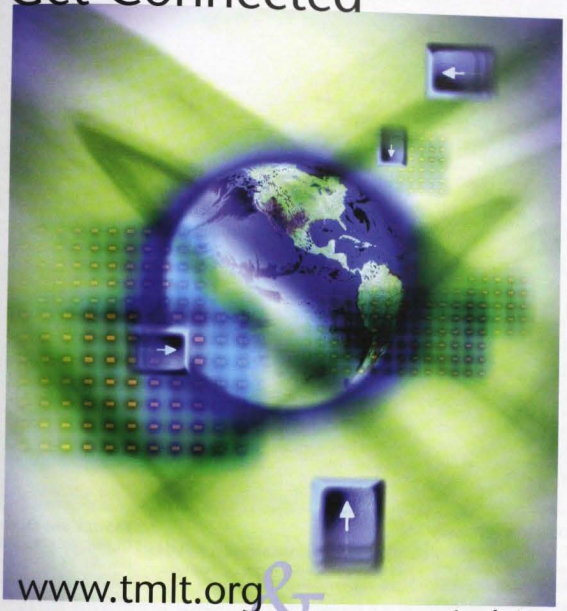

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