TEXAS D.O.

The Journal of the Texas Osteopathic Medical Association

Volume LVI, No. 8

September 1999

Eugene A. Oliveri, D.O.
President
American Osteopathic Association
1999-2000

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TEXAS D.O.
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Inside This Issue

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John Reilly Photography

CALENDAR OF EVENTS

SEPTEMBER

15-18

"Third Annual Family Medicine Board Review"

Sponsored by the University of Medicine and Dentistry of New Jersey School of Osteopathic Medicine/Department of Family Medicine, in conjunction with the New Jersey Association of Osteopathic Physicians and Surgeons

Location: DoubleTree Guest Suites, Mt. Laurel, NJ
CME: 31 hours category 1-A CME credits
Contact: (For registration brochure)
New Jersey Association of Osteopathic Physicians & Surgeons
One Distribution Way
Monmouth Junction, NJ 08852-3001
732-940-9000; FAX 732-940-8899
E-mail: njaops@njosteo.com

17-19

"Mid-Year Seminar"

Sponsored by the Florida Osteopathic Medical Association

Location: Hyatt Regency Westshore, Tampa, FL
CME: Approx. 20 hours category 1-A CME credits
Contact: Florida Osteopathic Medical Association
2007 Apalachee Parkway
Tallahassee, FL 32301 - 850-878-7364

24-26

"Business of Operating a Practice, Risk Management, & Legislative Update"

Sponsored by the Osteopathic Physicians & Surgeons of California

Location: Doubletree Hotel, Monterey, California
CME: 20 hours category 1-A CME credits
Contact: Jennifer Reuther
916-561-0224

24-26

"QME Reporting, Apportionment Issues, IMC Sanctions"

Sponsored by the Osteopathic Physicians & Surgeons of California

Location: Doubletree Hotel, Monterey, California
CME: 6 hours - QME credits
Contact: Jennifer Reuther
916-561-0224

OCTOBER

24-28

"AOA Annual Convention"

Sponsored by the American Osteopathic Association

Location: San Francisco, CA
Contact: AOA, 800-621-1773

28-31

"TOMA Postconvention CME Seminar"

Sponsored by the Texas Osteopathic Medical Association

Location: New York-New York Hotel, Las Vegas, NV
CME: 6 hours category 1-A CME credits
Contact: TOMA: 800-444-TOMA

NOVEMBER

3-7

"Fall CME Conference & Scientific Exhibition"

Sponsored by the Georgia Osteopathic Medical Association

Location: Atlanta Marriott Gwinnett Place, Atlanta, GA
Contact: GOMA, Holly Barnwell, Executive Director
2160 Idlewood Rd., Tucker, GA 30084
770-493-9278
E-mail: GOMA@mindspring.com

2000

JANUARY

28-30

"TOMA's 44th MidWinter Conference & Legislative Symposium"

Sponsored by the Texas Osteopathic Medical Association

Location: Renaissance North Dallas Hotel
Dallas, Texas
CME: Approx. 17 hours category 1-A CME credits
Contact: Texas Osteopathic Medical Association
512-708-8662 or 800-444-8662

23-27

"Osteopathic Medicine: A Universal Approach"

Sponsored by the Osteopathic Physicians & Surgeons of California

Location: Sheraton Universal Hotel, Universal City, CA
CME: 40 hours category 1-A CME credits
Contact: 916-561-0224; FAX 916-561-0728

IMPORTANT "CHANGE OF DATES" NOTICE
44th MidWinter Conference & Legislative Symposium
JANUARY 28 - 30, 2000

John Reilly Photography

"...I will tell every undergraduate student I meet this year: believe in yourself. Dream the impossible dream. Go out and be proud that you are a D.O...."

Eugene A. Oliveri, D.O., New President of the American Osteopathic Association

Eugene A. Oliveri, D.O., was installed as president of the American Osteopathic Association during the recent AOA House of Delegates meeting held in Chicago, Illinois.

Dr. Oliveri is a 1964 Summa Cum Laude graduate of the University of Health Sciences College of Osteopathic Medicine, Kansas City, Missouri. He interned at Detroit Osteopathic Hospital and completed an internal medicine residency at Ziegler Hospital (now Botsford General Hospital).

He had served as senior member of the Department of Internal Medicine, Section of Gastroenterology, at Botsford General Hospital, before retiring from active practice in 1997. Dr. Oliveri holds fellowships from the American College of Osteopathic Internists and the American College of Gastroenterology, and is a clinical professor of medicine at Michigan State University-College of Osteopathic Medicine.

Dr. Oliveri served as president of the Michigan Osteopathic Association (MOA) from 1991-92, at which time he succeeded in increasing membership.

Editor's note: the following are excerpts of the speech presented by Dr. Oliveri to the AOA House of Delegates:

For 102 years, presidents of the American Osteopathic Association have stood before this august body – the AOA House of Delegates – and delivered their presidential address. As I said in my Oath of Office a moment ago, I stand here as your honored and privileged servant ready to accept the responsibilities of this office and the challenges ahead.

I stand here as your new president on the shoulders of all those AOA presidents that have come before me, especially Howard Levine, D.O., and Ron Esper, D.O. ...On behalf of every one of the 43,500 D.O.s in our great country, thank you for your decisive leadership.

I was born in New York in 1937. ...I started working delivering ice during the summers from age nine to age 18, then went into the Army, was discharged and finished my undergraduate studies at Brooklyn College. It was there that I met my first mentor, Dr. Benjamin R. Coonfield. It is to this man I dedicate this address and thank you for the chance to be here today. Dr. Coonfield was an anatomist, biologist, and a great human being having the insight to see into other people their future potential. It was he that got me into D.O. school by calling his old friend and classmate from the University of Arkansas – Dr. K. J. Davis, then the dean of the Kansas City School of Osteopathic Medicine. The rest is history.

Therefore, I stand here as a student of the Kansas City College of Osteopathic Medicine and Surgery, from which I graduated in 1964. I stand here as a gastroenterologist and a proud member of the American College of Osteopathic Internists. I stand here on behalf of the Botsford General Hospital family, where I practiced medicine for 32 years, and on behalf of the Michigan State University College of Osteopathic Medicine, where I teach as a clinical professor of medicine. I stand here as a trustee, a delegate and as a member in good standing...of the American Osteopathic Association. You don't have to be here as president to know and feel how good that sounds.

I feel so humbled today by this office and the duties you have entrusted to this 62-year-old man. Believe me, I am so honored and privileged to have been chosen to lead this noble organization and profession. But little did I know, or even dream, that an Italian boy from the wrong side of town could grow up to become president of the AOA.

continued on next page

So, I say to you, and I will tell every undergraduate student I meet this year: believe in yourself. Dream the impossible dream. Go out and be proud that you are a D.O., having been entrusted to care for your fellow humankind. Become a D.O. Let me stand alongside you.

And, in saying this to every one of our D.O. students today – to the 10,000 students in our 19 colleges of osteopathic medicine – I hereby declare that 1999-2000 will be "The Year of the Student."

What does that mean? Two years ago, Howard Levine visited every campus and invited representatives of SOMA and CSCP to participate in the deliberations of the 21 bureaus, councils and committees of the AOA. This past year, actually four days ago, Dr. Ron Esper invited a student, Kevin Mulroy, to join us as an observer this year on the Board of Trustees. A resolution to make a student representative a full voting member of the board is before you for consideration at this meeting. I urge its adoption. We have made great strides to reach out and provide every student doctor with member services, opportunities and a chance to be heard. Why? Because the students – our colleges – all predoctoral education and OPTIs are the future of our profession. So to all the students, to all the faculty, to all the preceptors, mentors, DMEs, program directors and to AACOM, I say to you: this year's for you!

But there is more to this pledge than just a seat at the table or a chat page on our Web. We have a very serious problem on our hands. Last year and for many years before, barely two-thirds of our students went into osteopathic internships and residencies. Over 30 percent did not even participate in the intern match. Why is this occurring? It's not because they are disloyal; not because they don't want to be D.O.s. It's because there are just not enough funded and approved programs of sufficient quality in the location or specialties of their choice. And as our membership department will tell you, statistically speaking, 81 percent of those students who go into allopathic training never come back and join the AOA.

Despite the proud growth of new colleges and programs, 75 percent of our GME slots remain in just six states. Twenty-three states have no osteopathic training at all. As your president, I intend to do something about this. Earlier this year I asked our Board of Trustees to create a task force – the Osteopathic Graduate Medical Education State Development Task Force – under the chairmanship of Sid Ross, D.O., former dean of the Kirksville College. That task force has met twice already. Their charge, their mission, is to develop mechanisms that would establish new internships and residencies in these undeveloped states where there is little or no osteopathic GME presence. I am told that a series of recommendations will be made to our Board next October in San Francisco. I will urge their adoption. I will also recommend that we utilize the $700,000 in the AOA Student Loan Fund – a sum that has been unspent for several years – to establish matching grants to get these new programs off the ground. And I challenge, I beseech, I implore each and every state delegation in this House to stand with me on behalf of our students. Together, we can do it.

"...The moral, ethical and fiduciary responsibilities we share will be upheld. Our roles as leaders, advocates and models for others will be enhanced and hard work, sacrifice and commitment to the greater good will be expected..."

If we are ever going to make A. T. Still's vision regarding osteopathic medicine a reality, we have to stand even taller. Our distinctiveness should make us stand out in a crowd. The quality, the effectiveness and the sensitivity of our care is unique and should be made known to every household, every insurance company and every government agency in America. And, like my earlier pledge to the students, we can only do this if we stand together.

That is what the Unity Campaign is all about. Yesterday I outlined for you what we have accomplished in year one of this campaign. Together with the Blue Ribbon Committee and BSMG, we have put together a three-year program to achieve these goals. Resolutions to authorize this work are before you and I urge their support. But even as I stand here, even as I envision accomplishing these goals for the good of the profession, I ask myself, and you may be asking, is that all there is? A new definition, a new tag line, a video, news release, etc.? No, that is not all there is. Osteopathic medicine, our profession, the association and the "social movement" some say we represent means much more than just being "D.O.s: Physicians treating people, not just symptoms."

Thus, we must dedicate ourselves…to something even higher. For starters, that can be and should be the goal of the Unity Campaign. Beyond that, in the year 2005, we will convene a Unified Annual Convention where every element of the AOA official family is present and together. Work on that agenda has already begun. After this annual meeting adjourns…I will convene a second Summit, the Unity Summit II, at which two representatives of each component society will gather to answer the higher question: "Where do we want to be as a profession five years from now? Ten years from now? For the rest of our careers? For the rest of our lives?" That vision, that common mission, must come from you.

But that vision, too, will not become reality if we continue doing business as we have in the past. The turf wars, the fratricide, the "shooting in" mentality we exhibit every day has to cease. …Your competition is not each other, but rather managed care reimbursement systems. If we want this Unity effort to be successful, if we want osteopathic medicine to

survive as an organizational power in health care, then we must set aside these perceived "turf wars."

Abraham Lincoln was right: "A house divided against itself cannot stand." Nor can any association. Nor can this association. We stood as one beside the interns and residents at HealthONE in Colorado. We stood as one beside the NBOME at the FSMB. We stand behind our women patients and the newly created AOA Office of Women's Health. And, we stand as one beside our Patients' Bill of Rights in Washington, D.C. And, we will stand by you.

So I pledge, the AOA pledges, that from this day forward we will stand behind you, beside you and with you – whether you went to Kirksville or Pikeville – whether you are a pediatrician or an orthopedic surgeon – whether your osteopathic hospital is accredited by the AOA's HFAP or not – and whether you are a member of the AOA or not. We want everyone to be a member…but if you are a D.O., that is good enough for me and I will stand in union with you as the president of the AOA.

I have established a Code of Responsibility for the AOA Board of Trustees. These will set forth my expectations for your Board of Trustees. The moral, ethical and fiduciary responsibilities we share will be upheld. Our roles as leaders, advocates and models for others will be enhanced and hard work, sacrifice and commitment to the greater good will be expected. Every trustee has and will be a member in good standing. Every trustee will support the Unity Campaign. If they are married, as I am, every trustee's spouse is expected to play an active role in our Auxiliary. And, every trustee will be a member of the American Osteopathic Foundation and OPAC.

And so should you. As delegates, we must adhere to the same Code of Responsibility. Thus, Mr. Speaker, I would ask you at the appropriate time to entertain a motion from the floor that the AOA Board of Trustees' Code of Responsibility become the Code of Responsibility for delegates as well. We, as delegates, should stand for nothing less.

One hundred years from now, another president will stand before the AOA House of Delegates as A. T. Still and Gene Oliveri did before. Your descendants will represent many countries around the world, not just these United States. It is my hope and dream that our building at 142 East Ontario will still stand – that the American Osteopathic Association, your association – will still be strong and that that president, whoever she may be, will look back upon this day and say, "Carpe diem!" They seized the day!

Walk across the bridge with me into the next millenium, into a new dawn, into the next era of osteopathic medicine. For the best is yet to be. Stand by me, next to me, aside me so we can become unified.

OMCT Receives the Mother-Friendly Worksite Designation by the Texas Department of Health

Osteopathic Medical Center of Texas has been designated as a Mother-Friendly Worksite by the Texas Department of Health. Created by HB 359, signed by Governor Bush in 1995, the Mother-Friendly Worksite Program recognizes companies that provide accommodations for new mothers returning to work who desire to continue breastfeeding.

In order to be mother-friendly, companies must provide employees work schedule flexibility to allow time for pumping breast milk or to nurse their babies, and the company must ensure privacy, refrigeration for milk storage, and facilities for sanitation.

