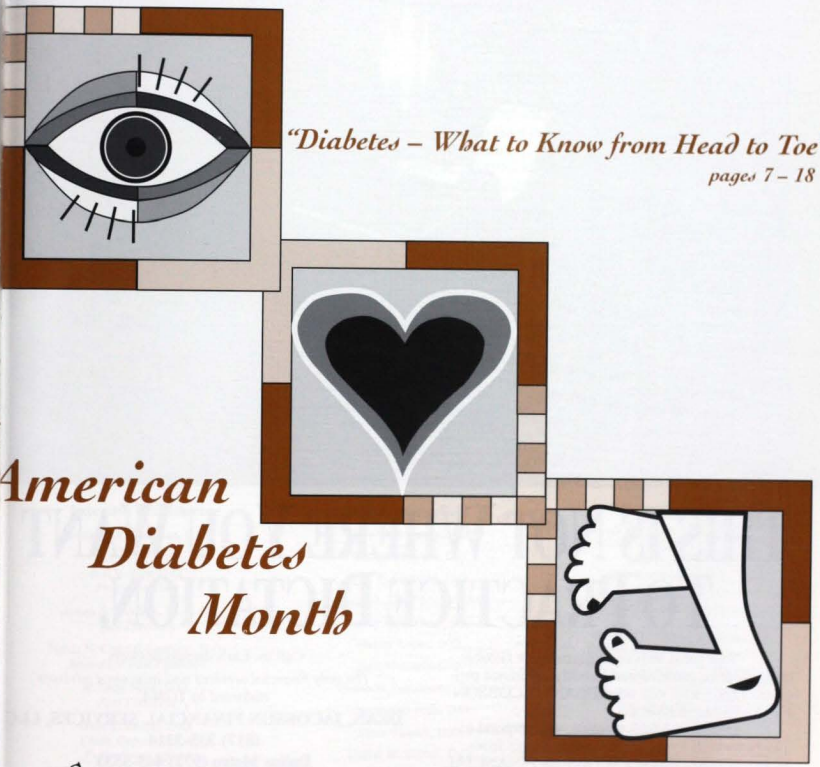
TEXAS D.O.

The Journal of the Texas Osteopathic Medical Association



"Diabetes – What to Know from Head to Toe"

pages 7 – 18

American Diabetes Month

PLUS

TOMA's 44th MidWinter Conference & Legislative Symposium

Program Information and Early Registration Form – pages 18 - 20

Volume LVI, No. 10 November 1999

THIS IS NOT WHERE YOU WANT TO PRACTICE DICTATION.

Your most important partner is a flexible, cost-effective professional liability insurance program. That's why you need DEAN, JACOBSON FINANCIAL SERVICES.

In your medical practice, you respond to questions with the confidence that comes from experience. At DEAN, JACOBSON FINANCIAL SERVICES, in association with Healthcare Insurance Services, Inc., we answer your professional liability needs with the confidence that comes from our experience.

Confidence and experience. Use yours to protect your patients. We'll use ours to protect you.

Call us. Let's discuss answers.

The only financial services and insurance advisors endorsed by TOMA.

DEAN, JACOBSON FINANCIAL SERVICES, LLC
(817) 335-3214
Dallas Metro (972) 445-5533
P.O. Box 470185, Fort Worth, TX 76147
(800) 321-0246

In association with:
Healthcare Insurance Services, Inc.
A Gaitney Group Company

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

NOVEMBER 1999

Texas D.O. is the official publication of the Texas Osteopathic Medical Association.

Published eleven times a year, monthly except for July. Subscription price is $50 per year.

Texas D.O. does not hold itself responsible for statements made by any contributor. The advertising contained in this magazine is not necessarily endorsed by the Texas Osteopathic Medical Association.

Published by the Texas Osteopathic Medical Association, Volume LVI, No. 10, November, ISSN 0275-1453.

PUBLICATION OFFICE
1415 Lavaca Street
Austin, Texas 78701-1634
1-800-444-TOMA (in Texas)
or 512-708-TOMA
FAX: 512-708-1415
E-mail: toma@txosteo.org
Website: www.txosteo.org

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

Inside This Issue

CALENDAR OF EVENTS

NOVEMBER

14-20

"National Osteopathic Medicine Week"
"Women's Health Care for an Active Lifestyle"

DECEMBER

1-3

"Texas' Seventh Minority Health Conference: Reflecting on the Past and Shaping the Future of Minority Health"
Sponsored by the Texas Department of Health
Location: Omni Hotel Galleria, Houston, TX
Contact: Eva Holguin at 512-458-7629

4

"Family Medicine Update"
Sponsored by the Washington Osteopathic Medical Association
Location: Seattle, WA
CME: 8 hours category 1-A credits
Contact: Washington Osteopathic Medical Association
P.O. Box 16486, Seattle, WA 98116
206-937-5358; FAX 206-933-6529

11

TOMA Board of Trustees Meeting
Location: TOMA Office, Austin, TX
10:00 am – 4:00pm
Contact: Paula Yeamans, Associate Executive Director
TOMA, 800-4448662 or 512-708-8662

2000

JANUARY

28-30

"TOMA's 44th MidWinter Conference & Legislative Symposium"
Sponsored by the Texas Osteopathic Medical Association
Location: Renaissance North Dallas Hotel
Dallas, Texas
CME: Approx. 17 hours category 1-A credits
Contact: Texas Osteopathic Medical Association
512-708-8662 or 800-444-8662

FEBRUARY

23-27

"Osteopathic Medicine: A Universal Approach"
Sponsored by the Osteopathic Physicians & Surgeons of California
Location: Sheraton Universal Hotel, Universal City, CA
CME: 40 hours category 1-A credits
Contact: 916-561-0224; FAX 916-561-0728

FEBRUARY 27 – MARCH 3

"Ski & CME Midwinter Conference"
Sponsored by the Colorado Society of Osteopathic Medicine
Location: Keystone Lodge & Resort, 800-258-0437
Code CA2CCSO
CME: 40 hours category 1-A credits
Contact: Brooke Chynoweth, 650 Cherry St., #440
Denver, CO 80246
Phone 303-322-1752 or 800-527-4578
FAX 303-322-1956
E-mail: info@ColoradoDO.org
http://www.ColoradoDO.org

MARCH

3-7

"10th Annual Clinical Medicine Update for Primary Care Physicians"
Sponsored by the University of North Texas Health Science Center at Fort Worth
Location: Harvey's Hotel & Casino
South Lake Tahoe, Nevada
CME: 20 hours category 1-A credits
Contact: UNTHSC Office of Continuing Medical Education
817-735-2539 or 800-987-2CME
http://CME.cjb.net

APRIL

15-16

"14th Annual Spring Update for Family Physicians"
Sponsored by the University of North Texas Health Science Center at Fort Worth
Location: Columbia Medical Center/Dallas Southwest
Dallas, TX
CME: 12 hours category 1-A credits
Contact: UNTHSC Office of Continuing Medical Education
817-735-2539 or 800-987-2CME
http://CME.cjb.net

November Spotlights

AMERICAN DIABETES MONTH

November is American Diabetes Month, an annual program conducted by the American Diabetes Association to raise awareness that serious diabetes complications can be prevented. The campaign's slogan, *"Diabetes – What to Know Head to Toe"* urges people to take charge of their diabetes by keeping their blood pressure and blood sugar in control; having annual dilated eye exams; and thorough foot exams at least once a year.

The American Diabetes Association

The American Diabetes Association (ADA) is the nation's leading voluntary health organization supporting diabetes research, information, and advocacy. Founded in 1940, the ADA has offices in every region of the country, providing services to more than 800 communities. Its mission is to prevent and cure diabetes, and to improve the lives of all people affected by diabetes.

For information on activities occurring in your local area during American Diabetes Month, call 1-800-DIABETES (342-2383), or visit the ADA's Web site at <www.diabetes.org>. Free American Diabetes Month packets are also available by phone request.

Diabetes: Profile of the Diagnosed

There are 15.7 million people, or 5.9 percent of the population in the United States, who have diabetes. There are two main types of diabetes: type 1, which usually occurs during childhood or adolescence; and type 2, the most common form of the disease, usually occurring after age 45.

- **Type 1**. An autoimmune disease in which the body does not produce any insulin, most often occurring in children and young adults. People with type 1 diabetes must take daily insulin injections to stay alive. Type 1 diabetes accounts for 5-10 percent of diabetes.
- **Type 2.** A metabolic disorder resulting form the body's inability to make enough, or properly use, insulin. It is the most common form of the disease. Type 2 diabetes accounts for 90-95 percent of diabetes. Type 2 diabetes is nearing epidemic proportions, due to an increased number of older Americans, and a greater prevalence of obesity and sedentary lifestyles.
- **Gestational Diabetes.** Develops in 2-5 percent of all pregnancies but disappears when a pregnancy is over. Women who have had gestational diabetes are at increased risk for developing type 2 diabetes later in life.
- **"Other specific types"** of diabetes result from specific genetic syndromes, surgery, drugs, malnutrition, infections and other illnesses.

Diabetes Complications

With its complications, diabetes is the seventh leading cause of death in the United States. Each year, at least 193,000 people die because of diabetes and its complications.

- Blindness. Diabetes is the leading cause of new cases of blindness in people ages 20-74. Each year, from 12,000 to 24,000 people lose their sight because of diabetes.
- Kidney Disease. Diabetes is the leading cause of end-stage renal disease. In 1995, nearly 28,000 people initiated treatment for end-stage renal disease because of diabetes.
- Nerve Disease and Amputations. About 60-70 percent of people with diabetes have mild to severe forms of diabetic neuropathy which, in severe forms, can lead to lower limb amputations. In fact, diabetes is the most frequent cause of non-traumatic lower limb amputations. The risk of a leg amputation is 15-40 times greater for a person with diabetes. Each year, more than 56,000 amputations are performed among people with diabetes.
- Heart Disease and Stroke. People with diabetes are 2 to 4 times more likely to have heart disease. And, they are 2 to 4 times more likely to suffer a stroke.
- High Blood Pressure. An estimated 60-75 percent of people with diabetes have high blood pressure.

Source: American Diabetes Association

During this month, the nationwide American Diabetes Association offices conduct a variety of activities to spread the message.

In addition, corporations, worksites, health care providers, government agencies and other community organizations assist in raising awareness about the seriousness of diabetes and the importance of taking early measures to reduce complications.

Diabetes

What to Know Head to Toe

Eyes

Diabetes can lead to vision loss or even blindness.

To take good care of your eyes:

- Keep your blood sugar under control.
- Bring high blood pressure down.
- Get a dilated eye exam by an eye doctor every year.
- See your eye doctor if:
  - Your vision is blurry.
  - You see double. You see spots or floaters.
  - One or both eyes hurt.
  - You feel pressure in your eye.
  - You can't see things at the sides like you used to.
  - You have trouble reading.

Heart

People with diabetes are twice as likely to develop high blood pressure than people without diabetes.

To have a healthy heart:

- Lose weight, if you are overweight.
- Become more physically active.
- Have your blood pressure checked at each health care provider visit.
- Ask your health care provider what your blood pressure goal should be. A blood pressure level under 130/85 mm Hg is the goal for most people with diabetes.
- Don't smoke.

Feet

Diabetes can harm the blood vessels and nerves in your feet.

To keep your feet healthy:

- Keep your blood sugar in control.
- Take off your shoes and socks and have your feet checked at least once a year—more often if you have any foot problems.
- Wash your feet every day. Dry them, even between toes.
- Check daily for cuts, blisters, redness, and swelling. If you cannot see the bottom of your feet, use a mirror or ask someone for help.
- Never walk barefoot.
- Wear shoes that fit well. If you have lost feeling in your feet, ask your health care provider for advice on proper shoes.
- Cut your nails straight across and file the edges.
- Don't smoke.
- Shake out your shoes before putting them on.

For diabetes information, call

1-800-Diabetes
(342-2383)
www.diabetes.org

NOVEMBER
★AMERICAN★
DIABETES MONTH

a program of

American Diabetes Association.

Type 2 Diabetes
A New Problem Emerging in Children

By C. W. Spellman, Ph.D., D.O., F.A.C.O.I.

There is an emerging health problem. It is not generally recognized or diagnosed. The problem is type 2 diabetes in children. Early reports by diabetologists first described type 2 diabetes among native children, age 5-14 years, in Manitoba, Canada(1,2). Since then, type 2 diabetes in children has been reported in Ohio, Arkansas, California and Texas (3-6).

It is known that those at highest risk include Mexican Americans, African Americans and Native Americans. Not only is the number of cases increasing, but also the incidence is accelerating. Before 1992, type 2 diabetes accounted for less than 4% of all childhood diabetes. By 1994, it comprised 16% of all new cases (3). Last year, almost 40% of all new cases of diabetes in the San Antonio, Texas, area were type 2 disease (7,8).

A significant risk factor for the onset of type 2 diabetes in the pediatric population is obesity. The increased rate of diagnosis parallels the increased rate of obesity in children (9). It appears that obesity plays a similar role in children and in adults (10). Obesity is related to hyperinsulinemia, acanthosis nigricans, hypertension, and hyperlipidemia. Often one or both parents may have diabetes. In other words, children with insulin resistance syndrome are at high risk to develop type 2 diabetes. However, little is known about the natural history of childhood type 2 diabetes. How many obese children have acanthosis nigricans? How many children with acanthosis nigricans develop impaired glucose tolerance or type 2 diabetes? Some estimates suggest that as many as 2-3% of obese children with acanthosis nigricans have abnormal glucose metabolism.

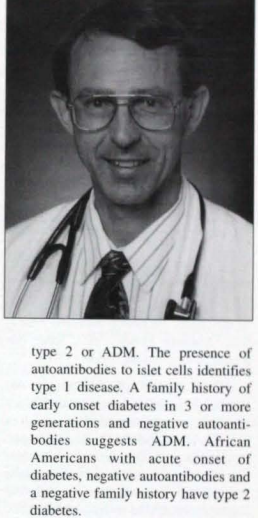
How common is type 2 diabetes in children? It is not known. Limited statistics are available. Type 2 disease appears with about equal frequency in males and females (7,8). Last year, the rate of diagnosis was about 20-30 cases per 100,000 Mexican American children. The same rate was found in African American children (7,8). However, these numbers are "just the tip of the iceberg". They represent only the cases diagnosed because the children became ill enough to present for medical attention. How many children have abnormal fasting or random blood glucose levels but are as yet asymptomatic?

Knowing that pediatric type 2 diabetes is an emerging health problem presents major issues to be addressed. There is no "grass roots" recognition of the problem yet. There are no agreed upon guidelines. We have no strategy for whom to screen, when to screen, or how to screen for this condition. How should insulin resistance be managed? What are the therapeutic strategies for treatment? Guidelines from the American Diabetes Association (ADA) are expected soon, and should contain screening recommendations for high-risk children.

When a child presents with classic signs and symptoms of diabetes, establishing the exact diagnosis may not be simple. The ADA recognizes 4 types of diabetes in children (11). They are: a) type 1 diabetes that occurs in all races, but is uncommon in Asians; b) type 2 diabetes that occurs in minority children; c) atypical diabetes mellitus (ADM) that presents as an autosomal dominant disease in African Americans; and d) maturity onset diabetes of the young (MODY) that is rarely seen and occurs only in European Americans.

Diagnostic difficulties arise because the presenting signs and symptoms are not unique for each type of diabetes. For example, not all type 1 disease presents with weight loss, and some children with type 1 disease may be obese. Not all type 2 diabetes patients are overweight. Ketosis is commonly seen in both type 1 and ADM (12). A practical approach is to determine whether the onset of illness is acute or slowly evolving. Based on this, the following algorithm is helpful (13).

1. Acute onset diabetes in African American children may be type 1, type 2 or ADM. The presence of autoantibodies to islet cells identifies type 1 disease. A family history of early onset diabetes in 3 or more generations and negative autoantibodies suggests ADM. African Americans with acute onset of diabetes, negative autoantibodies and a negative family history have type 2 diabetes.
2. Acute onset diabetes in other groups of children and youth may be type 1 or type 2 disease. The non-obese patient has type 1 diabetes. The obese patient has type 1 diabetes if autoantibodies to islet cells are present, and has type 2 diabetes if no autoantibodies are identified.
3. Slow onset diabetes may represent type 1, type 2 or MODY. The obese child has type 2 diabetes. The non-obese patient with positive autoantibodies has type 1 disease. MODY patients are non-obese, develop diabetes slowly, and have a family history of maternal inheritance of disease. (Maternal inheritance is seen because the genes are from the mitochondria.)



Thus, considering the time course of onset, ethnicity, and body mass index (usually >25 kg/m2) the classification of diabetes in children can be made. Autoantibody studies may be needed in obese patients and in some African Americans.

continued on next page

The treatment of diabetes is similar in children and adults. Insulin is absolutely necessary for Type 1 disease, and oral agents have no role. Insulin is often needed to treat ADM.

Most type 2 diabetes in children can be managed with diet and exercise (14,15). However, nonadherence is a major obstacle to successful treatment. Factors include lack of knowledge about diabetes, its long term consequences, denial of the disease, negative peer pressure and nonparticipation in diet and exercise needs (15,16-18). The life style changes required are difficult for anyone to achieve on a long-term basis. It is not clear whether any particular program is best. Classic approaches to behavior modification, including intensive education, summer camps, etc., have not produced long lasting results (14,19).

When control of diabetes is not attained with diet and exercise, oral hypoglycemic agents are used in children (14,15). These include the sulfonylureas, metformin and the thiozolidinediones. The strategy for use is similar in adults and children. Precautions and monitoring requirements are the same in children and adults. Oral monotherapy may be advanced to combination therapy if needed. Even though these agents are used in children, it is important to realize that no oral agents have been extensively tested in children. No oral agents are approved for use in children. Insulin may be used for long term treatment of type 2 diabetes, or used in short courses for "sick day" management to reestablish glycemic control so that diet and exercise or oral agents can be reintroduced. The same barriers that limit the effectiveness of diet and exercise also limit the effectiveness of therapeutic interventions. Compliance is difficult when the child or youth does not feel ill and does not appreciate the long-term complications of diabetes.

Where do we begin the challenge of prevention and treatment of type 2 diabetes in children? The state of Texas is playing one of the leadership roles in this area. Recently, the Texas Diabetes Program/Council, the Texas Department of Health and the Juvenile Diabetes Foundation International sponsored a national workshop in Austin, Texas. The purpose was to analyze available data, generate questions, identify issues, and develop research outlines. Much was accomplished. Childhood type 2 diabetes was elevated to a priority status for NIH funding. Specific recommendations were made to generate uniform protocols for screening, detection and treatment of type 2 diabetes. Further, research programs in Texas are underway focusing on drug therapy to prevent and treat the disease.

Texas physicians will play different roles in the management of childhood type 2 diabetes. Some will be focused on research and education programs. Others will specialize in management of difficult cases. But, all of us need to be aware that a new problem is emerging.

