TEXAS D.O.

The Journal of the Texas Osteopathic Medical Association

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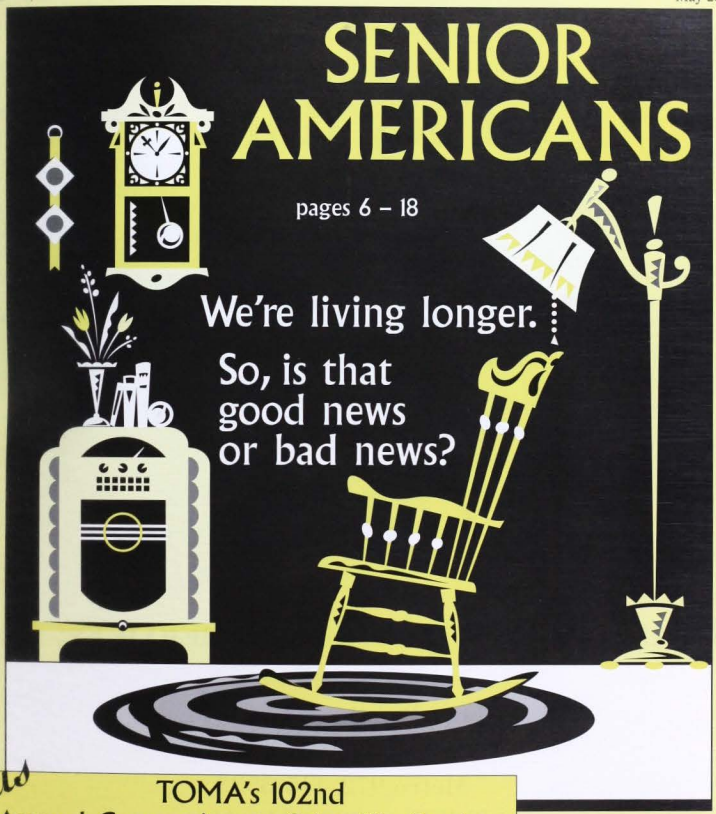

plus

TOMA's 102nd Annual Convention & Scientific Seminar

Program and Early Registration Form

pages 24 – 28

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The Journal of the Texas Osteopathic Medical Association

MAY 2001

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Clinical Focus – Senior Americans

CALENDAR OF EVENTS

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

JUNE 6 – 10
"102nd Annual Convention and Scientific Seminar"
Sponsored by the Texas Osteopathic Medical Association
Location: Arlington Convention Center, Arlington, TX
CME: 26 hours Category 1-A credits
Contact: Jill Weir, CAE, Projects Coordinator
800-444-8662 or 512-708-8662
FAX: 512-708-1415

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

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

JUNE 21 – 24
"Annual Conference"
Sponsored by The Cranial Academy
Location: Rancho Mirage – Palm Springs, CA
CME: 21 hours anticipated
Contact: The Cranial Academy, 317-594-0411
FAX: 317-594-9299
E-mail: CranAcad@aol.com

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

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

CME CORRESPONDENCE COURSE
"Medical Ethics: Applying Theories and Principles to the Patient Encounter"
Sponsored by the University of Pennsylvania School of Medicine, the University of Pennsylvania Center for Bioethics and Clinical Consultation Services
CME: 60 hours Category 2-B credits
Course Tuition: $1,200
Contact: 800-480-5542

❖❖ ATTENTION ALL TOMA & ATOMA MEMBERS ❖❖

At the ATOMA President's Installtion Breakfast during the TOMA Annual Convention, ATOMA will be accepting the following donations for the Women's Shelter in Arlington, Texas:

❖ New socks and underwear for children – all sizes
❖ New undergarments for women – all sizes
❖ New or gently used school backpacks
❖ New or gently used bath and hand towels
❖ New or gently used twin sheets and pillow cases
❖ New pillows
❖ New baby bottles and brushes
❖ Toilet paper and paper towels
❖ Packaged snacks for school lunches
❖ Pedialyte

❖PLEASE SHARE WITH THOSE WHO ARE IN NEED❖

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

www.txosteo.org

ON THE WEB in May

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

- **In Brief**
- **Health Notes**
- **Ten Years Ago in the *TexasD.O.***
- **TRICARE News and Related Military Issues**
- **HHS News**

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

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

- **Thank You**
  A Listing.

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

- **For Your Information**
  A Listing.

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

Avoid These Common Coding and Documentation Errors

Correct coding and documentation is the key to receiving prompt, appropriate reimbursement from insurance companies and to avoiding scrutiny by federal auditors. Yet many physicians and billing staffs lack a clear understanding of coding and documentation rules.

In working with medical practices throughout Texas, TOMA Physician Services consultants frequently encounter the following types of errors:

- ✓ Undercoding
- ✓ Inadequate or illegible documentation
- ✓ Forgotten or misused modifiers
- ✓ Confusion between a consultation and a referral
- ✓ Coding based on out-of-date codes or rules

In many cases, the practice may be losing money by failing to bill or billing incorrectly for services provided to patients. Procedures must fit the diagnosis with specificity, or the insurance company won't pay. For example, many times physicians will code for specialized procedures but use a generic diagnosis code, incorrectly assuming the insurance company will deduce the physician's line of reasoning in choosing the procedures. Some physicians habitually undercode because they don't understand evaluation and management guidelines, and others play it safe by downcoding instead of taking the time to learn the rules.

TOMA Physician Services can help by conducting a coding and documentation review of your practice. By analyzing a representative sample of your practice's patient charts and corresponding explanations of benefits, claims, and fees, TOMA's experienced consultants can identify problem areas, make recommendations for improvement, and provide on-site training in correct coding and documentation procedures.

Coding is complicated, and the rules change every year. An annual review and training session by a TOMA consultant will help assure your practice is receiving proper reimbursement for your services. TOMA Physician Services offers customized, practical solutions for your unique operational challenges. Contact us today for more information at 800-523-8776 or <physician.services@texmed.org>.

The Many Faces of *AGING*

The Growth of America's Older Population

The United States has long been considered a nation of youth. In colonial times, half of the nation's inhabitants were younger than age 16. Most people did not reach an old age as we know it today. Even by 1900, the average life expectancy of the American people was only 47 years. Fortunately, there have been breakthroughs in science and technology that have led to the extension of the life span. Most newborns can now expect to survive their infancy and, on average, live well into their eighth decade.

According to the U. S. Census Bureau, America's population age 65 or older grew by 74% between 1970 and 1999, from 20 million to almost 35 million people. The median age of the population has increased significantly from 28 in 1970 to almost 36 in 1999. But the growth of the older population in recent decades will pale in comparison to the burgeoning of older Americans that will take place, beginning in 2010, with the aging of the baby boomers.

The 76 million Americans born between 1946 and 1964 constitute the baby boom generation. In 1999, baby boomers represented almost 30% of the U. S. population. Over the next 12 to 30 years, the boomers will join the ranks of the population 65 years and older. While one in eight Americans was 65+ in 1999, this will rise to about one in five in 2030.

The "oldest-old" are those who are at least 85 years of age. This group is the fastest-growing segment of American's older population. The number of people aged 85 and older has more than tripled since 1970. The number of centenarians almost doubled in the past decade. Although the 4.2 million persons age 85+ now constitute less than two percent of the total population, they are having a major impact on the nation's health care and social service delivery systems and on the nation's family caregivers.

May is "Older Americans" Month

Previously unimaginable numbers of people are growing to an advanced age in America and, indeed, the world. The implications and profound impact of human longevity upon virtually every facet of our lives are staggering. The lead story of the 21st century is the gift of longevity, which offers many challenges and opportunities in a rapidly changing economic, political and social landscape – not just here in the United States, but all over the globe.

In recognition of aging as a "global" issue and of our own nation's rapidly increasing multi-cultural and multi-generational aging population, the Administration on Aging (AoA) of the U. S. Department of Health and Human Services has chosen the theme "The Many Faces of Aging" for this year's Older Americans Month 2001.

In 1963, President John F. Kennedy began the tradition of setting aside the month of May in honor of our country's older Americans, and every President since then has continued this great tradition. It is a month in which we, as a nation, come together to honor the contributions of older persons – past, present and future.

The Impact of Senior Americans in the New Millennium

- Today's older Americans are better educated than their counterparts 50 years ago. In 1998, a high school diploma was held by some 67 percent of older Americans, compared with just 18 percent in 1950. About 15 percent of older Americans had earned at least a bachelor's degree in 1998, increasing from 4 percent in 1950.[2]

- Chronic disease, memory impairment, and depressive symptoms affect large numbers of older people, and the risk of such problems often increases with age. In 1995, almost 60 percent of people age 70 and older reported having arthritis, up slightly from the proportion reporting arthritis in 1984. The prevalence of arthritis and other chronic diseases, such as hypertension, heart disease, cancer, diabetes, and stroke are also reported, and vary by race and ethnicity. Increases in memory impairment and depressive symptoms occur with advancing age; one-third or more of men and women age 85 and older have moderate or severe memory impairment and 23 percent of this group experience severe depressive symptoms.[2]

- The Institute of Medicine, the National Institute on Aging, the American Geriatrics Society and the Alliance for Aging Research have all described a critical shortage of geriatricians. A Rand Corp. study estimated that the United States should have at least 20,000 physicians trained in geriatric care – currently, there are just 7,000.[6]

- People age 85 and older are the most likely Americans to live in nursing homes. In 1997, only 11 people per 1,000 age 65 through 74 lived in a nursing home, compared with 192 people per 1,000 among those age 85 and older. About three-fourths of nursing home residents are women, roughly equal to their representation in the population age 85 and older. People in nursing homes today are more functionally impaired than their counterparts in previous years. The percentage of nursing home residents who were incontinent, who needed help with eating, or who were dependent on others for mobility increased slightly between 1985 and 1997.[2]

- For those who receive home care, the nature of assistance may be changing. Most home care is provided informally by family, friends, and the community, as it has been for quite some time. But since the 1980s, the use of informal support as an exclusive means of help appears to be declining. The percentage of older people receiving only informal care dropped from 74 percent in 1982 to 64 percent in 1994, while the use of combined formal and informal care increased from 21 percent to 28 percent during the same time period.[2]

- Reports to adult protective service agencies of domestic elder abuse increased 150 percent between 1986 and 1996. This increase dramatically exceeded the 10 percent increase in the older population over the same period. A national incidence study conducted in 1996 found that 551,011 persons aged 60 and over experienced abuse, neglect and/or self-neglect in a one year period. Almost four times as many new incidents of abuse, neglect, and/or self-neglect were not reported as those that were reported to and substantiated by adult protective services agencies. Persons aged 80 years and older suffered abuse and neglect two to three times their proportion of the older population. Among known perpetrators of abuse and neglect, the perpetrator was a family member in 90 percent of cases; two-thirds of the perpetrators were adult children or spouses.[4]

- By age 75, one in three men and one in two women engage in no regular physical activity.[5]

- Marriage has a positive effect on health behavior among the elderly, and the effect is larger for elderly men than for elderly women. Married elderly persons are more likely than widowed elderly persons to eat breakfast, wear seat belts, engage in physical activity, have their blood pressure checked, and not smoke.[1]

- During the past decade, the number of licensed drivers aged 70 years or older has increased by nearly 50 percent. As a group, adults age 70 years or older wear safety belts more often than any other age group except infants and preschool children. By the year 2010, the Public Health Service aims to reduce motor vehicle-related deaths among people of all ages to no more than 12 per 100,000 people. For adults over 70, the rate has remained stable at about 23 per 100,000 for more than a decade.[3]

References

1. *Selected Findings From AHRQ's Medical Expenditure Panel Survey: Fact Sheet. AHRQ Publication No. 00-P052, May 2000. Agency for Healthcare Research and Policy.*
2. *Older Americans 2000: Key Indicators of Well-Being. Federal Forum on Aging-Related Statistics. Press release, 8-10-2000*
3. *Motor Vehicle-related Deaths Among Older Americans: Fact Sheet. Administration on Aging.*
4. *Elder Abuse Prevention: Fact Sheet. Administration on Aging.*
5. *Leading Health Indicators: Healthy People 2010*
6. *Wanted: Geriatricians for an Aging Nation. Fort Worth Star-Telegram, 4-2-2001*

Seniors' Support Programs in Rural Texas

by Charles L. O'Toole, D.O.