"We have a breastfeeding room dedicated to Osteopathic Health System of Texas employees that provides a comfortable setting for mothers to pump their breasts," said Susie Juliano, Director of Maternal/Child Services at OMCT. "We have everything in the room that new mothers need to make them comfortable while they pump, like new cushioned rocking chairs, soft lighting, new breast pumps and a refrigerator to store milk while they are at work."

The OMCT nursing staff are trained to provide education and support to mothers returning back to work and who want to continue breastfeeding their infant.

Sandy McDavid, Director of Nutrition Services, is one OMCT employee currently using the new room. She said that it has allowed her to breastfeed her newborn much longer than she was able to with her first child.

"With my first child, I had to pump in my office and there was very little privacy. The phone was ringing off the hook, people were coming to the door and the conditions were not very sanitary," said Mrs. McDavid. "With my newborn daughter, I have used the room and it has allowed me to nurse my baby much longer than I was able to with my son."

To receive the Mother-Friendly designation, companies must develop a policy reflecting their support for breastfeeding mothers and complete an application which is then reviewed by the Texas Department of Health.

OMT Pearls: Treating Carpal Tunnel Syndrome and Tennis Elbow

By Conrad Speece, D.O.

Editor's Note: Conrad A. Speece, D.O., practitioner, author, lecturer, and inventor, is chairman of the Dallas Osteopathic Study Group, a think tank for Osteopathy.

The Dallas Osteopathic Study Group (DOSG) was started in the mid-sixties by Rollin Becker, D.O. and John Harakal, D.O and is the oldest continuous study group in the country. Dr. Speece joined DOSG in 1974 and has served as chairman since 1991. In 1982, the DOSG began developing a course on Dr. William Garner Sutherland's Ligamentous Articular Strain Techniques (LAST) which are Sutherland's forgotten techniques for treating the entire body, except for the head. They have presented this course annually since 1984. Additionally, the DOSG and its members have developed new OMT techniques for various parts of the body.

Students of the LAST courses and attendees of Dr. Speece's lectures presented at TOMA, AAO, AOA and Cranial Academy conferences over the years have requested a textbook on the subject. To that end, Dr. Speece has written a textbook, due out later this year. The Texas DO is delighted that the publisher, Eastland Press, has given us permission to publish excerpts from Dr. Speece's new book prior to its publication.

Over the next few months, Dr. Speece will present a series of articles detailing OMT techniques for Carpal Tunnel Syndrome, Tennis Elbow, spinal dysfunctions, lower extremities, sacrum, and pelvis.

Dr. Speece's first article begins the series with an overview of the work of the DOSG, descriptions of Ligamentous Articular Strain and the Principles of Corrective Techniques, and detailed instructions for Dr. Speece's techniques for Carpal Tunnel Syndrome, Tennis Elbow and other related injuries.

At the 1999 TOMA Mid-year Convention, I presented a lecture on Carpal Tunnel Syndrome. Daniel W. Saylak, DO, was in attendance and has recently communicated with me regarding his experience:

> "As you will recall, I was having severe problems with carpal tunnel syndrome in February of this past year. I attended your lecture demonstrating release techniques for Carpal Tunnel Syndrome. It was causing numbness and paresthesia that was affecting my ability to do my work in the emergency department.
>
> You demonstrated the technique for the class, and one of the students performed the technique on me. The release was painful initially, but within minutes, I could feel my 4th and 5th digits. Something I had not been able to do for about 2 months. All other symptoms had resolved within 12 hours.
>
> I have had no recurrence of the symptoms and have performed the release on several patients and colleagues. Thanks for everything. I avoided the surgeon's knife!"

This series of articles will introduce treatment techniques for various parts of the body that are just as effective and easy to perform as the Carpal Tunnel Syndrome Technique I taught at TOMA and have outlined in detail below. Based on the experiences of thousands of patients, all of the techniques have been proven to consistently correct somatic dysfunction with long-lasting results. The underlying principles for all of these techniques are from A.T. Still, M.D. and William G. Sutherland, D.O.

"...All of the techniques presented in this series of articles have been thoroughly tested, and the old methods have been tested many thousands of times..."

All of the techniques presented were developed over the thirty-five years the Dallas Osteopathic Study Group (DOSG) has spent studying OMT. The techniques in the text to be published are a distillation of hundreds of techniques that have been developed by members of the Study Group, or brought into the Study Group from outside conferences. Many of the techniques, which were not included, were eliminated because, though effective, they were ergonomic nightmares.

The DOSG's mission was to teach physicians and students OMT and compile and/or develop the most ergonomic, user- and patient-friendly, energy-conserving, and time-effecient techniques while adhering strictly to the principles of Drs. Still and Sutherland. The DOSG was well suited for this task since one of its founders, Rollin Becker, D.O. was a student of Dr. Sutherland. Dr. Becker directed the efforts and focus of the group beyond the works of Still and Sutherland "to become students of the laws of the mechanism that was their discovery." [1]

The DOSG did extensive study on the indirect methods of OMT found in the Lippincott Papers. This publication recorded

Dr. Sutherland's only presentation on Ligamentous Articular Strain Techniques (LAST) which was in 1947. Dr. Sutherland was best remembered for his cranio-sacral techniques. His LAS Techniques were developed for the rest of the body. There is strong evidence that these techniques go back to A.T. Still, M.D. himself, which means that they are probably well over one hundred years old.

Over the years, the Study Group and individual members found that there were ways to improve some techniques. The main difference between the original LAS Techniques found in the Lippincott Papers and new the techniques is that they have been streamlined, requiring less time to perform. Additionally, they have been simplified to be more user-friendly and modified to require no patient cooperation. (Asking for patient cooperation often leads to the patient tensing up while trying to comply to your request, which tends to interfere with the treatment.)

All of the techniques presented in this series of articles have been thoroughly tested, and while the old methods have been tested many thousands of times, even the new techniques presented have been used successful in at least a thousand cases.

Fundamentals of Ligamentous Articular Strain and Principles of Corrective Techniques

These techniques rely on an understanding of Ligamentous Articular Strain and the general principles of corrective technique including A.T. Still's principles of disengage, exaggerate, and balance. The best descriptions of Ligamentous Articular Strain and the basic Principles of Corrective Techniques are found in the Lippincott Papers.

Ligamentous Articular Strain

"Osteopathic lesions are strains of the tissues of the body. When they involve joints it is the ligaments that are primarily affected so the term "ligamentous articular strain" is the one preferred by Dr. Sutherland. The ligaments of a joint are normally on a balanced, reciprocal tension and seldom if ever are they completely relaxed throughout the normal range of movement. When the motion is carried beyond that range the tension is unbalanced and the elements of the ligamentous structure which limit motion in that direction are strained and weakened. The lesion is maintained by the overbalance of the reciprocal tension by the elements which have not been strained. This locks the articular mechanism or prevents its free and normal movement.

The unbalanced tension causes the bones to assume a position that is nearer that in which the strain was produced than would be the case if the tension were normal, and the weakened part of the ligaments permits motion in the direction of the lesion in excess of normal. The range of movement in the opposite direction is limited by the more firm and unopposed tension of the elements which had not been strained." [2]

Principles of Corrective Technique

"Since it is the ligaments that are primarily involved in the maintenance of the lesion it is they, not muscular leverage, that are used as the main agency for reduction. The articulation is carried in the direction of the lesion, exaggerating the lesion position as far as is necessary to cause the tension of the weakened elements of the ligamentous structure to be equal to or slightly in excess of the tension of those that were not strained. This is the point of balanced tension. Forcing the joint to move beyond that point adds to the strain which is already present. Forcing the articulation back and away from the direction of lesion strains the ligaments that are normal and unopposed, and if it is done with thrusts or jerks there is definite possibility of separating fibers of the ligaments from their bony attachments." [3]

There are only three basic components to remember in Ligamentous Articular Strain Technique: disengage, exaggerate, and balance.

Disengage — compress or decompress.

Exaggerate — carry the injured part back to the original position of injury by rotating, side-bending, flexing or side shifting, etc. until the balance point or still point is found.

Balance — maintain the area of dysfunction in the position of injury (balance point or still point) until a release occurs, the bones move back to their normal functional position, and the cranial rhythmic impulse (CRI) or tide returns through the tissues that were injured. Once the correction has occurred, the injured ligaments start their three month process of healing.

A Simple Method for Treating Carpal Tunnel Syndrome

In my practice I have seen an increasing number of patients with Carpal Tunnel Syndrome. The technique I developed for Carpal Tunnel Syndrome, is something you can quickly incorporate into your practice. It takes only thirty seconds to one minute to perform and requires no patient cooperation. After treating well over a thousand cases of Carpal Tunnel Syndrome, I've never found the need to refer one of these patients for surgery.

When treating the wrist, it is important to also treat the elbow as described below.

Carpal Tunnel Syndrome Treatment Technique

Normally, the hand deviates in the hypothenar direction from the forearm by approximately 15 to 30 degrees. Strains of the interosseous membrane of the forearm result in a loss of this normal carrying angle, or, even worse, exaggerate the malalignment of the hand into thenar deviation. The result is compression of the carpal tunnel between the distal heads of the radius and ulna. To treat Carpal Tunnel Syndrome, the physician must resolve the strain of the interosseous membrane between the radius and ulna, which is accomplished by the following technique.

Symptoms/Diagnosis: Numbness and/or pain in the fingers, hand, or wrist.
Patient: Supine, seated, or standing.
Physician: Seated or standing on the affected side and facing the patient.
Procedure: The description for treating a right wrist injury is on the following page. Simply, reverse the grip for a left wrist injury.

continued on next page

Carpal Tunnel Syndrome Treatment Technique

1. With the patient's right hand in full supination (palm up), grasp the hypothenar (little finger) side with your left hand, your fingertips in the patient's palm.

2. Reach across with your right hand (like you are going to shake hands) and grasp the patient's thumb (like you would grip a golf club).

3. Push the hand into full flexion with your grip on the thumb. Draw the hand into full radial deviation with your grip on the hypothenar side of the patient's hand.

4. With both hands maintaining full flexion and full radial deviation, start rotating the patient's hand from supination toward pronation (palm down). When you meet a barrier in the pronation process, maintain steady pressure against that barrier until it melts.

5. When you feel the barrier melt, allow the hand to come out of flexion, bringing it around into full pronation and ulnar deviation (toward the little finger). The treatment is complete.

Tennis Elbow and Other Related Injuries

Strains in the interosseous membrane between the radius and ulna also affects the elbow. So, if there is a strain in the interosseous membrane, both the wrist and elbow are usually involved. To get the entire forearm working properly, both ends should be treated.

Forearm and Elbow Treatment Techniques

Symptoms/Diagnosis: Elbow pain or stiffness (loss of motion).
Patient: Supine, seated, or standing.
Physician: Standing slightly in front and to the side of the patient and facing the patient.

1. Start with the patient's elbow bent to 90 degrees. Grasp the patient's olecranon process with your thumb and index finger; the index finger being on the medial aspect of the olecranon process. Both thumb and index finger should be at the proximal tip of the olecranon process with your thumb and fingertip just starting into the grooves on either side of the olecranon process. With your other hand, grasp the dorsum of the patient's fully flexed wrist. Rotate the patient's forearm into full pronation.

2. Compress the forearm between your two hands, drawing the patient's elbow toward complete extension. If dysfunction is present, you will notice a firm barrier against bringing the arm into full extension. Maintain steady balanced pressure against this barrier until the elbow straightens and your thumb and fingertip slide through the grooves on either side of the olecranon process. The treatment is complete. You have resolved torsional strains of the radial head and lateral or medial deviation of the olecranon process in the olecranon groove (i.e. lateral or medial deviation of the ulna on the humerus).

continued on next page

Conclusion

Whether you currently use OMT in your practice or not, I hope you will try these techniques. My participation in the DOSG has taught me the value of DO's sharing ideas, brainstorming and problem solving. Most of the techniques I use regularly in my practice are a direct result of the past 25 years I have spent as a part of the DOSG.

Rollin Becker, D.O., one of the founders of DOSG and my mentor, was constantly coaching us on how to use our bodies most efficiently so that while treating patients we could conserve our energy and not injure ourselves. Dr. Becker coached us like we were his sons and his diligence and patience went beyond dedication. He gave freely well over a thousand hours of his life to the Study Group and we will never be able to repay that debt. I hope in some small way publication of these techniques will help the profession.

The operating philosophy that has guided both the DOSG and my career as an Osteopathic Physician is best articulated by Dr. Becker:

"When you learn to listen to the body physiology of the patient, you may not look like you are doing anything outwardly, but you're working hard; it's hard work to listen for any length of time. But you can learn to do it, and you have the rest of your practice life. Still and Sutherland did it, I don't know why you can't. Dr. Still and Dr. Sutherland were students. They spent their entire lives studying the science of osteopathy, and one of the fundamental things they learned was that there is no time in which you can ever quit learning about the science of osteopathy. They consented to be used by the fundamental laws that are within each body physiology. They learned to know and use the rules of health as they apply within us, and it is these rules that are sought in the restoration to health for any dysfunction, disease, or trauma for which the patient is seeking service. Dr. Still and Dr. Sutherland studied every single mechanism within the body physiology as it applied to a given patient, and they were taught by each individual case the appropriate diagnostic and treatment program. They were taught by that which the body itself was trying to do

What is new in the science of osteopathy? The answer is simple: the next patient who walks in the office, the one who has been everywhere and tried everything. The body physiology is the teacher and the physician is the student. The mechanism of body physiology offers many doors for experimentation to promote better health. You, as the physician-student, create techniques based on understanding the mechanism, visualizing what you think should be for that area, and then developing techniques as you understand the mechanism for each individual case and each individual patient. In other words, you are allowed lots of room for experimentation, as long as you obey the laws of the science of osteopathy. You get results in proportion to your knowledge and your developing sense of touch. We, as students of body physiology, as physicians, can use and be used by the body physiology of the patient in the care of each individual patient. The future is very bright or those who choose to study and use the works of Dr. Still and Dr. Sutherland. Thank you."[4]

[1] *Life in Motion – The Osteopathic Vision of Rollin E. Becker, D.O.* Edited by Rachel E. Brooks, M.D. Rudra Press 1997; p. 7

[2] "The Osteopathic Technique of Wm. G. Sutherland, D.O."; H. A. Lippincott, D.O.,Reprinted from A.A.O. 1949 Yearbook, p. 1.