Literature Cited

1. *Dean HE, Mundy RLL, Moffatt M: Non-insulin –dependent diabetes mellitus in Indian children in Manitoba. Can Med Assoc J 147:52-57, 1992*
2. *Harris SB, Perkins BA, Whalen-Brough E: Non-insulin dependent diabetes mellitus among First Nations children: new entity among First Nations people of northwestern Ontario. Can Fam Physician 42:869-876, 1996*
3. *Pinhas-Hamiel O, Dolan LM, Daniels SR, Standiford D, Khoury PR, Zeitler P: Increased incidence of non-insulin-dependent diabetes mellitus among adolescents. J Pediatr 128:608-615, 1996*
4. *Scott CR, Smith JM, Cradock M, Pihoker C: Characteristics of youth-onset non-insulin-dependent diabetes mellitus and insulin-dependent diabetes mellitus at diagnosis. Pediatrics 100:84-91, 1997*
5. *Pihoker C, Scott CR, Lensing SY, Cradock MM, Smith J: Non-insulin dependent diabetes mellitus in African American youths of Arkansas. Clin Pediatr 37:97-102, 1998*
6. *Neufeld ND, Raffal LJ, Landon C, Chen Y-DI, Vadheim CM: Early presentation of type 2 diabetes in Mexican American youth. Diabetes Care 21:80-86, 1998*
7. *Hale DE, Danny NM: Non-insulin dependent diabetes mellitus in hispanic youth. Diabetes 47: Suppl A 82, 1998*
8. *Hale DE, Gomez JE: Prevalence of glucose abnormality in Mexican American youth. Diabetes 48: Suppl A28, 1999*
9. *Glaser NS: Non-insulin-dependent diabetes mellitus in childhood and adolescence. Pediatr Clin North Am 44:307-337, 1997*
10. *Martin MM, Martin ALA: Obesity, hyperinsulinism and diabetes mellitus in childhood. J Pediatr 82:192-201, 1973*
11. *The Expert Committee on the Diagnosis and Classification of Diabetes Mellitus: Report of the Expert Committee on the Diagnosis and Classification of Diabetes Mellitus. Diabetes Care 20:1183-1197, 1997.*
12. *Winter WE, Maclaren NK,Riley WJ, Clarke DW, Kappy MS, Spillar RP: Maturity onset diabetes of youth in Black Americans. N Engl J Med 316:285-291, 1987*
13. *Rosenbloom AL, Joe JR, Young RS, Winter WE: Emerging Epidemic of type 2 diabetes in youth. Diabetes Care 22:345-354, 1999*
14. *Dean H:NIDDM-Y in First Nation children in Canada. Clin Pediatr 39:89-96,1998*
15. *Jones KL: Non-insulin dependent diabetes in children and adolescents: the therapeutic challenge. Clin Pediatr 37:103-110, 1998*
16. *Watkins PB, Whitcomb RW:Hepatic dysfunction associated with troglitazone. N Engl J Med 338:908-909, 1998*
17. *Gochman DS: Some correlates of children's health beliefs and potential health behavior. J Health Soc Behav 12:148-154, 1971*
18. *Molnar D, Porszasz J: The effect of fasting hyperinsulinemia on physical fitness in obese children. Eur J Pediatr 149:570-573,1990*
19. *Cook VV, Hurley JS: Prevention of type 2 diabetes in childhood. Clinical Pediatr 37:123-129, 1998*

Dr. Spellman serves as Associate Professor of Medicine in the Department of Internal Medicine, Division of Endocrinology, and as Director of the Diabetes Clinics of the University of North Texas Health Science Center at Fort Worth.

Diabetes Education Plays a Critical Role in the Treatment Plan

By Jane Tischer Moore, M.S.R.N.

A 42-year-old female presents to your office with complaints of extreme thirst, frequent urination and dry, itching skin for the past three months. She also feels lethargic and indicates her body weight has decreased by 30 pounds over the same period of time. Her blood sugar is 258 mg/dl and her HbA_{1c} is 10.5%. You diagnose her with Type 2 Diabetes Mellitus. You decide to begin combination therapy of a sulfonylurea and Metformin. You give her a diet and tell her to follow it...

Then what happens?

All people with diabetes need to be educated. As a physician, you usually have neither the time nor the experienced personnel to answer all the questions this patient may have. This doesn't include all the information the patient needs to make an informed decision about her treatment plan.

What do you do?

You can utilize the services of a diabetes educator. These are specially trained nurses, dieticians, pharmacists and sometimes physical therapists who specialize in the education and care of the patient with diabetes.

Why is education important?

The UKPDS (United Kingdom Prospective Diabetes Study) for Type 2 diabetes indicates if the blood sugar and blood pressure are kept to near normal ranges, the risk of development of chronic complications are decreased anywhere from 25% for blindness and renal failure to 56% for heart failure.

People with diabetes need to understand what it means to have diabetes and how to handle the situation emotionally as well as physically. These patients must understand that diabetes is a puzzle; the pieces include monitoring, medication, meal planning, exercise and stress management. When all the pieces are in place and joined together, glycemic control is achieved.

So, can't they figure that out by themselves or by reading a book?

They could, but having the interaction between the educator and the patient allows the patient to ask questions; it provides a contact person. Many patients have also found classes to be helpful since techniques utilized for care may affect people differently. Handing a "diet" to any patient without some education as to how to achieve the weight and glycemic goals you set will end in failure.

In diabetes self-management training, patients are taught the nutritional values of foods and how foods affect the blood sugar. They are provided with enough information about meal planning and foods to be able to make informed decisions. They are taught there are no good foods or bad foods, right foods or wrong foods. They learn how to plan into their meals those foods they crave, how to make choices when dining out and how not to feel guilty about the choices they make.

How frequently should they monitor?

Most educators ask patients to monitor their blood sugar four times a day for a couple of weeks. This will help the patient to understand the relationship among the puzzle pieces...the type and amount of food eaten and how medication and exercise is working to lower their blood glucose. They may also find that stressful times will increase their blood sugar, forcing them to make some changes in their meal plan to correct the elevated glycemic response. After a few weeks of intense monitoring, the patient can decrease the monitoring to daily, twice a day or, if taking insulin, prior to injections.

Why are diabetes patients so anxious?

Most patients know that diabetes could lead to chronic complications. The anxiety develops when they don't know what to do to prevent the complications from forming. Many patients enter into denial, blaming their disease on a loved one or believing there is nothing wrong with them. If your patients are in denial, education will be difficult. To be successful, patients need to be ready to make some changes in their lives to manage their diabetes.

So many of my patients tell me they can't exercise. What do I do?

Many people with diabetes have not done structured exercise for years. Something as simple as walking out the front door to the mailbox is a great way of getting someone moving. Set the goals low and allow the patient time to meet the goals. Gradually elevate the goals to have something for the patient to work towards. Never start out telling the patient to walk 1-2 miles every day, unless they are already doing this. Remember, this is a team effort. To be successful in managing their diabetes, patients need to know how to use the tools. The diabetes educator can help the patient learn these tools and together, with you the physician, the patient could live a long, productive life.

How expensive are classes and does insurance pay for them?

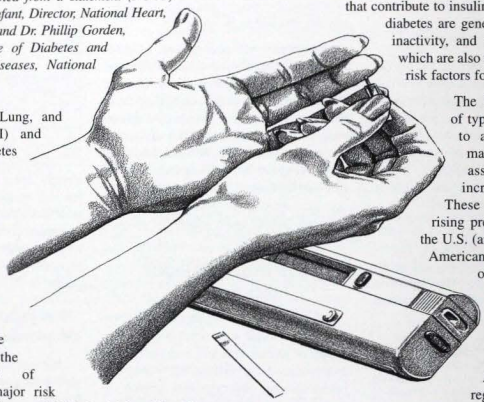
Medicare, Medicaid and private insurance reimburse for education and supplies for people with type 2 diabetes. The cost of classes varies with each facility. Some facilities can bill Medicare and private insurance for services while others can not. In order for a facility to be able to bill insurance, the program must be recognized by the American Diabetes Association. On the average, this recognition takes about two years to complete. In the meantime, the facility may charge for classes but it then becomes the responsibility of the patient to submit the information to the insurance company.

To find a Diabetes Educator in your area, call the American Association of Diabetes Educators at 1-800-338-3633, or check the availability of Diabetes Education classes at your local health care facility.

Ms. Moore is a Diabetes Educator at Osteopathic Medical Center of Texas, Fort Worth.

Diabetes Mellitus: A Major Risk Factor for Cardiovascular Disease

The following is excerpted from a statement (9-1-99) prepared by Dr. Claude Lenfant, Director, National Heart, Lung, and Blood Institute; and Dr. Phillip Gorden, Director, National Institute of Diabetes and Digestive and Kidney Diseases, National Institutes of Health.



The National Heart, Lung, and Blood Institute (NHLBI) and National Institute of Diabetes and Digestive and Kidney Diseases (NIDDK) of the National Institutes of Health (NIH) have collaborated with three leading private health organizations on a major public health statement to alert physicians, patients and the general public to the increasing significance of diabetes mellitus as a major risk factor for cardiovascular disease (CVD). In joining this effort, each organization reaffirms its commitment to better understand the causes and unique factors that contribute to excess risk of premature CVD in persons with diabetes, and to develop and implement improved treatments to reduce these complications. The private organizations that worked with NHLBI and NIDDK on the statement are the American Heart Association, American Diabetes Association and Juvenile Diabetes Foundation International.

Diabetes mellitus has long been recognized as an independent risk factor for several forms of CVD in both men and women (e.g., coronary heart disease, stroke, peripheral arterial disease, cardiomyopathy and congestive heart failure). Indeed, cardiovascular complications are now the leading causes of illness and death in the diabetic patient.

Type 2 diabetes, the most common form of the disease, affects approximately 90 percent of the 10.3 million Americans diagnosed with diabetes. An additional 5.4 million persons also are estimated to have type 2 diabetes but remain undiagnosed. Rates of diabetes and milder forms of glucose abnormalities are increasing in the U. S. Above age 65 years, almost half of Americans have abnormal glucose levels.

Type 2 diabetes most often occurs in overweight or obese adults after the age of 30 and typically is preceded by insulin resistance, which also is related to coronary heart disease (CHD). Factors that contribute to insulin resistance and type 2 diabetes are genetics, obesity, physical inactivity, and advancing age, all of which are also the major predisposing risk factors for CVD.

The increasing prevalence of type 2 diabetes is related to a variety of factors, many of which also are associated with an increased risk of CVD. These factors include: the rising prevalence of obesity in the U.S. (an estimated 97 million American adults are overweight or obese); the relatively low levels of physical activity among American adults (approximately 25 percent of adult Americans engage in regular physical activity of any intensity); increasing age of the population; the rapid growth in the U.S. of populations that are particularly susceptible to type 2 diabetes – African Americans, Hispanics, Native Americans, Pacific Islanders and Asians; and improved medical care which prolongs life, thus increasing the risk for development of type 2 diabetes and CVD complications.

NHLBI and NIDDK emphasize that both CVD and type 2 diabetes may be prevented or at least postponed by lifestyle changes that maintain normal weight and physical activity. Thus, modifications of life habits is at the heart of the public health strategy for reducing rates of type 2 diabetes and its cardiovascular complications.

Much of what we know about the cardiovascular complications of diabetes – and how they can be prevented or treated – has come from studies supported by NHLBI and NIDDK. In fact, in recent years these NIH institutes have substantially increased research in this area.

This year, NHLBI and NIDDK will start two large clinical trials designed to identify ways to reduce cardiovascular complications of type 2 diabetes. The Prevention of Cardiovascular Disease in Diabetes (PCDD) trial will study the benefits of inten-

sified control of high blood sugar, cholesterol and hypertension. The Study of Health Outcomes of Weight Loss (SHOW) trial will focus on the benefits of weight loss in obese individuals with diabetes. Together, they will provide important information about the effectiveness of several new medications and treatment regimens to reduce the complications of diabetes. Until ways to prevent or cure diabetes are found, such trials offer the best opportunity to reduce the burden of diabetes.

Surveys show that physicians often are not emphasizing approaches to reduce the risk of CVD in their patients with diabetes. For this reason, NHLBI and NIDDK, and the collaborating organizations named above pledge to work together to educate health professionals and the public about diabetes as a major CVD risk factor.

The following are excerpted from information released during the American Diabetes Association's 59th Annual Scientific Sessions, held this summer in San Diego.

Fewer Than 1 in 5 Americans with Diabetes Now Take ADA-Recommended Aspirin

A significant opportunity for reducing diabetes-related heart disease – by taking a daily aspirin tablet – has not been used by most Americans who could benefit, according to a report presented during the American Diabetes Association's (ADA) 59th Annual Scientific Sessions, held this summer.

"Fewer than one in five American adults with diabetes were regular aspirin users between 1988 and 1994," said Deborah B. Rolka, a statistician in the division of diabetes translation of the Centers for Disease Control and Prevention. Strong medical evidence in support of this effective and inexpensive treatment had been reported during those years.

"In the aftermath of the 1997 American Diabetes Association recommendation, we hope to see an increase in regular aspirin use in the next survey, which begins this year," she said. "Such an increase would be expected to reduce the number of heart attacks, strokes, and other adverse events."

To reduce the incidence of cardiovascular disease, the ADA recommends that enteric-coated aspirin in doses of 81 to 325 mg. daily be used for secondary prevention among people who already have evidence of such illness and for primary prevention among those with risk factors for heart disease.

"The CDC survey indicated that 98 percent of American adults with diabetes either have cardiovascular disease or one or more risk factors and therefore would be eligible for aspirin therapy, in the absence of contraindications such as aspirin allergy, bleeding tendency, recent gastrointestinal bleeding, and clinically active liver disease," reported Ms. Rolka.

The benefits of daily aspirin for helping prevent first heart attacks initially came to public attention in early 1988 when the U.S. Physicians Health Study was reported in The New England Journal of Medicine. Subsequently, further studies showed that aspirin therapy:

- is at least as effective for primary prevention of cardiovascular disease in those who have diabetes as in those who do not have it;
- also decreases the risk of further cardiac events in those with a history of both diabetes and cardiovascular disease;
- reduces risks in both men and women and in those with both type 1 and type 2 diabetes; and
- does not increase the risk for bleeding in the eye due to diabetic retinopathy, as had been feared by some physicians.

Diabetes and Depression Enhance Each Other's Severity and Cost

People who have diabetes and are also depressed suffer far more than those with diabetes alone – with a worsened quality of life, much higher medical costs, and more diabetes complications, such as heart disease.

Impaired Quality of Life

In a study at Washington University, 44 patients with major depression and type 2 diabetes were compared to 44 who had diabetes alone. Patients were matched for the severity of their diabetes, age and race, and evaluated on a wide range of quality of life issues.

"Those with depression and diabetes scored lower on every quality of life issue than those with diabetes alone, and this effect seemed to be independent of the severity of their diabetes," reported Patrick Lustman, Ph.D., professor of medical psychology in the department of psychiatry at Washington University School of Medicine, St. Louis.

He emphasized that depression tends to be a recurrent problem in those with diabetes, yielding an average of one episode a year. "However, in contrast to the association of depression seen in other diseases, such as heart attacks and cancer, only in diabetes has it been shown that specific depression treatment can make a difference in outcome of the underlying disease." Because depression therapy can improve prognosis, he urged simultaneous interdisciplinary treatment, with a physician and a psychotherapist each addressing both the medical and psychological issues.

Higher Health Care Costs

In a study at the Kaiser Permanente Center for Health Research in Portland, Oregon, the records of 5,059 HMO members with diabetes were compared with an age- and gender-matched non-diabetic control group.

Consistent with smaller studies, depression was much more prevalent in patients with diabetes than in control patients (18.5 percent vs. 11.4 percent). In both groups, depressed patients were younger, more likely to be female, and had more co-morbidities – other illnesses such as asthma or heart disease.

"Depressed individuals tended to weigh more in the diabetic but not the control group, which is troublesome because increased

weight makes diabetes harder to control," stated Gregory Nichols, Ph.D., a senior research associate at the Center. Within the diabetic group, depressed people were more likely to be using insulin and less likely to be using oral drugs or to be diet treated.

Overall annual health care costs, including inpatient and outpatient care and drug costs, were highest for those with both diabetes and depression – averaging $6,787. Similar costs were incurred by those with diabetes who were not depressed, at $4,233 and by depressed people who did not have diabetes at $4,337. Far less expensive was the care of people without either health problem, at $2,199.

Even Sub-Diabetic High Blood Sugar Levels Increase Death Risk

Experts Urge Better Detection and – Possibly – Treatment of Glucose Intolerance

The potentially fatal risks of high blood sugar levels begin long before people develop diabetes, according to a report presented during the ADA's annual sessions.

"There is a progressively rising risk of death as glucose tolerance worsens, and this risk is independent of established risk factors for cardiovascular disease," reported Frederick L. Brancati, M.D., associate professor of medicine and epidemiology at the Johns Hopkins University, a senior researcher on the study. "This makes it critically important that doctors identify people with abnormal blood glucose levels, especially those with undiagnosed diabetes."

Study Background

The study was based on data from the second National Health and Nutrition Examination Survey (NHANES II) and its Mortality Study, both conducted by the National Center for Health Statistics. In the survey, 9,250 adults (ages 30 to 74) had detailed health exams between 1976 and 1980. They were then followed through 1992 to assess overall as well as cause-specific mortality. Survival and cause of death were determined by computerized matching to the National Death Index and Social Security Administration Master Death File.

Understanding Impaired Glucose Tolerance (IGT)

The study focused on 3,246 adults who were randomly selected for oral glucose tolerance testing. Individuals are said to have impaired glucose tolerance (IGT) when results of the two-hour test are equal to or greater than 140 mg/dl, but under the 200 mg/dl cutoff point used to diagnose diabetes.

A major multi-center clinical trial, the Diabetes Prevention Program, is now underway to determine whether early treatment can prevent or delay the development of diabetes in people with IGT and, if so, whether lifestyle modification or drug therapy is the best approach.

Dramatic Increase in Mortality

The majority of those who received the glucose tolerance test were normal, but 496 had IGT, 190 had undiagnosed diabetes, and 262 had previously diagnosed diabetes.

"Compared to those with normal glucose levels, we found a gradient of mortality – due to any cause – associated with abnormal glucose tolerance, ranging from a 42 percent greater risk in people with IGT, to a 177 percent greater risk in those with undiagnosed diabetes, to a 211 percent greater risk in those with diagnosed diabetes," said Sharon H. Saydah, MHS, an epidemiology researcher at the University's School of Public Health, who presented the results at the meeting. A similar pattern of risk was seen with cardiovascular disease mortality.

These increased risks persisted after taking into account a wide variety of other risk factors for premature death, such as obesity, hypertension, high cholesterol levels, and smoking.

Dr. Brancati noted that the greater risk among the diagnosed likely relates to the fact that many people are not diagnosed with diabetes until they have had it for many years or it has become severe.

"By the age of 75, some 35 percent of all Americans are deceased," Ms. Saydah reported. "But those percentages rise when glucose tolerance is impaired – to 42 percent of those with IGT, 52 percent of those with undiagnosed diabetes, and 77 percent of those with diagnosed diabetes."

"This strongly suggests that the higher risk of death due to impaired glucose tolerance deserves medical attention independent of other mortality risk factors associated with diabetes, such as obesity, hypertension, and abnormal lipid levels," said Dr. Brancati.

Legislation Relating to Diabetes in the 106th Congress

H.R. 1472 – Stamp Out Diabetes Act of 1999. This legislation would allow postal patrons to contribute to funding for diabetes research through the voluntary purchase of certain specially issued United States postage stamps.

H.R. 1542 – The Medicare Diabetic Eye Exam Benefit Act of 1999. This legislation would amend title XVIII (Medicare) of the Social Security Act to provide for Medicare coverage of screening retinal eye examinations for diagnosed diabetics under the care of a managing physician, who certifies that such examinations are needed under a comprehensive plan of care. Waives the applicable deductible for such a new benefit.

H.R. 2369 – Medicare Diabetic Foot Ulcer Care Improvement and Savings Act of 1999. This bill would amend Title XVIII of the Social Security Act to provide for Medicare coverage of certain biologicals used in treating lower extremity ulcers in patients with diabetes.

The Texas Diabetes Prevention and Control Initiative

By Nancy Stancic
Texas Diabetes Program/Council
Texas Department of Health

Diabetes is a costly, chronic disease, and its toll is growing. It is a drain on resources and causes premature mortality, morbidity, and disability. Tragically, it is a leading cause of heart disease, blindness, lower extremity amputations, and kidney failure in the United States. In addition to reducing its victims' quality of life, diabetes causes an economic burden on affected persons.

Diabetes has reached epidemic levels and is a true public health problem with the potential for catastrophic outcomes. In the United States, approximately 16 million people have diabetes and at least one third of that number is undiagnosed. Approximately 800,000 new cases are diagnosed each year. In Texas, it is estimated that diabetes affects approximately 1.6 million people and is the 6th leading cause of death. Diabetes disproportionately impacts minorities and the elderly, the two fastest growing sectors of the United States population. But ultimately, it impacts all sectors of society, including the health care industry and the families of diagnosed individuals.

In response to this health crisis, the Texas Department of Health, Texas Diabetes Program/Council, and Bristol-Myers Squibb Company joined to create the Texas Diabetes Prevention and Control Initiative. It takes a socio-ecological perspective and is designed to affect individuals and communities on multiple levels: intra-personal, interpersonal, organizational, community, and policy.