Senior care medicine in "rural" Texas is in evolution. This is an evolution being driven by need, demand and standards. As in the community in which I practice, the number of "senior citizens" is steadily increasing, creating increased specialized seniors' "needs." Additionally, these "rural" seniors are no longer totally isolated from the metropolitan world. These individuals visit, came from, have friends that live in the "big city" or have families that they stay with there, and are exposed to the vast numbers of seniors' support agencies and activities that are available there. This creates a "demand" for the same type of services in a rural setting by these educated seniors. Lastly, the standards required for rural medicine are steadily merging toward the metropolitan standards with a vast difference between medical care in the "big city" and the "country" no longer being accepted. As such, rural communities are being required to meet increasing standards of care in the areas of senior support programs. This article will be a brief review of needs and some options that our community has taken to meet these needs. The intent is to focus on awareness in rural Texas medical practice on the special needs of seniors and offer some options that have worked in our community. It is not intended to be an "all knowing" article but to start physicians in rural Texas thinking about needs and options to meet those needs.

Basic review of seniors' needs reveals what I believe is a list of basic needs for this special group of patients. The list includes social interaction facilities, transportation needs, outpatient home health nursing needs, nutritional needs and physical fitness support agencies, aging assessment capabilities, logistic support agencies and a variety of available levels of assisted living facilities. I will review each of these areas with no particular priority being given but purely to offer thoughts, ideas, and some things that have worked well for the community in which I practice.

Geriatric evaluation capabilities are essential for all communities that have significant numbers of senior citizens. Just as has been said for pediatrics, "they are not just little big people"; seniors are not just "older big people." They have very special needs, medication adjustments, and special assessments required. We are all aware of the physiologic changes that occur with aging. The problem is recognizing the changes and requirements induced by these changes. Our community has been able to recruit a geriatric nurse practitioner who is excellent in geriatric assessment utilizing the variety of assessment tools. More importantly, she has been able to impart this information to the staffs at numerous agencies including the senior citizens center, nursing homes, etc. Point being, someone in your community is going to have to develop the expertise to provide the specialized geriatric evaluations, whether it is the physician, physician's assistant, a nurse practitioner, nursing staff in the physician's office, or social worker at the hospital. These evaluations form the basis for interventional therapies or services for the individuals. If fortunate, you may have a referral center or satellite referral center that can assist with this. If not, you may be able to contact a tertiary referral facility that is willing to provide this service.

Nutritional support is a prime problem in the elderly. Services all the way from nutrition instruction to the actual providing of meal services are a large concern in the elderly population. The Council On Aging conducted a study on aging impairment impact. This study revealed that physical deconditioning and poor nutrition had more adverse impact on the well-being of America's geriatric population than did any particular disease process. Our community is very fortunate in that an active senior citizen center exists. It provides "Meals on Wheels" as well as serving breakfast and lunches on a daily basis. This operation receives funding from federal, state and local governmental agencies. They work with the local hospital to provide nutritional consult services and education to the senior citizens. Basic office staff awareness and observation of patient nutritional status is paramount. Staff will need to innocently question patients about their meal habits. You will be surprised at how many senior "two Twinkies and a cup of coffee" meals go on for a variety of reasons. Bottom line, physicians need to work with community leaders to develop options to approach the nutritional needs of the senior population within your community.

Assisted living is an obvious big stumbling block for senior medical needs. One, convincing most seniors they are to the point of requiring assistance is a major challenge. After that hurdle is overcome, finding affordable, appropriate level of care is the next challenge. Facilities can range from luxury apartment type facilities that provide daily meals, variable maid service, and transportation for shopping trips to classic full-care nursing home facilities. There is a large, growing market of people investing in "retirement facilities" that range from the luxury facilities

"In rural communities, a greater sense of family exists but still large numbers of seniors are left with a sense of abandonment and social isolation."

mentioned above to the classic nursing home. If your community has the numbers to warrant such a facility, it usually is not hard to convince these people to invest in a facility in your community. Cost to the individuals is the biggest stumbling block and one our community has not totally found an answer for. Most of the nursing facilities have social workers that can work with these individuals to address these issues. A less costly alternative for some seniors is the community home setting. In this situation, community homes that house four to eight individuals can provide twenty-four hour attendants, bathing assistance, meals services, and medication supervision at a much lower costs than nursing homes, but are purely private funded. A variety of levels of care may be needed in your community. As physicians, we may need to take the lead in recruiting these services to our communities.

Social support is an important factor for the senior population. This group has often lost a spouse with total disruption of social patterns and behavior. The seniors are then lost with no idea where to turn to regain social interaction with peers. This leads to a variety of problems including depression, malnutrition and a variety of other maladies. In rural communities, a greater sense of family exists, but still large numbers of seniors are left with a sense of abandonment and social isolation. Church groups often fill this void. However, active senior citizen centers with a variety of activities fills this void best. Multiple funding sources are out there including foundations, local, state and federal grants. Physicians need to take a lead role if such facilities are not available.

Transportation is a critical need for seniors. Often these patients become unable to drive or have the loss of spousal transportation support. It becomes a major task for these individuals to obtain transportation anywhere, including to the doctor and for diagnostic testing. In our community, a county transit system has been established. It receives funding from the county government, along with federal grants. It provides discount fares for seniors and reasonable rates for transportation, both within the city limits and within the county. Local chapters of organizations, such as the Cancer Society, provide transportation for radiation therapy, etc. These and other options need to be looked at.

Logistic support including bill payment assistance, medication assistance programs, and legal assistance referral are also all key issues. Multiple agencies have assisted with bill payment (completion) programs including retired businessmen, retired teachers, and even some of the church organizations that will go so far as to provide guardians for seniors with no children or family. Medication assistance programs have become a big item and require a rather labor intensive process even if the patients send for the forms via one of the commercial advertised agencies. Again, options such as above or the senior center can be resources for providing these services. Even the social worker from home health can do these services if the patients are on home health and actually get paid to do the service for the patient. Legal assistance is a large item for seniors. Having a cost effective and available attorney to assist this group is essential. The senior center or a senior's circle through the local hospital may be a group that could do the groundwork and set up such services. Physicians again may need to take the lead or provide emphasis to help establish such services.

Last, is the establishment of physical fitness training geared for the senior population. Attending an aerobics class geared for 22-year-olds is not going to work for the 70-year-old. Developing programs for the seniors through local fitness centers or through the hospital has been effective and even profitable. This meets that major health problem of poor physical fitness of seniors previously mentioned by The Council On Aging. Inpatient and outpatient rehab programs also fall in this category. This includes physical rehab and entities such as cardiac rehab. If not locally available in the outpatient setting or existing as an established referral programs for inpatient care, most seniors will not participate and benefit. However, our experience has been that these are very successful programs when supported in the smaller communities by the local physicians and hospitals. This provides a direct health benefit and functional life extender for our seniors.

In summary, local physicians in rural Texas need to take an active role to expand support services for our "seniors." This segment of the population is steadily increasing. They do have specialized needs and requirements. It is unfair that unless the seniors live in a large metropolis area, they are unable to find these support services. We, as physicians, need to take an active role in reviewing these requirements and using our influence and abilities to develop all resources to provide these special senior needs. The capabilities are present in many of our "rural" communities if options are explored and developed.

Charles L. O'Toole, D.O., is a fellow of the American College of Osteopathic Internists, and is certified in general internal medicine and geriatrics. He practices primary care medicine in Granbury, Texas, a community of 6,000. He has privileges at a 55-bed community hospital as well as patient care in the community's three nursing home facilities. Dr. O'Toole has practiced in this locale for 20 years and has watched the evolution of senior care problems and support systems.

Improving the Quality of Life for Geriatric Patients in Nursing Homes

by Christopher Dalton, Ph.D.

The good news is Americans are living longer. The not-so-good news is these extra years are not always quality years. As a Clinical Psychologist providing psychological assessments, clinical consultation, individual and group therapy, as well as supervision of psychotherapists in nursing homes, I would like to offer some recommendations that can provide valuable assistance to primary care physicians with geriatric patients in nursing homes. These recommendations can be particularly useful for those patients with emotional problems who may, or may not, be receiving psychotropic medications. For physicians who recognize, or suspect, that a geriatric patient may have a comorbid psychological disorder in addition to medical, physical, or cognitive problems, there are psychological services available to help improve the quality of life and enhance their patient's medical treatment.

What are the behaviors that most frequently form the basis for referrals for psychological evaluation in nursing home residents? Interpersonal problems with other residents, staff and visiting family members are very common. Other frequent referrals are for non-compliance with daily routine and care including refusal to shower or follow other basic hygiene requirements, refusal of some or all medications, and refusal to participate in physical rehabilitation. All too common is a general apathy including disinterest in social interaction, non-participation in activities, and lack of productive activity. Many depressed residents retreat to their room or their bed and do nothing but watch television hour after hour. It requires a vigilant staff to recognize that even though these residents are not "causing problems," this behavior can be evidence of other, more subtle problems with serious consequences to their physical and mental health.

There is little dispute that a great number of nursing home residents have comorbid psychological or cognitive problems, in addition to their medical condition. Fortunately, for the patient, the family members and the attending physician, many nursing homes now have a contract or working relationship with a licensed psychologist. Some of the more progressive facilities have begun contracting with private companies to provide in-house psychological assessment and therapy teams several days a week. The optimum environments have teams comprised of a licensed psychologist and a support group of licensed therapists.