[3] Ibid

[4] *Life in Motion – The Osteopathic Vision of Rollin E. Becker, D.O.* Edited by Rachel E. Brooks, M.D. Rudra Press 1997; p. 8-9.

Membership on the Move

Look for Membership Dues Statements

The annual TOMA Dues Statements will be mailed on October 1, 1999 for the 2000 dues cycle. Members have until December 31 to pay their dues to TOMA.

In response to numerous requests, the Texas Osteopathic Medical Association is pleased to announce that members will be able to pay membership dues with the credit card of their choice. In addition, credit cards will be accepted to register for conferences, contribute to the Building Fund, become a Sustainer, and to support the TOMA Political Action Committee.TOMA is delighted to provide this new service our members.

Have YOU Been On the Move?

TOMA is currently compiling information for the Official TOMA Directory which is published in December of each year. If you have any membership information changes (i.e. address, certifications, e-mail, etc.), please contact:

Lucy Gibbs
TOMA Membership Coordinator
800-444-8662 or, in Austin, 708-8662
FAX: 512-708-1415
E-mail: LucyG@txosteo.org

TMF Elects Officers, Board of Trustees Members

During its annual membership meeting on July 10, the Texas Medical Foundation elected the following physicians to its board of trustees (no osteopathic physicians were up for re-election):

Priscilla Ray, M.D., Houston
Byron Howard, M.D., Dallas
D. Clifford Burross, M.D., Wichita Falls
Susan Strate, M.D., Wichita Falls
Antonio Falcon, M.D., Rio Grande City
Charles Wilkins, M.D., Lubbock

In addition, the following officers were elected for the period 1999-2001:

President – D. Clifford Burross, M.D.
Vice President – William Jones, D.O.
Secretary – John E. Eisenlohr, M.D.
Treasurer – Priscilla Ray, M.D.

IN BRIEF

NOM Week '99 To Be Celebrated November 14-20

National Osteopathic Medicine Week is scheduled for November 14-20 this year. The theme will be "Women's Health Care for an Active Lifestyle."

Information on the following topics will be included in the NOM Week kit:

- Alcoholism
- Drug abuse
- Depression and Suicide
- Dieting, Obesity and Eating Disorders
- Skin Diseases and Eye Injury
- Pre-Pregnancy, Pregnancy and Post-Pregnancy
- Reproductive Health
- Contraception
- Mammograms
- Annual Exams

NOM Week kits may be obtained by calling the AOA's Public Relations Department.

Celebrex Breaks Viagra's Record

Celebrex, the new arthritis pill, has surpassed Viagra as the country's fastest-selling new drug ever.

Introduced in January, Celebrex has sold 6.86 million prescriptions during its first six months on the market, compared with approximately 5.30 million for Viagra during its first six months.

Celebrex, which is usually covered by insurance, promises pain relief with fewer stomach problems than associated with other arthritis drugs.

Reminder – CME Cycle is Over Half-Way Point

Physicians are reminded that the 1998/2000 AOA CME cycle is over the half-way mark. The three-year cycle runs from January 1, 1998 to December 31, 2000. By the end of the cycle, all D.O.s must have a minimum of 150 hours of CME, 60 of which must be AOA category 1-A.

AMOPS Establishes Web Site

The Association of Military Osteopathic Physicians & Surgeons has established a Web site at www.amops.org. The site contains information about the association, as well as timely updates relevant to physicians in the military services.

Aetna Becomes Largest HMO

With the recent purchase of Prudential Health Care, Aetna has become the nation's largest HMO, with 9.7 million members, surpassing Kaiser Permanente's 8.5 million.

Last year, Aetna bought the national operations of NYLCare Health Plan, the number two HMO in North Texas with 211,000 members. However, in July Aetna agreed to sell the North Texas and Houston HMO divisions to obtain approval from the Department of Justice for its purchase of Prudential. That approval came in June.

The combination of Aetna and Prudential Health Care will provide benefits to about 22 million people nationwide.

AOA Unity Campaign Update

The American Osteopathic Association has announced that they have achieved 100% support for the Unity Campaign from divisional societies, specialty colleges and non-practice affiliates.

In addition, the progress of the public relations campaign is ongoing. As of July 1999, nearly 6.5 million media impressions were generated. Cities that saw coverage included Chicago; Auburn, Maine; Charlotte, North Carolina; Raleigh, North Carolina; Toledo, Ohio; Erie, Pennsylvania; Cheyenne, Wyoming; Rochester, New York; and Miami, Florida.

As of this writing, plans were being generated for AOA and BSMG representatives to meet with newspapers and magazines such as Newsweek, Fitness and The New York Times to talk about the possibility of future articles highlighting osteopathic medicine.

HMOs Lost Money Last Year

According to a study by Weiss Ratings, a Florida-base insurance rating company, more than half of the nation's HMOs lost money in 1998, with the bulk of the losses in Texas. The study indicated that 56 percent of 576 companies surveyed were in the red last year, for combined total losses of $490 million.

Although that total was down from 1997, when losses totaled $768 million, the percentage of HMOs in the red remained steady. Fifty-seven percent of those surveyed lost money in 1997.

The report noted that Texas HMOs accounted for more than $300 million of the national losses in 1998. According to State Insurance Commissioner Jose Montemayor, and Melissa Gannon, vice president of Weiss, two plans operating in North Texas were big contributors to the state losses: Prudential Health Plan and Harris Methodist Health Plan. Harris reported losses of $99.1 million and Prudential lost $63.6 million.

The 76th Texas Legislature created new solvency requirements for companies this year, and the insurance department has been in contact with HMOs to determine if they will meet the standard. As of September 1, the law requires new health plans to have a net worth of $1.5 million before entering the Texas market. By the year 2002, it will require established HMOs to meet the $1.5 million requirement.

A 15,000-member HMO in San Antonio known as Well Choice, stopped operating this year, dropping its members and leaving $7 million in unpaid bills.

Re-cap of the 76th Texas Legislative Session

The 76th Texas Legislature officially ended its 140-day session on May 31. According to the Legislative Reference Library, more than 5,600 bills were introduced and more than 1,400 were approved during this session.

The following are highlights of bills of particular interest to the medical profession. All became effective September 1, 1999, unless otherwise noted.

HB 27 – Relating to the medical records of the patient of a physician. Effective January 1, 2000, this legislation amends the Medical Practice Act to stipulate that, on receipt of a written request by a subsequent or consulting physician of a patient, the requested physician must furnish a copy of the complete medical records of the patient not later than the 15th business day after the date of receipt of the written consent.

SB 30 – Relating to parental notification of an abortion. This bill will require physicians to notify a parent either by mail or in person before performing an abortion on a minor. If the physician does not comply, he or she is subject to a $10,000 fine and perjury charges. The only way a minor can avoid notification is by asking a judge for a ruling that she is capable of making that decision on her own, a process known as judicial bypass. Before January 1, 2000, when the legislation takes effect, the Texas Supreme Court must write rules for confidentiality and for making the process for bypassing notification of parents.

SB 43 – Relating to making controlled substance overdoses reportable. This legislation calls for the establishment of a statewide system of tracking drug overdoses by requiring deaths and injuries resulting from overdoses to be reported to the Texas Department of Health.

SB 99 – Relating to testing for accidental exposure to hepatitis B or hepatitis C. In the case of accidental exposure of a health care worker to blood or other body fluids of a patient in a licensed hospital, the hospital, following a report of the exposure incident, is authorized to test the patient for hepatitis B or hepatitis C without the patient's specific consent to the test.

HB 110 – Relating to public access to certain information regarding medical practitioners. This legislation directs the Texas State Board of Medical Examiners to post profiles of licensed Texas physicians for public access. Information to be profiled includes: education, hospital privileges, nationally recognized specialty certification, primary practice location, whether a physician participates in the Medicaid program, and information on past criminal conduct and/or disciplinary actions during the 10-year period preceding the date of the profile. The TSBME is to make the initial physician profiles available to the public not later than September 1, 2001.

SB 254 – Relating to the prescription forms used under the Texas Controlled Substances Act. This legislation restores Texas' triplicate prescription law for prescribing controlled substances, and authorizes the Texas Department of Safety to permit the use of triplicate or single prescription forms. In 1997, the triplicate prescription program was repealed and replaced with a system utilizing stickers for certain controlled substance prescriptions.

SB 445 – Relating to the Children's Health Insurance Plan. Signed into law on May 27, this state health care program will cover thousands of children who have fallen between the cracks of Medicaid and private health insurance. The program covers children from birth to age 18 if their parents earn no more than twice the federal poverty level (approximately $33,600 for a family of four). The state is required to identify children who qualify for Medicaid but aren't covered. In addition, children of legal immigrants are to be covered by CHIP. Under the plan, about $154 million from the initial installments on the tobacco settlement will go to the program, and the federal government will triple the state's contribution.

This legislation is the result of two years' work to provide medical care for about 1.4 million Texas children without insurance. CHIP is expected to provide coverage for about 500,000 children. The bill became effective August 30, 1999.

HB 573 – Relating to the continuing education requirements for certain medical professionals. This bill allows physicians and physician assistants to earn a limited amount of informal continuing medical education hours by providing volunteer medical services at a site serving a medically underserved population, other than a site that is a primary practice site of the license holder.

HB 610 – Relating to prompt payment of amounts owed to health care providers. This legislation requires that health plans pay "clean" claims within 45 days or provide written notice as to why a claim is being denied. If a claim is partially disputed by a health plan, the plan will be required to pay the portion not in dispute. The Texas Department of Insurance is to define what constitutes a "clean claim." Health plans violating the 45-day

deadline could be fined up to $1,000 per day for each day a claim is not paid.

HB 692 – Relating to the confidentiality of the Social Security number of an applicant or holder of a license or other form of permission to practice an occupation or profession. This legislation prohibits the Texas State Board of Medical Examiners and other professional licensing boards from making public the Social Security number of any physician licensed to practice medicine in Texas. The bill states that such information is confidential and is not subject to disclosure under the open records law. Signed by the governor on May 29, it became effective immediately.

HB 1051 – Relating to the treatment of glaucoma and surgical procedures by optometrists. This bill authorizes therapeutic optometrists in consultation with an ophthalmologist, to treat certain diseases and conditions with specific classes of pharmaceuticals. In addition, it sets forth conditions and protocols under which a therapeutic optometrist may treat glaucoma. The act prohibits therapeutic optometrists from performing surgery or laser surgery.

SB 1468 – Relating to the regulation of physician joint negotiation. Medicine's biggest victory was the passage of the physician negotiation bill, which was signed by Gov. George W. Bush on June 20. With its passage, Texas has become the first state to allow physicians to join together and negotiate fees with large HMOs. Senator Chris Harris (R-Arlington), author of the bill, said the legislation will help small-practice physicians remain in business during an era when large health care groups are dominating the industry. "I feel very strongly that we were destroying small doctor practitioners, and this gave them a way to continue to be doctors and start making sure they were able to give quality care."

Under the legislation, physicians are allowed to form negotiating networks that are no larger than 10 percent of the licensed physicians in a market. The HMOs would not be required under the law to negotiate with a physician's network.

HB 2025 – Relating to the establishment and operation of the Border Health Institute. This legislation, signed by the Governor on June 19 and effective immediately, establishes a Border Health Institute in El Paso. The Institute will facilitate or assist the activities of international, national, regional or local health-related institutions working in the Texas/Mexico border region, and will conduct research in fields of study affecting public health in such areas as infectious diseases, diabetes, environmental health issues and children's health.

HB 3021 – Relating to an HMO's complaint and appeals procedures. This legislation creates a health care ombudsman office to help consumers make appeals within their HMOs or pursue complaints against them. It becomes effective September 1, 1999 and will apply to appeals or complaints made after that date.

HB 3216 – Relating to the standardization of credentialing of physicians. The Texas State Board of Medical Examiners is to develop and administer a standardized credentials verification program, which provides that once a physician's relevant data is collected, validated, maintained and stored, such information need not be duplicated. The legislation also allows appropriate entities to access this information with the physician's permission to verify the core credentials the entity requires.

HB 3285 – Relating to covenants by physicians not to compete. This legislation ensures that physicians terminated from a group practice have access to their patients' records. The bill also requires any contract that includes a covenant not to compete to contain a buyout provision. The bill applies to a covenant entered into on or after the effective date, which is September 1, 1999.

Did You Know that...

Legal Eagles are not an Endangered Species

The number of attorneys licensed to practice law in Texas during the past 10 years climbed by about 25%, from 51,000 in 1988 to almost 64,000 in December, 1998. In the same period, the number of women joining the bar soared by 73%, or 7,100. Today, one out of four attorneys is a woman.

About two-thirds of Texas lawyers hang their shingles in private practice, while 11% choose government service and 10% work as in-house counsel. Three-fourths of the practicing attorneys graduated from a Texas law school.

Of the 63,800 lawyers with Texas licenses, about 58,500 live in the state. Of those, more than half live in just three counties: Harris, Dallas and Travis.