The Initiative's goal is to reduce diabetes morbidity and mortality in Texas by identifying people at risk for diabetes and helping adults get treatment. The Initiative is being tested in three pilot sites: Houston, El Paso, and the Lower Rio Grande Valley. Each site is a conduit for diabetes care in its defined area. The sites were chosen through a competitive Request for Proposals process. The projects began October 1, 1999, and will continue through September 30, 2000.

Three components comprise the Texas Diabetes Prevention and Control Initiative: Continuing Medical Education (CME), a diabetes awareness campaign, and a diabetes screening and provider referral.

The first component, the Texas Diabetes Program/Council CME program, will be offered to primary care physicians from the three pilot sites. The core CME program includes an overview of diabetes in Texas, Medical Management of type 2 diabetes, and Standards of Diabetes Care. Other special topics are added, based on audience interest. Additionally, Bristol-Myers Squibb Company will offer its own CME program to physicians and other health care providers in the selected sites throughout the program year.

The second component, the diabetes awareness campaign, is designed to increase diabetes awareness, educate Texans about preventive measures that can be taken to reduce their risk of developing diabetes and/or its complications, and encourage Texans with diabetes to properly manage their condition. The campaign will generate attention to the Texas Diabetes Prevention and Control Initiative events and other diabetes-related activities.

The third component of the Initiative, early screening and provider referral, identifies persons with type 2 diabetes and aims to prevent its complications. The target population for the screening is those who are at high risk for diabetes. Ability to pay for services is not a defining factor for participant recruitment as the screening will be offered free of charge. Pilot sites' staff follow the protocol developed by the Texas Diabetes Prevention and Control Initiative steering committee and endorsed by the Texas Diabetes Council. The protocol is based on recommendations from the American Diabetes Association and calls for three stages of testing: 1) American Diabetes Association Diabetes Risk Assessment; 2) Random Blood Glucose (RBG) or Fasting Blood Glucose (FBG); and 3) Oral Glucose Tolerance Test (OGGT).

Based on screening values at each level, persons are diagnosed as at-risk or referred on for more diagnostic diabetes screening. People who are determined to have impaired glucose tolerance or diagnosed with type 2 diabetes are referred to a health care provider for follow-up medical care. They will be contacted again in three months to determine outcome of the referral and to determine if current blood glucose levels are within the acceptable range. At-risk individuals are given educational materials and informed about prevention strategies. Another diabetes test in three years, keeping with the American Diabetes Association recommendations, is advised for those at risk. Three thousand people will be screened each month. It is anticipated that the Initiative will identify approximately 3,600 undiagnosed adult Texans with diabetes.

As a result of the activities related to the Initiative, TDH and Bristol-Myers Squibb expect the community infrastructures to identify and refer adults with diabetes to medical care that were created for the project to continue beyond the project period. They also foresee that communities will be mobilized to educate their citizens and address diabetes and its impact on them. Finally, the burden of diabetes in each pilot location will be reduced.

RECENTLY APPROVED

New Drugs & Devices for Diabetes

Rosiglitazone is Approved for Type II Diabetes

The Food and Drug Administration has approved rosiglitazone (Avandia), a new drug in the thiazolidinedione class of drugs to treat type 2 diabetes. Rosiglitazone is approved for patients with type 2 or adult-onset diabetes who are not taking insulin. Patients taking this drug should also maintain appropriate weight and follow a careful diet.

In clinical trials involving more than 4,000 patients previously treated with diet alone or with metformin, rosiglitazone was shown to improve patients' ability to utilize insulin produced in the body. In general, rosiglitazone was well-tolerated in clinical studies. Adverse events commonly reported included infection, pain and headache, but these occurred at rates comparable to those in the placebo-treated patients. Mild to moderate edema, an increase in blood cholesterol and anemia were also reported in patients treated with rosiglitazone, but did not usually require discontinuation of treatment.

In clinical studies, there was no evidence of drug-induced hepatotoxicity. However, because of the liver toxicity associated with Rezulin, the FDA recommends that liver enzymes be checked at the start of rosiglitazone therapy and every two months during the first year. After the first year, testing should continue periodically.

The drug will be manufactured by SmithKline Beecham of Philadelphia, Pennsylvania.

Source: FDA Talk Paper, May 26, 1999

Pioglitazone is Approved for Type 2 Diabetes

The FDA has approved pioglitazone (Actos), a new drug in the thiazolidinedione class of drugs to treat type 2 diabetes. Pioglitazone is approved as a monotherapy for patients with type 2 or adult-onset diabetes who are not adequately controlled by diet and exercise alone. Pioglitazone is also approved for use in combination with sulfonylureas, metformin, or insulin in patients who are not adequately controlled on these agents alone. Patients taking this drug should also maintain appropriate weight and follow a careful diet.

In clinical trials involving more than 2,300 patients in the U. S., pioglitazone was shown to improve patients' ability to utilize insulin. In general, pioglitazone was well-tolerated in clinical studies. Adverse events commonly reported included headache, upper respiratory infections, and muscle pain.

In clinical studies, there was no evidence of drug-induced hepatotoxicity. Nevertheless, because of the liver toxicity associated with Rezulin, the FDA recommends that liver enzymes should be checked at the start of pioglitazone therapy and every two months during the first year. After the first year, testing should continue periodically.

Takeda Chemical Industries, Ltd., will manufacture the drug, and Takeda Pharmaceuticals America, Inc., and Eli Lilly and Company will co-promote it in the U. S.

Source: FDA Talk Paper, July 16, 1999

New Glucose Monitoring System for Diabetics Approved

A new medical device that provides physicians with continuous measures of tissue glucose levels in adults with diabetes was approved by the FDA on June 16, 1999. The product is the first of its kind.

The Continuous Glucose Monitoring System, made by MiniMed Inc., of Sylmar, California, records tissue glucose levels at five-minute intervals for up to three days. The information is then downloaded on a computer for review by health care professionals.

"Continuous tissue glucose monitoring is breakthrough technology that ultimately could revolutionize the care of diabetics," said FDA Commissioner Jane E. Henney, M.D. "This new system is a first step in that direction. It identifies patterns or trends in the fluctuation of a patient's glucose level above or below the desired range. That information can help the doctor make adjustments in therapy."

The new system is not intended to replace the standard fingerstick testing. The continuous glucose monitoring system is currently intended for one-time or occasional testing, rather than ongoing daily use. The information collected is intended to supplement that obtained by standard fingerstick testing. Diabetics must continue to do fingerstick tests while using the system.

Glucose levels can fluctuate widely throughout the day in people with diabetes—from very high to very low. This makes it difficult to determine when it is important to do fingerstick tests. Until now, there has been no way to continuously monitor those fluctuations.

The new system, available only by prescription, consists of a replaceable glucose sensor, a monitor, and a unit with a special program for transferring data from the monitor to a computer. The sensor, which contains a glucose-sensing mechanism, is inserted under the skin at the abdomen like a tiny needle. The sensor is connected by wire to the monitor, which is worn externally by the patient and is about the size of a pager. The sensor measures tissue glucose every five minutes and stores the data in the monitor's memory.

After up to 72 hours, the patient removes and discards the sensor. The information collected is then transferred to a computer in a doctor's office for review. The patient does not see the tissue glucose information while wearing the device because it is not displayed on the monitor. However, the doctor may review the results with the patient as part of ongoing therapy planning.

FDA based approval of the monitoring system on results of a study involving more than 7,000 glucose readings in 62 diabetic adults who were evaluated at four medical centers in the United States. The study showed that the system could help identify glucose trends and supplement standard readings obtained with traditional blood glucose fingerstick measurements.

The MiniMed system was approved for use based on experience in Type 1 patients.

Source: HHS release, June 16, 1999

GlucoWatch® Biographer Pending FDA Approval

An experimental device that will enable people with diabetes to check their glucose levels painlessly has been shown to be as effective as current techniques that require pricking the finger to obtain blood samples, according to a report presented during the American Diabetes Association's Annual Scientific Sessions, held this summer.

The new device, called the GlucoWatch® biographer, is based on a technique called reverse iontophoresis, which extracts interstitial fluid from the skin. The fluid is absorbed by a small disposable pad, called an Auto Sensor, underneath the monitor. The glucose level in the fluid is then measured electrochemically. The process requires applying a small electric current to the skin – using a AAA battery – whenever glucose levels are to be measured.

A study at the University of Colorado Health Science Center in Denver involved 39 individuals (average age 31), who had had diabetes for an average of 18 years. Thus, all had extensive experience with self-monitoring of blood glucose. Each wore two of the devices on their forearm. They must be placed with the sensor on the middle of the inner arm, at least three inches away from the wrist or elbow joint, to avoid excess hair or movement.

For the first part of the study, they remained at the clinic for 12 hours. After the first three hours, participants also checked their glucose levels twice an hour using a Hemocue®, a well-respected, standard blood glucose monitoring device, according to Satish K. Garg, M.D., director of the adult diabetes program at the university. In addition, 11 participants wore the device for three days at home and self-monitored with a OneTouch®, another standard blood glucose monitor.

"This study confirmed the utility of the GlucoWatch," said Dr. Garg. "Results showed that it gave glucose values that were nearly identical to those obtained using the two blood glucose monitors."

The product still must be approved by the Food and Drug Administration and is not likely to be commercially available for a year or more. The GlucoWatch is expected to sell for about $300, and the disposable Auto-Sensor pads (changed once a day) for about $4.

Source: American Diabetes Association news release

Diabetes Care Coverage

Insurance

According to figures from the American Diabetes Association (ADA), approximately 35 states have enacted diabetes insurance coverage, in which state-regulated health plans must provide coverage for diabetes supplies and self-management education. Similar legislation was passed in Texas in 1997.

The ADA's strategic plan calls for passage of such coverage in all 50 states by the year 2003.

Medicare

On July 1, 1998, Medicare expanded its coverage of preventive benefits for people with diabetes. As part of the Balanced Budget Act of 1997, all Medicare beneficiaries with diabetes are eligible for coverage of the glucose monitors, test strips, and lancets they need to monitor their blood sugar levels.

Previously, Medicare beneficiaries with diabetes who did not use insulin had to cover all of their monitoring supplies or do without.

In addition, on September, 24, 1999, the Health Care Financing Administration announced that Medicare will cover insulin infusion pumps for eligible beneficiaries with type 1 diabetes. HCFA will soon issue coverage instructions, including coding and billing information, to all of its contractors that will specify an effective date that payment will become available for insulin infusion pumps.

CHRONIOLOGICAL HIGHLIGHTS OF DIABETES RESEARCH

1889
Drs. Oskar Minkowski and Joseph von Mering discover that removing the pancreas causes diabetes.

1898
Heredity is a factor in causing diabetes.

1900's (early)
Urine glucose levels are measured with ferric chloride. The procedure takes about 30 minutes and can only be done in a hospital. Before the discovery of insulin, diabetes can only be treated with diet modification.

1902
Secretin (a gastric secretion) is discovered and the term "hormone" is introduced.

1910
At this time, the "diabetic diet" consisted of 70% fat, 18% protein, and 12% carbohydrate and was considered to be a diet of "undernutrition." The artificial sweetener, saccharin, is available although it is recommended that diabetics restrict sweets.

1912
Frederic Allen experiments with restricting the carbohydrate intake of diabetics and develops the "Allen Diet" for treating diabetes.

1915
Glucose monitoring was done using Benedict's Solution. This was an inexpensive and easy way to measure urine glucose and was called the "Rainbow Test."

1921
Dr. Frederick Banting and Charles Best discover insulin and save a diabetic dog.

1922
A Canadian man is the first person to be given insulin.

1923
Insulin becomes widely available to patients. At this time, only short acting insulin is available and must be taken before every meal and during the night.

Glass syringes are the only type available and must be sterilized. Large steel needles (non-disposable) are used.

The recommended diet consists of 70% fat, 20% carbohydrate, and 10% protein. Diet must be coordinated throughout the day to meet the action of the insulin.

1936
Protamine Zinc Insulin (PZI), the first long-acting insulin, is developed by a Danish physician.

1943
The kidney dialysis machine is invented.

1945
Investigators begin to focus on the liver and its regulation of blood sugar.

1947
Based on an U.S. Public Health Service survey, it is believed that one in 170 people has diabetes.

1948
Hagedorn, a Danish physician, develops another delayed action insulin, referred to as NPH for "Neutral Protamine Hagedorn," and could be mixed with fast-acting "regular" insulin. This enabled many patients to be able to manage their diabetes with a single daily injection.

The ADA begins the first nationwide study to determine the prevalence of diabetes in the population.

1950
Diets are still restricted, with fat now comprising a smaller percentage of the total caloric intake (40% fat, 40% carbohydrate, and 20% protein).

Recognition that insulin promotes glucose transport.

1952
Lente, another insulin with intermediate action, is developed.

1953
First human kidney transplant from a live donor is performed.

The first meeting of the International Diabetes Federation is held with diabetes organizations around the world attending.

1955
Vascular bypass surgery in the lower leg is developed.

Sanger and his colleagues determine the amino acid sequence of insulin.

1956
Oral hypoglycemic agents become available to help patients with type 2 diabetes manage their condition.

1959
Krebs and Fischer discover protein phosphorylation.

1960
Immunoassay is developed which allows researchers to measure insulin in blood. This assay showed that people with Type 1 diabetes produced no insulin, but that individuals with Type 2 diabetes have more insulin than normal.

Self-monitoring of glucose begins with "Wet" method using glucose oxidase strips.

1964
Kidney transplants begin in diabetic patients.

Diagnostic criteria for gestational diabetes are established.

1965
Clinical laboratories switch to a Somogyi-Nelson method to measure blood glucose. This method is more accurate and faster.

1966
The first successful pancreas transplant in humans is performed.

1967

Panretinal laser photocoagulation is developed to seal off blood vessels in the retina that have been compromised by diabetic retinopathy.

The structure of insulin is determined by X-ray crystallography.

The first human heart transplant is performed.

1971

The insulin receptor is identified.

1972

The Diabetic Retinopathy Study begins to test the effectiveness of laser treatment of the eyes to prevent blindness in patients with diabetic retinopathy.

The first successful islet cell transplant in rodents with diabetes is performed.

Dextrostix reagent strips and the Ames Reflectance meter are used to measure blood glucose.

1973-1975

Investigators in Europe and the United States describe the association of insulin-dependent diabetes with the HLA genes that control the immune system. No association was found between these genes and non-insulin dependent diabetes, which indicates a difference in the cause of these diseases.

1974

Report of antibodies to insulin-producing cells in newly diagnosed patients with insulin-dependent diabetes, adding to the evidence that Type 1 diabetes is an autoimmune disease.

Federal law provides access to kidney dialysis or transplant to everyone with end stage renal disease.

1975

"Insulin drip" is presented as a new approach for treating diabetic acidosis.

1976

Investigators reveal that hemoglobin becomes glycosylated (attached to glucose molecules) easily. This allows glycohemoglobin (HbA1) determinations to become widespread clinically to assess blood sugar control in the preceding two to three months.

Evidence for altered insulin receptor function in obesity and diabetes is reported.

1977

Improved blood sugar control through better monitoring is advocated as a means of preventing congenital malformations in the infants of women with diabetes.

Battery-operated insulin pumps become available to deliver a continuous subcutaneous dose. They require frequent monitoring and judgments regarding appropriate doses.

The cDNA for rat insulin is cloned.

1979

The National Diabetes Data Group publishes new classification criteria for diabetes. This distinguishes insulin-dependent (Type 1) from non-insulin dependent (Type 2) diabetes. The World Health Organization publishes similar but simpler criteria in 1980.

The Early Treatment of Diabetic Retinopathy Study (ETDRS) begins to refine standards determining when to use laser surgery to prevent vision loss from diabetic eye disease.

The DNA for human insulin is cloned.

1980

Syringes and needles are sterile and disposable.

Aspartame is introduced as an artificial sweetener.

Fat substitutes are developed.

Home glucose monitoring improves meal flexibility.

Genetically engineered human insulin is clinically available, alleviating problems of supply and allergic reactions to animal insulins.

Home glucose monitoring allows for individualized dosing of insulin.

Diets become much lower in fat (30% of total calories) to help prevent heart disease.

Discovery of the translocation mechanism whereby insulin increases glucose transport.

1981

Studies by the British Diabetes Association demonstrate that environmental as well as genetic factors are involved in causing Type 1 diabetes.

Discovery that the insulin receptor is an enzyme – a receptor tyrosine kinase.

1983

Cyclosporine is approved as an immunosuppressant, which benefits transplanting the whole pancreas in kidney recipients.

The Diabetes Control and Complications Trial (DCCT) begins. This is a 10-year randomized trial to determine the effectiveness of intensive diabetes management in the prevention or delay of complications.

Researchers identify mutations in the insulin gene that cause rare forms of diabetes.

Researchers find that islet cell antibodies can identify individuals who are in the process of developing Type 1 diabetes up to 8 years before clinical symptoms appear.

1985

Recognition of incipient nephropathy – microalbuminuria – leads to early recognition, treatment, and possible prevention of diabetic kidney disease.

Cloning of the insulin receptor gene.

Cloning of the first glucose transporter.

1988

Scientists discover that mutations in the insulin receptor gene may cause rare forms of diabetes.

continued on next page

1990
The first transplant of human islet cells that reverses insulin dependency in humans is performed.

1991
One of the genes for Maturity Onset Diabetes of the Young (MODY) is discovered.

Microalbuminuria assay becomes available as a routine laboratory test for early detection and treatment of kidney disease.

1993
The results of the randomized Collaborative Study of Diabetic Nephropathy show that anti hypertensive agents (ACE inhibitors) significantly reduce the need for kidney dialysis and transplantation, and result in fewer deaths related to heart disease.

The Diabetes Control and Complications Trial (DCCT), a 10-year comparative study of over 1,400 patients, proves conclusively that tight diabetes control reduces or delays the risk of diabetic eye disease, kidney disease and nerve damage.

1995
Cloning of the sulfonylurea receptor and subunit of beta cell potassium channel.

1997
Several new drugs with different methods of therapeutic action from sulfonylureas become available to treat type 2 diabetes in the U. S.

Source: "Conquering Diabetes: A Strategic Plan for the 21st Century," a report of the Congressionally-established Diabetes Research Working Group, 1999.

The *Texas D.O.* will feature the following clinical topics during 2000:

January	**Obesity**
February	**Heart Disease**
March	**Organ Tissue Donation**
April	**Parkinson's Disease**
May	**Alcoholism**
June	**Summertime Allergies**

If you would like to contribute a clinical article for any of the above issues, please submit it to:

TOMA
ATTN: Editor in Chief
1415 Lavaca Street
Austin, Texas 78701-1634
FAX: 512-708-1415

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

TOMA's 44th MidWinter Conference & Legislative Symposium

January 28 - 30, 2000

What's New for the New Millennium

The 44th MidWinter Conference & Legislative Symposium Program Chair, George Smith, D.O., has planned an exciting program specifically designed to educate the physicians, in attendance, about "What's New for the New Millennium". It will feature new procedures, new products and new techniques as well as timely updates on OMT, risk management, ethics and resent legislation; all presented to help keep our D.O.s well informed as we begin the next millennium.

This year the conference will also include an "Opening Reception" on Friday evening, January 28th, and "TOMA's Centennial Celebration Kick Off" Dinner on Saturday evening, January 29th. Spouses are invited to both events.

Topics, Speakers and the Program Schedule are on the following page. The Early Registration Form is on page 20.

Be sure to fill out the registration form and return it by January 3, 2000, to get your early registration discount.

DON'T MISS OUT ON A GREAT CONFERENCE. REGISTER TODAY!