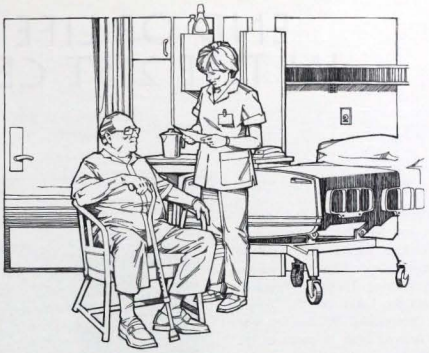
The January 2001 issue of the *Texas D.O.* briefly covered the topic of clinical depression and seniors. The statistics cited are truly sobering. However, although depression can be a frequently encountered problem in an aging patient, it is just one of the psychological disorders I encounter in my practice with elderly nursing home residents. There is a high incidence of comorbid psychological disorders in many residents. These can be precipitated by a reaction to the onset of debilitating physical problems, the anxiety and depression that frequently accompanies the onset of dementia, or the adjustment difficulties for a generation of independent adults for whom their loss of this independence is devastating.

With all we know about the lifetime prevalence of numerous anxiety, mood, and thought disorders, it follows that many elderly patients will have a history involving psychological problems, or certainly a history of living with an immediate family member with these problems, resulting in long term consequences for the patient. We also know that stress or trauma in these patients can cause a relapse of a prior condition. Cognitive impairment often increases in the late years of life, but may also be due to various dementing conditions, including Vascular and Alzheimer's dementia. Further, there is little dispute about the deleterious effects of these problems on a patient's attitude, outlook, treatment compliance and even immune system. It is incumbent on us, as their caregivers, to recognize and understand the many psychological factors affecting our patients and to make our best effort to assure that their emotional needs, as well as their physical needs, are addressed to maximize their quality of life as it nears its end.

The first step I recommend is proactive. If possible, the attending physician should request a brief psychological evaluation conducted upon initial admission of the patient to a nursing home. This need not be an extensive, nor expensive evaluation, merely a brief assessment of the patient's mental status, a brief questionnaire addressing depressive symptoms, and a clinical interview by a psychologist or other trained professional, to detect possible unnoticed psychological, cognitive, or other problems. In addition to providing early detection, this becomes an invaluable baseline of information that can be referenced in the future. In a number of cases in my practice, the availability of this information has allowed the facility treatment team, as well as the primary care physician, to recognize subtle yet significant declines in a patient's mental health that might have otherwise gone unnoticed had only anecdotal information been available. These include, but are not limited to: 1) subtle changes in language or cognition, 2) relatively rapid loss of ability to

concentrate or remember (markedly more pronounced than the course of most common dementias), 3) delusions which are more severe, or atypical for the individual, and 4) evidence of delirium. It has been my experience that with immediate medical evaluation, often including urinalysis or blood work, the majority of patients are found to have many of the common infections so frequently encountered in the elderly. With prompt medical intervention, their new "psychological" problems may quickly remit.

The next step, following this initial screening, is to begin documented, ongoing observation of the patient. This is of primary importance for the detection of the subtle psychological signs noted above. These subtle changes can signal the onset of medical conditions or indicate worsening psychological distress. Whichever reason, physical or mental, both benefit from early detection and treatment. With a little guidance and encouragement, staff members in a nursing home can readily recognize the importance of this procedure and be willing to note and report these observations to the attending physician or therapist. In addition to the important patient information gathered, the staff is gratified by having a contributing role in the treatment team which, in turn, helps create a more effective working environment at the facility. Of course, if a baseline assessment has been conducted, it is possible to describe and quantify the reported changes more accurately. Of equal importance is the availability of this ongoing data collection to inform the primary care physician when positive changes also occur during medical treatment of the patient. This can include adjustment of medications, particularly with so many of the psychotropic medications having anticholinergic effects and



their resulting effect of dampening cognitive function. This is critical in the elderly, given the natural decline in their ability to concentrate, access short and long term memory, and to perform cognitive tasks necessary to daily life. I find this loss of memory and ability to concentrate to be one of the most distressing aspects of aging for most of my patients. Many find adjustment to medical problems easier than cognitive decline. In patients with dementia, it is of paramount importance that the minimum necessary doses of these anticholinergic drugs are prescribed. Ongoing psychological observation and assessment can greatly aid the primary care physician in titrating psychotropic medication to their optimal effectiveness while minimizing the risk of dampening cognitive function further than necessary.

Clinicians who work in nursing homes, whether they are physicians, nurses, social workers, or psychologists, are well aware of the myriad challenges thwarting opportunities to provide a high quality of life to the residents regardless of their level of function. These few suggestions, most of which are relatively inexpensive and do not require additional time spent with the patient on the part of the primary physician, are offered based on my personal clinical experience in nursing homes.

In summary, increased initial data collection, documented, ongoing clinical observation and assessment, and enhanced communication among treatment professionals can result in less frustration in our respective jobs working with geriatric patients. More importantly, we can optimize the effective level of care for our patients and, consequently, their quality of life.

For more information about providing psychological services for residents in nursing homes, contact Dr. Dalton at <daltonphd@aol.com>.

Christopher Dalton, Ph.D., is a licensed clinical psychologist with Senior Connections, Inc., a company that specializes in providing psychological services to geriatric residents in nursing homes throughtout Texas. He practices in Austin, Texas.

Medicare Patients Who Purchase Supplemental Insurance for Prescription Drugs Pay More for Policies Than Three Years Ago

According to a study by Weiss Ratings of ten standard Medigap policies sold by insurers nationally that provide seniors coverage for some deductibles and co-payments not paid by Medicare, increased use of drugs and escalating prices contributed to the sharp increase in premiums for the supplemental policies. The study noted that premiums rose an average of 15.5 percent from 1998 to 2000 for the seven plans that do not offer a drug benefit, and that premiums for similar coverage can vary widely within geographic regions, citing Salt Lake City as an example where a senior could pay $1,404 to $4,329 for a similar drug policy offered by different insurers.

(USA Today, 3-27-2001)

END OF LIFE CARE IN THE 21ST CENTURY

by Alexander Peralta, Jr., M.D.

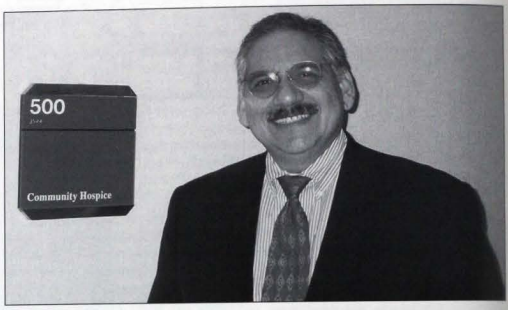
Introduction

It was in the 20th century that a social movement was born out of compassion for dying persons. We know this era as the modern hospice movement that focused on dignity in dying. The word "hospice" comes from the Latin root for "hospitality" or "hospitable." Its meaning was probably derived from hospices in the Middle Ages that were used as way stations for pilgrims going to the Holy Lands. The Sisters of Charity were the first to open hospices in Dublin (1879) and later in London (1905). These early hospices provided a shelter and refuge for patients who were dying but had no place to live, or patients who could no longer be cared for at home. The nuns viewed death as the final stage of a journey, realizing that someday they too would make the same pilgrimage and that ultimately, every traveler had to find their own way.

In 1967, Cicely Saunders, a physician with a background in social work, founded St. Christopher's Hospice in Sydenham, England, south of London. Even today St. Christopher's Hospice remains the prototype for all hospices worldwide. Her interdisciplinary approach in addressing total pain by physicians, nurses, chaplains, social workers, bereavement counselors and volunteers, remains the axiom for end of life care. It was in addressing all of the domains of suffering – physical, social, psychological and spiritual – that patients could hope to find peace and meaning in the dying process. She pioneered research in pain and symptom management, including the holistic approach of patient and family as a unit of care.

Hospice in America

There are strong parallels in the birth of our nation and the hospice movement in the United States. Dr. Saunders sent her protégé, Dr. Sylvia Lack, in the mid-1970s to help Americans start a hospice in



New Haven, Connecticut. Dr. Josefina B. Magno, the matriarch of the hospice movement in the United States, later became our physician champion. Dr. Magno, a medical oncologist and a breast cancer survivor, also studied under Dame Cicely Saunders. The first Annual Meeting of the National Hospice Organization in November 1978, organized by Dr. Magno, marks the beginning of our hospice movement.

Early hospice care in the United States was not a place, rather it was a concept of care. The goals were to help a patient be alive until he or she died. Hospices maximized the quality of life when cure of disease was no longer possible. Hospice stresses that while an individual is "dying," he or she should be "living" until the last breath of life is taken.

Hospice Care as the Gold Standard

While the concept and goals of hospice care were considered an innovative approach to end of life care 30 years ago, advances in education, research and hospice services has significantly improved on those standards by developing greater expertise in delivery systems and palliative medicine. Advances such as the correct dosing of opioids orally, subcutaneously, intravenously and inhaled have crushed the myths of opiate addiction and respiratory depression. The provocative use of high dose steroids for severe lancinating pain, topical and parenteral local anesthetics for neuropathic pain syndromes, midazolam and barbiturates for palliative sedation are now part of the armamentarium of the cognoscente palliativist. Our commitment still is firmly rooted on providing patients a peaceful, comfortable, dignified death in a setting of their choice.

Hospice services are usually provided in a home setting, however, inpatient hospice and palliative care centers have flourished over the last 10 years. The inpatient hospice setting provides highly skilled short term symptom management and respite for families exhausted from caring for their loved one at home.

The physician's role was an enigma in the early years of hospice. It is more clearly defined today as more evidence-based data becomes available and the specialty of Palliative Medicine is more widely recog-

nized. Hospice now cares for patients with terminal cancer and non-cancer illnesses. Patients in nursing homes are eligible for hospice care. Pediatric hospice programs are being developed nationwide and research in pain and symptom management has grown exponentially.

The attending physician and hospice medical director play a pivotal role in the delivery of hospice services. Hospice programs ask these physicians to provide:

- A terminal diagnosis with a presumptive prognosis of 6 months or the normal course of an advanced disease
- Oversight of appropriate therapies and treatment options consistent with the hospice philosophy of care, i.e., comfort vs. cure
- Continued open and sensitive communication with patients and families
- Referral of patients at a time in the course of their disease that will optimize the benefits of hospice services
- Collaboration with the hospice team in the formulation, implementation and serial evaluation of the plan of care.

However, the challenges of short length of stay in hospice programs still reflects the difficulty of prognostication of a limited life expectancy in patients with advanced diseases. The mean length of stay for patients in hospice programs has decreased from >60 days to <40 days. The median length of stay is less than two weeks.

These challenges were addressed by the recent changes in the Hospice Medicare Benefit under Subtitle C, Section 322 of the Benefits Improvement and Protection Act (BIPA) 2000. It amends Section 1814(a)(7) of the Social Security Act and removes the guesswork in prognosticating a limiting life expectancy. It clarifies that the certification of terminal illness of an individual who elects hospice "shall be based on the physician's or medical director's clinical judgement regarding the normal course of the individual's illness." The amendment clarifies current policy that the certification is based on the clinical judgment regarding the normal course of illness, and further emphasizes the understanding that making medical prognostication of life expectancy is not always exact. The implementation date of this amendment was February 1, 2001.

BIPA 2000 literally removes "the 6 months or less" barrier and allows attending physicians and medical directors of hospice programs the freedom to refer patients earlier to hospice programs without the fear of reprisal if the patient lives longer than 6 months.