Source: Fiscal Notes, May, 1999

Family Physicians Rank Fourth in Number of Malpractice Claims

According to he Rockville, Maryland-based Physician Insurers Association of America, family physicians held the number four spot among more than two dozen medical specialists in the total number of malpractice claims filed against them in 1997.

Of 28 specialties reporting malpractice claims to the PIAA database, general and family practice ranked fourth, with 952 claims. Ranked first were obstetrics and gynecology, with 1,263 claims; internal medicine was second, with 1,085 claims; and general surgery was third, with 993.

News

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

Texas College of Osteopathic Medicine Integrates New Teaching Curriculum

The University of North Texas Health Science Center's Texas College of Osteopathic Medicine will implement a new curriculum in August, emphasizing a body organ system-based format and an integrated curriculum that incorporates additional computer technology in the learning process. The new curriculum will begin with TCOM's Class of 2003.

The new curriculum is designed to enhance incoming medical students' ability to understand, remember and apply their medical knowledge and skills to clinical practice. This method allows students to study clinical cases throughout the first two years, which is earlier than the previous curriculum allowed. Existing course content will be reorganized by body organ systems, such as cardiovascular, nervous and respiratory systems.

According to Warren Anderson, Ed.D., dean for educational affairs, the integration of clinical teaching and basic science knowledge will be key to the new learning method. The goal with increasing clinically related teaching throughout the first two years is to create more clinical relevance to the basic sciences, such as anatomy, physiology and molecular biology, rather than the basic sciences taught in isolation.

"When student doctors work in clinic settings their third and fourth years of medical school, the basic science knowledge will be easier to recall and apply with this approach," said Dr. Anderson. "We also want to design teaching that can be shared through the use of electronic media, such as conducting small group learning experiences via the Internet."

For faculty, a new curriculum enables new approaches to teaching and increased effectiveness in educating medical students due to greater collaboration among faculty from both basic science and clinical departments.

According to Benjamin L. Cohen, D.O., executive dean for TCOM and vice president for health affairs at the UNT Health Science Center, wider use of computer-based teaching and testing in the new curriculum will prepare medical students for the use of computers in licensure testing and in their medical practices.

"Board exams rely heavily on clinical formats, so the new curriculum will allow for better student preparation for board exams," said Dr. Cohen. "The new curriculum will allow us to remain dedicated to the development of primary care osteopathic physicians."

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Long-Term Care:
A Discrepancy between Perception and Reality

A few statistics go a long way in revealing the mindset of Americans toward long-term care. According to The American Health Care Association, 76 percent of Americans do not expect to need long-term care. This belief can be affected by a variety of factors, including a feeling of immorality or the assumption that family will take the responsibility of caring for an elderly adult.

However, The New England Journal of Medicine estimates that 43 percent of people who turned 65 in 1990 could expect to spend time in a nursing home during their lifetime. Of that number, 21 percent will spend five or more years in a nursing home. As another way of looking at it, seven out of 10 couples will see one partner go into a nursing home. Of course, these numbers stand in marked contrast to the vast majority who believe there will never live with the assistance of a nursing facility.

Now let's look at the financial impact of a nursing home stay. In 1997, $82.8 billion was spent on nursing home care. Medicare paid 12 percent of the total, while 31 percent was paid out-of-pocket by patients.[1] With the current average annual cost of nursing home care now standing at $40,000,[2] that would mean that the patient and his or her family would pick up a bill of $3,333 per month for long-term care expenses. Since many people do not prepare for these expenses, it's not hard to see why more than half the couples who see one spouse go into a nursing home are reduced to the poverty level.

The harsh reality of long-term care expenses, coupled with the fact that the 65-and-up age group is the fastest-growing segment of the population, means that the need for long-term care insurance is increasing. Long-term care insurance is not always appropriate for everyone, but generally those 65 and older are well served by having a policy in place that would prevent adverse economic effects from being visited on their family or other loved ones.

Certain groups of people should give special consideration to obtaining long-term care coverage. The first is women, who currently make up 75 percent of the over-65 nursing home population.[3] Since women live an average of five to seven years longer than men, they are more likely to require long-term care for an extended period of time.[4]

Another group who may consider the benefits of long-term care insurance is the children of aging parents. If nursing home care is ever needed, children can ensure quality care for their parents, and avoid the time, money and emotional demands of caring for an aging parent themselves.

Those with a family history of debilitating illnesses such as Alzheimer's or strokes should also consider purchasing a long-term care policy, for obvious reasons.

As the Baby Boom generation nears retirement and improving health care leads to lengthening life expectancies, long-term care will continue to be a topic on many people's minds. To ensure quality care for yourself, your spouse or family members during the twilight years without incurring financial burden, long-term care insurance offers an attractive solution.

If you would like to know more about long-term care insurance, or to discuss your individual situation to see if it is suitable for you, please give us a call.

1 Health Care Financing Administration, Office of the Actuary, National health Statistics Group, 1997

2 Health Insurance Association of America, "Guide to Long-Term Care Insurance," 1996

3 American Health Care Association

4 Bull and Bear News, "Women and Investing. An untapped Resource," Summer 1995 p.1

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08/99

Health Science Center Welcomes Future Medical Professionals

The University of North Texas Health Science Center faculty welcomed and initiated incoming health professions students, including the first class of the newly approved School of Public Health. The annual White Coat and Convocation Ceremony took place on August 6 at the Will Rogers Auditorium at the Amon Carter Jr. Exhibit Hall in Fort Worth. The ceremony was led by David M. Richards, D.O., health science center president.

The White Coat Ceremony is a rite of passage for students entering the academic health community, and by being literally "coated" for the first time with a white coat, signifies their pending entry into professional ranks. The UNT Health Science Center's White Coat ritual included 115 incoming students of the Texas College of Osteopathic Medicine, 36 students at the Graduate School of Biomedical Sciences, 19 new students in the Physician Assistant Studies Program and 48 in the School of Public Health.

Dr. Samuel T. Coleridge, chairman of family medicine at the health science center, welcomed the incoming students with the presentation of the keynote address.

Supporters of the White Coat and Convocation ceremony included the Texas Osteopathic Medical Association, the Robert Wood Johnson Foundation, the Society for Experimental Biology in Medicine, and the Arnold P. Gold Foundation.

Texas College of Osteopathic Medicine Class of 2003

Kenneth Paul Adams – Fort Worth
Tasneem Fazal Ahmed – Houston
Hameed Qutub Ali – Arlington
Lisa Elana Allen – Boyertown, PA
Shaad Amer – Sugarland
Jeffrey Ansell – Irving
Adibeh Walif Awaida – Arlington
Giti Azmabalani – Portland
Mojgan Arashvand Baker – Plano
Michael David Baldovsky – Carrollton
Carolyn Alexis Beebe – Austin
Akash Gopal Bhagat – Houston
Gary Wayne Binkley – Irving
Joseph Aaron Bradbury – Roosevelt, UT
Damon Lee Brooks – Lufkin
Dennis Colman Carlson – Round Rock
Arturo Felix Enage Castro – Fort Worth
Carena Lee Chai – Katy
Sheri Annette Chance – Houston
Yuchieh Chang – Houston
David Michael Chao – Kenner, LA
Patricia Marie Chisum – Corpus Christi
Linda Kay Christensen – De Soto
Eugene J. Chung – Farmers Branch
David Michael D'Spain – San Marcos
Benjamin Charles Dagley – Katy
Adair Frierson DeBerry-Carlisle – Houston
Richard Rodrigo Deleon – Houston
Marenda Dawn Dent – Pearland
Sarang Narendra Desai – Round Rock
Tejas Dilip Desai – Sugarland
Nimret Kaur Dev – Houston
David Frank Dohi – Houston
Ajit Dwivedi – Houston
Cynthia Ann English – Crowley
Joe Michael Etter – Midlothian
Jill Ann Feezell – Fort Worth
Kevin John Formes – Haltom City
Kari Grimsmo Frano – Braintree, MA
Vincent Chadwick Freemyer – Helotes
Rajpaul Ganesh – Missouri City
Genevieve Michelle Garcia – Plano
Steven Arnold Grant – Fort Worth
Terry Dale Hashey – Gainesville, FL
Thao Xuan Ho – Houston
Jeffrey Lynn Holloway – Abilene
Mitchel Timothy Holm – South Ogden, UT
Amy Elizabeth Huggins – Bryan
Meredith Elaine Hulsey – Granbury
Reza Izadi – Plano
Valeh Karimkhani – Littleton, CO
Zainab Zamir Kayani – Beaumont
Hui Tzu Kiang – Fort Worth
Shwol Huo Kiang – Fort Worth
Nicole Christine Koske – Abilene
Que Thu Thi Lam – Haltom City
Sonya Beth Larson – Austin
Dewey Le – Sacramento, CA
Shelley Guzman Lenamond – Fort Worth
Amy Lily Liaw – Sugarland
Migdalia Machado – San Antonio
Joseph Michael Martellotto – Bedford
Thomas Jojeph May – Keller
James Patrick McClay – Euless
John Gregory McCray – Fort Worth
Elizabeth Nicole McCurdy – Urbandale, IA
Therese I. Mendenhall – Waxahachie
Heather Marie Miller – Fort Worth
Monalisa Mojumdar Mitra – Grand Prairie
Brian Tucker Montague – Denver, CO
Matthew Colin Moreland – Fort Worth
Earle Christopher Munns – Fairview
Christopher John Najberg – Waco
Jennifer Marie Nenno – Orange
Nicole Ngoc Nguyen – Arlington
Phuc Nguyen – Fort Worth
Amy Jo Nichols – Grand Prairie
Benjamin Anders Olsson – Dallas
Faguna Chandrakant Patel – San Antonio
Kartik Narendra Patel – Highland Village
Reina Manilal Patel – Sugarland
Sonal Arvind Patel – Houston
Matthew Troy Perry – Fort Worth
Linh Duy Pham – Katy
Melissa Sue Popp – Dallas
Alice Benjamin Prescott – Fort Worth
Jon Michael Rich – Fort Worth
Mohamad Deeb Saad – Arlington
Donald Evan Selby – Duncanville
Judson Malcome Severson – Bedford
Anish P. Shah – Houston
Seema Lakho Sidhwani – Spring
Nicole Rene Siegert – The Woodlands
Arun Ravindrana Singh – Grand Prairie
Turner Slicho – Dallas

Melissa Ruiz-Cady Sneed – Austin
Steven Thomas Solby – Arlington
Connie Janel Speece – Dallas
Jason Todd Sperberg – Denver, CO
Frances Shelly Spiller – Austin
Suzanne Marie Stovall – Fort Worth
Matthew David Thompson – Euless
Vilay Thongkham – North Richland Hills
Nha Ke Ton – Wichita Falls
Traci Lynne Torbert – Houston
Nhu Quynh Tran – Fort Worth
Kavita Ashok Trivedi – Plano
Marci Leigh Troxell – Austin
Grace Mary Ann Varas – Fort Worth
Hayley S. Voige – Fort Worth
Alexandra Juliana Wesolowski – Fort Worth
Michael Anthony White – Fort Worth
Vickie Lynn Willoughby – San Diego, CA
Scott Edwin Young – Fort Worth
Christine Marie Zalucki – West Point, NY

Physician Assistant Studies Program

Jennifer Carr – Aubrey
Tang Chung – Houston
Fidencio Gonzales – Junction
Brenda Hale – Arthur City
Julia Health – Irving
Ellie Iwu – Dallas
Stanley Kotara – Arlington
Stephanie Lawrence – Fort Worth
Sofia Lopez – Houston
Steffany Martin – San Antonio
Julie Parham – Houston
Brian Pendleton – Midland
Jana Peretti – Arlington
Robin Person – Bonham
Christina Reid – Jacksonville, AR
Kathryn (Kate) Sanders – Fort Worth
Kimberly Saunders – Brackettville
Gena Willard – Friona
Farivash Hamraie – Grapevine

Graduate School of Biomedical Sciences

Kathleen Badeaux – Arlington
Heather Callen – Burleson
Joung-Il Choi – Chenju, South Korea
Nils Confer – Euless
Lorna Damo – San Francisco, CA
Swapan Gaddam – Hyderabad, India
Byron Graves – Amarillo
Janelle Hardisty – Keller
Van Huynh – Fort Worth
Cassie Johnson – Southlake
Kari Jones – Baton Rouge, LA
Roopesh Kantala – Kyderabad, India
Feng-hua Liu – Beijing, People's Republic of China
Miguel Medina – San Benito
Matthew Milholland – Fort Worth
Michael Moeller – Iowa City, IA
Sanghamitra Mohanty – Cuttack, India
Suzan Parhizgar – Laredo
Yamini Patel – Arlington
Anson Pierce – Spring
Ryan Rich – Rupert, ID
Mohamed Salama – Cairo, Egypt
James Saunders – Dallas
Ritu Shetty – Mumbai, India
Theophlous Sims – Fort Worth
Anjuli Sinha – College Station
Bhooma Srinivasan – Madras, India
Riley Stewart – Fort Worth
Sonja Swiggum – San Antonio
George Umeadi – Houston
Xin Wang – Shandong, People's Republic of China
Thomas Weilbacher – San Antonio
Maurice Williams – Baton Rouge, LA
Xingyu Zhang – Jianxi, People's Republic of China
Yu Zhao – Beijing, People's Republic of China
Huiling Zhang – Fenghua, People's Republic of China

School of Public Health

Olubumi Akiwumi – Freetow, Sierra Leone
John Benjamin – Kerala, India
Patricia Blevins – Fort Worth
Margaret Budd – Erie, PA
Lisa Carlson – Bartlesville, OK
Satish Chandrashekaran – Mumbai, India
Stacy Davlin – Irving
Latunya Davidson – Baton Rouge, LA
Jennifer DiMaggio – San Antonio
Richard Wayne Fernando – Fort Worth
Ramona Finnie – Phoenix, AZ
Kimberly Fulda – Port Arthur
Aleshia Hall – Greenwood, MS
Rebecca Hall – Weatherford
Sandralyn Hampton – Fort Worth
Keli Hawthorne – Fort Worth
Selena Hung – Milpitas, CA
Zahidul Islam – Dhaka, Bangladesh
Tracy Johnson – Fort Worth
Kenneth Jones – Waco
William Kennedy – Mena, AR
Hsiu-Fang Kuo – Taipei, Taiwan
Brian Long – Cleburne
Tom Mammo – Phoenix, AZ
Robert Martinez – San Antonio
Shane Mathew – Colleyville
Virginia McElroy – Vienna, VA
Christine McGrath – Austin
Srikant Nannapaneni – Hyderabad, India
Chaka Norwood – Mound Bayou, MS
Joelle Oishi – Houston
Nicole Peralta – Pearland
Anthony Rasey – Fort Worth
Camillia Redd – Brandon, MS
Sharon Reese – Fort Worth
Christy Rice – LaMarque
Valarie Rios – San Antonio
Dahl Rollins – Liberty
Christine Sammer – Burleson
Scott Sawyer – Arlington
Jessica Smart – Austin
Bryan Smith – Bedford
Sophie Tran – Fort Worth
Caroline Weerstra – Billings, MT
Matthew Woods – Dallas
Katrina Wright – Greenwood, MS
Janice Wyatt – St. Louis, MO
Sharon Young – Fort Worth

ATTENTION
ALL TOMA MEMBERS
The dates for the 44th MidWinter Conference & Legislative Symposium have been changed to January 28 - 30, 2000.