MidWinter 2000 Conference Topics & Speakers

Friday, January 28, 2000 • 6:00pm to 9:00pm

Management of Gastroesophageal Reflux Disease
Marc Zuckerman, M.D., F.A.C.P.
Professor of Medicine, Chief, Division of Gastroenterology-Texas Tech University Health Sciences Center in El Paso
Sponsored by Wyeth-Ayerst

Inhalant Flu Treatment Drugs
Sponsored by Glaxo Wellcome

OMT for the Lower Extremities - Conrad Speece, D.O.
Osteopathic Manipulative Medicine, Dallas, Texas

Saturday, January 29, 2000 • 8:00am to 5:30pm

Rules of 6th Scope of Work
Presentation by the Texas Medical Foundation

Diagnosis and Treatment of Sleep Disturbances
Elliott Schwartz, D.O.
Oklahoma City, Oklahoma
Sponsored by Wyeth-Ayerst

Asthma - "Why We Do the Things We Do"
Michael Ruff, M.D.
Private Practice, Associate Professor-Internal Medicine Allergy Division, University of Texas Southwestern Medical Center at Dallas
Sponsored by AstraZeneca

OMT Followup to Nebulizer Steroids
Presentation by Texas College of Osteopathic Medicine

Allergic Rhinitis: Pharmacotherapy-What's New and What's on the Horizon
Mark Olmstead, D.O.
Allergy & Immunology
Garland, Texas
Sponsored by Wallace Laboratories

Insulin Pump Therapy: "How to Treat the Patient and Not the Just the Disease" - Michael Mitchell, D.O.
Wichita Falls, Texas
Sponsored by MiniMed

Diagnosis and Management of Peripheral Arterial Disease
Michael Krupski, M.D.
Professor and Chief of Vascular Surgery, University of Colorado Health Sciences Center, Denver, Colorado
Sponsored by Otsuka America Pharmaceutical

Immune Responses - Alfred Johnson, D.O.
Internal Medicine, Dallas, Texas

Sleep in Space – Sleep on Earth - Richard Jennings, M.D.
NASA Flight Surgeon
Sponsored by Searle

Sunday, January 30, 2000 • 8:00am to 1:15pm

Risk Management - 3 Part Program
David C. McCue, J.D., Susan J. Travis, J.D., Victoria Berry, M.S.N., R.N., C.N.S.
Sponsored by Dean, Jacobson Financial Services, Inc.

MidWinter 2000 Conference Schedule

Friday – January 28, 2000

3:00pm – 8:30pm	Registration Open
3:00pm – 7:30pm	Exhibit Hall Open
4:30pm – 5:30pm	Reception with Exhibitors
6:00pm – 7:00pm	*Management of Gastroesophageal Reflux Disease*
7:00pm – 8:00pm	*Inhalant Flu Treatment Drugs*
8:00pm – 9:00pm	*OMT for the Lower Extremities*
9:00pm – 10:30pm	Meeting of the Friends

Saturday – January 29, 2000

7:00am – 4:30pm	Registration Open
7:00am – 3:30pm	Exhibit Hall Open
7:00am – 8:00am	Breakfast with Exhibitors
8:00am – 9:00am	*Rules of 6th Scope of Work*
9:00am – 10:00am	*Diagnosis and Treatment of Sleep Disturbances*
10:00am – 10:30am	Pharmaceutical Update with Exhibitors
10:30am – 11:30am	*Asthma - "Why We Do the Things We Do"*
11:30am – 12:00pm	*OMT Followup to Nebulizer Steroids*
12:00pm – 1:30pm	Legislative Update Luncheon
1:30 pm – 2:30pm	*Allergic Rhinitis: Pharmacotherapy What's New and What's on the Horizon*
2:30pm – 3:30pm	Pharmaceutical Update with Exhibitors
3:30pm – 4:30pm	*Insulin Pump Therapy "How to Treat the Patient and Not the Just the Disease"*
4:30pm – 5:30pm	*Diagnosis and Management of Peripheral Arterial Disease*
4:30pm – 5:30pm	*Immune Responses*
5:30pm – 7:30pm	"TOMA's Centennial Celebration Kick Off" Dinner *Sleep in Space – Sleep on Earth*

Sunday – January 30, 2000

7:30am – 8:00am	Continental Breakfast
8:00am – 1:15pm	*Risk Management Program* Part I: "Physician Litigation: Manage and Avoid the Risk" Part II: "Medical Malpractice Litigation Update" Part III: "Physician High Risk Management 2000"

Registration form on next page →

TOMA's 44th MidWinter Conference & Legislative Symposium

January 28 - 30, 2000 • Renaissance Dallas North Hotel • Dallas, Texas

EARLY REGISTRATION FORM

PLEASE PRINT or TYPE

Name:_____

Name for Badge (if different):_____

Address:_____

City:_____ State:_____ Zip:_____

Business Phone: (____) _____

Home Phone: (____) _____

FAX: (____) _____

Spouse/Guest Name:_____

D.O. College:_____

Graduation Year:_____ AOA#:_____

Specialty:_____ TOMA District:_____

REGISTRATION INFORMATION

	Postmarked by Jan. 3, 2000	Postmarked after Jan. 3, 2000
TOMA Member	$175 (includes one luncheon ticket)	$250 (includes one luncheon ticket)
Non-Member	$275 (includes one luncheon ticket)	$350 (includes one luncheon ticket)

Please include _____ additional tickets for the Legislative Luncheon on Saturday, January 29, 2000 at $25 each.

REGISTRATION TOTALS

Registration Fee(s) $_____
Additional Luncheon Ticket(s) $_____
TOTAL $_____

REGISTRATION FORM OF PAYMENT

Check enclosed in the amount of $_____

OR

Credit Card Payment

Check One:
☐VISA ☐MasterCard ☐Discover ☐American Express

Amount: $_____

Credit Card #_____

Expiration Date:_____

Name on Card:_____

Signature:_____

REFUND POLICY

- **Requests postmarked on or before January 3, 2000 will receive a refund less 25% administration fee.**
- **All refund requests MUST be made in writing.**
- **No refund will be issued after January 3, 2000.**

RETURN COMPLETED FORM WITH PAYMENT IN FULL TO:

TOMA
Attention: MidWinter 2000 Registration
1415 Lavaca Street
Austin, Texas 78701-1634

Hotel Information

TOMA's 44th MidWinter Conference & Legislative Symposium will be held at the Renaissance Dallas North Hotel in Dallas, Texas, 4099 Valley View Lane (LBJ Freeway & Midway Road).

Please call the hotel directly to make reservations at 800-808-1011 or 972-385-9000. **Reservations must be made no later than JANUARY 7, 2000** to receive the discounted group rate of $119 single/double. Be sure to mention TOMA MidWinter Conference to receive the discounted rate.

National Class Action Lawsuit Filed Against the Nation's Largest HMO Charging RICO, ERISA Violations

Allegations include mail and wire fraud, "Heavy-handed extortionate conduct"

Hattiesburg, Mississippi
October 7, 1999

Charging the nation's largest health maintenance organization with misrepresentation, fraud and extortion to "systematically limit, delay or deny medical care" to its members, a group of nationally renowned attorneys, called the REPAIR1 Team, filed a national class action lawsuit on behalf of 18 million HMO enrollees against Aetna, Inc., and 25 subsidiaries alleging violations of the Racketeer Influenced and Corrupt Organizations (RICO) Act and the Employee Retirement Income Security Act (ERISA).

The lawsuit charges that Aetna engaged in a "nationwide fraudulent scheme" to enroll members by promising quality healthcare and then denying needed services to boost corporate profits and dominate the HMO marketplace. It also charges a "pattern of heavy-handed extortionate conduct against Aetna's physicians" designed to coerce them into accepting contracts imposing "unreasonable, and often unsafe, restrictions on the level of medical services that may be delivered."

"Never again will Aetna or any HMO place profits before patient care," said Richard Scruggs, counsel for class representative Jo Ann O'Neill and the 18.3 million Aetna enrollees who are members of the class. "When you get sick, you need a physician, not an M.B.A. Unfortunately, Aetna used accountants, not doctors, to make life-or-death medical decisions.

"Our lawsuit will hold this Goliath accountable for its broken promises to millions of Davids," Scruggs said. "It will compensate Aetna enrollees for the value of care promised but denied them and change forever the way this HMO operates. Thus, it has the potential to dramatically improve the quality of healthcare throughout the nation.

"Clearly, Aetna needs to learn some lessons in responsibility," Scruggs charged. "Just yesterday, The *Wall Street Journal* reported that Aetna CEO Richard Huber claims 'If medical mistakes are made…it's the doctors' fault, not Aetna's.' In fact, our lawsuit proves that Aetna used extortion to force doctors to sign contracts that the American Medical Association says are "dangerous,' 'interfere with medical decision-making' and 'undermine the patient-physician relationship.'

"In a perfect world," Scruggs said, "No HMO would substitute hypocritical business practices for the Hippocratic Oath. No HMO would promise its members services it has no intention of delivering. And no HMO would be allowed by Congress or regulatory authorities to get away with it. But in the real world, our lawsuit is the last line of defense for millions of men, women and children who were sold a bill of goods at the expense of their health. They have asked us to change this unconscionable healthcare system through the Courts and that is what we will do."

The lawsuit seeks compensatory damages to class members, which can be tripled under RICO; an injunction preventing Aetna from pursuing the practices alleged by the class action; punitive damages; the imposition of a Cy Pres Trust to be administered by the Court; prejudgment and post-judgment interest; and other relief the Court deems appropriate.

Filed today in U. S. District Court, O'Neill v. Aetna details Aetna's alleged strategy "of fraudulently inducing increased membership to obtain revenues, while actually aggressively and deceitfully seeking to reduce the delivery of quality healthcare services provided its members to maximize its profit. " It cites multiple acts of mail and wire fraud, violations of the Travel Act, "heavy-handed extortionate conduct," and a breach of Aetna's fiduciary duties under ERISA.

The lawsuit charges that Aetna engages in a variety of practices that run contrary to what the company tells enrollees and that harm the quality of care, including:

- Limiting referrals to specialists and penalizing doctors who violate Aetna's profit-driven criteria;
- Gagging doctors' ability to communicate openly with their patients about their care and the inadequacy of Aetna's' policies;
- Denying reimbursement for emergency care despite assurances that Aetna complies with the "prudent layperson" standards;
- Usurping sound medical and clinical standards by controlling medical necessity determinations;
- Imposing dangerous financial incentives that discourage inpatient or more expensive procedures and tests;
- Restricting prescription drug formularies despite promising beneficiaries that they will get the medications prescribed by their doctors; and

continued on next page

- Imposing harsh economic sanctions on doctors who challenge Aetna on behalf of their patients.

The lawsuit notes that Aetna's merger with U.S. Healthcare in 1996, its acquisition of NYLCare in 1998 and its purchase of Prudential Healthcare this August have given it disproportionate market clout. This gives Aetna the power to engage in "Undisclosed heavy-handed profit and market dominance strategies designed to coerce physicians into accepting contracts and policies and practices on a 'take it or leave it' basis…The defendants engage in extortionate conduct designed to exploit physician fear of economic loss or loss of business."

"Under Aetna's incentive and disincentive arrangements, the fewer the services provided to members, the greater the physicians' compensation," the lawsuit charges. "Conversely, the more services provided, even where deemed by Aetna physicians to be medically necessary, the greater the likelihood the physicians will owe money at the end of the reconciliation of budget period. These arrangements are specifically designed to cause Aetna physicians to become unwilling co-conspirators in the reduction or limitation in the delivery of healthcare services to the plaintiff and the class in order to maximize profits."

The RICO count of the lawsuit seeks the "return of the portion of premium payments allocable to the profits the defendants derived through fraud and non-disclosure" or "alternatively, disgorgement of profits made by the defendants through fraud and nondisclosure," either of which are subject to treble damages.

The ERISA breach of fiduciary duty count seeks "restitution of all sums of money paid to the defendants during such time as defendants were engaged in the breach(s) of the fiduciary obligation(s) imposed by law. The defendants properly should be compelled to disgorge all such revenues received during the period of its wrongful conduct, including fiduciary breach, fraud and non-disclosure of its conflicted private interests.

Scruggs noted that this lawsuit is unrelated to the "Patients' Bill of Rights" before Congress. "That legislation would give individuals the right to sue if they are harmed by HMO treatment decisions. Our class action is designed to transform the entire system so that no patient is ever again harmed by an HMO."

Members of the class are enrollees in any of Aetna's HMO plans at any time between July 19, 1996 (the date Aetna acquired US Healthcare) to the present.

Members of the REPAIR Team filing on behalf of the class are Richard F. Scruggs and Sidney A. Backstom of Scruggs, Millette, Bozeman & Dent, P.A.; Ronald L. Motley, H. Blair Hahn and Donni E. Young of Ness, Motley, Loadholt, Richardson & Poole, P.A.; Walter Umphrey and Keith Kebodeaux of Provost Umphrey Law Firm, L.L.P.; Paul S. Minor of Minor & Associates; John Eddie Williams and Herbert T. Shwartz of Williams Bailey Law Firm, L.L.P.; Joseph C. Langston of Langston, Langston, Michael, Bowen & Tucker; Wayne D. Blackmon, Esq.; Hiram Eastland of Eastland Law Offices; George Chandler, Attorney at Law; Fred Furth and Ben Furth of Furth, Fahrner & Mason; Harry Potter; David O. McCormick, P.A.; and Cary Patterson of Nix, Patterson & Roach, L.L.P.

Texas Receives Federal Funds in National Campaign to Eliminate Syphilis

The Texas Department of Health (TDH) will receive $400,000 in federal money as part of a national campaign to eliminate syphilis. The announcement was made October 7th in Nashville by the U.S. Centers for Disease Control and Prevention (CDC). TDH officials said most of the money will be spent to combat the sexually transmitted disease in Dallas and Houston. According to the CDC, Dallas County, with 126 cases, ranks ninth nationally in the number of primary and secondary syphilis cases recorded in 1998. Harris County (Houston), with 99 cases, ranks 12th.

The national program calls for the elimination of syphilis as a public health threat in the next five years. "We have an unprecedented opportunity to eliminate syphilis as a public health threat, and we need to take full advantage of it," said Texas Commissioner of Health William R. Archer, M.D. "But it's going to require the cooperation of our public health system, private medicine, communities and individuals." He also said the keys to elimination include getting infected people to refrain from risky sexual behavior, to seek testing and treatment and to let their sex partners know that they, too, should be tested.

Texas rates for primary and secondary syphilis plummeted from 29 cases per 100,000 population in 1991 to two cases per 100,000 in 1998, a rate lower than the national rate of 2.6. The number of Texas cases dropped from 5,012 in 1991 to 430 in 1998. Of the 430 cases of syphilis recorded in Texas in 1998, 67 percent were African-American, 16 percent were Hispanic and 11 percent were white. However, rates for syphilis in African-Americans dropped from 203 cases per 100,000 in 1991 to 13 per 100,000 in 1998. Almost half of the 430 cases in Texas last year were in persons 20 - 34 years old. Only 11 percent of the cases were teen-agers.

For more information contact Casey Blass, Director, TDH HIV/STD Health Resources Division, at 512-490-2535; or Doug McBride, TDH Pubic Information Officer, at 512-458-7524.

THE INDEPENDENT
INVESTOR

DEAN, JACOBSON FINANCIAL SERVICES, LLC
A Registered Investment Advisor

SECURITIES SOLD THROUGH LINSCO/PRIVATE LEDGER • MEMBER NASD/SIPC

Low Inflation Drives High Real Growth

Few factors can influence market performance like the Federal Reserve's ability to increase the federal funds rate. Watchers of the stock market wait breathlessly for Fed Chairman Alan Greenspan's next move, and constantly speculate not only whether or not the Fed will increase rates, but by how much, and when the increase will occur.

With two rate increases already in the books for 1999, it's important to look at the Fed's goal when it takes this action. Different perceptions exist about what exactly the Fed tries to accomplish.

The case has been made that the Fed acts as a traffic cop, enforcing speed limits on the U.S. economic highway. Proponents of this theory assert that rate hikes are necessary if the economy is exceeding the maximum sustainable rate of growth. If you accept these two assumptions: first, that "excessive" growth causes inflation and second, that the Fed knows the growth limit, then the case for the Fed raising rates to slow growth is impeccable. The trouble is that neither assumption holds.

The premise behind the "growth causes inflation" model is that most growth results from consumers demanding more goods and services and that rising demand pushes prices higher. That is a plausible assumption, but is equally plausible that technical innovations, high worldwide capacity, increasingly skilled and equipped labor and especially the information technology revolution are raising production at lower cost. In other words, it may be that supply is outpacing rising demand. If so, then there is no speed limit and attempts to slow growth may be counterproductive.

Suppose the Fed's efforts to restrict growth had resulted in less telecom capacity or prevented Mircosoft's or Hewlett Packard's growth. Would these restrictions have led to lower prices? Surely not, since double-digit real growth in the technology sector has clearly delivered lower prices to consumers. Suppressing growth in high tech and investment in recently deregulated areas of the economy like power generation could raise consumer prices.

How about other areas? Traditional economic thinkers point to consumer spending. After all, retail sales constitute half of Gross Domestic Product, so this could be an important area of possible "demand-pull" price pressure. There the argument that rising demand would push up prices seems sensible. However, there is one glaring problem - the data do not support the notion that faster growth in consumer spending pushes prices up. Rather the data indicate the opposite conclusion - that lower retail prices push real consumer spending higher. In other words, consumers tend to buy more cars, TVs, kitchen appliances and furniture when prices are slowing or falling. These days, it takes a sale to move the merchandise.

Of course, retail business has figured this out. The days of building profit margins by raising prices are over. Successful retail businesses are cutting costs, increasing efficiency and service and providing consumers with better products at lower prices. If they don't then they are likely to be out of business. Consumers are not buying ahead of price increases; instead they are rejecting price increases and going to Wal-Mart or the Internet for a better deal.

The Fed's job is to take the U.S. economy to price stability and keep it there. It is not the Fed's job to act as a traffic cop by setting and enforcing speed limits on U.S. economic growth. Former Fed Chairman, William McChesney, described the Fed's role as taking away the punch bowl before the party really gets started. The problem with that line of thought is that the U.S. economy isn't a party and U.S. consumers and investors are not partygoers that cannot drive home. By limiting growth, instead of taking away the punch bowl, the Fed may be taking away a once in a lifetime opportunity to achieve a major increment to the nation's capital stock and standard of living.

FORT WORTH 817-335-3214

DALLAS 972-445-5533

TOLL FREE 800-321-0246

AOA State Government Affairs UPDATE

Osteopathic Physician Joint Negotiations

At its July 1999 Annual Meeting, the AOA House of Delegates voted to support antitrust exemptions at the state and federal level for osteopathic physicians wishing to enter into joint negotiations with managed care organizations.

Thus far, one state has passed legislation allowing this. Texas Governor George W. Bush signed into law SB 1468, the Managed Care Freedom of Choice Act, on June 20th, 1999, one day before a signing deadline. This new law allows up to 10% of a health plan's service area physicians to jointly negotiate contract terms. Specifically, the law address: 1) procedures for specialist referrals; 2) procedures for drug formulary determinations; 3) methods to enhance preventive and early detection care; and 4) ensuring the delivery of quality health care. Further, the law allows for the negotiation of reimbursement only if the attorney general determines that the health plan has "substantial market power," and the inability to jointly negotiate reimbursement issues has already affected, or threatens to affect, the quality or availability of patient care. Notably, the attorney general must approve all final agreements or contracts within 30 days under this new law.

Spinal Manipulation Legislation

This year, there have been 25 pieces of legislation in 13 states that deal with the regulation of spinal manipulation. Even though the state legislative sessions are winding down, three new bills dealing with the regulation of spinal manipulation have been introduced. In New York, AB 9059 brings the total number of bills dealing with spinal manipulation in that state to six. None of the six bills, if passed, will affect a D.O.'s practice. South Carolina also has had spinal manipulation bills introduced just before the legislature's adjournment. These bills will be carried over into the 2000 session. Since the bills did not exclude D.O.s from the hourly requirements, the AOA wrote to the sponsors of both bills outlining why D.O.s should not be required to fulfill any hourly requirements.

A comprehensive "study bill" was passed in early August in North Carolina. Included was a provision to study limiting the practice of manipulation to chiropractors. The AOA and NCOMA will be providing applicable materials as well as actively contacting relevant lawmakers.

Medical Directors

The AOA House of Delegates approved a resolution in July 1999 supporting mandated physician licensure of medical directors of Managed Care Organizations (MCOs). This resolution voices support for state legislation or regulation requiring MCO medical directors to be licensed by the state osteopathic medical board where the care is being provided, thus placing the physician under the authority of the board.