This expanded definition of the Hospice Medicare Benefit, which was originally enacted in 1983, will provide greater access to patients and families who are suffering from life-limiting advanced disease. The Act defines hospice services as:

- Medically directed compassionate care with a focus on comfort rather than cure
- Patient and family as the Unit of Care
- Home oriented services with acute care backup, including the nursing home when it becomes the primary residence of the patient
- Coordination of community resources
- Use of volunteers as mandated by the Act
- Grief and bereavement care follow-up for a minimum of 13 months
- Palliative Care with special emphasis on the control and elimination of pain and other distressing symptoms
- Addresses ethical issues and advanced care planning
- Strong emphasis on social, psychological and spiritual issues in order to provide a template of growth and development at the end of life.

It also defined the basic core services to be provided by a hospice program. They are:

- Palliative and support services to patients, their families and significant others
- Twenty-four hours a day/seven days a week – service provided
- Medical, nursing and personal care
- Routine home, general inpatient, continuous and respite care
- Social and chaplaincy services
- Grief and bereavement counseling
- Durable Medical Equipment, medical supplies and medications related to the terminal diagnosis.

Hospice care gives physicians an opportunity to extend a network of consultants and professionals beyond the boundaries of their office while still supervising their patient's care. When physicians refer a patient to hospice they also give the patient's family the valuable gift of grief and bereavement support. These services beyond the death of the patient provide a direct positive impact on the care of the patient's family.

We as Community Hospice of Texas believe that hospice is a step up in care; that it is the most appropriate medical care for patients with advanced life-limiting disease regardless of etiology. In the face of crumbling social health care systems, we believe that hospice services in the U. S. are quickly becoming the gold standard of end of life care in the world.

The Hospice Heart

Hospice is intensive human caring. It is the integration of the bio-technical primary worldview of treatment of diseases with the psychosocial and spiritual secondary worldview of symptom management when cure is no longer an option. Texas physicians like Gerald Holman, Marion Primomo, Porter Storey, J. R. Williams, Dan Handel, Jose Benavides, Dennis Pacl, including pediatric experts like Marcia Levetown and Javier Kane, have played leadership roles nationally and internationally in the hospice movement. Our newest Texan is Dr. Eduardo Bruera, a premier expert and researcher from Edmonton, Alberta, who is now director of the Palliative Care Program at M. D. Anderson in Houston. As physicians, we believe that the privilege to learn from patients as they write their final chapters is where the art and science of medicine truly lives.

The Hospice Heart is clearly exemplified by the work of Dr. Magno, who stated that "hospice believes that the last days or weeks or months of a human being's life can be the most meaningful part of that

life, because it is the time when material things can be put in order, when good-byes can be said, when broken relationships can be healed, when forgiveness can be extended or received, and when love, which may never have been expressed before, can finally be given."

Alexander Peralta, Jr., M. D., is Vice President of Medical Services for Community Hospice of Texas and President of Community Center for Palliative Care. He is a board member of the Texas Partnership for End-of-Life Care and is certified in Hospice and Palliative Medicine.

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Civil Aviation Medical Association Against Forced Retirement of Pilots Based Solely on Age

The Civil Aviation Medical Association (CAMA) contacted its flight physician membership in 2000 concerning their views on the FAA Age 60 Rule at its pertains to certification of commercial airline pilots in the U. S. This information was summarized and presented to the Board of Trustees for their evaluation and decision as to the stand CAMA should take on the subject. The January 2001 consensus of CAMA is that retirement for an individual operating as a pilot under FAR Part 121 should not be made mandatory solely on attaining age 60. In the experience of this group of physicians, it is felt that if the pilot passes the FAA appropriate physical examination requirements (placed on all pilots regardless of age), the age 60 limitation placed on airline pilots is unjust and unfounded. The Civil Aviation Medical Association supports the concept that pilots operating under FAR Part 121 should not be forced to retire from piloting duties based solely on attaining age 60.

HHS Launches National Family Caregiver Program

On February 15th, Health and Human Services (HHS) Secretary Tommy G. Thompson approved the release of $113 million in grants to states under the new National Family Caregiver Support Program, which helps family members provide care for the elderly at home. Texas received $6,147,379.

Secretary Thompson said the grants will be used by states to run programs that provide critical support, including home and community-based services, to help families maintain their caregiver roles. It is the largest new support program under the Older Americans Act since 1972, when Congress established nutritional programs to serve the elderly.

"We must do all we can to ensure that our older residents can remain at home and receive care from loved ones for as long as possible," Secretary Thompson said. "This money will allow states to develop systems of support to ease the burden on hundreds of thousands of family caregivers nationwide."

In November 2000, Congress created the new caregiver program as part of the Older Americans Act Amendments of 2000. The principal component of the program consists of grants to states distributed through a congressionally mandated formula. Other components include innovative competitive grants and a new Native American caregiver support program. Information about these components will be announced in the near future.

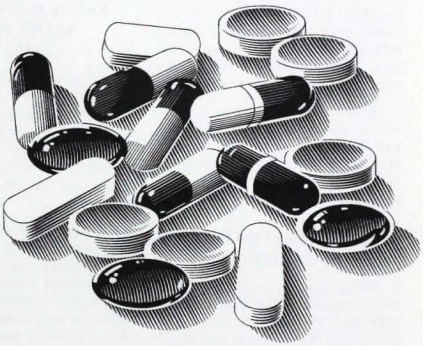
In January, the department's Administration on Aging (AoA) issued comprehensive program guidance to states and has been providing technical assistance as states provide needed information for the grant program. AoA's Web site includes a description of the program and a list of frequently asked questions about the Older Americans Act and the new caregiver program <www.aoa.gov>.

"States will work closely with their local area agencies on aging and other service providers in the community to put into place program services," said Norman L. Thompson, acting principal deputy assistant secretary for aging.

"Among those services are information and assistance, training, counseling and support, and respite opportunities to allow caregivers to take short breaks from their often stressful daily caregiving responsibilities."

Appropriate Prescribing to the Older Adult

by Janice A. Knebl, D.O., FACP, FACOI, CMD



As osteopathic physicians in Texas, it is important to know that the "age wave" is coming our way. It is projected that by the year 2030, 17% of the Texan population will be over the age of 65, compared with 10% in 1990.[1] Caring for an increasingly aged population presents many challenges, especially in the area of drug prescribing and pharmacotherapy. In fact, adverse drug reactions in the older adult are the most common form of iatrogenesis that leads to increased hospitalizations, length of stay and complications. One of the major contributing factors is polypharmacy.

What can physicians do to prevent adverse drug events and decrease polypharmacy in older patients? First, it is necessary to obtain a complete drug history, both prescribed and over the counter (OTC) medications. Many older adults and their caregivers do not consider OTC medications as "drugs" and will not mention them in the routine health and medication history. Questions from the physician about drugs that the patient may be taking for such conditions as constipation and sleep disturbances are important to ask. In addition, it is important to ask about vitamins and herbal remedies that the older adult may be taking for prevention.

Obtaining an accurate prescription drug history is also challenging when older patients have multiple physicians who prescribe new medications between office visits to the primary care physician. There may also have been changes in medications initiated by home health nurses between visits. Review medications at each office visit and before prescribing a new medication. Asking the older patient to bring in all of their medications to each office visit is helpful so that a visual inspection can be made. At our geriatrics clinic we provide brown bags with our office logo to our patients to bring in their medications at each office visit. This has been an effective marketing tool for our program and also an efficient means of getting the patients and caregivers to bring in all of the medications they are taking. We also require the home health nurses and assisted living facilities to fax the complete list of medications prior to the office visit.

Involving the caregiver, spouse or family member in the responsibility for the drug regimen can also be helpful. In the Institute of Medicine's report last year (2000), *To Err is Human: Building a Safer Health System*, a study by Greenberg et al. found that 4.3% of elderly enrolled in Medicare Social HMOs required assistance with the administration of medications by another person. In fact, the inability to manage complex drug regimens explains why some elderly are in institutional based care environments rather than remaining in their own homes.[2]

It is necessary to avoid prescribing a medication before a diagnosis is made. In this case it is better to prescribe a nondrug if a treatment is needed. A 1987 National Medical Expenditure Survey study found that physicians prescribe potentially inappropriate medications for nearly a quarter of all older people living in the community.[3]

The mantra of geriatric drug prescribing is "start low and go slow." In treating chronic disease in the elderly, there is usually not an emergent need to begin the highest dosage regimen to treat the problem. Therefore, it is prudent to begin at the lowest dose and gradually increase the dose to response or tolerance. Many older patients can be maintained on doses lower than the "reported" usual dose for their chronic problems. This is due to the pharmacokinetic and pharmocodynamic changes that occur with aging.[4] Although absorption of most drugs is not affected by aging, drug distribution, metabolism and elimination changes with age. It is particularly important to consider decreased renal elimination of those drugs which are primarily excreted via the kidney, since a normal serum creatinine is deceptive when an older adult has decreased muscle mass.

Attempt to use one drug to treat two or more conditions. I refer to this as looking for a "two-for." For example, if an older male patient presents to your office with hypertension that is uncontrolled and also significant symptoms of benign prostatic hypertrophy, it would be wise to consider an alpha-blocking agent which could reduce blood pressure and treat his prostatism symptoms. This approach can greatly help to reduce polypharmacy in older patients. In conjunction with this approach is the avoidance of using an additional medication to treat the side effects of another medication. Withdrawal of the original medication causing the side effect can prevent complications most effectively.

continued on next page

Texas ACOFP Update

by Janet Dunkle, Executive Director

ACOFP Annual Convention Report

Texas was well represented at the recent ACOFP Convention in Philadelphia. Thank you goes to the following physicians for volunteering to serve as Texas Delegates: Ronda Beene, D.O., Tim Boserma, D.O., John Bowling, D.O., Tim Coleridge, D.O., Robert Deluca, D.O., Royce Keilers, D.O., Greg Maul, D.O., Robert Maul, D.O., Carl Mitten, D.O., Joe Montgomery-Davis, D.O., Irvine Prather, D.O., Daniel Saylak, D.O., George Smith, D.O., Rodney Wiseman, D.O., and Eugene Zachary, D.O.

Texas was proud to have the opportunity to sponsor three students from the UNTHSC to this convention. S/D Mickey Machaldo, S/D Andy Metz, and S/D Roy Morrison represented our Zeta Chapter in Philadelphia.

"Physician of the Day" at the Capitol in Austin

During legislative session, the Capitol recruits physicians to serve as "Physician of the Day". The osteopathic profession is given a week of session to provide elected officials and staff with medical treatment. This year, the following physicians served the Capitol during osteopathic week: Robert Deluca, D.O., Eastland, Robert Stark, D.O., Brenham, Gloria Wright, D.O., San Antonio, and Robert Peters, D.O., Round Rock.

Texas ACOFP and TOMA thank these physicians for volunteering their time to represent the osteopathic profession during this legislative session.

Rodney M. Wiseman, D.O. ACOFP Physician of the Year

The American College of Osteopathic Family Physicians (ACOFP) presented its Family Physician of the Year Award to Rodney M. Wiseman, D.O., of Whitehouse, Texas. The award was presented on Wednesday, March 28, 2001 at the Society's 38th Annual Convention and Exhibition in Philadelphia.