Texas ACOFP UPDATE

42nd Annual Clinical Seminar Update

The Texas ACOFP 42nd Annual Clinical Seminar was a great success. Held at the Arlington Hilton July 22 – 25, members enjoyed an interesting mix of lectures specific to family practice as well as great social events. There were many winners as well as donations made by our attendees to the Lone Star Race Track. Dr. Bob Deluca and Dr. John Bowling were among the winners and those in the other category we will keep anonymous.

We did our job initiating ACOFP president-elect Eugene Pogorelec, D.O., from Ohio as a Texan by presenting him with the official hat and boots. He and his wife Irene attended lectures and social events, mixing with our members and answering questions about the ACOFP. We thank him and Irene for spending the weekend with us.

The President's Reception and Dinner, honoring Patrick Hanford, D.O., was another success. The TCOM Alumni Affairs Department sponsored the reception to honor alumnus Dr. Hanford.

This year's T. R. Sharp Meritorious Service Award was presented to Joe Montgomery-Davis, D.O., from Raymondville for all of his service to the D.O.s in Texas. As author of many of the resolutions submitted to the AOA and ACOFP, he brings important issues to the attention of our national associations. Joe protects us by publishing his findings on Medicare and Medicaid coding updates and he is often our voice during legislative sessions.

The Family Physician of the Year Award was presented to Ruth Carter, D.O., from Colleyville. Her dedication to her community and to her patients over the past 30 years was recognized as well as her accomplishment of delivering 21 babies in 2 days when she was a young physician in Lubbock.

Casino Night was enjoyed by the families attending and prizes for adults and children were given to those with the highest number of chips.

As always, the OMT workshop on Sunday was one of the highlights of the seminar. This workshop again sharpened the OMT skills of our members as well as served as a reminder of the unique gift of manipulative therapy.

Dr. Bob Maul show off the bet he won by wearing his "Darth Maul Boxers" at the Membership meeting.

We will again be at the Arlington Hilton for the 43rd Annual Clinical Seminar to be held July 27 – 30, 2000. Hope to see all of you there!

TxACOFP President, Dr. Patrick Hanford, welcomes members to the TxACOFP Membership Meeting.

Dr. Hanford presents ACOFP President Elect, Dr. Eugene Pogorelec, with his official "Hat & Boots"

Dr. Joe Montgomery-Davis (L), 1999 Recipient of the T.R. Sharp Meritorious Service Award, with Chair, Dr. David Garza and Dr. T.R. Sharp

Dr. Ruth Carter, 1999 Family Physician of the Year, and her proud family.

L to R: Dr. John Bowling, his father, Ardyce Bowling, and Dr. Eugene Pogorelec (Buckeyes from Ohio)

The traditional TxACOFP Birthday Cake is cut by T.R. Sharp, D.O.

IMPORTANT CHANGE!!

The National ACOFP has changed its meeting date and location for its March 2000 meeting. The new date and location are:

March 26 – 31, 2000
Bally's Las Vegas
LasVegas, Nevada

Please mark your calendars and consider serving as a Texas Delegate to this meeting.

2nd Annual OMT Update and Review

The 2nd Annual OMT Update and Review will be held September 24 – 26 at St. Joseph Gardens in Fort Worth. This program will be cosponsored with the UNTHSC at Fort Worth and will provide 21 hours of Category 1A Credit. Texas ACOFP members, TCOM alumni, and those participating in TCOM's Preceptorship Program will receive reduced registration rates.

Topics will include OMT technique in areas including OMT in Sports and Occupational Injuries, OMT for ENT and TMJ, as well as, Cardiovascular and Pulmonary OMT. Dr. Conrad Speece will continue teaching us Ligamentous Articular Strain, an older OMT technique, and there will be other lectures offered during meals.

Please contact the TxACOFP Headquarters at 888-892-2637 or the UNTHSC CME Department at 800-987-2263 for registration information.

New TxACOFP Board of Governors

The new TxACOFP Slate of Governors was approved at the recent Annual Membership Meeting. The 1999-2000 Board of Governors is as follows:

John R. Bowling, D.O., President
Robert Deluca, D.O., President-Elect
Harold Lewis, D.O., Vice President
Craig Whiting, D.O., Secretary
Rodney Wiseman, D.O., Treasurer
Ronda Beene, D.O., Governor
David Garza, D.O., Governor
Tony Hedges, D.O., Governor
Donald Peterson, D.O., Governor
Jerry Smola, D.O., Governor
Robert Stark, D.O., Governor
R. Greg Maul, D.O., Liaison to ACOFP
Robert Peters, D.O., Liaison to AOA
Samuel Coleridge, D.O., TCOM Advisor
T. Eugene Zachary, D.O., Parliamentarian
S/D Adriana Hwa, Zeta Chapter Representative

Please don't hesitate to contact our Board if you have ideas, questions or concerns regarding our Society.

John Bowling, D.O. 1999 - 2000 TxACOFP President

John Bowling, D.O., was installed as the 1999 - 2000 TxACOFP President at the 42nd Annual Clinical Seminar in Arlingrton, Texas. The following are excerpts from his acceptance speech.

On February 18, 1943 a baby boy was born at a central-Ohio Osteopathic hospital. The doctor who delivered that baby was an Osteopathic family physician. At the age of three, that child was diagnosed with asthma. Through the years, the child was treated by an osteopathic family physician. The treatment consisted of regular osteopathic manipulative treatments and a red liquid medicine which was given during acute attacks. Undoubtedly, that red liquid was a theophylline preparation, as Albuterol had not yet been discovered. There were no inhalers of any kind and Accolate was far in the future. Of particular significance in the management of this asthmatic child was the fact that the osteopathic family physician instructed the parents in the use of specific osteopathic techniques to be used during the acute attacks. These techniques consisted basically of what we would call lymphatic techniques and rib raising. Since the major allergen turned out to be house dust, (which we now know is caused by the dust mite) the environment was regulated and all dust collecting items were removed from the child's bedroom. The treatment of the disease was successful and that individual has no evidence of asthma today.

Eventually he went on to become an osteopathic family physician. Trained in the philosophy of treating the whole patient, the early personal experiences with osteopathic family physician role models played a major role in shaping the direction of his career. That person stands before you today accepting the responsibility of President of the Texas Chapter of the American College of Osteopathic Family Physicians. I consider it an honor and a privilege to have been selected to serve my colleagues in this capacity. It is especially fitting that Dr. Pogorelec is our honored guest this year as president-elect of the National ACOFP. I know that to have one Buckeye administer the oath to a former Buckeye may make y'all nervous, but I can assure you that Bluebonnets are my favorite flower and the Texas Rangers is my favorite baseball team. I am however, glad to see that the Cleveland Browns will be back this fall.

I would like now to present you with three challenges as members of the Texas ACOFP:

Steep yourself in the history and philosophy of the osteopathic profession. Understand the importance of treating the whole person. I don't believe Dr. Still knew anything about neurobiology and certainly could not imagine PET scans and brain mapping of cognitive function, but he did understand the human body and the interrelationship of mind, body, and spirit. He developed a philosophy of medical practice that recognized

Dr. John Bowling is installed as 1999 - 2000 TxACOFP President by Dr. Eugene Pogorelec.

the superiority of our creator and the miracle of life. He recognized the person as a total being and taught that man should live life nourishing all aspects of the whole person-mind/body/and soul. He was quite intolerant of "poison" which man puts into his body. This to Dr. Still included drugs, alcohol, and unhealthy foods. How appropriate it is to revisit his philosophy today as we teach and practice prevention in our medical practices.

My first challenge then is for you to pay attention to the person. Listen to what they are really telling you and devise a treatment plan that treats the mind, body, and soul. The patient may be in your office, a family member, or even yourself. Listen actively, think responsibly and act compassionately.

Second, I would challenge you to work actively in the Texas ACOFP to enhance the educational opportunities to our membership. I challenge you to think beyond our summer convention.

Managed care is changing the face of medical education. The balanced budget act has impacted heavily on teaching hospitals, residency programs, and student rotations done at these sites. More and more reliance is being placed on community-based physicians to provide community-based educational experiences. The Osteopathic profession has long recognized "at-the-site" or community-based training. Dating back to the '50's with the Kirksville Rural Clinic model, our schools have stressed educational experiences in "preceptor practices". These rotations have provided realistic, real-world experiences and have been instrumental in a majority of our graduates entering family practice. With more and more physicians working under the restraints of pleasing an employer, whether that employer is an HMO, hospital, or academic health center, the physician has less and less time to teach and the historic, low volume, academic practices are disappearing. Teaching time in the clinic is at a premium as we are prodded into productivity criteria. HCFA and Medicare regulations make it increasingly difficult to train students and residents in sound educational models that prepare them for medical decision-making before they begin their practice.

To continue to produce osteopathic family physicians, we will need more and more to increase the experience with the community-based physician. Clerkship rotations in family medicine, geographically placed at the academic health center, may become a rarity. Four years ago, we placed our first clerkship students in rural locations. Those of you selected to participate in this program agreed to elevate your participation in our educational programs from that of a preceptor to a faculty level. This means more attention to goals and objectives, evaluation mechanisms of the student and participatory study with the student. I am pleased to report that this past June we graduated the first four students to complete the four-year longitudinal rural track. This program has been extremely popular and I expect it to serve as a model for more off-campus community-based family medicine clerkships. With the implementation of a new medical school curriculum at the University of North Texas Health Science Center Texas College of Osteopathic Medicine this fall, the role of the community physician will become increasingly important during the first two years. It is my hope to expand the relationship between the Texas chapter of the ACOFP and the Department of Family medicine at the college, to work cooperatively in activities which promote educational opportunities for our students and residents. We will continue to provide the faculty training and development workshop at our summer convention.

This is designed to help the faculty teaching in the rural track and our preceptors who support our students in such a fine way to become better teachers for our students and residents. I would like to invite you to attend this afternoon's workshop to learn more about the new curriculum and its impact on community preceptors both urban and rural.

Resident education is relatively new to our osteopathic family practice organization. Although early programs were established in the '70's, residencies were not required until the 90's. We have a well established program for ACOFP student organizations including representation at the National Congress of Delegates. It was not until 1996 that resident delegates were seated at the Congress of Delegates at the National ACOFP. Begun in Palm Springs in 1992, this initiative was led by your Texas delegation. We now must take this to the next level. We need to reach the residents in family practice programs in the State of Texas and provide activities and support to complement their training. This may come through volunteering to have a resident for a one-month elective or required rotation, being a "sponsor" for a given resident during their residency training, or helping to fund a resident position. With the balanced budget act, Medicare funding for training programs was severely curtailed. Federal funds through Medicare are no longer available to fund new resident positions.

I challenge this organization and the long-range planning committee to develop a mechanism whereby the Texas ACOFP pursue continual funding for one or more new family medicine residency positions in the State of Texas. I plan to propose the expansion of the education program committee to include pre- and post-doctoral subcommittees. I will challenge these groups to establish better and regular communication with our students and residents and that we encourage their active involvement in this organization

and in our osteopathic profession. It is my hope that this will allow the TxACOFP to give better assistance in any way appropriate to the Department of Family Medicine, the students, and the family practice residents across the state. As you continue your commitment of working with students and residents, I urge you to emphasize in your practice, the prevention of Cancer and heart disease, the two most common causes of morbidity and mortality to our patients. Osteopathic family physicians can make a difference. We can cure disease by doing all we can to assure the whole is in functional relationship to its parts—Mind/Body/and Soul.

The third challenge I give you involves your active participation in TxACOFP organizational activity to help control infringement by government and managed care organizations upon the right of patients to chose their physicians, and the ability of physicians, especially family practice physicians to provide good quality health care without being encumbered with the multiplicity of rules, regulations, and paperwork present in our practices today.