Thus far this year, two states (Hawaii and South Dakota) have passed legislation requiring full licensure of medical directors, bringing the total number of states with such a requirement to 17.

Managed Care Liability

While there were over 90 bills introduced this year that would have granted patients a cause of action against a MCO for denied services, only two bills were enacted which allow any level of liability to fall upon the MCO. Following the 1997 Texas Managed Care Liability Act, Georgia enacted SB 732 that similarly mandates a standard of "ordinary diligence" be met by MCOs. This law establishes an independent, external appeals process so that patients may seek recourse against adverse treatment determinations they feel do not meet the standard. The decisions of the external appeals agency are then considered binding – a failure to meet the ruling is then considered a tort that can be grounds for action. Notably, Georgia's law does not allow for collection of punitive damages.

Louisiana also passed similar legislation, however the law is more limited in its scope. Unlike Texas and Georgia, the Louisiana bill does not establish any standard of care that need be met. Rather, the new law establishes an external appeals process much like the Georgia law. A cause of action can be maintained if a decision made by the plan or the independent review organization "was rendered in bad faith or involved negligence, gross negligence, or intentional misrepresentation of factual information about the covered person's medical condition."

Independent Review

This year has seen a large number of bills introduced establishing external, independent appeals processes for enrollees of managed care plans, or altering existing processes. Such legislation aims at giving patients who receive adverse treatment decisions a mechanism for appeal. The level of independence of the review organization varies from state to state, as does how binding such a decision is. Twenty-nine states introduced independent review legislation this year, with Arizona, Colorado, Georgia, Illinois, Indiana, Iowa, Kansas, Louisiana, Minnesota, Montana, Ohio, Oklahoma and Virginia having enacted new laws.

Postgraduate Training Requirements

Two states introduced legislation aimed at increasing the number of postgraduate training years required for licensure. Alaska enacted such legislation this year, bringing its current requirement to two years. A bill in Nevada did not pass through the legislature. The AOA supports the requirement of one year of postgraduate training for licensure since the rotating internship provides osteopathic physicians with a broad base of primary care training.

Women's Contraceptive Coverage

The AOA House of Delegates voted in July to adopt a resolution voicing support

for state legislation that would require the coverage of FDA-approved contraceptive services for women by health insuring companies. The year 1999 has seen 60 bills in 30 different states requiring such services. Only Georgia and Vermont have enacted contraceptive coverage legislation this year.

Online Prescribing

The much-publicized issue of prescribing to patients over the Internet received a great amount of attention in 1999. While many Web sites are actual online pharmacies, other sites have been found to offer consultations and prescriptions to patients in need of certain medications. While this practice has come under scrutiny, few states have been able to adequately devise a means to regulate this practice.

At the July 1999 AOA House, delegates voted to support legislation requiring establishment of a physician-patient relationship before prescribing any medications online. This resolution, adopted as policy, states it is unethical for a physician to prescribe and dispense medication to a patient via the Internet without having first physically examined him or her.

The State Medical Board of Ohio has proposed rules dealing specifically with online prescribing. These rules, if approved, require a physical examination of a patient prior to any prescription.

Illinois, Indiana, New York and Virginia all introduced legislation in 1999 addressing online prescribing. Virginia passed its resolution requesting a study of the issue, and Indiana passed a bill requiring online pharmacies that dispense medication into that state to adhere to the home state's laws for real pharmacies. However, Illinois passed the most comprehensive law. IL H.B. 1879 was enacted on August 6 and requires all Internet pharmacies that dispense medications into the state to register annually as a nonresidential pharmacy.

Questions on these or any other state issues may be directed to Dan Walter, Legislative Analyst, at DWalter@aoanet.org or by phone at 800-621-1773, extension 8185.

Dr. Earl Kinzie Honored by Baylor University

Earl Christian Kinzie, D.O., of Lindale, recently received the degree "Alumnus by Choice" from Baylor University and the Baylor Alumni Association of Waco.

The degree reads as follows:

Baylor University
Waco, Texas
and the
Baylor Alumni Association
extend greetings and felicitations to
Earl C. Kinzie, D.O.
upon the occasion of your official designation as an
Alumnus by Choice

This decree is made on behalf of the Board of Regents, faculty, staff, students,
and alumni in recognition of your loyalty to,
and extraordinary interest in
Baylor University
and as a testimony of your faithful support of its purpose and goals.

September 11, 1999

A retired TOMA life member, Dr. Kinzie is a 1935 graduate of the University of Health Sciences College of Osteopathic Medicine in Kansas City. Following an internship and four years of practice in Kansas, he relocated to Lindale where he established a general practice in 1941. During his 49 years of practice, he delivered approximately 2,000 babies.

A source of pride to Dr. Kinzie is that among those babies he delivered was his namesake, Heisman Trophy winner Earl Christian Campbell, born in 1955 in Tyler. Campbell was inducted into the College Football Hall of Fame in 1990, and into the NFL Hall of Fame in 1991. The Texas Legislature passed a bill in 1987 proclaiming Campbell as the fourth official State Hero of Texas, putting him in a class with three other men: Stephen F. Austin, Davy Crockett and Sam Houston.

TOMA members who attended the 1993 convention in Austin may recall that Campbell served as the guest speaker during the Keynote Luncheon. Campbell, who suffers from panic disorder, shared his personal knowledge of the disorder. During the luncheon, Dr. Kinzie was introduced as "the only man that whipped his butt and got away with it."

Dr. Kinzie has been extremely active in the osteopathic profession. In 1989, he was awarded a TCOM Founders' Medal, the highest award presented by TCOM. In presenting the award, TCOM president David M. Richards, D.O., noted , "Dr. Earl C. Kinzie is a role model for what a family and community physician should be. He is a doctor who knows and practices the therapeutic value of listening to what his patients have to say. He is a physician who believes in nurturing those just entering the profession." TOMA congratulates Dr. Kinzie on his newest honor.

New Interns and Residents

The following is a continuation from last month's issue of new interns and residents who have begun training programs in Texas hospitals and medical centers.

Doctors Hospital (Groves)

David Abrams, D.O.
NSU/COM
Resident

Mary Q. Bartlett, D.O.
Western U
Intern

Tiffany L. Beggs, D.O.
UOMHS/COMS
Resident

Jonathan S. Coolidge, D.O.
UNTHSC/TCOM
Intern

Dionne M. Curran, D.O.
UNTHSC/SOM
Intern

Irma V. Dailey, D.O.
UOMHS/COMS
Resident

David P. Frick, D.O.
UHS-COM
Resident

Gary W. Hillman, D.O.
UOMHS/COMS
Resident

Paul R. Hunt, D.O.
Western U
Resident

Kimberly R. Pitts, D.O.
Western U
Intern

Mark Strazynski, D.O.
Western U
Resident

Christus St. Elizabeth Hospital (Beaumont)

Greg Rampey, D.O.
OSU-COM
Family Practice Resident

Scott & White Memorial Hospital (Temple)

Richard H. Ames, D.O.
UOMHS/COMS
Pediatrics Resident

Tri D. Dang, D.O.
UNTHSC/TCOM
Pediatrics Resident

Richard V. Daniels, D.O.
KCOM
Emergency Medicine Resident

Huy X. Duong, D.O.
UNTHSC/TCOM
Pulmonary Fellowship

David D. Fletcher, D.O.
CCOM
Emergency Medicine Resident

Alan C. Gowan, D.O.
UHS-COM
Internal Medicine Resident

Ginger S. Goodchild, D.O.
UNTHSC/TCOM
Family Practice Resident

Kristy O. Heatly, D.O.
UNTHSC/TCOM
Family Practice Resident

John K. McIlwaine, D.O.
UHS-COM
Internal Medicine Residenthip

John K. Midturi, D.O.
UNTHSC/TCOM
Internal Medicine Resident

Cindy C. Parker, D.O.
Western U
Emergency Medicine Resident

Kyle D. Phillips, D.O.
UNTHSC/TCOM
Family Practice Resident

Jenny L. Peloquen, D.O.
UNTHSC/TCOM
Psychiatry Resident

Hari Reddy, D.O.
UNTHSC/TCOM
Pediatrics Resident

Milan J. Sheth, D.O.
UNTHSC/TCOM
Internal Medicine Resident

Mark L. Spencer, D.O.
UHS-COM
Internal Medicine Resident

Scott R. Stoughton, D.O.
Western U
Emergency Medicine Resident

Texas Tech University Health Sciences Center at Amarillo

Nektaria Paraskevopoulos, D.O.
NSU/COM
Intern

Stephen Stoffel, D.O.
UNTHSC/TCOM
Intern

Texas Tech University Health Science Center at El Paso

Charles Burk, D.O.
UNTHSC/TCOM
OB/GYN Residentt

Kelly Chura-Singh, D.O.
MUS-COM
Psychiatry Resident

Scott L. Hofer, D.O.
Western U
Orthopedics Resident

Sandra Nothvogel, D.O.
UNTHSC/TCOM
Family Medicine Resident

Cecilia Placencia, D.O.
OUCOM
Family Medicine Resident

Alejandro Rocha, D.O.
UNTHSC/TCOM
Family Medicine Resident

Kerri Trainer, D.O.
UNTHSC/TCOM
Anesthesiology Resident

Tri-City Hospital (Dallas)

Chandi Bankston, D.O.
UNTHSC/TCOM
Family Medicine Resident

Cheryl Grayum, D.O.
UHS-COM
Family Medicine Intern

Tracy Kidwell, D.O.
OSU-COM
Family Medicine Resident

Daniel Ladd, D.O.
UOMHS/COMS
Family Medicine Intern

Rudell Lee, D.O.
OSU-COM
Family Medicine Intern

Bruce McDonald, D.O.
OSU-COM
Dermatology Resident

Peggy Newcomer, D.O.
Western U
Family Medicine Resident

Denny Parton, D.O.
OSU-COM
Family Medicine Resident

Keith Pensom, D.O.
UNTHSC/TCOM
Family Medicine Resident

John Sanchez, D.O.
CCOM
Family Medicine Intern

Soledad Wang, D.O.
OSU-COM
Family Medicine Resident

U.S. Army Surgeon General Ronald R. Blanck Named New President of UNT Health Science Center at Fort Worth

Fort Worth (UNT), Texas – Concluding a nationwide search, the University of North Texas System Board of Regents selected on October 28, 1999, Lt. Gen. Ronald R. Blanck to become the new president of the UNT Health Science Center at Fort Worth.

Blanck, 58, currently is the Surgeon General of the United States Army and commander of the U.S. Army Medical Command – with more than 46,000 military personnel and 26,000 civilian employees throughout the world.

UNT launched the search early this year after UNT Health Science Center President Dr. David M. Richards announced plans in December of 1998 to serve one final year and then retire. Blanck will begin his new duties at the UNT Health Science Center on August 15, 2000, after he retires from the Army on July 31.

When the UNT Regents meet this month (November), they will consider a nomination by UNT System Chancellor Alfred F. Hurley, developed in consultation with Blanck and Richards, of an interim president to serve between the time of Richards' retirement and Blanck's arrival.

"I am absolutely delighted that General Blanck has decided to focus his post-Army career on this key leadership role in the UNT system," said Hurley. "He has demonstrated admirable leadership skills and vision in a series of increasingly responsible experiences in Army medicine."

"In addition," Hurley said, "General Blanck has demonstrated a keen commitment to the education and training of future osteopathic physicians and other health professionals that will position him to build on the excellent foundation that Dr. Richards has laid at the UNT Health Science Center at Fort Worth."

Blanck said, "My wife, Donna, and I are very pleased and excited at the prospect of becoming part of the University of North Texas, the UNT Health Science Center and the Fort Worth community. I look forward to continuing to promote the tradition of excellence the UNT Health Science Center stands for."

After entering the Army in 1968, Blanck, an osteopathic physician certified in internal medicine, was initially assigned as a medical officer in Vietnam. In his distinguished 31-year military career, Blanck has served as commander of Walter Reed Medical Center North Atlantic Region Medical Command and director of professional services and chief of Medical Corps Affairs in the office of the Surgeon General of the Army. He also has served as assistant chief of General Medicine Service in the Department of Medicine at Walter Reed, assistant dean of student affairs at the Uniformed Services University School of Medicine and chief of the Department of Medicine at Brooke Army Medical Center.

He is a fellow and past governor of the American College of Physicians. He also is an active member of the Association of Military Surgeons of the United States, the American Osteopathic Association, the Association of Military Osteopathic Physicians and Surgeons and the American Medical Association. His academic credentials include adjunct teaching positions at Georgetown University, George Washington University, Howard University School of Medicine and the University of Texas Health Science Center at San Antonio. He earned his doctor of osteopathy degree from the Philadelphia College of Osteopathic Medicine. His bachelor of science degree is from Juniata College in Huntingdon, Pa.

Retiring president Richards was widely acknowledged as a leader in his field from the time that he took the job in 1986. He played a key role in the development of partnerships between the UNT Health Science Center and other health eduction and health care institutions across the nation.

Citing Richards for his accomplishments, Hurley said, "Throughout his tenure as president, Dr. Richards has brought national attention to the capabilities of the UNT Health Science Center, especially to its work in primary care medicine and in related research such as its nationally recognized study on cholesterol. General Blanck will take the helm of an already highly successful institution – one that has as its centerpiece the leading osteopathic medical school in the United States along with a growing number of other components," Hurley said.

Blanck and his wife have been married for 28 years. They have two daughters, Jennifer, a student at Trinity College in Washington, D.C., and Susan, a student at the University of Vermont. He was born in Manheim, Pa.

Call for Awards Nominations

The TOMA Board of Trustees is currently accepting nominations for four awards:

- **Distinguished Service Award**
- **Meritorious Service Award**
- **Outstanding Community Service Award**
- **Public Service Award**

These awards represent the highest honor that TOMA can bestow in recognition of outstanding service and contributions to the osteopathic profession in Texas.

The Distinguished Service Award is presented to an osteopathic physician in recognition of outstanding accomplishments in scientific, professional, osteopathic education, or service to the osteopathic profession in Texas or at the national level. The candidate must be a member of the Texas Osteopathic Medical Association; a longtime member of their district society; and a member of the American Osteopathic Association. Those holding an elective office in TOMA are ineligible to receive the award during their term of office.

The Meritorious Service Award is presented to an individual in recognition of outstanding accomplishments in scientific, philanthropic, or other fields of public service to the osteopathic profession in Texas. The candidate does not have to be an osteopathic physician.

The Community Service Award is presented to an osteopathic physician in recognition of outstanding service to their community through the promotion of and dedication to osteopathic medicine in their practice. The candidate must be a member in good standing of the Texas Osteopathic Medical Association, have provided excellent service to their local, regional, or state community, exceptional care to their patients, and demonstrated a commitment to the principles and philosophy of osteopathic medicine. The candidate should exemplify what the profession perceives to be the "typical" osteopathic physician who cares for patients and is an unsung, local hero. Those holding an elective office in TOMA are ineligible to receive the award during their term of office.

The Public Service Award, TOMA's newest award, may be presented to a maximum of two governmental officials whose works and accomplishments are outstanding in promoting the health care needs of the state of Texas, while recognizing the unique value of the osteopathic philosophy.

The Nomination Process

TOMA districts that wish to nominate persons for these awards should complete a nomination form, available from Paula Yeamans at the TOMA State Office, and include pertinent biographical data about the individual as well as information about the person's accomplishments that make them deserving of the award. The nomination form must have at least five signatures of TOMA members in good standing; however, no member holding an elective office in TOMA is eligible to sign the nomination. The nomination form should then be sent to the TOMA Executive Director, no later than March 1, 2000, who will forward it to the TOMA Awards and Scholarship Committee for consideration.

Upon receipt of the nomination form, the TOMA Awards and Scholarship Committee will conduct a discreet but thorough investigation as to the accuracy of the information. After careful review, the committee chairman may nominate a candidate, as recommended by the committee, presenting necessary information to the Board of Trustees. An affirmative vote by three-fourths of the members of the Board of Trustees will be required to grant any award.

Award recipients will be notified by the Board of Trustees and will be requested to attend TOMA's annual convention, at which time the award will be presented by the TOMA President or Master of Ceremonies during the President' Banquet on Saturday night.

Please note that not more than one of each award will be granted in any one year, except for the Public Service Award. Additionally, these awards are not necessarily annual awards.

TRICARE Prime Remote Enrollment Opens

Sue Bailey, D.O., assistant secretary of defense for Health Affairs, announced on October 5th that thousands of active duty service members, who live in the United States but far from military hospitals and clinics, can immediately enroll in a new program, known as TRICARE Prime Remote.

TRICARE Prime Remote facilitates access to primary medical care in the local areas where service members live and work. Active duty personnel who live and work more than 50 miles from a military hospital or clinic must enroll in TRICARE Prime Remote. In areas where there are TRICARE network providers, service members can select a primary care provider from the network as their Primary Care Manager (PCM). If there are no network providers, service members may select any local, TRICARE-certified provider. Service members will no longer need to call the nearest military hospital or clinic in order to schedule an appointment for primary care services.

"Our approach in designing the Prime Remote benefit is to focus on the needs of the service members and their commanders," said Bailey. "We understand that duty in a remote area brings its own hardships. So when our service members are sick, we want them to see their doctors without the hassle of long-distance phone calls or requirements to travel unreasonable distances."

"When specialty care is needed, either the primary care doctor or service member must call and get an authorization," continued Bailey.

"Additionally, there will be instances when we will need to determine if the medical condition will impact a member's fitness for duty."

Authorization for specialty care is obtained from the regional contractor.

"I want to stress, however, that in the event of an emergency, service members should seek medical care immediately," Bailey emphasized. In these cases, preauthorization is not required, but authorization must be obtained within 24 hours following the emergency.

The most important action that service members must take is to enroll in the program. Units will be receiving enrollment packets that include an enrollment form for each assigned member. In the event a unit or service member does not receive an enrollment packet, the service member or commander should call the regional contractor to get enrollment forms and other information on TRICARE Prime Remote. These toll-free phone numbers are listed at the end of this release.

If service members live in remote areas and have not yet enrolled, they still have their medical benefits. When they need nonemergency medical care, they should call the regional contractor at the number below to get an authorization. The regional contractor will also ensure the service member receives an enrollment form and other information on TRICARE Prime Remote.

Under TRICARE Prime Remote, pharmacy and mental health services are covered benefits. Services such as toll-free health care information lines, access to preferred provider networks, utilization of regional Health Care Finders are all services available to military members in remote areas. The same TRICARE contractors that handle family member claims will now handle medical claims processing services for all active duty service members.

TRICARE Prime Remote includes dental care benefits. Service members in remote areas may obtain care from any licensed dentist (or VA facility where dental care is available to service members). Specialty dental care, like medical care, must be approved before treatment. However, unlike medical care, the Military Medical Support Office (MMSO), Great Lakes Naval Station, Illinois, will approve dental specialty care. The MMSO will also process and pay all military claims for dental care.

DoD established the MMSO, a joint service office, as part of the TRICARE Prime Remote initiative. The Navy serves as executive agent with medical representatives from the Army, Navy, Air Force and Coast Guard on the staff. The MMSO, like the regional contractors, provides 24-hour, 7-day a week service to military members who have questions about obtaining civilian health care or who experience an emergency hospitalization. The MMSO will help guide callers to the appropriate regional contractor. The MMSO can be reached at 1-888-MHS-MMSO (1-888-647-6676) or on the internet at <http://navymedicine.med.navy.mil/mmso/>.

At this time, family members are not eligible for TRICARE Prime Remote. However, there are some programs for family members in remote areas in Regions 1 (Northeast), 2 (Mid-Atlantic), 5 (Heartland) and 11 (Northwest).

The Department is studying various options for expanding family member choices in the coming year. In the meantime, family members continue to have TRICARE Standard, and they may use TRICARE Extra in areas where network providers are available.

Personnel serving in remote areas overseas will continue to be served by the TRICARE Overseas Lead Agents (Europe, Pacific, and Latin America) in the same manner as previously arranged for remote units. Additional information about TRICARE Prime Remote can be obtained by calling the following toll-free numbers, or by visiting the TRICARE Prime Remote Website:<http://www.tricare.osd.mil/remote> .