This prestigious award is presented to an osteopathic family physician who has demonstrated outstanding service to his or her profession, community, and patients. Dr. Wiseman's contributions include a tour of duty as an airborne medic in Vietnam, associate clinical professor at the Texas College of Osteopathic Medicine, and district Reviewer for the Texas State Board of Medical Examiners.

Dr. Wiseman received the TCOM Alumnus of the Year Award in 1993 and the Texas Physician of the Year Award from the TxACOFP in 1998. The City of Whitehouse proclaimed September 1998 "Rodney M. Wiseman, D.O. Appreciation Month." He also served as President of the Texas ACOFP in 1992 and as President of TOMA in 1999.

Dr. Wiseman and his wife Marie have four children: Danny, Michael, John, and Marissa.

"Appropriate Prescribing to the Older Adult" continued from previous page

Communication with other prescribers and the patient and their family member(s) or caregiver is critical. This is particularly challenging as more seniors are enrolled into managed Medicare plans where they are having to change physicians and, therefore, drug regimens are frequently altered. In fact, many of the prescription drug plans have formularies of preferred medications that are reimbursed at different levels so that the patient's drug regimen will change based on financing rather than patient tolerance.

Finally, patient and caregiver education about their medications is most important. If the patient does not see the benefit from the medication they will not take it. In fact, many of the chronic diseases in older adults do not provide physical symptoms. Patients decide to choose between medications or other necessary living needs such as food or shelter when trying to manage on a fixed income in retirement. In addition, the older adult and their caregivers are becoming increasingly knowledgeable about drugs from information obtained from books, such as the AARP publication, *Best Pills, Worse Pills* and numerous Internet sources.

Overall, drug prescribing to an older population is best managed when consideration is given to age related changes, a focus on the reduction of polypharmacy and use of nondrug therapy when indicated. Osteopathic physicians are particularly well positioned to successfully treat older adults based on our holistic approach to care and the ability to utilize nondrug treatments when appropriate.

Dr. Knebl serves as Chief of the Division of Geriatrics, Department of Medicine, at the University of North Texas Health Science Center at Fort Worth

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In Memoriam

Sheron Lynn Cunniff

Sheron Lynn Cunniff passed away on April 7, 2001, at home. She was 48. A private service was held at Green Acres Cemetery. A reception was held April 10 at St. Matthew, a Cumberland Presbyterian Church in Burleson, with a memorial service following.

Ms. Cunniff was born in 1952 in Fort Worth. She was a resident of the Joshua and Burleson areas since 1989, where she was a member of St. Matthew. She attended violin-making school in Salt Lake City, Utah, Texas Wesleyan University and the University of Texas at Arlington.

Survivors include a daughter, Dinora Cunniff, and a son, Sam Cunniff, both of Joshua; parents, Dr. Nelda Cunniff-Isenberg and Lewis Isenberg of Granbury; brothers and sisters-in-law, Allen Wayne and Karen Cunniff of Olympia, Washington, Jerry and Judy Cunniff of Joshua, John Isenberg and wife, Kristen, of Burbank, California, Jennifer Isenberg of Audtin, California; grandmother, Hazel Cobern of Granbury; nieces and nephews, Jason Cunniff, Michelle Cunniff, Jaycob Cunniff, Cayden Cunniff, Makynna Cunniff and Meara Isenberg; numerous special aunts, uncles and cousins; friend and soulmate, Roland deCastro of Athens; and many loyal and loving friends.

Memorials may be made to: St. Matthew, 380 N.W. Tarrant, Burleson, Texas 76028; Osteopathic Medical Center, Oncology Dept., 1000 Montgomery St., Fort Worth, Texas 76107; or M.D. Anderson Hospital, Lymphoma Research, 1515 Holcombe, Houston, Texas 77030.

Popular Pain Analgesics Found to Affect Central Nervous System

Widely prescribed pain killers that provide relief with minimal side effects may have more pain-relieving properties than previously identified. A new study funded by the National Institute of Neurological Disorders and Stroke (NINDS) shows that NSAIDs not only relieve pain at the local (peripheral) site of inflammation but in fact affect the entire central nervous system. Results of the study appear in the March 22, 2001, issue of *Nature*.

A research team led by Clifford J. Woolf, M.D., Ph.D., at Massachusetts General Hospital in Boston used an animal model to study Cox-2's role in inflammatory pain. When inflammation occurred, researchers found Cox-2 throughout the central nervous system, as well as at the local site of inflammation. They also found that inhibiting Cox-2 production within the spinal cord and brain decreased pain and reduced hypersensitivity to normal sensations such as touch. Researchers now believe the widespread distribution of Cox-2 within the central nervous system may contribute to muscle and joint pain, depression, lethargy, and loss of appetite that often occur with inflammation and infection.

"The findings indicate new treatment options for arthritis and other inflammatory pain conditions," said Cheryl A. Kitt, Ph.D., program director for pain research at the NINDS. "Targeting the central nervous system when using NSAIDs, rather than the specific peripheral pain site, may result in more effective pain relief."

This release will be posted on EurekAlert! At <www.eurekalert.org> and on the NINDS Web site at <http://ninds.nih.gov/news_and_events/index.htm>.

Texas Department of Insurance to Crack Down on Late Payers

The Texas Department or Health is taking steps to assure that state prompt-payment laws are followed by HMOs and insurance companies with preferred provider plans.

TDI Commissioner Jose Montemayor announced new initiatives to target late payments by health plans, among them the appointment of Senior Associate Commissioner Audrey Selden as the health care providers' ombudsman for prompt-payment issues. Selden, who is also head of the TDI's Consumer Protection Program, will be responsible for resolving all complaints about slow payment to providers.

In keeping with the initiatives, Selden will head a team of TDI staff whose responsibilities will include:

- Making the complaint-filing process easier for health care providers through such options as a special Web site, which will then feed the information into a database;
- Analyzing complaint data so that trends can be pinpointed and major offenders identified;
- Organizing a summit with managed care officials this summer in order to encourage better compliance;
- Studying ways to improve the TDI's processing of complaints in an expeditious manner; and
- Changing TDI rules, if necessary, to improve compliance.

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Bear Markets . . . There is some Good News

You have just turned on the morning news, poured a cup of coffee, and are wondering what effect the stock market will have on your investment portfolio today. Your concern is shared by many investors.

Historically, bull and bear markets can be associated with ups and downs in the economy. Traditionally, downswings in the economy and market have been shorter than upswings. The average decline lasted eight months and 75% of the loss was recouped within seven months. It is important to stick with your long-term investment plan so that you have the opportunity to be invested during a longer-term upswing.

Keep on Course

Long-term investors have seen several prior bear markets. The bear markets of the '70s, '80s, and early '90s prepared the way for the future bull markets. In fact, from 1950 through June, 2000, the S&P dropped only 15 times by at least 15% and, on average, full rebounds took just over a year. Watching as your investments experience a market decline can be disappointing, but it is important to remember that a meltdown of the U.S. economy is not occurring. What is occurring is a *re-establishment* and *revaluing* of the markets.

Managing the economy is often very complex. But a combination of the Fed's willingness to lower interest rates along with the possibility of a changing U.S. tax structure may shorten the current bear market blip. The two economic controls of managing interest rates and easing tax burdens can exert a fair amount of incentive that generally can keep the U.S. economy growing.

Stick to Your Plan

It is only natural to ask, "What's my next move now that many stock market experts have said we are in a bear market?" What all long-term investors should realize is that bear markets create opportunities, often excellent opportunities. It is the long-term goal picture that investors need to keep in mind. Your original investment goals are probably still unchanged whether they are accumulation for retirement or funding for college education.

Since this market reflects a long expansion cycle of growth, it is often easy to lose track of some of the basics that will see investors through the bear market. Investment opportunities are always present. Therefore, the general rule of thumb is to continue in the same direction by maintaining a well-diversified portfolio.

The wisdom of the day is to stay on your investment course and resist the temptation to become involved in trying to time the gyrations of the stock market. It would be beyond anyone's comprehension to think it is possible to predict when any market will turn higher or lower. Continued involvement, while using a long-term investment strategy, will serve the long-term investor far better than trying to predict the direction of the stock market.

April, 2001

Country Dean, CFP
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NEWS YOU CAN USE

TOMA Provides Tips on Preparing for Compass21

The National Heritage Insurance Company (NHIC), administrator of the state Medicaid program, will begin using the new Compass21 system to handle claims on August 6. TOMA has listed 10 things physicians' offices should know or do before Compass21 comes online.

1. Begin using the Texas provider identifier (TPI) on August 6. The TPI will replace your current Medicaid provider number. TPIs will be issued in May. If you have not received your number by mid-June, call NHIC Customer Service at (800) 925-9126 or the Compass21 Provider Line at (512) 514-3609. Test the new number with your billing system before August 6. If you use a billing service for submitting claims to NHIC, you must give the TPI to the service. Although you may still use your "old" Medicaid provider number during a six-month transition period, TOMA encourages you to begin using your TPI on August 6, 2001.
2. If you are using TDHconnect software to file electronic claims, you must install version 2.0 and begin using it on August 6. The old version will not work with Compass21, and version 2.0 will not work before August 6.
3. If you submit claims using TDHconnect, ensure that your system meets the minimum requirements specified by NHIC and the Texas Department of Health. TDHconnect 2.0 will be distributed only on CD-ROM.
4. If you submit electronic claims using a billing service or vendor, make sure it has successfully tested Compass21 and that your system is compatible with the changes the service or vendor made for the system.
5. Periodically check the TOMA and NHIC Web sites for updates: <www.txosteo.org> and <www.eds-nhic.com>.
6. Use the HCFA 1500 form instead of the T19-007 form for submitting paper claims for eyeglasses. Family planning services are no longer billed on the HCFA 1500. You must use the new Family Planning 2017 paper claim form or the electronic format.
7. Plan ahead for month-end billing. Electronic transmission (i.e., claims and eligibility inquiries) will not be accepted between 12:01 a.m., July 27, and 6 a.m., August 6.
8. Paper claims will be accepted any time. However, anything accepted after July 20 will be entered into Compass21 and will not appear as received on a Remittance and Status Report until the implementation of Compass21.
9. Attend a Compass21 provider workshop in May or June. Physicians will be notified of the locations and dates by letter. The information also will be on the NHIC Web site.
10. Review the Compass21 Special Medicaid Bulletin. This will act as a supplement to your Medicaid Provider Procedures Manual. It will be distributed in the first week of July.

X-ray Training

The Texas Department of Health (TDH) has approved regulations authorizing TOMA to offer physicians an on-the-job training program for noncertified radiologic technicians.

The program allows physicians to train individuals to perform routine diagnostic x-ray procedures in their offices. Students who successfully complete the program will comply with minimum TDH educational requirements so that "hardship exemptions" will not have to be renewed.

The Texas Osteopathic Medical Association, the Texas Medical Association, and the Texas Academy of Family Physicians support the program. The cost is $200, plus sales tax, for members of the three organizations, and $400, plus tax, for nonmembers.