When I joined the faculty at TCOM eleven years ago, we seldom heard complaints from students about the paperwork needing to be done. Now it is not uncommon to hear "I am having second thoughts about family practice because of the hassles you all must put up with". Those hassles include the steps necessary to get a referral approved and scheduled, paying attention to the formulary of multiple HMO's, and being held accountable for the medication prescribed by the specialist to whom we refer our patients. Students see these processes as unnecessary burdens on the family practice physician burdens they don't see on other specialty rotations. All of this placed on top of the decreasing reimbursements for patient care, I'm afraid will impact negatively on the students' choice of specialties. We must act both individually and as an organization to assure future graduates of TCOM and other osteopathic institutions will continue to choose family practice as their specialty.

Historically, 50-60% of our graduates have chosen family practice as a career. We speak often of how the osteopathic philosophy is suited for this specialty. We point with pride to family practice physicians as the cornerstone of preventive care and necessary for the survival of a cost effective rational health care system.

"...emphasize in your practice, the prevention of Cancer and heart disease, the two most common causes of morbidity and mortality to our patients..."

If we believe this, then we must act to convince those policy makers of the health care system, both physician and non-physician, that we are getting choked by the rules and regulations of managed care and that patient care suffers at the expense of trying to make the system work. We must not cry we are underpaid. We cannot bombard the policy makers with multiple issues but chose one and negotiate change. We as family physicians cannot afford to be encumbered by useless and unnecessary paperwork as dictated by managed care and other regulatory agencies.

Regulations are necessary, but they must not drive the system. I plan to appoint an ad hoc subcommittee to work with the Texas Academy of Family Physicians to develop a strategy whereby the family physicians of Texas can speak as one voice to demonstrate that excessive bureaucratic regulations and paperwork is decreasing the attractability of family practice as a chosen specialty, and has not been shown to provide any better care for our patients. Our staff, and we, as family physicians, must be able to spend the time with our patients, not with our patients' paperwork.

The AOA and AMA have demonstrated through pro-active cooperation that we can make a difference. These organizations by banding together, were able to delay the implementation of the new HCFA guidelines for evaluation and management codes. We must continue to speak out against this unnecessary burden which does not enhance patient care, but detracts from it. To initiate dialogue between the two family practice organizations in the state of Texas, we invited Dr. Benold, President of the Texas AFP to our pre-convention board meeting. This was a first step in dialog with our family practice counterparts to seek a unified voice to promote issues vital to the specialty of family practice in the state of Texas. It is my hope that you, the community family practitioner, will step forward with the Tx ACOFP and begin the initiative to take back medical decision making from the insurance companies and government agencies and give it to the physician where it belongs. In turn, we must accept this responsibility and not over-utilize or overcharge, but make responsible, prudent medical decisions based on evidence-based criteria, but also not giving up alternative methods that do work and are not harmful to the patients.

In summary, let me repeat my three challenges:

1. Know Osteopathic Medicine - listen actively - think responsibly - act compassionately

2. Make a commitment through active participation in expanded ACOFP educational activities.

3. Become involved with ACOFP initiatives designed to restore medical decision making to its rightful place-with the physician.

Fraternally,

John R. Bowling, D.O.
President
Texas ACOFP

In Memoriam

David L. Bilyea, D.O.

David L. Bilyea, D.O., of Fort Worth, passed away on August 4. He was 70. Funeral services were held August 7 at University Christian Church.

A 1953 graduate of Kirksville College of Osteopathic Medicine in Kirksville, Missouri, Dr. Bilyea competed his internship at Lakeview Hospital in Milwaukee, Wisconsin.

He practiced family medicine in his hometown of Louisiana, Missouri, for 13 years. In 1966, he continued his training with a surgical residency at Grandview Hospital in Dayton, Ohio, followed by a pulmonary fellowship and cardiovascular thoracic surgical residency at Ingham Medical Hospital in Lansing, Michigan.

Dr. Bilyea relocated to Fort Worth in 1972, where he practiced as a thoracic cardiovascular surgeon. He was certified in thoracic surgery and was a fellow of the American College of Osteopathic Surgeons. Dr. Bilyea was affiliated with the Osteopathic Medical Center of Texas in Fort Worth and taught at the University of North Texas Health Science Center at Fort Worth/Texas College of Osteopathic Medicine until his retirement in 1987.

A TOMA life member, he had been extremely active in TOMA affairs, having been a member of the TOMA House of Delegates and serving on various committees in the past. Dr. Bilyea had also been active in TOMA District II, holding various offices throughout the years.

Other memberships included the American Osteopathic Association, in which he was a past chairman of the Thoracic Cardiovascular Surgery division, and the American College of Osteopathic Surgeons.

Survivors include his wife, Carolyn Dornoff Bilyea; daughters, Kathryn Bilyea and her husband, Loren Dunn, and Cynthia McKenney and her husband, Kregg; son, Richard Bilyea and his wife, Lisa; and seven grandchildren.

Memorials may be made to Osteopathic Medical Center of Texas Cardiac Surgery Unit, 1000 Montgomery St., Fort Worth, TX 76107; or Parkinson Support Group of Tarrant County, in care of Kay Stephan, 4816 Lariat Trail, North Richland Hills, TX 76180-7828.

District Stars

News from TOMA/ATOMA District VI

By Marguerite Badger
Corresponding Secretary

TOMA/ATOMA District VI held its July 13th meeting at Tony's Restaurant in Houston. Carl Mitten, D.O., TOMA District VI President, conducted the meeting and discussion. The speaker, sponsored by Pfizer, Inc., was Michael Coburn, M.D., Professor of Urology at Baylor College of Medicine.

The election of officers for the coming year took place, and are as follows:

President – Morton Rubin, D.O.
Vice President – Theresa Bobo, D.O.
Recording Secretary – Cuong Nguyn, D.O.
Corresponding Secretary – Marguerite Badger
Treasurer – Harlan Borcherding, D.O.

Unapproved HIV Home Test Kit Gives False Negatives

In a joint investigation conducted by the Food and Drug Administration and the Federal Trade Commission, an unapproved HIV rapid home-use test kit promoted on the Internet and sold domestically was tested by FDA and, in some cases, gave false negative results. FDA is notifying consumers who purchased the "EZ MedTest" marketed by Cyberlinx Marketing, Inc. on the Internet that the test results given by the test are unreliable. Kit purchasers are advised to consult with a health professional regarding other available FDA approved tests that detect antibodies to HIV.

The "EZ MedTest" Website has been removed from the Internet by Cyberlinx Marketing, Inc., and the firm has voluntarily turned over all remaining test kits to FDA's Office of Criminal Investigations. There is an ongoing FDA investigation of the U.S. firm that supplied the test kits to Cyberlinx Marketing, Inc. The letter can be found at the following site: <http://www.fda.gov/medwatch/safety/1999/ezmedt.htm>.

Approval Sought for Pediatric Combination Vaccine

SmithKline Beecham is seeking U.S. approval for a combination pediatric vaccine for five diseases: tetanus, polio, diphtheria, whooping cough and hepatitis B. The company has asked for an expedited review of its combination vaccine, which is available in Europe.

Dr. Melinda Wharton, chief of child vaccines at the U.S. Centers for Disease Control and Prevention, noted, "Anything that reduces the number of injections will be welcome by medical providers and parents."

Currently, infants need nine shots during their first 12 months to gain protection against the five diseases. The use of the combination vaccine would require year-old infants to need only three shots to acquire the same protection.

FDA Approves Topiramate for Pediatric Use

The Food and Drug Administration has approved topiramate, an epilepsy drug used by adults, for use as an add-on therapy for young patients with partial-onset seizures.

The FDA allowed the new use of topiramate for pediatric patients ages two to 16, who suffer from partial-onset seizures, one of 20 type of seizure disorders.

Although drugs are already prescribed to treat pediatric epilepsy patients, topiramate is the first of a new generation of anti-epileptic drugs approved for partial-onset seizures for patients as young as two.

Study to Test Hepatitis C Treatments

The government is launching an eight-year study to test anti-viral drug treatments for the four million Americans infected with chronic hepatitis C. The $28 million clinical trial will be funded by the National Institute of Diabetes and Digestive and Kidney Diseases, a division of the National Institutes of Health.

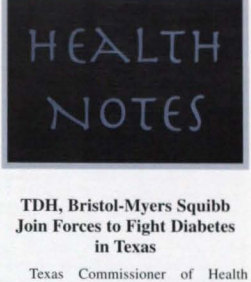
The objective of the study will be to determine if long-term treatment with drugs can slow or prevent the progression of liver disease in hepatitis C patients.

CDC Advises Temporary Halt in Use of RotaShield

The Centers for Disease Control and Prevention have recommended that physicians temporarily stop giving children RotaShield, the vaccine against rotavirus, because at least 20 infants have developed a bowel obstruction after taking the medication. Although the vaccine has not been conclusively linked to bowel obstruction, CDC said that early studies show it may increase the risk.

The obstruction occurs when one part of the bowel becomes enfolded within another. Symptoms include vomiting, bloody stools and abdominal pain. Unless caught at an early stage, surgery is often needed to clear the blockage.

The CDC has recommended suspending use of the vaccine in all children – including those who have begun the three-dose series – until November so health officials can complete additional studies. Rotavirus, an intestinal infection, is the leading cause of severe diarrhea in children younger than five in the U.S.



TDH, Bristol-Myers Squibb Join Forces to Fight Diabetes in Texas

Texas Commissioner of Health William R. Archer, M.D., has signed an agreement with the Bristol-Myers Squibb Company creating the Texas Diabetes Prevention and Control Initiative, a public-private partnership to prevent, detect and control diabetes in the state. The agreement was signed in a Capitol ceremony. Bristol-Myers Squibb agreed to provide $1 million in funds and services to the two-year pilot project. Major components of the initiative include public screenings to detect diabetes, an education program for health care providers and activities to alert the public to diabetes signs and symptoms and help those with diabetes manage their disease." Today some 1.6 million Texans have diabetes, but half of them don't know they have it," Archer said. "I'm confident this special partnership will reduce both these numbers in future years and lead to longer healthier lives for our citizens." The initiative will supplement TDH's on-going professional education, elementary school health, physical activity, prevention, disease management and annual eye examinations programs. The public screening component will be carried out by local agencies in several metropolitan and rural sites to be selected. Bristol-Myers Squibb area vice president N. Anthony Coles, M.D., said, "We recognize the critical need to work in concert with governments, medical institutions, international organizations and community-based groups to effectively address disease prevention and treatment." The Texas Diabetes Council, chaired by Maria Alen, M.D., McAllen, also is a partner in the initiative. The council advises TDH on diabetes programs. Bristol-Myers Squibb is a worldwide health and personal care company headquartered in Plainsboro, New Jersey.

continued on next page

FDA Approves Relenza (Zanamivir for Inhalation) for Influenza Treatment

FDA has approved Relenza (zanamivir), an inhaled anti-viral drug, for adults and adolescents aged 12 years and older for the treatment of uncomplicated influenza virus. This product is approved to treat type A and B influenza. Though the principal trials enrolled over 1000 patients with type A influenza, a much smaller number (approximately 120) had type B influenza. Relenza is the first approved drug for the treatment of influenza since the approval of rimantadine (Flumadine) in 1993.

Clinical studies determined that patients with influenza receiving Relenza had shorter times to improvement in influenza symptoms. Part of the evidence for efficacy was provided by studies in the Southern Hemisphere and Europe. Efficacy treatment studies enrolled more than 1500 patients with influenza-like illness, for example, fever, headache, muscle aches, cough and sore throat.

Effectiveness was demonstrated only in patients who started treatment within 2 days of symptoms. Relenza appears less effective in patients who do not have elevated temperature or severe symptoms.

Safety and effectiveness have not been established for the drug's use in preventing influenza.

This product has not been shown to be effective, and may carry risk, in patients with severe or decompensated asthma or chronic obstructive pulmonary disease. Bronchospasm was documented in some patients with mild or moderate asthma following administration of zanamivir. Any patient who develops bronchospasm should stop the drug and call their health care provider. Patients with underlying respiratory disease should be instructed to have a fast-acting inhaled bronchodilator available when they are being treated with zanamivir.

Relenza is taken twice daily for five days using a breath-activated plastic inhaler device called a Diskhaler. The device holds a Relenza Rotodisk, which is a blister package containing a powder mixture of Relenza and lactose. After a Rotadisk is loaded into the Diskhaler, a blister is pierced and the drug treatment is released into the air stream created when the patient inhales through the mouthpiece.

Before using this product, patients should be instructed by their health care provider in the proper use of the inhaler — including a demonstration whenever possible. Patients should also read and carefully follow the Patient Instructions for Use included with the drug.

Relenza will be marketed by Glaxo Wellcome, headquartered in Research Triangle Park, North Carolina.

The Auxiliary to the American Osteopathic Association
Cordially Invites You to its
Installation Luncheon
"A Toast to the Year 2000"

For

Incoming AAOA President
Rita Baker

Tuesday, October 26th, 1999
1:00 P.M. Luncheon & Program
San Francisco, Marriott

Guest Speaker
Rena Tarbet
National Sales Director for Mary Kay
& Motivational Speaker
Presenting
"How to Succeed in Spite of Life's Challenges"

If you would like to atend, please reply by September 10

*M*_____

_____*Persons will attend - $40.00 per person*

Make check payable to the AAOA
Mail to: AAOA Installation Luncheon
142 East Ontario Street
Chicago, IL 60611

The Auxiliary to the American Osteopathic Association
Cordially invites you to the
PRESIDENT'S RECEPTION
in honor of
AAOA President
DEBRA EDWARDS
&
President Elect
RITA BAKER
and All Presidents

Monday, October 25th, 1999
6:00 pm to 8:00 pm
San Francisco Marriott
San Francisco, California

Texas Osteopathic Medical Association

44th MidWinter Conference & Legislative Symposium

January 28 - 30, 2000

Renaissance Dallas North Hotel
Dallas, Texas

What's New for the New Millennium

NEWS You Can USE

Senate Bill 30 Re-enrollment Date Extended

As physicians are aware, the 75th Texas Legislature passed SB 30, which mandated that the Texas Department of Health re-enroll all Texas Medicaid providers. SB 30 was signed into Texas law by Gov. George W. Bush on June 20, 1997, and is intended to address program integrity in the Texas Medicaid Program. National Heritage Insurance Company (NHIC) has been contracted by the state to facilitate the re-enrollment for all Texas Medicaid providers.