Northeast (Region 1) 1-888-999-5195

Mid-Atlantic (Region 2) 1-800-931-9501

Southeast (Region 3) 1-877-249-9179

Gulfsouth (Region 4) 1-877-249-9179

Heartland (Region 5) 1-800-941-4501

Southwest (Region 6) 1-800-406-2832

Central (Regions 7/8) 1-877-554-2224

Southern California (Region 9) and Golden Gate (Region 10) 1-800-242-6788

Northwest (Region 11) 1-800-404-2042

Pacific (Region 12), Alaska and Hawaii 1-800-242-6788

continued on page 40

FYI

Free Immunization Information Kits

According to the Centers for Disease Control and Prevention (CDC), almost 60,000 Americans die each year from flu and pneumococcal disease. Flue and pneumonia combined are the sixth leading cause of death in people over the age of 65. Most of these deaths could be prevented with a simple vaccination paid for by Medicare.

The influenza vaccine can prevent up to 70 percent of hospitalizations and 85 percent of deaths from influenza-related pneumonia. The pneumococcal vaccine can prevent up to 60 percent of serious pneumococcal infections. In 1997, only 38.8% of Texas Medicare beneficiaries not enrolled in managed care plans received a flu shot. The pneumococcal vaccination rate was even lower at 22.5%. The low rates can be attributed in part to the fact that many providers are not aware of a very simple process for billing Medicare for flu and pneumococcal shots.

The Texas Medical Foundation (TMF), the Texas Department of Health and the Texas Department on Aging are campaigning to increase immunization rates among Medicare beneficiaries. Beginning in September, a series of television and radio public service announcements began broadcasting throughout the state.

TMF is offering free immunization tool kits to assist health care providers in handling the increased consumer demand for flu and pneumococcal vaccinations among Medicare beneficiaries. Each tool kit contains patient education brochures and posters, medical chart stickers, and Medicare electronic and roster billing and coverage information.

To order a free informational immunization tool kit from TMF or to take part in an immunization effort in your area, call Sylvia Garcia at 800-725-9216.

Rural Hospitals, Health Care Systems Strengthened by $13 Million in Grant Awards

On September 10, Vice President Al Gore announced the first grant awards under the new Rural Hospital Flexibility Program, giving $13 million to 43 states to support a new approach in improving access to health care in rural communities and developing health care networks to expand services.

"For people living in rural communities rural hospitals are a lifeline, and yet today 20 million Americans in our rural communities do not have adequate access to quality health care," Vice President Al Gore said. "That is why we are taking this important step to help assure that rural hospitals can meet the health care needs of working families."

The Rural Hospital Flexibility Program is a 5-year $125 million program administered by HHS' Health Resources and Services Administration's Office of Rural Health Policy. This nationwide program allows the creation of a new category of rural hospitals called "critical access hospitals," or CAHs.

"These grants will help rescue financially at-risk rural hospitals and make sure they continue to provide much needed care," said HHS Secretary Donna E. Shalala. "We're giving states the resources and flexibility to develop their own unique plans for revitalizing small rural hospitals and building the strong networks needed to give rural residents access to comprehensive, quality health care."

In 1997, more than 54 million Americans lived in rural areas, making up 20 percent of the U.S. population. Of those, more than 20 million have inadequate access to health care. The critical access hospital is a new designation that entitles a rural public or non-profit hospital to receive cost-based reimbursement for their Medicare patients. For a hospital to qualify as a CAH, it must operate a limited number of inpatient beds, keep patients a maximum of four days, provide 24-hour emergency medical services and be designated by the state.

HRSA's grants to the states will help rural communities determine how local care should be delivered, what resources are needed, and what problems and barriers must be overcome to achieve better health care for all rural residents. This program is designed to bring together key local organizations that provide or support health care service delivery, including hospitals, clinics, community health agencies, local public health agencies, emergency medical service providers, social service agencies, local government, and business and consumer groups.

"What's unique about this new program is that it gives rural communities a chance to save their local hospitals, and helps develop a broader range of essential health care services to their residents through the community networks," said HRSA Administrator Claude Earl Fox, M.D., M.P.H.

In April 1999, HRSA provided up to $200,000 to each of 48 states to jump start the program. Rhode Island and New Jersey did not receive funds because they do not have any counties in non-metropolitan areas. With today's award, HRSA made available up to $600,000 to each state that applied for the funding. Five states—Connecticut, Delaware, Pennsylvania, Utah and Oregon—chose not to apply for the additional funding but remain eligible in subsequent years. Five HRSA-funded rural health research centers and the Rural Policy Research Institute have developed a consortium to provide technical assistance to states, develop a management information system and evaluate program implementation. A technical assistance center will also be established to help grantees improve their skills and expertise.

The new program is modeled after two successful demonstration projects conducted in the early 1990s: the Montana Medical Assistance Facility program and the Essential Access Critical Hospitals/Rural Primary Care Hospital program in New York, West Virginia, North Carolina, Kansas, South Dakota, Colorado, and California.

HRSA is the lead U.S. Department of Health and Human Services agency responsible for improving access to health care for all Americans. Through a range of programs that bring health care to rural and isolated areas, HRSA improves access to primary care and preventive services in rural areas, where health care providers are in short supply.

continued on next page

Rural Hospital Flexibility Program Fiscal Year 1999 Grant Awards

- Alaska Department of Health & Social Services . . . $382,705
- Alabama Department of Public Health 162,650
- Arkansas Department of Health 478,381
- The University of Arizona 124,379
- California Department of Health Services. 220,055
- Colorado Department of Public Health and Environment 382,705
- Florida Department of Health. 191,352
- Georgia Department of Human Resources 411,408
- Hawaii Department of Health. 162,650
- Iowa Department of Public Health 231,378
- Idaho Department of Health and Welfare 334,867
- Illinois Department of Public Health 478,381
- Indiana Department of Health. 287,029
- Kansas Department of Health and Environment 550,138
- Kentucky Department for Public Health 191,352
- Louisiana Department of Health and Hospitals. 220,055
- Massachusetts Department of Public Health 81,325
- Maryland Department of Health & Mental Hygiene . . 83,717
- Maine Department of Human Services 124,379
- Michigan Department of Community Health 224,839
- Minnesota Department of Health 550,138
- Missouri Department of Health 81,325
- Mississippi Department of Health. 171,403
- Montana Department of Public Health & Human Services 574,057
- North Carolina Department of Health & Human Services 287,029
- University of North Dakota School of Medicine and Health Sciences 541,712
- Nebraska Health and Human Services System 550,138
- New Hampshire Department of Health and Human Services. 95,676
- New Mexico Department of Health 153,082
- University of Nevada School of Medicine 220,055
- New York Department of Health. 550,138
- Ohio Department of Health 95,676
- Oklahoma Department of Health 478,381
- South Carolina Department of Health and Environmental Control. 263,110
- South Dakota Department of Health. 287,029
- Tennessee Department of Health 399,448
- Texas Department of Health 478,381
- Virginia Department of Health 167,433
- Vermont Department of Health. 167,433
- Washington Department of Health 550,138
- Wisconsin Department of Health & Family Services 550,138
- West Virginia Department of Health and Human Resources 358,786
- Wyoming Department of Health. 220,055

Total $13,114,506

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

- Plans were already underway for TOMA's 1990 convention, which was to be held in El Paso. James E. Froelich, III, D.O., was introduced as the 1990 program chairman.

- An international symposium to discuss important new developments in the function of high density lipoprotein in preventing coronary heart disease was held at Texas College of Osteopathic Medicine. More than 100 researchers and scientists, including participants from Sweden, France, Italy, Australia, Israel, Canada and other foreign countries, attended the International Symposium on Reverse Cholesterol Transport and Coronary Heart Disease, the first conference of its kind held in the U.S. The symposium was co-sponsored by TCOM and the University of British Columbia, Vancouver, B.C., Canada, and endorsed by the American Heart Association.

- Donald M. Peterson, D.O., was re-elected to his second one-year term on the American Medical Peer Review Association (AMPRA) Board of Trustees. In addition, John H. Boyd, D.O., was elected to serve on AMPRA's Bylaws Committee.

- TOMA purchased a duplex in the northwest section of Austin in an effort to assure higher visibility for the association. The duplex was to be used by TOMA staff, physician leadership and other osteopathic representatives throughout the year, with the heaviest usage expected during regular and special legislative sessions. In addition, osteopathic physicians serving on various state boards and committees were urged to make use of this duplex while in Austin.

- The American Board of Quality Assurance and Utilization Review Physicians (ABQAURP) announced the certification of Patrick Hanford, D.O. The ABQAURP, a non-profit organization dedicated to setting a standard of excellence in the new specialty of Quality Assessment and Utilization Management, recognized its diplomates as experts in the field.

Physician Assistants

PArtners for Healthy Communities

Changes in the delivery of health care in the United States have placed new burdens on patients. Today, consumers may find themselves confused by the variety of health care providers in a clinic. One profession that has become a recognized member of the medical team is the physician assistant.

Physicians Assistants, or PAs as they are commonly called, are licensed medical professionals who provide medical care under the supervision of physicians, providing patient care services, which would otherwise be performed by physicians. As part of their comprehensive services, PAs take medical histories, perform physical examinations and interpret lab tests, diagnose and treat illnesses, suture lacerations, assist in surgery and, in more than 40 states, Texas included, they can write prescriptions when authorized to do so by their written protocols.

On October 6, PAs around the United States, including the members of the Texas Academy of Physician Assistants, celebrated National Physician Assistant Day. It was on that day in 1967 that the first class of PAs graduated from Duke University in North Carolina.

Physician assistants build healthy communities by working with physicians to increase access to medical care. "Physician assistants have a record of more than 30 years of providing quality, cost-effective health care to patients," said Ron Nelson, PA-C, President of the American Academy of Physician Assistants (AAPA).

PAs are employed by solo physicians, HMO group practices, nursing homes, and hospitals. The largest segment of physician assistants – more than 47 percent – practice family and internal medicine. PAs also serve as commissioned officers in all branches of the military and practice as members of the White House medical team, caring for the president and vice president.

In addition, PAs provide health care services where there is a lack of general physicians, such as urban inner cities and rural underserved areas.

The relationship between a physician and a physician assistant is one of mutual trust and reliance. It is common in rural areas for the supervising physician to live in another community and to make routine visits as required or necessary, while the PA provides day-to-day medical care to the local residents. There must always be a means for consultation between the physician and the PA, but not necessarily the physical presence of the supervising physician when the PA is treating patients.

Because physicians and PAs usually train together during their education and work as teams during clinical rotations, physicians have become increasingly supportive of the physician/PA team. Patients also report satisfaction with care provided by physician assistants. A 1994 poll conducted by the Gallop Organization revealed that a majority of Americans in both rural and urban communities support the use of physician assistants to provide health care.

The Texas Academy of Physician Assistants (TAPA) is embarking on a campaign to educate the public regarding the dangers of tobacco use. This includes cigarette, cigar, pipe, chewing tobacco and snuff use as well as the hazard of second hand smoke on non-smokers. Texas PAs are being trained to educate civic groups on the hazards of tobacco abuse.

TAPA would like to thank the Texas Osteopathic Medical Society for their support of the physician/PA team. We look forward to working together to make quality health care a reality for all Texans.

TAPA would like to ask any physician who currently employs a PA to nominate that PA for the Texas Academy of Physician Assistants' "PA of the Year" award. Submission should include the PA's name, address and phone number. Deadline is January 31, 2000. Nominations should be sent to TAPA, 401 West 15th St., Austin, TX 78701. Please call 800-280-7655 with questions.

TxACOFP Update

TxACOFP 1999-2000 Committees

The following is a listing of the TxACOFP Committees and their members. A big thanks to those who have agreed to serve this year.

Education and Program Committee

Program Chair Robert DeLuca, D.O.
Assistant Chair Harold Lewis, D.O.
Members Kathyrn Schmidt, D.O., Catherine Carlton, D.O., Craig Whiting, D.O., Gregory Dott, D.O., Lisa Nash, D.O.

Subcommittee-Resident Relations

Chair Tony Hedges, D.O.
Members Ronda Beene, D.O., Ted Alexander, D.O. Jamie Inman, D.O., David Hill, D.O., Lisa Nash, D.O., Mary Ward, D.O.

Subcommittee-Student Relations

Chair Robert DeLuca, D.O.
Members Bruce Maniet, D.O., Steve Ellerbe, D.O., Carolyn McDougald, D.O., Adriana Hwa, President, Zeta Chapter; Kevin Denton, Past President, Zeta Chapter; Robin Stewart, Rural Representative, Zeta Chapter

Membership Committee

Chair Harold Lewis, D.O.
Members Sara Apsley-Ambriz, D.O., Harlan Borcherding, D.O., Charles Hall, D.O.

Awards Committee

Chair Pat Hanford, D.O.
Members Rodney Wiseman, D.O., Jerome Smola, D.O., T.R. Sharp, D.O.

Constitution and By-Laws

Chair T. Eugene Zachary, D.O.
Members Pat Hanford, D.O., Greg Maul, D.O., Monte Mitchell, D.O.

Nominating Committee

Chair John R. Bowling, D.O.
Members Pat Hanford, D.O., Sara Apsley-Ambriz, D.O.

Long Range Planning Committee

Chair Jerome Smola, D.O.
Members R. L. Erickson, D.O., T. R. Sharp, D.O., Rodney Wiseman, D.O., R. Greg Maul, D.O., Jack McCarty, D.O.

Government and Legislative Committee

Chair David Garza, D.O.
Members Don Peterson, D.O., Henry Underwood, D.O., Pat Hanford, D.O., Robert Stark, D.O., Robert L. Peters, Jr., D.O., Irvine Prather, D.O.

Resolutions Committee

Chair Craig Whiting, D.O.
Members Joe Montgomery-Davis, D.O., Pat Hanford, D.O., T. Eugene Zachary, D.O.

Pacers Committee

Chair Pat Hanford, D.O.

TCOM Observer

Samuel Coleridge, D.O.

Ex-Officio Appointments

Liaison to the AOA Board	Robert L. Peters, Jr., D.O.
Liaison to ACOFP Board	R. Greg Maul, D.O.
Liaison to Family Practice Residents	Tony Hedges, D.O.
Liaison to Zeta Chapter	John R. Bowling, D.O.
Parliamentarian	T. Eugene Zachary, D.O.,
Zeta Chapter Representative	Adriana Hwa
Resident Representative	Chandi Bankston, D.O.
Editor	Janet Dunkle

A Message from the TxACOFP President

On Thursday, October 8th, the U.S. House of representatives passed a patients' bill of rights that sets new restrictions on managed care. The vote on the Norwood-Dingell Bipartisan Consensus Managed Care Improvement Act, H.R. 2723, was 275-151. This bill would set new restrictions on managed care companies, and hold them accountable for decisions made by them which prevent, delay or restrict patients' access to care.

Some of the provisions in this House bill are:

- Lift the federal ban on lawsuits against many insurance companies, allowing patients to sue in state courts if a benefit is denied or delayed.

- Allow patients to take complaints to independent review panels outside the health plan
- Require plans to pay for needed specialists
- Require plans to pay for routine care associated with clinical trials
- Allow direct access to OB/GYN care for women
- Patients would be protected against disruptions in care because of a change in their health plan or a change in the "provider's" network status.
- Patients would have access to non-formulary medications when prescribed by the physician.

Below is a copy of the summary of this bill. Please read it and be informed. It may not go far enough toward getting all the health decisions back to the physician but it's a start. Stories that aided in the support of this bill included documentation of adverse effects when the health insurance plan denied care even though the doctor had recommended it. This is not a perfect bill and, in fact, will no doubt undergo significant revision during the House/Senate conference committee. It does send a message that Congress agrees the insurance companies must share the liability when they make medical decisions.

As I indicated in my inaugural remarks in July, it is time medical decision making is given back to the physician. This is a positive step in that direction. Your national ACOFP organization has joined the AOA, AMA, the American Cancer Society and others in working toward managed care reform. We need individual physicians and their patients to become involved and let your Senators and Representatives in Congress know that the American public will not tolerate rules and regulations that limit what we can do for our patients.

Contact your congressman. Let them know how intolerable the system is for our patients. Support your ACOFP and your AOA groups so they can continue to support us on issues like this that will affect the future of health care to our patients.

We are busy, making your osteopathic family medicine organization stronger in the state of Texas. Let us hear from you. Contact Janet Dunkle at our Austin headquarters 888-892-2637) or feel free to e-mail me <jbowling@hsc.unt.edu>.

Fraternally,
John R. Bowling D.O., F.A.C.O.F.P.

Bill Summary & Status for the 106th Congress H.R.2723 Sponsor: Rep. Charlie Norwood

SUMMARY

THE BIPARTISAN CONSENSUS MANAGED CARE IMPROVEMENT ACT OF 1999 OUTLINE

ACCESS TO CARE

- *Emergency Services.* Individuals should be assured that if they have an emergency, those services would be covered by their plan. The Bipartisan Consensus Bill says that individuals must have access to emergency care, without prior authorization, in any situation that a "prudent lay person" would regard as an emergency.
- *Specialty Care.* Patients with special conditions must have access to providers who have the requisite expertise to treat their problem. The Bipartisan Consensus Bill allows for referrals for enrollees to go out of the plan's network for specialty care (at no extra cost to the enrollee) if there is no appropriate provider available in the network for covered services.
- *Chronic Care Referrals.* For individuals who are seriously ill or require continued care by a specialist, plans must have a process for selecting a specialist as a gatekeeper for their condition to access necessary specialty care without impediments.
- *Women's Protections.* The Bipartisan Consensus Bill provides direct access to ob/gyn care and services.
- *Children's Protections.* The Bipartisan bill ensures that the special needs of children are met, including access to pediatric specialists and the ability for children to have a pediatrician as their primary care provider.
- *Continuity of Care.* Patients should be protected against disruptions in care because of a change in plan or a change in a provider's network status. The Bipartisan Consensus Bill lays out guidelines for the limited continuation of treatment in these instances. There are special protections for pregnancy, terminal illness, and individuals on a waiting list for surgery.
- *Clinical Trials.* Access to clinical trials can be crucial for treatment of an illness, especially if it is the only known treatment available. Plans must have a process for allowing certain enrollees to participate in approved clinical trials, and the plan must pay for the routine patient costs associated with these trials.
- *Drug Formularies.* Prescription medications should not be one-size-fits all. For plans that use a formulary, beneficiaries must be able to access medications that are not on the formulary when the prescribing physician dictates.
- *Choice of Plans.* Choice is one of the key components of consumer satisfaction with the health system. The Bipartisan Consensus Bill would allow individuals to elect a point of service option when their health insurance plan did not offer access to non-network providers. Any additional costs of this option would be borne by the patient.

INFORMATION

- *Health Plan Information.* Informed decisions about health care options can only be made by consumers who have access to information about health plans. This bill requires managed care plans to provide important information so that consumers understand their health plan's policies, procedures, benefits, and other requirements.

GRIEVANCE AND APPEALS

- *Utilization Review.* When a plan is reviewing the medical decisions of its practitioners, it should do so in a fair and rational manner. The Bipartisan Consensus Bill lays out basic criteria for a good utilization review program: physician participation in development of review criteria, administration by appropriately qualified professionals, timely decisions (within 14 days for

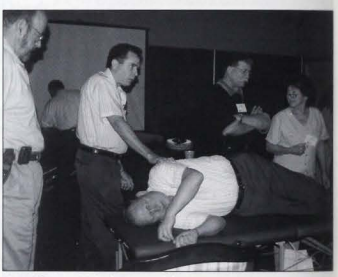
continued on page 37

TxACOFP's 2nd Annual OMT Update and Review

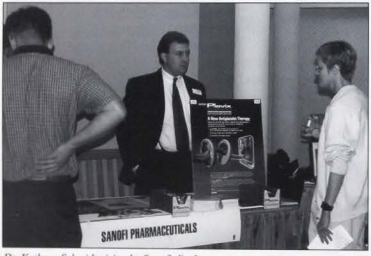
Dr. Carl Mitten performs OMT on Dr. Orrin Dana as taught by Dr. Richard Anderson.

Juan Gonzales (L) and Jay Reynolds representing Pfizer.

Susan Telton of the TCOM of CME and Dr. Charles Winters visit the exhibit hall.