If you have questions about the rules or exemption status, call TDH at 512-834-6617. To order the program, call Member Services at 512-370-1456 or 800-880-1300, ext. 1456 or e-mail to <shirley.lavergne@texmed.org>.

Member News

Lloyd W. Brooks, D.O., a fellowship trained cardiologist, has been named the new Chief of Staff at Osteopathic Medical Center of Texas, Fort Worth. Dr. Brooks is board certified in internal medicine and cardiology. He is a member of the medical staff at Osteopathic Medical Center of Texas and practices at Fort Worth Heart & Vascular Institute. Dr. Brooks is a 1985 graduate of Texas College of Osteopathic Medicine.

Christopher J. Pham, D.O., has received the United States Patent Award for neurosurgery invention – "Elastic loaded retractable pin device for cranial bone attachment." Granted on March 6, 2001, the U. S. Patent No. is 6,197,030. Currently pending is another U. S. Patent for neurosurgery invention: "Method of securing anterior cervical spine with an invented screw device." Dr. Pham is a 1996 graduate of the University of Osteopathic Medicine and Health Sciences/College of Osteopathic Medicine and Surgery, Des Moines, Iowa.

Self's Tips & Tidings

By Don Self

Critical Care and E&M Same Day

If you see a patient in the hospital, ER, office, or other outpatient service on one day and then, due to the patient's critical condition, you're required to see the patient again and treat the critical condition, you can bill for both and be paid for both services. The most important factor is that you document the times on each of the services, so that you can clearly show the two services are separate. You must also be treating the patient's critical condition.

Location of Medical Records

There are some that preach in the seminars that only medical records found in the patient's chart may be counted in the event of an audit. There are also some that say if you take a patient's chart, hold it upside down and shake vigorously, anything that falls out can not be counted in an audit. I don't believe any of them. You may keep your documentation in any place you so wish, as long as it is accessible to the physician should the need arise. Remember, when you attend a seminar and the seminar leader says something that doesn't sound right, ask for sources or documentation to prove it. There isn't a week that goes by that I don't get asked about some kind of rubbish heard in a seminar.

Billing for 99211

A question regarding the documentation needed in your chart for the 99211 service comes up quite often. Once more, some consultants say you have to document the vitals or that you spend at least five minutes on the encounter. This is not required in the CPT, the 95 HCFA documentation guidelines or the 97 guidelines. All that is required is that there be medical necessity for the visit and the chief complaint be documented. It's really that simple.

EKGs and Chest X-ray in the ER

Hospitals usually require that all X-rays and EKGs done in the emergency room be over-read for quality control and malpractice reasons. Assuming you order one of these on your own patient in the ER and you use the information derived from the diagnostic test, then you should bill for the interpretation of the test if you document it properly. The question has been raised as to whether the interpretation has to be on a separate sheet or not. We have never seen anything requiring a separate paper. Yes, you must document the interpretation separately in your documentation. Keep in mind that Medicare will probably pay the first claim they receive for the interpretation, so don't sit on the claim. If the radiologist or cardiologist gets their claim in first, you will have to appeal your claim to Medicare. I recommend the same billing practice for non-Medicare claims as well.

Patient Puts Stop Payment on Check

Most offices have a sign in their office stating there will be a $25 fee for NSF checks. Some patients believe that by putting a stop payment on the check, they can avoid this fee imposed by your practice. Some even believe you cannot turn the check over to the district attorney if they issued a stop payment on the check. They're wrong, but to help alleviate the problem before it ever happens, we recommend you change the sign(s) in your office to read: "THERE WILL BE A $25 FEE ASSESSED FOR RETURNED CHECKS FOR ANY REASON. "

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HCFA Delays Medicare Rules for Physician Supervision of Certified Registered Nurse Anesthetists

In accordance with a call by the Bush Administration for a temporary delay in the effective date of certain federal regulations, HCFA published a notice in the March 19 Federal Register announcing that the effective date of the new hospital conditions of participation for anesthesia services has been officially delayed for 60 days, and will now become effective May 18, 2001. HCFA's final rule published in the January 18 Federal Register revises the physician supervision requirement and allows CRNAs to provide anesthesia services in hospitals and ambulatory surgical centers without physician supervision where state laws permit.

Delaware Valley Healthcare Council, 3-23-2001

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

UNT Health Science Center Recognized for Minority Outreach Efforts

An organization working with the National Institutes of Health has designated the University of North Texas Health Science Center a "Role Model Institution" for its efforts in recruiting minority students.

Minority Access, Inc. assists federal agencies, universities, and corporations to diversify their worksites and/or classrooms. It works with the National Institutes of Health's (NIH) Office of Minority Research to identify institutions with an exemplary commitment to and success in producing minority biomedical student researchers. It will provide the names of all role model institutions to the NIH's newly established National Center on Minority Health and Health Disparities.

The UNT Health Science Center was selected as a role model because of the ongoing outreach efforts of its Graduate School of Biomedical Sciences. The outreach efforts contributed to an increase in African-American and Hispanic students at the health science center while national enrollment figures were declining.

"We designed creative strategies to reach new students, and they've been the key to recruiting minority students into studying science here," said Thomas Yorio, Ph.D., dean of the Graduate School of Biomedical Sciences. "We encourage students from elementary school through their college years to enter science fields."

In the academic year 1999-2000, the graduate school was recognized as the leading State of Texas health science center based on the percentage of its minority graduate enrollment. In the present entering class, fully 36 percent of the class is under-represented minorities, almost equal to the 39 percent of the class that is Caucasian students.

"We recruit one student at a time and then ask those students to recruit others," said Robert Kaman, Ph.D., J.D., director of the Minority Outreach Office at the health science center. "We also build relationships with institutions that have strong science programs but no doctoral degrees. Working together, we can bridge their students' education into a doctoral degree in biomedical sciences."

The Role Model Project identifies institutions that excel in producing minority researchers. As an award recipient, the health science center will share its methods at a national conference this fall in Washington, D.C.

UNT Health Science Center Outreach Office Program Examples

The Outreach Office of the Graduate School of Biomedical Sciences of the UNT Health Science Center operates several programs that aim to increase the numbers of under-represented and disadvantaged students entering graduate programs in the biomedical sciences.

- Contact with students begins through Adopt-A-School partnerships with Fort Worth Independent School District elementary, middle, and high schools that serve predominantly Hispanic and African-American neighborhoods. Health science center faculty serve as research mentors, judge science fairs, and speak at career day events.
- Student Teacher Applied Research Training (START) provides practical experience for high school students and their science teachers during summer internships at the health science center.
- Summer Minority Advanced Research Training (SMART) offers college sophomores the opportunity to conduct focused research at the health science center. They then present the results of their studies at the prestigious National Minority Research Symposium.
- The UNT Health Science Center is one of only two free-standing graduate schools of the 159 institutions chosen to participate in the Ronald E. McNair Post Baccalaureate Achievement Program. The health science center has established a continuity of exposure to biomedical research by selecting its McNair scholars from the ranks of its SMART students and partner institutions.
- In the Bridges to the Doctoral Degree program, the health science centers partners with predominantly minority universities to help develop under-represented and disadvantaged students who are entering doctoral programs. The program results in faculty exchange activities and an influx of students from the partner institutions into the doctoral program at the health science center. In addition, these partnerships have enabled other students from the partner institutions to pursue their graduate and professional education at the health science center in non-Bridge programs.
- A partnership with Jarvis Christian College started in 1980 with a grant-supported effort to train faculty from historically black colleges for new areas of research in diseases that impact Blacks, specifically hypertension. The relationship with the college has expanded to include seminars, joint research grants, and training support. Several Jarvis students have graduated from the health science center, and the college continues to be a partner in the McNair and SMART programs.
- Sponsorship of Minority Graduate Student Organizations has grown with the support of the Outreach Office. The Black Graduate Students Association, the Society for the Advancement of Latin Scholars in America (SALSA), and the McNair/SMART Scholars Association provide support for entering students to enhance their sense of belonging and ownership of the institution. These students assist in recruiting new students into the health science center, serve on the selection committee for SMART/McNair Scholars, and act as mentors for new students entering the institution.

Ronald R. Blanck, D.O., Inaugurated as President of the University of North Texas Health Science Center

Hundreds of people glimpsed the future of the University of North Texas Health Science Center on April 7 when its newly inaugurated President Ronald R. Blanck, D.O., offered his thoughts on the overall direction of the health care system.

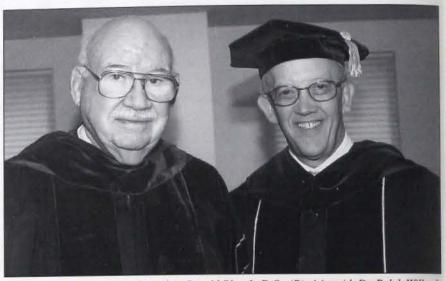
Dr. Blanck addressed community leaders, visiting delegates and health science center students, faculty and staff after being formally installed as president of the UNT Health Science Center. On a beautiful spring afternoon, nearly 1,000 people witnessed Dr. Blanck's investiture at the Perry R. and Nancy Lee Bass Performance Hall in downtown Fort Worth. During the ceremony, he received the presidential chain of office from UNT System Chancellor Alfred Hurley and his inaugural medallion from health science center Provost Benjamin Cohen, D.O. After the ceremony, festivities continued with the first-ever President's Ball, a black-tie gala to raise funds for health science center programs.

As president, Dr. Blanck said he wants the health science center to work, as part of a growing network of academic health centers, in providing the necessary education and training to enable future generations to be healthier.

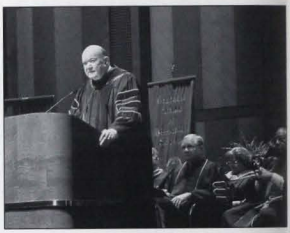
"I think of a time when my great granddaughter asks, 'What is a hospital?' and I have to drive a long way to show her a place that's a center only for the very, very sick. Health care will be decentralized and hospitals very rare," Dr. Blanck said in his inaugural address. "I want us to be working toward an age where diabetes, coronary heart disease, cancer are as a far away a thought to her as bubonic plague is to us."

He continued, "Patients will demand someone who uses technology to its full extent, but also someone who touches them. Osteopathic manipulative treatment will continue to have a role, as will herbs, acupuncture, and other treatment modalities that are now thought of as complementary or alternative medicine. Patients will expect a collaborative system of care that is not only the highest tech, but also the highest touch."

Dr. Blanck stressed that he wants the health science center to focus on doing what's important, not what is simply popular, lest the result is a mediocre health care system that fails to live up to its promise, much as the medium of television has. "It's a future we choose, and with your help, we will succeed."



UNT Health Science Center President Ronald Blanck, D.O., (R) visits with Dr. Ralph Willard, president of the health science center's Texas College of Osteopathic Medicine in its early years, during inauguration ceremonies on April 7th, in Fort Worth.



Robert Bernstein, M.D., M.P.H., former Texas Commissioner of Health, welcomed Dr. Blanck as the new president of UNT Health Science Center.

Dr. Blanck trained under Dr. Bernstein at Walter Reed Army Medical Center.