The 76th Texas legislature recently adjourned after passing HB 2641 & 2896, which allows an extension to the original SB 30 law date of September 1, 1999, to March 31, 2000.

This new law requires the following for Medicaid providers:

- Current providers must re-enroll in the program by March 31, 2000, by completing and signing a new provider agreement.
- New providers enrolling in the Medicaid Program on or after November 16, 1998, must complete and sign a new provider application, information form and agreement to comply with the SB 30 provisions.

NHIC has established a Web page at <www.eds-nhic.com> which provides helpful information on the re-enrollment process. Physicians may view pertinent documents on-line or download files.

The following was downloaded from the NHIC Web page for your information.

Top Five Questions Pertaining to the Provider Agreement (Pages 8-1 through 8-9 of the Re-enrollment Packet)

1. What is a "subcontractor"? (Page 8-8)

A subcontractor is anyone who agrees, either through a contract or a purchase order, with the Medicaid provider to provide any part of the services or supplies that the Medicaid provider is responsible for as part of the Medicaid provider's agreement with the State. The term "subcontractor" does not include employees of the Medicaid provider but rather means independent third parties. Two extreme examples are: a company with whom the Medicaid provider has an agreement to provide durable medical equipment would be a subcontractor under this certification. The companies or individuals that provide only general office supplies such as copier paper to the Medicaid provider would not be covered subcontractors under this agreement.

2. If I checked "No" in the middle of the page, why do I have to fill out the bottom? (Page 8-8)

Although the State can determine whether a provider has been suspended or debarred, federal law requires that each provider certify that he or she has not been debarred or suspended and that he or she will attempt to assure that any subcontractors the provider has under this contract have not been debarred or suspended. This is explained in a bit more detail below.

Even if a Medicaid provider checks the "no" box in the middle of page 8-8, the Medicaid provider must also fill out the bottom of the page because that part of the certification does something in addition to the "yes" and "no" boxes in the middle of the page. This certification does two things: first, it requires the Medicaid provider to certify that the provider is not debarred, suspended, proposed for debarment, declared ineligible, or voluntarily excluded from participating in this contract. An example of being ineligible to participate in this contract is if the Medicaid provider has been excluded from participation in the Medicaid program as a result of an investigation by the Office of Investigations and Enforcement at the Texas Health and Human Services Commission. This part of the certification is set out in the bottom part of the page, with the two boxes right above the box that says "Name of Potential Contractor." The second thing that the certification does is to require the Medicaid provider to make the same type of certification regarding any subcontractors the Medicaid provider has under this provider agreement. The question in the middle of the page is whether the Medicaid provider plans to have subcontractors under the provider agreement. If so, the Medicaid provider agrees to putting the same certification (that the subcontractor is not debarred, suspended, ineligible or voluntarily excluded from participating in this agreement) in the provider's subcontracts. The Medicaid provider is also agreeing not to knowingly enter into a contract with a subcontractor who has been debarred, suspended, declared ineligible, or been voluntarily excluded from the covered contract. So even if the Medicaid provider is not planning on having subcontractors, the Medicaid provider must still complete the bottom portion of page 8-8 to certify his or her own status regarding debarment, suspension, ineligibility, and voluntary exclusion.

3. Can you explain the addendum statement on page 8-7?

The addendum statement 7 is a place for a Medicaid provider to list additional Medicaid provider numbers that the provider wants to re-enroll. On page 8-1, there is room for only one Medicaid provider identification number; consequently, the addendum statement simply allows a Medicaid provider to list all of the Medicaid provider numbers that he or she wishes to re-enroll onto one agreement.

4. Is it true that the agreement is all I have to send to be Senate Bill 30 compliant?

Yes, to be Senate Bill 30 compliant, a Medicaid provider must send in to NHIC by March 31, 2000, page 8-1 through and including page 8-9, the provider agreement, properly filled out. The State may determine that it needs some of the other information included in the re-enrollment packet after March 31, 2000, and may ask for it at a later date. Consequently, a Medicaid provider may also turn in a completely filled out re-enrollment packet.

5. Can I send pages 8-1, 8-7, and 8-8 only?

No, to be Senate Bill 30 compliant, a Medicaid provider must turn in the entire agreement, properly filled out, page 8-1 through and including page 8-9.

Medicare Proposes 2000 Physician Fee Schedule

The Health Care Financing Administration (HCFA) published a proposed physician fee schedule for calendar year 2000 that continues the transition to a fairer physician payment system. Continuing the reforms initiated in the 1999 fee schedule, the 2000 Medicare physician fee schedule relates payment for physician practice expenses to the actual resources used to provide medical services rather than physicians' historical charges.

"Breaking the link between Medicare practice expense payments and historical charges will create a fairer payment system," said HCFA Deputy Administrator Michael Hash. "The proposed 2000 fee schedule represents an important next step in making sure Medicare pays physicians fairly. By refining the payment system to be more equitable, we help Medicare beneficiaries to stay healthy and productive by preserving access to physicians."

HCFA, the agency that runs Medicare, published the proposed regulation in the July 22 Federal Register. The final version will be published later this fall.

The fee schedule specifies payments to physicians for more than 7,000 services and procedures, ranging from routine office visits to cardiac bypass surgery. In 2000, Medicare will spend about $37 billion on physician services.

Under the proposed fee schedule for calendar year 2000, physicians who provide services primarily in office settings, such as family practice and internal medicine specialists, would receive slightly increased payments, while physicians who provide services primarily in the hospital setting would receive slightly decreased payments. However, because of the malpractice insurance cost adjustments, emergency department physicians would receive a 2.7 percent increase and nephrologists a 1.3 percent increase. No specialties are expected to receive payment decreases or increases greater than 1 percent.

The resource-based practice expense component of the Medicare fee schedule is being phased in during a four-year transition period that began January, 1999. Payments under the 2000 fee schedule will be based on blend of 50 percent of the resource-based practices expenses and 50 percent of the old, charge-based system. When the resource-based practice expense is fully effective in 2002, all components of the fee schedule, including physician services, malpractice insurance expense and practice expense, will be resource-based, creating a more equitable system.

The proposed rule would implement the resource-based malpractice relative value units required by the 1997 Balanced Budget Act. Using data on how much various medical specialties spent on malpractice insurance, HCFA adjusted each service for the cost of malpractice insurance associated with it. This adjustment is not expected to have a significant effect on overall payments made to various medical specialties.

The proposed rules also would extend Medicare coverage for prostate cancer screening tests for all male beneficiaries, effective January 1, 2000. President Clinton's proposal to modernize Medicare contained a recommendation to eliminate all coinsurance and copayments associated with health screening tests. Prostate cancer is the most commonly diagnosed cancer in men and the second leading cause of death from cancer among American men.

The new payment system was prompted by studies that showed that the old charge-based system did not fairly compensate physicians for practice expenses. For example, under the old system, coronary bypass surgery would receive practice expense payments more than 100 times greater than those for an office visit, although costs for bypass surgery are only about 40 times higher.

Practice expenses are composed of direct and indirect expenses. Direct expenses include non-physician labor, medical equipment and medical supplies needed for each procedure. Indirect expenses such as the cost of general office supplies and utilities cannot be tied to individual procedures, so HCFA used accepted accounting techniques to allocate expenses to each medical procedure. Working with all major medical specialty societies, HCFA convened expert panels and conducted extensive research to estimate the direct expenses for different medical procedures and services. HCFA also used information gathered by the American Medical Association's Socioeconomic Monitoring Survey.

Before implementation of the fee schedule in 1992, Medicare based payments on each physician's charges. The fee schedule was created to relate payments to the resources physicians use to provide a service rather than what physicians charge for a service.

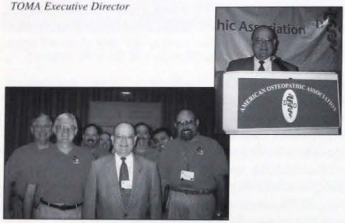
For two of the three categories of resources—physician work and practice expenses—each medical procedure is now measured relative to all other procedures according to the amount of resources used. The third element—resource-based malpractice insurance expense—is being incorporated into the fee schedule for 2000.

The fee schedule allowance for a procedure equals the sum of the three rankings, expressed as relative value units (RVUs), adjusted for payment locality cost differences and multiplied by a conversion fact that translates RVUs into dollars.

The relative values for physician work—the physician's own time and effort and the intensity of the procedure—have been established since the inception of the Medicare fee schedule. In 1994, Congress instructed HCFA to design a similar resource-based value system for physician practice expenses. The law required the new payment system to be budget neutral, meaning total physician payments cannot exceed what they would have been without the changes.

Texas Delegates Report the Activities of the AOA House of Delegates

by Terry R. Boucher, M.P.H.
TOMA Executive Director



The Texas delegation to the American Osteopathic Association's House of Delegates, led by Chairman Mark A. Baker, D.O. and Vice Chairman Rodney M. Wiseman, D.O., met in Chicago on July 15 through July 18, 1999 for the AOA Annual House of Delegates. Sixteen delegates, four alternate delegates and four students from the Texas College of Osteopathic Medicine traveled to the meeting. The Texas Delegation included: Drs. David R. Armbruster of Pearland; Mark A. Baker of Fort Worth; Frank J. Bradley of Dallas; George M. Cole of Amarillo; James W. Czewski of Fort Worth; Al E. Faigin of Fort Worth; James E. Froelich, III of Bonham; Royce K. Keilers of LaGrange; Robert G. Maul of Lubbock; R. Greg Maul of Rowlett; Jack McCarty of Lubbock; R. Gene Moult of Dallas; Elizabeth A. Palmarozzi of Fort Worth; Robert L. Peters, Jr. of Round Rock; Bill H. Puryear of Fort Worth; Daniel W. Saylak of College Station; George N. Smith of West; Arthur J. Speece, III of Burleson; Monte E. Troutman of Fort Worth; and Rodney M. Wiseman of Whitehouse. Jeffrey Siu was the student doctor delegate and Niraj Mehta was the student doctor alternate. Student doctors Roberta Abbott and Emai Ho also attended and observed the activities of the House.

The TOMA delegation would like to extend a special "Thank You" to Dr. Al Faigin for providing each delegate and alternate with a bright red TOMA sportshirt. The delegation wore the shirts on Sunday during the officer installation march when Dr. Zachary was installed as AOA Speaker of the House. Many positive comments were received about our unified look. Thanks, Dr. Faigin!

The TOMA delegation met for over three hours on Thursday evening, prior to the release of all resolutions and their assignment to reference committees, to review the resolutions that were available at that time. The delegation met again on Friday and Saturday mornings to discuss other resolutions and to decide which reference committee each delegate would attend and monitor. The TOMA delegation is to be commended for their participation and input on the resolutions. Delegates – a job well done.

Many of the reference committees heard testimony and reviewed over thirty resolutions submitted by various committees, specialty colleges and divisional societies. TOMA was well represented as several members of our delegation served on AOA reference committees in various capacities:

Mark A. Baker, D.O., chaired the Committee on Constitution and Bylaws;
James E. Froelich, III, D.O., served as a member of the Ad Hoc Committee;
R. Greg Maul, D.O., served as a member of the Joint Board/House Budget Review Committee;
Elizabeth A. Palmarozzi, D.O., served as a member of the Resolutions Committee;
Authur J. Speece, III, D.O., served as a member of the Committee on Public Affairs; and,
Rodney M. Wiseman, D.O., served as a member of the Committee on Professional Affairs;

Eugene A. Oliveri, D.O., of Milford, Michigan, assumed the presidency of the American Osteopathic Association. Other officers elected were **Donald J. Krpan, D.O.** (California) President Elect; **Walter B. Flesner** (Florida) 1st Vice President; **Amelia G. Tunanidas, D.O.** (Ohio) 2nd vice president; and **Karen J. Nichols, D.O.** (Arizona) 3rd vice president. Those elected to 3-year terms on the AOA Board of Trustees are: **Boyd W. Bowden, II, D.O.** (Ohio); **Robert D. McCullough, II, D.O.** (Oklahoma); **Anthony A. Minissale, D.O.** (Pennsylvania); **Max T. McKinney, II, D.O.** (Michigan); **George Thomas, D.O.** (Ohio); and **James E. Zini, D.O.** (Arkansas). Elected to serve an unexpired two-year on the AOA Board of Trustees was **Joel B. Cooperman, D.O.** (Colorado). Re-elected to his 19th term as AOA Speaker of the House was **T. Eugene Zachary, D.O.** (Texas). Others elected were **Robert S. Seiple, D.O.** (Ohio) vice speaker; **Ethan R. Allen, D.O.** (California) Osteopathic Progress Fund; and, **Paul Grayson Smith, Jr., D.O.** (Tennessee) to a 3-year term on the Bureau of Insurance.