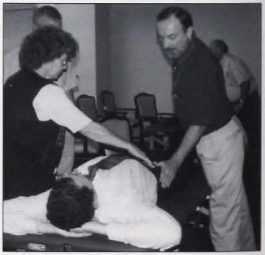


Conrad Speece, D.O., lectures and demonstrates OMT on Ligamentous Articular Strain.



Dr. Kathryn Schmidt visits the Sanofi display.

Dr. Catherine Carlton teaches treatment for low back and pelvis.



Robbye Richard, D.O., and John Marshall, D.O., demonstrate a technique on Dr. David Teitelbaum.

continued from page 35

ordinary care, up to 28 days if the plan requests additional information within the first 5 days, or 72 hours for urgent situations), and the ability to appeal these decisions.

- *Internal Appeals.* Patients must be able to appeal plan decisions to deny, delay, or otherwise overrule doctor-prescribed care and have those concerns addressed in a timely manner. Such an appeal system must be expedient, particularly in situations that threaten the life or health of the patient, and conducted by appropriately credentialed individuals.
- *External Appeals.* Individuals must have access to an external, independent body with the capability and authority to resolve disputes for cases involving medical judgment. The plan must pay the costs of the process, and any decision is binding on the plan. If a plan refuses to comply with the external reviewer's determination, the patient may go to federal court to enforce the decision. The court may award reasonable attorneys' fees in addition to ordering the provision of the benefit and may assess a penalty against the plan of $1,000 per day up until the benefit is provided.

PROTECTING THE PROVIDER-PATIENT RELATIONSHIP

- *Anti-Gag and Provider Incentive Plans.* Consumers have the right to know all of their treatment options. The Bipartisan Consensus Bill prohibits plans from gagging doctors and from retaliating against providers who advocate on behalf of their patients. It protects providers in these situations from retribution. It also prevents plans from providing inappropriate incentives to providers to limit medically necessary services.
- *Provider Selection.* Providers should not be discriminated against based on the basis of license in selection for plan participation. The Bipartisan Consensus Bill forbids discrimination against providers based on license, location, or patient base. Plans would, however, be able to limit the number and mix of providers as needed to serve enrollees for covered benefits.
- *Prompt Payment of Claims.* Health plans should operate efficiently and pay providers in a timely manner. This bill would require that claims be paid in accordance with Medicare guidelines for prompt payment.
- *Paperwork Simplification.* In order to minimize the confusion and complicated paperwork that providers face, this bill would require that the industry develop a standard form for providers to use in submitting a claim.

ACCOUNTABILITY

- *Insurer Liability.* Health plans are not currently held accountable for decisions about patient treatment that result in injury or death. Currently, the Employee Retirement Income Security Act preempts state laws and provides essentially no remedy for injured individuals whose health plans' decisions to limit care ultimately cause harm. If the plan was at fault, the maximum remedy is the denied benefit itself. The Bipartisan Consensus Bill would remove ERISA's preemption and allow patients to hold health plans accountable according to state law. However, plans that comply with an external reviewer's decision may not be held liable for punitive damages. Additionally, any state law limits on damages or legal proceedings would apply.

The provision also protects employers from liability when they were not involved in the treatment decision. It explicitly states that discretionary authority does not include a decision about what benefits to include in the plan, a decision not to address a case while an external appeal is pending or a decision to provide an extra-contractual benefit.

What Our Members Are Doing

Charles Childers, D.O., became the founding director of the central Texas Veterans Health Care System's new outpatient clinic in Brownwood.

Liz Chapek, D.O., has opened a new Family Medicine/OMT Clinic at 6760 Abrams Drive in Dallas.

George Beasley, D.O., was elected secretary-treasurer of the Texas Independent Osteopathic Physicians Association.

Rob Cooksey, D.O., was elected president of the Permian Basin Medical Society for 1999-2000. Dr. Cooksey also serves as EMS Director the City of Big Spring, Texas.

2nd Annual OMT Update and Review

The 2nd Annual OMT Update and Review for Primary Care was a huge success. This collaborative effort with the UNTHSC Department of CME combined OMT workshops with clinical lectures to provide attendees with 20 hours of Category 1-A CME. The OMT workshops were led by faculty from the Department of OMT at the UNTHSC, members of the Dallas Osteopathic Study Group, as well as TxACOFP members who are passionate about the importance of incorporating OMT into family practice.

Many pharmaceutical companies and the TCOM Alumni Association generously donated grants to help support lectures and meals as well as participated in the exhibit hall.

The Department of CME and the TxACOFP thank all who attended and supported this event. We have big plans for the 3rd Annual OMT Update and will keep you informed.

Self's Tips & Tidings

By Don Self

With November upon us, there are several issues that need to be discussed this month and not all of them deal with Medicare. I realize that some will completely discount what this month's issue relates, and there may even be some whose denial of the facts surrounding these issues will cause them to become angry with me. Because the Texas osteopathic physicians have been such a blessing to me over the past 12 years, I feel compelled to bring these facts to you, regardless.

CPT and HCPCS have come out with their new codes for 2000, so you need to make sure you order a new copy of both of these coding books. There are code changes, so having a new book is mandatory if you wish to stay compliant on your coding. You can order them from many sources (AMA, St Anthony's, PMIC, Unicor, etc.). We have an arrangement with Unicor 800-725-7421 in that if you mention our name, you will receive a discount. We do not make one penny from this endorsement and we order (and pay for) all of our books from them as well. Contrary to what some may tell you, the ICD-9 codes are not changing for 2000, due to HCFA trying their best to become Y2K compliant before April of 2000.

Medicare's fee update, which usually happens January 1st of each year, is currently scheduled for April 1st, 2000 because HCFA fears non-Y2K compliance with many carriers and providers.

Compliance

Compliance seems to be a buzz word in almost every medical facility today. To reduce confusion, we will discuss the two kinds of compliance that will affect you.

HCFA, BBA, HIPA Compliance: This use of the term compliance refers to your complying with all existing Federal and State laws in use of coding, documentation, correct billing procedures, adherence to fee laws, collection laws and the steps you have outlined in your practice to avoid fraudulent billing.

Since 1998, Medicare has been performing random pre-pay compliance audits on E&M documentation to make sure that physicians are billing appropriately for the services documented. So far, more than 67% of those audits have resulted in physicians either having the claims they submitted for visits downcoded to a lower level or completely denied. Medicare has also begun the "similar documentation" audits. In these audits, also performed randomly (so far), Medicare will request documentation on 10-15 visits coded with the same level of code (99212, 99213, etc.). The auditor will look to see if each visit has identical documentation (which does happen in some offices that use templates or automated documentation). If the physician has not noted something about the particular visit that is different from others - Medicare will assume that fraud has happened and investigate further. This is due to the fact of the high number of physicians who routinely bill for services not provided - when the patient did not present to the office. While it is a minute number of physicians that defraud the system like this, the amount of money involved is very high, so Medicare has become suspect of all claims which necessitated these audits. Remember - your documentation is your only defense - so protect yourself.

The Office of Inspector General (OIG) has released its final rule revising the exclusionary plus civil money penalties (CMP) for providers who commit fraud and abuse. The new rule:

- expands the OIG's power to exclude providers beyond Medicare and state health care programs, to include all public health care programs;
- establishes permanent exclusions for individuals convicted of three or more health care-related crimes and 10-year exclusions for individuals convicted of two health care-related crimes;
- assesses CMPs of up to $10,000 against institutional providers that knowingly employ or enter into contracts for medical services with excluded individuals;
- establishes a new CMP of up to $25,000 for health plans that fail to report information to the Healthcare Integrity and Protection Data Bank; and
- creates CMPs for providers who violate the anti-kickback statute of up to a maximum of $50,000 per violation, including a maximum penalty of not more than three times the amount of remuneration offered, paid, solicited, or received in the kickback scheme.

With these new rules physicians have to take notice and set up compliance plans in their practices, clinics and hospitals if they wish to avoid catastrophic problems.

Y2K Compliance: This kind of compliance refers to your ability to continue submitting claims electronically to Medicare, your ability to maintain control of your computerized programs, accounts receivable, billing and ability to continue practicing throughout the year 2000.

As of mid October, HCFA reports that only 2% of Medicare providers in this country have tested for Y2K compliance and more than half of those were not Y2K compliant. With that in mind, we are recommending you stock up on a supply of HCFA 1500 claim forms in case electronic transmittal of claims becomes impossible

for the first few months of 2000. We're not saying it will, but it's best to be safe.

I have spent more than 250 hours studying Y2K and so far, it's been my experience that more than 90% of personal computers we have tested are not compliant in either the hardware, operating system, software, data files or windows registry. If you are relying on your software vendor to make sure your system is compliant, demand that same vendor provide you a written certification that your hardware, software, operating system, data files and registry are in fact compliant with a guarantee. If that vendor is still in business throughout all of 2000, that guarantee may help you.

Contrary to what some doomsayers are voicing, we do not believe that Y2K will bring a permanent end to our current lifestyle although we are expecting some complications and long lasting problems. We also do not believe that all of the Y2K related problems will manifest themselves on January 1st or even in the first quarter of 2000. Due to the embedded problems in some software, data files and operating systems, any problems with your own system may not become apparent until well into the year, when you discover that your software has been producing inaccurate data. We cannot say this will happen in your office, but the potential is 10 times higher that this will happen than the chance that you will have a malpractice claim against you in 2000; and you carry insurance for that possibility.

We encourage you to prepare a backup system in your office to protect your accounts receivable, patient data, claims filing capability and appointment scheduling functions. Remember, your ability to keep your practice profitable does not rely solely on your own computer system - as long as you are also dependent upon power, postal service, water, communications, outside suppliers, off-site labs and diagnostic equipment which may have interruptions. If you do not believe that possibility exists, ask the provider of that outside service for a written guarantee that they will not have interruptions. Don't be surprised if not one will give it to you.

Action You Should Take

Please consider the ramifications of both kinds of compliance and consider taking the following steps:

1. Set up a compliance plan in your office where all processes of claims filing, documentation, billing and education of changing billing regulations are constantly updated.
2. Set up a self-audit program in your practice, clinic or hospital so that either compliance trained personnel in your own practice or an outside auditing service has the authority to randomly double check documentation and coding issues, and report to the management any discrepancies or additional training requirements. Whether you use the documentation slide-rules we sell or some other kind of documentation checklist, tool or program, you should be performing self-audits.
3. Ensure to the best of your ability that your computer hardware and software is Y2K compliant. So far, we have found one software that will perform a five-step test, checking your hardware, operating system, program files, data files and registry to make sure it is compliant and will prepare a printed report outlining what is compliant and what is not. We have arranged with the company to have the free testing software on our Website. This is the only company that we have found that issues a Certificate of Compliance that covers your hardware and software. If you do not have access to the Internet, you can call them for a disk that performs this test, although I believe there is a minor fee for the testing disk. We recommend you contact PME, Inc. at 800 541-2618.
4. Set up contingency plans in your office to protect your accounts receivable and permit you to continue seeing patients if (heaven forbid) your computer is unable to perform this task for a period of a week to a month. We recommend you have a pegboard system as a backup (also available from PME)
5. Set up a contingency plan in your office to have extra flashlights, water (essential to any practice), paper claim forms and an extra amount of cash available in case your local banks suffer outages for any reason (panic, electricity, computer programs, etc.).

Before you discount all that I've said about either compliance, please stop and think of the ramifications of not preparing for either, and forgive me if I've stepped on your toes. "A wise man sees trouble ahead and takes precautions. A fool goes along his way and suffers mightily for it." Please be the wise man mentioned in the Bible and prepare.

New Seminar Schedule
which includes Isle of Capri Casino
<http://www.donself.com/seminars.html>

Don Self, CSS, BFMA
Don Self & Associates, Inc.
P.O. Box 1510
Whitehouse, TX 75791
Voice (800) 256-7045
Fax (903) 839-7069
http://www.donself.com
E-mail: donself@donself.com

TRICARE News...continued from page 30

Cancer Clinical Trials Claims Mailing Addresses for Participants

TRICARE-eligible persons who participate in the National Cancer Institute's (NCI) cancer-prevention and treatment clinical trials should send their claims for care received during the trials to one of two addresses, depending on the TRICARE region in which they live.

The NCI's cancer prevention and treatment clinical trials allow TRICARE-eligible patients access to the latest cancer therapies. Under the demonstration project, patients can have their treatment covered while they participate in research studies designed to find better ways to prevent, diagnose and treat cancer.

TRICARE Regions 1, 2, 3, 4 and 5:

Palmetto GBA
DOD Cancer Prevention and Treatment Clinical Trials Demonstration
P.O. Box 100514, Florence, SC 29501
Toll-free telephone: 1-800-779-3060

TRICARE Regions 6, 9, 10, 11, 12 and the Central Region (formerly Regions 7/8):

Palmetto GBA DOD Cancer Prevention and Treatment Clinical Trials Demonstration
P.O. Box 870060
Surfside Beach, SC 29587
Toll-free telephone: 1-800-395-7821

TRICARE Region 1 consists of the District of Columbia, Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, certain northern Virginia ZIP codes located near the Washington, D.C., area, and a few ZIP codes in the northeastern part of West Virginia.

TRICARE Region 2 is made up of North Carolina and most of Virginia, except for the small part of northern Virginia that's part of Region 1.

Region 3 includes South Carolina, Georgia, and most of Florida, except for the Panhandle.

Included in Region 4 are the Florida Panhandle, Alabama, Mississippi, Tennessee, and the eastern third of Louisiana, generally including Baton Rouge and points east.

Region 5 is made up of Wisconsin, Michigan, Illinois, Indiana, Ohio, Kentucky, the St. Louis area in Missouri, and most of West Virginia, except for a small part of the northeastern corner of the state that's part of Region 1.

Region 6 includes Oklahoma, Arkansas (except for a small part of northeastern Arkansas that's in Region 5), the western two-thirds of Louisiana generally west of Baton Rouge, and all of Texas except for part of the southwestern corner of the state that includes El Paso.

The Central Region consists of Arizona (except for the Yuma area), Nevada, New Mexico, Colorado, Wyoming, Utah, most of Idaho (except for six counties in northern Idaho), Montana, North and South Dakota, Kansas, Nebraska, Minnesota, Iowa, Missouri (except for the St. Louis area), and that piece of southwestern Texas which includes El Paso.

Regions 9 and 10 consist of southern and northern California, respectively. Region 9 also includes the Yuma, Ariz., area.

Region 11 is made up of Washington, Oregon, and six counties in northern Idaho.

Region 12 includes Alaska and Hawaii.

In Memoriam

Thomas G. Brown, D.O.

Thomas G. Brown, D.O. of Amarillo, passed away September 2, 1999. He was 79.

Dr. Brown received his bachelor's degree in chemistry from Wayne State University in Detroit, and his D.O. degree from the Chicago College of Osteopathic Medicine. During World War II, he served from 1943 until 1946 in France. Discharged as a corporal, he received a Bronze Star.

He specialized in pathology and served as president of the Rhode Island Society of Osteopathic Physicians and Surgeons, as well as assistant professor of pathology at the University of New England in Maine.

Dr. Brown was active in the Masons and was 33rd degree from Daylight Lodge No. 48 in Cranston, Rhode Island. He was a member of York Rite Doric Council No. Seven, Whirlaways Square Dancing Club and Coventry Seniors Bowling League. In 1984 and 1988, he was a delegate to the Republican National Convention.

Survivors include his wife, Marion Elizabeth Brenton Brown of Dallas; a daughter, Jean Loveall of Amarillo; and three grandchildren.

The family requests memorials to the American Lung Association, Wayne State University, or an educational charity of choice.

Aspirin Takes Its Place in Smithsonian Institution's National Museum of American History

A century after its discovery, aspirin took its place among more than 250,000 items in the Smithsonian Institution's division of science, medicine and society. Bayer Corporation, the U.S. subsidiary of Bayer AG of Germany, donated a sample of aspirin's active ingredient, acetylsalicylic acid, along with a replica of the first Bayer bottles made in 1899.

German scientist Felix Hoffmann is credited with the synthesis of acetylsalicylic acid in August 1897.

To all Members of the Provider Advisory Council

The new implementation date for Compass 21 is May 1, 2000. In the near future, you will be receiving more information concerning the implementation.

Normal Cellular Enzyme – Marker for Alzheimer's Disease

Scientists have discovered a new molecular marker for Alzheimer's disease (AD) – a cellular protein that piles up in nerve cells ravaged by AD.

A research team supported by the National Institutes of Health (NIH) examined the brains of people who had died from AD and found abnormally large amounts of the cellular signpost – a normal enzyme in the body called casein kinase-1 (CK-1). The researchers found that a high level of CK-1 was present in nerve cells inside cellular sacs called vacuoles. The findings indicate that a high CK-1 level in vacuoles may be a useful marker for AD, along with the two other long-recognized cellular abnormalities, or "lesions," associated with the disease: plaques and tangles.

Previous research had already shown that such vacuoles, called "GVD (granulovacuolar degeneration) bodies," were a prominent feature in about half of all AD cases. Scientists also already knew that the vacuoles tended to accumulate in a region of the brain called the hippocampus that is particularly vulnerable in AD, and is normally very important for learning and memory. Nonetheless, GVD bodies have remained poorly understood by scientists because they have been stubbornly difficult to locate within autopsied brain tissue. Until now, no good markers for GVD bodies were available to scientists studying AD.

The new work not only enables researchers to use CK-1 as a molecular label for studying GVD bodies, but also forges a link between GVD bodies and the more commonly studied plaques and tangles typical of AD brains.

"The most important conclusion form our work is the existence of a molecular connection between the different lesions of Alzheimer's disease," said Dr. Jeffrey Kuret of Ohio State University and senior author of the new study. The work appears in the October, 1999 issue of the *American Journal of Pathology*.

A release is available on the internet at: <www.nih.gov/nigms/news/releases/kuret.html>.

Washington Update

- Upon returning to Washington in September, Congress was almost two months behind schedule on the 2000 budget. Among appropriations bills still in the works: the Labor-Health and Human Services-Education bill, one of the most contentious in Congress. With discretionary funding already reduced piecemeal for other spending measures, House and Senate appropriators face allocations that are at least $16 billion below FY 1999 levels. Under budget constraints put into place by the Balanced Budget Act of 1997 (BBA), Congressional leaders have a difficult choice: find additional sources of funding, breach spending caps, or resort to the Social Security surplus for discretionary spending. Both parties have loudly proclaimed a hands-off approach on the Social Security program.

- Given this dilemma, Republication leaders agreed in mid-September to bust BBA spending caps for labor, health, and social programs. Under the agreement, overall spending for FY 2000 would be frozen at current year levels. Implementing the approach would require a number of accounting "gimmicks," including bookkeeping decisions to shift portions of next year's spending to FY 1999 or 2001.

- With limited time left until adjournment, health care providers are stepping up efforts to persuade Congress to pass legislation restoring payment cuts made by the BBA. With hospitals, skilled nursing facilities, home health agencies, and other providers vying for up to $20 billion or more in GGA "givebacks," prospects appear to be increasing that Congress could take action. Whether it will do so yet this year is far from clear. How much, over how long, for whom, and from what funding sources also are open questions. Meanwhile, in recent testimony before the Medicare Payment Advisory Commission (MedPAC), the Health Care Financing Administration contends that pinning hospitals' financial woes on the BBA alone fails to consider the effects of private sector payment reductions.

- Also unclear is whether Congress or the Administration will end up taking the lead on patient privacy. Under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), Congress had until August 21 to pass legislation on medical record confidentiality. With its failure to act, responsibility shifted to the Secretary of Health and Human Services to develop regulations by February 2000. Although the August deadline has passed, Hill staffers maintain that Congress still could take the initiative, a course the Administration favors because Congressional efforts could be more far-reaching.

- On September 10, Vice President Al Gore announced $13 million in grants to 43 states under the new Rural Hospital Flexibility Program. Under the program, intended to improve and expand services in rural areas, rural hospitals designated critical access hospitals (CAHs) would be entitled to receive cost-based reimbursement for their Medicare patients. To qualify, a hospital would have to operate a limited number of inpatient beds, keep patients no more than four days, provide 24-hour emergency medical services, and receive CAH designation from its state. According to the HHS Secretary, the grants "will help rescue financially at-risk rural hospitals," allowing them to continue providing much needed care.