William Anderson, D.O., former president of the American Osteopathic Association and Barbara Ross-Lee, D.O., former dean of the Ohio University College of Osteopathic Medicine, were two of Dr. Blanck's special guests at a brunch held prior to his inauguration ceremonies.

LOOKING BACK

"CELEBRATING 100 YEARS OF OSTEOPATHIC MEDICINE IN TEXAS"

Editors Note: One of the great osteopathic pioneers for practice rights in Texas was D.L. Clark, D.O., who moved to Texas in 1898 and established a practice in Sherman. He served as the first president of the Texas Association for the Advancement of Osteopathy, elected during the organizational meeting held in Sherman on November 29, 1900. Dr. Clark was a key figure in preserving the practice of osteopathic medicine in the state through legislative means. He was successful in his attempts to thwart the intent of the Wilson Bill, introduced in the Texas Legislature - which sought to eliminate practitioners of the occult and the unorthodox, including D.O.s – by the addition of a one-line amendment into the bill – that it would not apply to osteopathy.

Dr. Clark later moved to Colorado and continued to serve the profession as president of the AOA in 1928. He served on the Colorado State Board of Medical Examiners for 20 years and, on February 20, 1936, he passed away. Texas D.O.s are truly the beneficiaries of Dr. Clark's dedication.

The following is an editorial written in the March 1936 Journal of the American Osteopathic Association, *upon the occasion of Dr. Clark's death. It sheds more light on his activities after leaving Texas, and reveals the sterling character of this great osteopathic physician.*

A Past President Dies

In the passing of D.L. Clark on February 20, the osteopathic profession suffers the loss of a unique character.

Dr. Clark was always a pioneer. He entered osteopathy, as so many of the early disciples did, because Dr. Still brought him relief when other methods of treatment failed to remove the effects of an injury.

Graduated in 1898, he is said to have been the first osteopathic physician in Texas where he carried on a campaign for legislative recognition to such good effect that when, in 1905, he located in Colorado, he was drafted into the legislative campaign in that state. For ten years, until the present practice act was passed, he served on the legislative committee.

He was appointed to membership on the state medical board and was reappointed time after time to terms of six years each. Twice he was chosen president of that board, which was made up largely of M. D.s. He had a very important part in laying the groundwork for the meeting held in Chicago in 1923 for the purpose of arranging for an impartial scientific investigation of all schools of healing. He was a charter member of the American Osteopathic Association and its second Treasurer. Later, he served with honor as a Trustee, Bureau Chairman, Vice President, and President.

It was not only in licensure and regulation, and in organization that Dr. Clark was outstanding, but also in his professional work. In his treatment of the spine and pelvis, he had few peers, and patients came from many hundreds of miles to undergo the specific adjustments he gave. He was one of the early doctors of osteopathy who recognized the importance of the adjustment of the feet.

He was a neighbor and a friend. He was never too busy when the day came for his work with a choir of underprivileged boys. Never a writer, never pushing himself forward on convention programs, he went on his quiet way doing his osteopathic work, counseling and guiding his fellow physicians, jealously striving for the best good of his profession. He was among the first twenty or twenty-five doctors to receive a Distinguished Service Certificate, his being conferred "for service in organization and legislation."

After a Decade with Managed Care, the Nation's Health System is No Better at Controlling Medical Costs

According to a report by the Center for Studying Health System Change, most concerns about the costs of medical care have not changed. Factors identified by the report that are making health costs difficult to control include:

- A "medical arms race" in which physicians, hospitals and insurers are competing to provide the latest procedure or technology.
- Managed care insurers responding to consumer backlash by backing off from cost ontrols such as requiring prior approval for referrals to specialists.
- Lawmakers setting mandatory requirements such as 48-hour hospital stays after childbirth.
- Patients being resistant to paying a percentage of physician office visit charges beyond the typical current flat amount of $10 to $20.
- Large health insurance mergers having led hospital companies and physician groups to consolidate, which in turn have given them more negotiating clout and have won payment increases lost during the early days of managed care.

USA Today, 3-8-2001

TOMA's 102nd Annual Convention & Scientific Seminar • June 6 – 10, 2001

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REGISTRATION

PRINT CLEARLY or TYPE

Name_____

First Name for Badge (if different from above)_____

Mailing Address_____

City_____ **State**_____ **Zip**_____–_____

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D.O. College_____ **Year Graduated**_____ **AOA#**_____

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☐ Please check here if you have a disability, require a special diet or accommodations. You will be contacted to discuss your needs.

REGISTRATION FEES

	EARLY Registration (Postmarked by 5/9)	Registration (Postmarked after 5/9)	
TOMA Members*	$450**	$550**	$_____
• 1st or 2nd Year in Practice**	$275	$375	$_____
• Retired/Life Members**	$200	$300	$_____
• Guests**	$200	$300	$_____
Non-Members**	$700	$800	$_____
Other Healthcare Professionals** (such as P.A.'s, Nurses)	$300	$400	$_____
Students/Interns/Residents***	$0	$0	$ 0

* Includes members of other state osteopathic associations.

** Registration includes one ticket to all meal functions and one ticket to President's Banquet.

*** Registration does **NOT** include tickets to any meal function or special activities listed below. Meal tickets can be purchased by package only. See "Meal Ticket Package" below.

REGISTRATION FEES SUBTOTAL $_____

SPECIAL EVENTS

Family Day*. . . . . $20 x # _____ tickets $_____

YES __I/We will ride the TOMA Shuttle. # of riders in your group____

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* Tickets are limited to 175 people on a "First-Come First-Served" basis.

ATOMA Golf Tournament . . . . . $75 x # _____ tickets $_____

Name: Player #1_____ Handicap_____

Player #2_____ Handicap_____

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Sustainers Party (*Open to Sustaining Members - Adults Only*)

Number of tickets (circle one) 1 2 N/C

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NO __I/We will NOT ride the TOMA bus.

SPECIAL EVENTS SUBTOTAL $_____

ADDITIONAL TICKETS/MEAL TICKET PACKAGE

Convention Meal Package* . . . . . $140 per person x # _____ packages $_____

Includes Breakfast-Thurs., Fri., Sat., Sun.; Keynote Luncheon; AOA Luncheon

TOMA President's Banquet . . . . $75 x # _____ tickets $_____

ATOMA President's Installation Breakfast

. . . . . $30 x #_____ tickets $_____

* Convention Meal Packages can be purchased on-site. A ticket must be presented for each meal. Meal tickets **CAN NOT** be purchased separately or at the meal function.

ADDITIONAL TICKETS/ TICKET PACKAGES SUBTOTAL $_____

PAYMENT SUMMARY

Convention Registration Fee(s) $_____

Special Events $_____

Additional Tickets/Packages $_____

TOTAL $_____

FORM OF PAYMENT

☐ Check in the amount of $_____

Credit Card

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TOMA's 102nd Annual Convention & Scientific Seminar
PROGRAM
26 Category 1-A CME Hours Available

Wednesday, June 6

4:00pm – 7:00pm Registration Open
5:00pm – 7:00pm Exhibits Open
5:30pm – 6:30pm Reception with Exhibitors

Thursday, June 7

7:00am – 5:00pm Registration Open

8:00am – 9:00am Asthma Prevention and Control
Sponsored by GlaxoSmith Kline

9:00am – 10:00am Psychosis in the Elderly
George N. Smith, D.O.
Sponsored by Eli Lilly

10:00am – 10:45am Pharmaceutical Update

10:45am – 11:45am Functional Foods: Hip or Hype
Shalene McNeil, Ph.D., R.D.
Sponsored by the Texas Beef Council

Noon – 1:30pm AOA Luncheon

1:30pm – 3:30pm HeartCare Partnership
Bob Hillert, M.D.
Sponsored by Merck

3:30pm – 4:00pm Pharmaceutical Update

4:00pm – 5:00pm Temperature Controlled Radio Frequency Treatment of Snoring and Sleep Apnea
Richard C. Grossman, D.O.
Sponsored by Somnus Medical Technology

Friday, June 8

7:00am – 1:00pm Registration Open

8:00am – 9:00am A System Approach to Improving Diabetes Care
Steven L. Yount, D.O.
Celeste A. Frangeskou, BSN, RN
Sponsored by Texas Medical Foundation

9:00am – 10:00am Bioterrorism
Paul McGaha, D.O.
Sponsored by the Texas Department of Health

10:00am – 10:30am Pharmaceutical Update

10:30am – 12:30pm 3 Breakout Workshops
(Repeat on Saturday afternoon)
Workshop 1 – Advanced Cardiac Life Support Protocol
Daniel Saylak, D.O.
Sponsored by Wyeth Ayerst
(*continued on next column*)

Workshop 2 – OMT Workshop
Conrad Speece, D.O.
Workshop 3 – Medicare Fraud and Abuse
Janet Horan, J.D.
Sponsored by the American Osteopathic Association

2:00pm ATOMA Golf Tournament
Sponsored by Dean, Jacobson Financial Services

5:00pm Family Fun Day – Picnic and Texas Rangers Baseball Game

Saturday, June 9

7:00am – 4:00pm Registration Open

8:00am – 9:00am Are We Vegetarians or Carnivores
Bill Roberts, M.D.
Sponsored by Pflizer, Inc.

9:00am – 10:00am Psychological Perspective of Tattoos
Mark Bell, D.O.
Sponsored by Pfizer, Inc.

10:15am – 11:15am Depression – Picking the Correct Medications
Nick S. Pomonis, D.O.
Sponsored by Forest Pharmaceuticals

11:15am – Noon Rheumatoid Arthritis: "Nuts and Bolts"
Scott Stein, D.O.
Sponsored by Centocor

Noon – 1:15pm Keynote Luncheon

1:30pm – 2:30pm Sleep Disorders
Elliott Schwartz, D.O.
Sponsored by Cephalon

2:45pm – 4:45pm 3 Breakout Workshops
(Repeat of Friday, 10:30am – 12:30pm)

6:00pm – 7:00pm President's Reception

7:00pm – Midnight President's Banquet

Sunday, June 10

7:30am – 10:30am Registration Open

8:00am – 1:15am Risk Management Program*
Sponsored by Dean, Jacobson Financial Services

** One hour of this course has been designated by the Texas Osteopathic Medical Association for one (1) hour of education in medical ethics and/or professional responsibility.*

For more information contact Jill Weir, CAE, TOMA Projects Coordinator, at 800-444-7886 or 512-798-8662

TOMA Welcomes the Following Exhibitors of the 102nd Annual Convention & Scientific Seminar

Abbott Laboratories
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Don Self Associates
Education Center for Texas Health Steps
John Alderman
Jones X-Ray, Inc.
Micro4
Novo Nordisk Pharmaceuticals
Osteopathic Health System of Texas
Ortho-McNeil Pharmaceuticals
Physician Manpower Training Commission
Physician Oncology Education Program
Records 123
Tachyon Enterprises
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Wyeth-Ayerst Laboratories

The Texas Osteopathic Medical Association extends a very special THANK YOU to all Educational Grant Sponsors of the 102nd Annual Convention and Scientific Seminar

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Wyeth Ayerst

We regret that we are unable to list those who chose to support the conference after this issue of the Texas D.O. *went to press.*

Conference Speakers

L. Mark Bell, D.O.
Dr. Bell maintains a private practice in Minot, North Dakota, where his professional interests are Adolescent and Child Psychiatry, General Adult Psychiatry, Women's Health, Patient Education, and Attention Deficit Disorder. He serves as medical director of the Therapeutic Life Changes Program at UniMed Medical Center, Minot, and is the past medical director of the Child & Adolescent Partial Hospitalization Program at UniMed. An accomplished public speaker, Dr. Bell is a member of the Bristol Myers Speakers Bureau. He is board certified in Family Practice.