Source: AOHA Washington Update

TEXAS STARS

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

Abbott Labs Pharmaceuticals
Rene Acuna, D.O.
Bruce Addison, D.O.
Ted C. Alexander, Jr., D.O.
Richard Anderson, D.O.
Sara Apsley-Ambriz, D.O.
David Armbruster, D.O.
Astra Merck
ATOMA
ATOMA District II
Aus-Tex Printing and Mailing
Mark Baker, D.O.
Rita Baker
Gordon H. Barth, D.O.
Elmer Baum, D.O.
Kenneth Bayles, D.O.
James Beard, D.O.
Jay G. Beckwith, D.O.
Cindy Boucher
Terry Boucher
Jan Bowling
John R. Bowling, D.O.
Teresa Boyd, D.O.
Daniel Boyle, D.O.
Frank Bradley, D.O.
Joanne Bradley
Dale Brancel, D.O.
Robert Breckenridge, D.O.
John Brenner, D.O.
Lloyd Brooks, D.O.
Carol S. Browne, D.O.
Mary Burnett, D.O.
Jeffrey Butts, D.O.
D.Y. Campbell, D.O.
Catherine Carlton, D.O.
Juanita Carmichael
Ross M. Carmichael, D.O.
Dr. Thomas and Kathleen Castoldi
John Cegelski, D.O.
Robert Chouteau, D.O.
William Clark, D.O.
George Cole, D.O.
Linda Cole
Samuel Coleridge, D.O.
Robert Collop, D.O.
Ralph Connell, D.O.
Daniel P. Conte, III, D.O.
Robbie Cooksey, D.O.
William Cothern, D.O.
Michael Cowan, D.O.
B. J. Czewski
Jim Czewski, D.O.
Dallas Southwest Osteopathic Physicians
Don Davis, D.O.
William Dean
George DeLoach, D.O.
Joseph Del Principe, D.O.
Robert DeLuca, D.O.
Doctors Hospital
Iva Dodson
Cynthia Dott, D.O.
Gregory Dott, D.O.
Janet Dunkle
DuPont Merck Pharmaceuticals
Bradley Eames, D.O.
Eli Lilly & Company
Wayne R. English, Jr., D.O.
Carl Everett, D.O.
Al Faigin, D.O.
V. Jean Farrar, D.O.
Robert B. Finch, D.O.
Roy B. Fisher, D.O.
Gerald Flanagan, D.O.
Charles E. Fontanier, D.O.
Richard Friedman, D.O.
James Froelich, III, D.O.
Jake Fuller
D. Dean Gafford, D.O.
Samuel B. Ganz, D.O.
Paul M. Garmon, D.O.
John E. Garner, D.O.
David E. Garza, D.O.
Mark Gittings, D.O.
Glaxo Wellcome, Inc.
Myron L. Glickfeld, D.O.
GM Pharmaceuticals
Brent Gordon, D.O.
David Gouldy, D.O.
Charles Hall, D.O.
Richard Hall, D.O.
Donna Hand, D.O.
Wendell Hand, D.O.
Patrick Hanford, D.O.
Jane Harakal
Patrick Haskell, D.O.
Vernon Haverlah, D.O.
Dwight W. Heaberlin, D.O.
Healthcare Insurance Services
Tony Hedges, D.O.
Harry Hernandez, D.O.
H.S. Hewes, D.O.
Wayne Hey, D.O.
David P. Hill, D.O.
Frederick Hill, D.O.
Teri Hill-Kinsfather, D.O.
Hoechst Marion Roussell
Bret Holland, D.O.
Joel D. Holliday, D.O.
John P. Hood, D.O.
William D. Hospers, D.O.
Houston Osteopathic Hospital Foundation
Bobby Howard, D.O.
Christopher Hull, D.O.
Lewis Isenberg
Nelda Cunniff-Isenberg, D.O.
Jake Jacobson
Constance Jenkins, D.O.
William R. Jenkins, D.O.
V.L. Jennings, D.O.
Daniel Jensen
William R. Jones, D.O.
Douglas A. Karpen, D.O.
Dawn Keilers Mirran
Elva Keilers, D.O.
Royce Keilers, D.O.
Alex Keller, D.O.
Earl Kinzie, D.O.
Brian Knight, D.O.
William J. Lagaly, D.O.
Clare Laminack, D.O.
Jere Lancaster, D.O.
Victorija Laucius, D.O.
Edward J. Leins, D.O.
Neil Levy, D.O.
A. Ray Lewis, D.O.
Harold Lewis, D.O.
Peggy Lewis
Carl F. List, D.O.
John Longacre, D.O.
Hector Lopez, D.O.
Lubbock Osteopathic Fund, Inc.
George J. Luibel, D.O.
Edward Luke, Jr., D.O.
Richard Male, Jr., D.O.
Marion Merrell Dow, Inc.
Masterpath Groves Pathology Consultants
James Matthews, D.O.
R. Greg Maul, D.O.
Robert G. Maul, D.O.
Cindy McCarty
Jack McCarty, D.O.
Bruce McDonald, D.O.
James McLaughlin, D.O.
Merck
Ivri Messinger, D.O.
Linus Miller, D.O.
Michael A. Mitchell, D.O.
Carl Mitten, D.O.
Lois Mitten
John Mohney, D.O.
Joseph P. Molnar, D.O.
Joseph Montgomery-Davis, D.O.
Rocco Morrell, D.O., P.A.
Dareld Morris, D.O.
Ray Morrison, D.O.
R. Gene Moult, D.O.
Ira Murchison, D.O.
Gary K. Neller, D.O.
Richard E. Nichols, D.O.
Robert H. Nobles, D.O.
Ann Nolen, D.O.
Bill Nolen, D.O.
Henry Norrid, D.O.
Novartis Pharmaceuticals Corporation
Osteopathic Health System of Texas
Elizabeth Palmarozzi, D.O.
Alice Pangle, D.O.
Michael Parisi, D.O.
Parke-Davis
Robert Peters, Jr., D.O.
Ruby Peters
Donald Peterson, D.O.
Wilma Peterson
Dean L. Peyton, D.O.
Pfizer, Inc.
Herman H. Plattner, D.O.
William Pollan, D.O.
R. Mark Probst, D.O.
Paul Proffitt, D.O.
Bill Puryear, D.O.
Daniel L. Rader, D.O.
David Randell, D.O.
H.H. Randolph, Jr., D.O.
Jeffrey Rettig, D.O.
Jeannie Rhodes, D.O.
Merilyn Richards
John Riggs, D.O.
Peggy Rodgers
Randall Rodgers, D.O.

Steve E. Rowley, D.O.
J. Michael Russell, D.O.
Peggy M. Russell, D.O.
Celina A. Sanchez
Mario Sanchez, D.O.
Les T. Sandknop, D.O.
Richard Saunders, D.O.
John Sawtelle, D.O.
Amy Saylak
Daniel Saylak, D.O.
Hubert Scadron, D.O.
Schering Sales Corporation
Jeff Schmeltekopf
Kristin M. Sears, D.O.
Susan Selman
A. Duane Selman, D.O.
T. R. Sharp, D.O.
Rick Siewert, D.O.
Sarah Smiley, D.O.
George Smith, D.O.
Selden Smith, D.O.
Smith Kline Beecham
Jerry Smola, D.O.
John Sortore
Sparks Osteopathic Foundation
Arthur J. Speece, III, D.O.
Dodi Speece
Kevin Stahl, D.O.
Robert Stark, D.O.
Wayne Stockseth
C. Ray and Edna Stokes Student Associate Auxiliary
Summit Bancshares, Inc.
J. Ross Tanner, D.O.
TAP Pharmaceuticals
H. Sprague Taveau, D.O.
Texas ACOFP
R. Russell Thomas, Jr., D.O.
TOMA District II
TOMA District III
TOMA District V
TOMA District VI
TOMA District VII
TOMA District VIII
TOMA District IX
TOMA District X
TOMA District XII
TOMA District XV
Monte Troutman, D.O.
UCB Pharma, Inc.
Stephen F. Urban, D.O.
Christopher Vanderzant, D.O.
Wakefield Pharmaceuticals, Inc.
Kenneth R. Watkins, D.O.
Darlene Way
Bill V. Way, D.O.
Linda Welch, D.O.
Bill E. Weldon, D.O.
Timothy Werner, D.O.
Craig D. Whiting, D.O.
Dean Wierman, D.O.
Arthur Wiley, D.O.
Peter Wiltse, D.O.
Marie Wiseman
Rodney Wiseman, D.O.
James Woodruff, D.O.
Paul S. Worrell, D.O.
John L. Wright, D.O.
Capt. Benjamin Young, D.O.
Steven Yount, D.O.
Nancy Zachary
T. Eugene Zachary, D.O.
Irvin Zeitler, D.O.
Victor Zima, D.O.
John R. Zond, D.O.

If you would like to contribute to the Building Fund and become a "Texas Star," call Paula Yeamans at 800-444-8662. Please note that contributions received three weeks prior to each issue may not appear until the following issue.

TOMA would like to thank the following "Texas Stars" who have contributed above the $1,000 donation level

Richard Anderson, D.O.
David Armbruster, D.O.
Auxiliary to the Texas Osteopathic Medical Association
Dr. and Mrs. Mark A. Baker
Jay G. Beckwith, D.O.
Dr. and Mrs. John Bowling
Dr. and Mrs. Frank Bradley
Mary Burnett, D.O.
Jeffrey Butts, D.O.
DeWeese Y. Campbell, D.O.
Dr. and Mrs. Thomas Castoldi
Robert M. Chouteau, D.O.
Dr. and Mrs. George Cole
Dr. and Mrs. Jim Czewski
Dallas Southwest Osteopathic Physicians
William Dean
Drs. Cynthia and Gregory Dott
Carl E. Everett, D.O.
Al E. Faigin, D.O.
D. Dean Gafford, D.O.
Samuel B. Ganz, D.O.
Glaxo Wellcome, Inc.
Myron L. Glickfeld, D.O.
Drs. Donna and Wendell Hand
Patrick Hanford, D.O.
Healthcare Insurance Services
Joel D. Holliday, D.O.
John P. Hood, D.O.
Houston Osteopathic Hospital Foundation
Bobby D. Howard, D.O.
Lewis Isenberg and Nelda Cunniff-Isenberg, D.O.
Jake Jacobson
Constance Jenkins, D.O.
William R. Jenkins, D.O.
Dr. and Mrs. Douglas Karpen
Drs. Elva and Royce Keilers
Victorija Laucius, D.O.
Dr. and Mrs. Harold Lewis
Lubbock Osteopathic Fund, Inc.
R. Greg Maul, D.O.
Robert G. Maul, D.O.
Dr. and Mrs. Jack McCarty
Dr. and Mrs. Carl Mitten
Dareld R. Morris, D.O.
Ray L. Morrison, D.O.
Robert H. Nobles, D.O.
Drs. Ann and Bill Nolen
Osteopathic Health System of Texas
Dr. and Mrs. Robert Peters, Jr.
Dr. and Mrs. Donald M. Peterson
Pfizer, Inc.
Dr. and Mrs. Randall Rodgers
Steve E. Rowley, D.O.
Dr. and Mrs. Mario A. Sanchez
Dr. and Mrs. Daniel Saylak
Schering Sales Corp.
Jeff Schmeltekopf
A. Duane Selman, D.O.
T. R. Sharp, D.O.
Sparks Osteopathic Foundation
Dr. and Mrs. Arthur J. Speece
Wayne Stockseth
Texas ACOFP
TOMA District II
TOMA District V
TOMA District X
TOMA District XV
Monte E. Troutman, D.O.
Kenneth R. Watkins, D.O.
Dr. and Mrs. Bill V. Way
Arthur S. Wiley, D.O.
Dr. and Mrs. Rodney Wiseman
Capt. Benjamin Young, D.O.
Dr. and Mrs. T. Eugene Zachary

Opportunities Unlimited

PHYSICIANS WANTED

DALLAS - Physician needed at walk-in GP clinic. Flexible hours or part-time. (214) 330-7777. (11)

UNIVERSITY MEDICAL GROUP IN DURANT, OKLAHOMA, is expanding and seeks to hire two Internal Medicine physicians. We are also considering an OB/GYN position. You may visit our Web site at <www.umg.com>. Please contact Donna Hyde, University Medical Group, at (580) 924-3400, ext. 150. (16)

NEEDED – D.O. Board Certified Family Practice physician in Houston. I-45 and 1960 area. Fax resume to (281) 895-6401. (19)

FAMILY MEDICINE & MINOR EMERGENCY CENTER looking for energetic BE/BC physician. Fast growing 2 physician group. Now accepting applications for immediate opening. Competitive salary and benefit package. Very limited call or hospital. Enjoy the great lifestyle offered by this central Texas location. Beautiful new facility in Georgetown, just minutes from hill country and Austin. Call Sandy at (512) 869-7310 or Fax CV to (512) 869-5616. Richard C. Male, Jr., D.O. (22)

DALLAS/FORT WORTH — Physician opportunity to work in low stress, office based practice. Regular office hours. Lucrative salary plus benefits. No call and no emergencies. Please call Lisa Abell at (800) 254-6425 or FAX CV to (972) 256-1882. (25)

AMBULATORY FAMILY PRACTICE has opportunities for FT/PT BC/BE physician. Full benefits package for FT including malpractice, paid time off, expenses for CME/Lic. fees. Flexible schedule, no night call, no hospital work, no administrative hassles. Enjoy the lifestyle afforded by the Metroplex. Please FAX CV to (817) 283-1059 or call Shannan at (817) 283-1050. (36)

OFFICE SPACE AVAILABLE

MEDICAL LEASE SPACE – 2,184 square feet, finished out in excellent condition with private office, 3 baths, 5 treatment rooms, lab, nurses lounge, business and reception area. Hulen South Professional Building. Great location in SW Fort Worth (near Hulen Mall). (817) 292-1510. (02)

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

GULF COAST CLINIC — 4,100 sq. ft. to include lab and (4) suites. Near Navy base on beautiful Gulf of Mexico. Growing community. Hospital and nursing home three blocks away. Lease (possible purchase in future). Contact Mrs. Kumm at (512) 758-3660. (17)

MEDICAL PRACTICE, EQUIPMENT AND BUILDING – FOR SALE. Established 1982, no HMO, 50% cash. Good location. Call TOMA (800) 444-8662. (18)

MEDICAL LEASE SPACE AVAILABLE in Houston area – FM 1960 and Red Oak Dr.; 1,170 sq. ft. Already built out. Call (281) 895-9565 for information – ask for Margie. (20)

FOR SALE – Family Practice, Dallas, Texas. Net $200,000 per year. No hospital. Will work with new owner during transition period. Established practice 40 years-plus. Call TOMA (800) 444-8662. (23)

MISCELLANEOUS

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

CLASSIFIED ADVERTISING RATES

TOMA Members - $10 per insertion
Non-Members - $1.00 per word
(25 word minimum)

For more information call
Mary Waggoner
(TOMA Office)
512-708-8662 or 800-444-8662

For Your Information

OSTEOPATHIC AGENCIES

American College of Osteopathic Family Physicians 800/323-0794
Texas Society of American College of Osteopathic
Family Physicians 888-892-2637
..... 512/708-9959
American Osteopathic Association 312/202-8000
..... 800/621-1773
Washington Office 202/544-5060
..... 800/962-9008
American Osteopathic Healthcare Association
..... 301/968-AOHA (2642)
Dean, Jacobson Financial Services
For Premium Rates, Enrollment & Information 800/321-0246
TOMA Major Medical Insurance 800/321-0246
TOMA Disability Insurance Program 800/321-0246
UNTHSC/Texas College of Osteopathic Medicine 817/735-2000
Dallas Metro 429-9120
Medicare Office
Part A Telephone Unit 800/813-8868
Part B Telephone Unit 903/463-4495
Profile Questions 214/766-7408
Provider Numbers
Established new physician (solo) 214/766-6162
Established new physician (group) 214/766-6163
All changes to existing provider number records 214/766-6158
Medicaid/NHIC 512/343-4984
CHAMPUS/General Inquiry 800/406-2833
Texas Medical Foundation 512/329-6610
Toll free 800/725-9216
Texas Osteopathic Medical Association 512/708-TOMA (8662)
in Texas 800/444-TOMA (8662)
FAX: 512/708-1415
E-Mail..... toma@txosteo.org
TOMA Physicians' Health and Rehabilitation Program 800/896-0680
TOMA Med-Search 800/444-TOMA

TEXAS STATE AGENCIES

Texas Health and Human Services Commission 512/416-0366
Department of Health 512/458-7111
Department of Public Safety:
Controlled Substance Division 512/424-2188
Triplicate Prescription Section 512/424-2189
Texas State Board of Medical Examiners 512/305-7010
FAX:..... 512/305-7006
Registration 512/305-7020
Formal Complaints 800/201-9353
Consumer Disciplinary Hotline 800/248-4062

Texas State Board of Pharmacy 512/305-8000
Texas Workers' Compensation Commission 512/448-7900
Medical Review Division..... 512/707-5889
Texas Hospital Association 800/252-9403
Texas Department of Insurance 512/463-6169
Texas Department of Protective and Regulatory Services 512/450-4800
Texas Poison Control Center Network 800/POISON-1
..... 800/764-7661

FEDERAL AGENCIES

Drug Enforcement Administration
For state narcotics number..... 512/424-2000 ext. 2150
For DEA number (form 224)..... 214/640-0801
Diversion policy & related questions..... 214/640-0849

CANCER INFORMATION

Cancer Information Service 713/792-3245
in Texas 800/392-2040

For twenty years . . .

Texas Medical Liability Trust has been protecting the physicians of Texas. We have a history of educating, protecting and defending Texas physicians. We have a history of providing unique benefits such as risk management resources, on-call claims management and loss free discounts. We have a history of experience you can trust.

In 1998, TMLT earned an initial rating of A- excellent from the A.M. Best Company, the nation's premier, independent financial rating agency. This rating confirms what we have known all along – TMLT sets the standard for physician-centered service.

The future will bring even higher standards of coverage and service. We will continue to integrate technology into our account servicing for faster, more convenient delivery. Visit the TMLT website to earn CME credit, request a quote or apply for coverage. Explore the possibilities at www.tmlt.org.

TMLT

Your Practice Is Our Specialty

Rated A- excellent by the A.M. Best Company.

Texas Medical Liability Trust Austin, Texas 800.580.8658 www.tmlt.org

Looking for a **DYNAMIC, SOPHISTICATED**, yet

MANAGEABLE INVESTMENT PHILOSOPHY?

WE'VE GOT THE ANSWER...

Strategic Asset Management

Setting a new standard in Fee-based Asset Management

- Over 2000 no load/load waived Mutual Funds with varying investment objectives.*
- Access to individual Stocks and Bonds.
- Professional Management through a Strategic Asset Allocation investment methodology.
- Fee-based compensation. No more loads, commissions or surrender charges.*
- Ability to switch between Funds and Fund Families.
- Easy-to-understand Consolidated Quarterly Statements.

DEAN, JACOBSON
FINANCIAL SERVICES, LLC
A Registered Investment Advisor
800-321-0246

SAM is offered through:
LINSCO/PRIVATE LEDGER
A Registered Investment Advisor
Member NASD/SIPC

*Nominal transaction costs may occur depending on account size. Certain mutual funds available in the SAM program pay 12b-1 fees. Dean, Jacobson Financial Services, LLC is located at 3112 W. 4th Street, Fort Worth, TX 76107.

10/97

Texas Osteopathic Medical Association
1415 Lavaca Street
Austin, Texas 78701-1634

CHANGE SERVICE REQUESTED

DID YOU KNOW?

Included among the many products and services we offer is:

DISABILITY INSURANCE

"Own-occupation" definition of total disability
Lifetime benefits, cost of living adjustments (COLA), guaranteed future increases
Business overhead expense and business buy-out policies
Top-rated insurance carriers and discounts for TOMA members

Call the financial planners you can trust.

DEAN, JACOBSON FINANCIAL SERVICES, LLC
Fort Worth (817) 335-3214
Dallas Metro (972) 445-5533
Toll Free (800) 321-0246

The only financial services firm endorsed by the Texas Osteopathic Medical Association.