Dr. Bell earned his D.O. degree in 1978 from the Kirksville College of Osteopathic Medicine, Kirksville, Missouri.

Richard C. Grossman, D.O.

Dr. Grossman is in private practice at Metropolitan Surgical Specialties in Colleyville, where his practice is limited to medical and surgical treatment of the bones and soft tissue of the ear, nose, throat, head, face, neck and sinuses, including facial plastic surgery. He also performs tumescent liposuction of the face and body. He is board certified in Otorhinolaryngology and Oro-facial Plastic Surgery by the American Osteopathic Board of Ophthalmologists and Otorhinolaryngologists.

Dr. Grossman received his D.O. degree in 1978 from the University of Osteopathic Medicine and Health Sciences/College of Osteopathic Medicine in Des Moines, Iowa.

Shalene H. McNeill, PhD, RD
Dr. Shalene McNeill is the registered dietitian for the Texas Beef Council, the non-profit education, research and marketing arm of the beef industry. She is an active volunteer of the American Cancer Society (Texas Division), currently serving as Chair of the Nutrition and Physical Activity Committee. She is also a member of the board of directors of the Texas Dietetic Association and in 1999 the Texas Dietetic Association recognized Dr. McNeill as a Registered Young Dietitian of the Year. She is a graduate of Texas A&M University and her doctoral research was in the area of functional foods.

Nick S. Pomonis, D.O.
A 1985 Texas College of Osteopathic Medicine Graduate. He is in solo private practice in Orange, Texas. He has a special interest in Sports Medicine, Disability Medicine, Geriatrics, Correctional Medicine and Medical Ethics. He is married to Reneé and has five children.

William C. Roberts, M.D.
Dr. Roberts serves as medical director of the Baylor Heart and Vascular Center and as dean of A. Webb Roberts Center for Continuing Education at Baylor University Medical Center in Dallas. In addition, he is editor in chief of both the *American Journal of Cardiology* and *Baylor University Medical Center Proceedings*. He has authored and co-authored numerous books.

and is on the editorial board of a host of professional publications. Dr. Roberts is board certified by the American Board of Anatomical Pathology, and board-qualified in Internal Medicine. He earned his M.D. degree in 1958 from Emory University, Atlanta, Georgia.

Daniel W. Saylak, D.O.

Dr. Saylak is a 1983 graduate of Texas College of Osteopathic Medicine in Fort Worth, Texas. After 12 years in private practice, he entered a full-time osteopathic medical practice in the emergency department at College Station Medical Center in College Station, Texas. Dr. Saylak is board certified by the American College of Osteopathic Family Practitioners. He is a regional affiliate faculty member for Advanced Cardiac Life Support for the American Heart Association, an instructor in Pediatric Advanced Life Support, and medical director of four emergency medical services and the Blinn College EMS training program in Bryan, Texas.

Elliott R. Schwartz, D.O.

Dr. Schwartz maintains a practice in Oklahoma City, Oklahoma, where he also serves as clinical assistant professor at Oklahoma State University College of Osteopathic Medicine. Additionally, he serves as co-medical director of the Sleep Disorders Center of Oklahoma at Southwest Medical Center, and as medical director/chairman of the Pharmacy and Therapeutics Committee at Hillcrest Health Center. He is certified by the American Osteopathic Board of Internal Medicine in Internal Medicine, Pulmonary Disease and Critical Care Medicine, and by the American Board of Sleep Medicine in Sleep Disorders Medicine.

Dr. Schwartz is a 1973 graduate of the University of Osteopathic Medicine and Health Sciences/College of Osteopathic Medicine and Surgery, Des Moines, Iowa

George N. Smith, D.O.

Dr. Smith maintains a family practice in West, where he also serves as medical director of West Emergency Medical Services and West Rest Haven, and as a member of the Board of Directors of West Hospital Authority and the Texas Medical Directors Association. In addition, Dr. Smith is a clinical associate professor in the Department of Family Practice at the University of North Texas Health Science Center at Fort Worth/Texas College of Osteopathic Medicine.

He is board certified in Family Practice and is a Certified Medical Director. He received his D.O. degree in 1974 from the University of Health Sciences College of Osteopathic Medicine, Kansas City, Missouri.

Conrad A. Speece, D.O.

Board certified in Family Practice, Dr. Speece has been in continuous practice in Dallas since 1975. He is a 1974 graduate of the University of Health Sciences College of Osteopathic Medicine, Kansas City, Missouri. He conducts numerous postgraduate seminars and lectures on Ligamentous Articular Strain Techniques and Cranio-Sacral Techniques. He is one of the leading authorities in both the United States and Europe on Osteopathic Manipulative Treatment. Dr. Speece is currently the chairman of the Dallas Osteopathic Study Group, a think tank on refining and expanding the osteopathic approach to treating the human body.

Dr. Speece developed and patented BackMaster® Lumbar and Thoracic OMT Devices now used by physicians and their patients in the U.S. and abroad. He has patents pending on a new ergonomic keyboard and mouse, designed to prevent carpal tunnel syndrome. Additionally, Dr. Speece co-authored a textbook, published in 1999, on the subject of OMT for the entire body.

Scott P. Stein, D.O.

Board certified in Rheumatology, Dr. Stein has practiced in Victoria, Texas since 1995, where he currently lives with his wife Desiree and their four sons. He completed a fellowship at Cabrini Medical Center in association with the Hospital for Joint Disease at NYU, St. Vincent's Medical Center and Mt. Sinai in 1995. He has authored numerous research articles on arthritis and rheumatism.

He is a 1989 graduate of the New York College of Osteopathic Medicine at the New York Institute of Technology in Old Westbury, New York.

Steven L. Yount, D.O.

Dr. Yount graduated from the Texas College of Osteopathic Medicine in 1983, after his undergraduate degree at Houston Baptist University. After an internship at Riverside General Hospital in Wichita, Kansas, he began a seven year career in the U.S. Air Force as a Flight Surgeon, serving in both Strategic Air Command, and in Tactical Air Command. Board Certified in Family Practice by the ACOFP, he has been in solo practice in Bastrop, Texas since 1991.

He holds the position of Clinical Assistant Professor in the Department of Family Medicine at the University of North Texas Health Science Center, as a part of the innovative Rural Track Program. Married in 1990, he and his wife, Melody Ann, have two daughters.

Convention Hotel Information

The host hotel for the 102nd Annual Convention is the Wyndham Arlington Hotel

Please call the hotel directly to make your room reservations at 800-442-7275 or 817-261-8200.
Be sure to say you are with "Texas Osteopathic Medical Association" to receive the group rate of $135.00 single, double or triple per night.

Reservations must be made no later than Wednesday, May 16, 2001 to receive the discounted rate.

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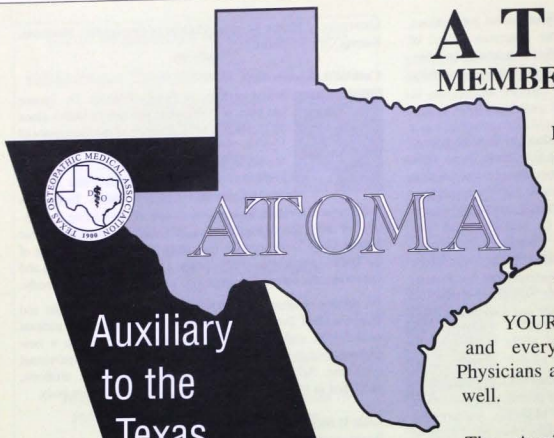

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GENERAL OPHTHALMOLOGY – Busy 22-yr.-old solo practice w/2 offices needs additional ophthalmologist. Fort Worth, Metroplex location. Opportunity for partnership/ownership. FAX CV to: 817-571-9301. (2)

PSYCHIATRIST NEEDED – Fort Worth, TX. Open rank for a full time academic faculty position. Responsibilities include classroom teaching and clinical supervision of medical students enrolled in the Texas College of Osteopathic Medicine, and teaching on psychiatry topics to Internal Medicine residents. Patient care responsibilities include evaluation and treatment of adults in a primarily outpatient setting with some hospital consultation and inpatient psychiatry responsibilities; and provision of psychiatric consultations at the local Federal Medical Center, Federal Bureau of Prisons. Research opportunities are available and could be developed based on the interests of the faculty member. The position includes a competitive salary and a comprehensive benefits package. Applicant qualifications include a D.O. or M.D. degree, completion of a psychiatry residency program, and board certification or eligibility. The psychiatrist should be familiar with osteopathic principles and philosophy. Prospective candidates should be energetic and capable of managing multiple responsibilities. The ability to work as a team member and to establish collegial relationships with clinical faculty within the department and other departments is a high priority. Send inquiries, a current Curriculum Vitae, and three letters of reference to Kenneth N. Vogtsberger, M.D., Professor and Chief, Psychiatry Division, Department of Internal Medicine, University of North Texas Health Science Center (UNTHSC), 855 Montgomery Street, 3rd floor, Fort Worth, Texas 76107. Telephone: 817-735-2334; FAX: 817-735-5441. (03)

PART-TIME Physician Wanted – The Davisson Clinic. Dallas, Texas. 214-546-7266. (06)

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

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 Gross at 1-888-525-4642 or 972-255-5533 or FAX CV to 972-256-0056. (25)

AMBULATORY FAMILY PRACTICE has opportunities for FT/PT BC/BE FP. 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 817-283-1944 or call Shannan at 817-283-1050. (36)

POSITIONS WANTED

POSITION WANTED: BOARD CER-TIFIED FP for outpatient full time, part time or locum tenens, prefer 60 miles radius of D/Ft. Worth area. $65.00 hour. Excellent references will be furnished. Call Eric M. Concors, D.O., @ 214-365-9013. Leave message. (13)

BOARD CERTIFIED FAMILY PHYSI-CIAN, 20 years practice & teaching, skilled in OMT, good surgical skills, broad knowledge of herbs, public speaking, graduate in counseling. Seeks position in consultation, administration or teaching & patient contacts in or near Metroplex. Contact TOMA at 800-444-8662. (51)

PRACTICE FOR SALE/RENT

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

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

FOR SALE – Moderate to large broad-base family practice, 20 years, suburban area, no Medicaid. Available for immediate take over. Patient base OMT, Pediatric & Senior Care. Fort Worth area. Contact TOMA at 800-444-8662. (52)

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MISCELLANEOUS

FOR SALE – McManis Table, new top – Excellent condition, $700.00. James Mahoney, D.O., 817-337-8870. (50)

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)

Texas Osteopathic Medical Association
1415 Lavaca Street
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