The TOMA House of Delegates referred eighteen resolutions to the AOA House of Delegates for consideration and action. This number included one resolution from 1998 that the Board of Trustees resubmitted. The actions on those resolutions are as follows:

TOMA #	AOA#	TITLE	ACTION
98-04	261	AOA Board Certification (Resubmitted)	*Disapproved*
99-01	278	AOA Annual Convention Transportation	*Disapproved*
99-06	279	CME Credits for Divisional Society Administrative Meetings	*Approved*
99-12	280	Confidentiality of Patient Records	*Approved*
99-21	281	Diversity in Leadership Positions	*Approved*
99-02	282	Drug Therapy Surveyor Guidelines for Nursing Homes	*Approved*
99-16	283	Due Process for Alleged Impaired Physicians	*Approved*
99-11	284	HCFA Communication With Physicians	*Approved as Amended*
99-15	285	Latex Allergy	*Approved*
99-20	286	National Rural Health Congress	*Approved and Referred to the Bureau of Finance to report back to the House in July, 2000*
99-08	287	Information on Osteopathic Postdoctoral Training Programs	*Approved and Referred to the Council on Post-doctoral Training to report back to the House in July, 2000*
99-18	288	Preventive Care	*Disapproved*
99-14	289	Professional Courtesy	*Withdrawn in favor of Resolution 230*
99-10	290	Protection of Hospital Privileges	*Withdrawn in favor of Resolution 250*
99-04	291	Retirement of UNTHSC President	*Approved*
99-19	292	Rural Health Clinics - Location and Quality of Care	*Approved*
99-13	293	State Jurisdiction Over ERISA Plans	*Approved*
99-07	294	Telemarketing to the Elderly	*Approved as Amended*

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Joint Board/House Budget Review Committee

This committee met on July 16th to review the proposed budget for the American Osteopathic Association for 1999-2000. In addition to the regular AOA dues, the Committee recommended a three-year mandatory $50/year assessment on all members of the AOA (other than students, interns and residents) to continue the Campaign for Osteopathic Unity; however, the House approved a substitute resolution making the assessment voluntary. The committee also reported that the AOA has achieved its goal of having one year's operating funds in reserve. The basic figures listed below reflect the proposed budget for the fiscal year 2000.

Total Operating Revenues	$14,537,789.00
Total Operating Expenditures	$14,505,883.00
Excess of Operating Revenue over Expenses	$31,906.00
Non-operating Revenues. (AOA Building and Investments)	$612,365.00
Certifying Boards Income	$58,795.00
Increase AOA Net Assets in FY '00	$271,610.00
TOTAL ASSETS	$42,500,825.00
TOTAL LIABILITIES	$13,907,619.00
TOTAL NET ASSETS	$28,593,206.00

This budget was recommended to the house and was approved as of July 18, 1999. A copy of the complete AOA budget is on file in the TOMA office for examination by the membership.

Committee on Constitution and bylaws

The following proposed amendments to the AOA Constitution and Bylaws were approved:

Bylaws

Article III – Dues and Assessments, Section 2 – Dues Rates was approved:

> a. Members. The annual dues of regular members of the Association shall be determined by the House of Delegates and administered by the Board of Trustees.

Explanatory Statement: This amendment will allow the AOA House of Delegates to establish the dues for each class of member.

Article V – House of Delegates, Section 11 – Representation of Interns and Residents was approved:

> The osteopathic interns and residents may be represented in the House of Delegates by one intern and one resident selected by vote of the AOA's Intern/Resident Committee (or such intern's alternate and resident's alternate selected by the AOA's Intern/Resident Committee). No intern or resident delegate or alternate shall also be a member of a divisional society or specialty college delegation to the AOA's House of Delegates. The chair of the Intern/Resident Committee shall certify the name of its own delegate and alternate and resident delegate and alternate to the Executive Director of the AOA in writing or by wire at least 30 days prior to the first day of the annual meeting of the AOA House of Delegates. Each delegate and alternate must be a member in good standing of this association.

Explanatory Statement: The interests and concerns of the osteopathic physicians in postdoctoral training are often different from the concerns of students and practicing physicians. Providing for postdoctoral physician delegates at the AOA House of Delegates will provide for representation of their special concerns and will strengthen the AOA's efforts to recruit and hold new members, and as such, promote the growth of the Association and the profession. The Board of Trustees approved the additional positions in the House of Delegates at its midyear 1999 meeting.

Constitution

Article VII – Officers, Section 1 – Elected Officers

The second paragraph of Article VII was deleted and the following language was approved:

> In the case of the inability upon the part of the president to serve during the term of office for which he/she has been elected, and therefore the office becomes vacant, the president elect shall become president for the unexpired term portion of the term and continue in that office for the term in which the president elect was originally elected. In such case, if the president elect is unable to serve for the full-unexpired term of the president's office, then the responsibility of filling the office of president shall devolve upon the Board of Trustees.

Explanatory Statement: In October, 1997, the AOA Board of Trustees adopted the proposed amendment to the AOA Constitution and the proposed amendment was introduced to the House of Delegates at the July, 1998 meeting and was brought to the House in 1999 for final action.

Proposed Amemdments to the Constitution

Article VIII – Board of Trustees and Executive Committee, Section 1 – Board of Trustees – Referred to the Committee on Constitution and Bylaws for action at the July, 2000 House of Delegates meeting.

This proposed amendment would increase the number of members on the Board of Trustees to nineteen (19) by adding a student member. It was referred to the Committee on Constitution and Bylaws/House of Delegates:

> ...and a student member elected by the House of Delegates to serve one year. Candidates for the student position shall be nominated, in alternating years, by the Council of Student Council Presidents (CSCP) and the Student Osteopathic Medicine Association (SOMA).

Explanatory Statement: The student position would be an additional position on the Board of Trustees. It is suggested that the appointments be made based on the nominations in alternating years by the CSCP and SOMA, so that one year CSCP would submit the nomination and the next year the nomination would be made by SOMA. Each year the nomination should be made from the floor of the House of Delegates by the President of the nominating organization at the appropriate time in the nominating process.

Supplemental Resolution #295

Article VIII – Board of Trustees and Executive Committee, Section 1 – Board of Trustees – Referred to the Committee on Constitution and Bylaws for action at the July, 2000 House of Delegates meeting.

This proposed amendment imposes a term limitation of twelve years total, not just consecutive years, which a trustee may serve on the AOA Board of Trustees. Any trustee who has a total of less than twelve years (e.g., ten years) may be elected to a three-year term and may serve out that term, even though it may exceed twelve years. The change shall not apply to any trustee serving at the time of adoption or to the President, President Elect and the Past Presidents for the preceding two years.

Committee on Professional Affairs

211	Health Care Costs	*Approved as Amended*
213	Industry Gifts to Physicians	*Approved*
215	Managed Healthcare Systems Freedom of Choice	*Approved as Amended*
217	Multiple Prescription Programs	*Approved as Amended*
218	Osteopathic Family Physicians	*Approved as Amended*
219	Osteopathic Graduate Medical Education Funding	*Approved*
220	Peer Review	*Approved*
222	Physician Administered OMT	*Approved as Amended*
231	Use of the Term Osteopathy	*Approved as Amended and Referred*
236	Evaluation and Management Audits	*Approved as Amended*
237	Oversight of the National Board of Osteopathic Examiners	*Withdrawn*
239	Residency Training Slots	*Approved as Amended*
246	Practice Rights of Osteopathic Physicians	*Approved and Referred to AOA Board of Trustees*
247	Young Physicians	*Approved as Amended*
248	American Osteopathic Association Accreditation Process	*Disapproved*
249	Certification of Postgraduate Training Programs	*Withdrawn*
256	Osteopathic Physicians – Expert Witnesses	*Disapproved*
257	Osteopathic Physicians – Medical Directors	*Withdrawn*
258	Osteopathic Physicians – Peer Reviewers	*Disapproved*
259	Peer Reviewers	*Withdrawn*
261	American Osteopathic Association Board Certification	*Disapproved*
262	Standards for OPP in Colleges of Osteopathic Medicine	*Disapproved*
265	Osteopathic Internship	*Approved as Amended*
266	Opposition of Expansion of Practice Privileges for Psychologists	*Approved*
267	Alternative Pathway for Board Certification	*Approved as Amended*
272	Per Diem for Physician AOA Representatives	*Approved*
276	Psychometric Testing	*Withdrawn*
278	AOA Annual Convention Transportation	*Disapproved*
282	Drug Therapy Surveyor Guidelines for Nursing Homes	*Approved*
287	Osteopathic Postdoctoral Training Program Information	*Approved and Referred to the Council on Postdoctoral Training for policy development and report back to the House in July, 2000.*
290	Protection of Hospital Privileges	*Withdrawn*
300	Unity Campaign: Public Relations Campaign	*Approved*
301	Unity Campaign: 3-Year Funding Proposal	*Substitute Resolution Approved*
302	Unity Campaign: Compliance With FY 1999 Assessment	*Withdrawn*
303	OPTI Annual Accreditation Fee	*Disapproved*
304	Unionization of Physicians	*Approved*
305	Online Prescribing	*Approved as Amended*
307	Promotion of Non-Medical Products	*Disapproved*
308	Optional Participation In OPTIs	*Disapproved*
309	Sale of Health Related Products and Devices	*Approved*
311	National Match Day	*Withdrawn*
312	Osteopathic Manipulative Treatment	*Approved*
313	Collective Bargaining	*Withdrawn*

Committee on Public Affairs

202	Alcohol Abuse	*Approved*
203	Anabolic Androgenic Steroids and Substance Abuse	*Approved as Amended*
205	Development of Programs to Prevent Violence	*Approved as Amended*
206	Discrimination in Medicine	*Approved*
208	Firearms – Handgun	*Approved*
209	Government Intervention in Private Practice	*Approved as Amended*
210	Gun Control	*Approved as Amended*

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212	Health Care, Government Involvement	*Approved and Referred to the Committee on Health Related Policies for clarification and report back to the House of Delegates in July, 2000*
216	Medicare – Physician Coverage	*Approved*
224	Postgraduate Medical Education Programs	*Approved*
225	Primary Care, Definition	*Approved as Amended*
227	Student Loan Interest Deductions	*Approved as Amended*
234	Spinal Manipulation Legislation or Regulation	*Approved as Amended*
235	State Licensure of Managed Care Medical Directors	*Approved*
240	Home-Based Care for Frail Elderly	*Approved as Amended*
241	Physician Assistants and Registered Nurse Practitioners	*Approved and Referred to the Committee on Health Related Policies for development of a position paper on allied health care providers*
242	Service, Access and Costs in Managed Care Plans	*Approved as Amended*
244	Reporting Tobacco Use Status in the Medical Record	*Approved as Amended*
250	Hospitalist(s)	*Approved as Amended*
253	Physician's Ability to Negotiate with Insurance Companies and Managed Care Organizations	*Disapproved*
260	Pharmacies/Pharmaceutical Companies Partnership	*Approved as Amended*
264	Onsite Lab Work	*Approved as Amended*
268	Rights of Children	*Disapproved*
269	Ten Guiding Principles for Teaching Children and Adolescents About Medicines	*Approved*
274	Discrimination in Healthcare	*Approved as Amended*
275	Women's Contraceptive Coverage Legislation	*Approved as Amended*
284	HCFA Communication With Physicians	*Approved as Amended*
286	National Rural Health Congress	*Approved as Amended and Referred to the Bureau of Finance*
292	Rural Health Clinics – Location and Quality of Care	*Approved*
293	State Jurisdiction Over ERISA Plans	*Approved*
294	Healthcare Telemarketing	*Approved as Amended*
306	Medicare Reform	*Approved as Amended*
310	Use of the Term "Provider" to Describe Physicians	*Approved*

Ad Hoc Committee

200	Active Institutional Membership	*Substitute Resolution Approved as Amended*
201	Affirmative Action	*Approved as Amended*
204	AOA, Strategies and Initiatives	*Approved as Amended*
207	Driver Intoxication	*Approved*
214	Inflammatory and Unethical Advertising by Attorneys	*Approved*
221	Pharmaceutical Packaging/ Environmental Responsibility	*Approved*
223	Physician Assistants /Nurse Practitioners	*Approved and Referred to Committee on Health Related Policies*
226	Emerging States: Assistance by Other States and the AOA	*Approved*
228	Sudden Infant Death Syndrome	*Approved as Amended*
229	Teen Suicide Prevention	*Approved as Amended*
230	Third Party Payers and Utilization Review Firms	*Approved as Amended*
232	National Practitioner Data Bank	*Approved as Amended*
233	Professional Courtesy	*Approved as Amended*
238	Managed Care Organizations' Fiduciary Responsibilities	*Approved and Referred to the Department of State and Socioeconomic Affairs to report back to the House in 2000*
243	Fee Changes, Timely Notice	*Approved*
245	Unity Campaign	*Approved*
251	AOA Sponsor Approval of CME Hours	*Approved and Referred to the Council on Continuing Medical Education to report back to the House in 2000*
252	Health Care Fraud	*Approved*
254	CME Programs via the Internet	*Approved as Amended*
255	Investment Tax	*Approved*
263	CME Credits	*Approved and Referred to the Council on Continuing Medical Education*
270	Federal Funding for Graduate Medical Education	*Approved*
271	Life Membership – AOA	*Approved*
273	Breastfeeding Endorsement	*Approved*
279	CME Credits for Divisional Society Administrative Meetings	*Approved*
280	Confidentiality of Patient Records	*Approved*
281	Diversity in Leadership Positions	*Approved*
283	Due Process for Alleged Impaired Physicians	*Approved*
285	Latex Allergy	*Approved*
288	Preventive Care	*Disapproved*

289	Professional Courtesy	*Withdrawn*
296	Immunization Registries	*Approved*
297	Explanation of Benefits Form	*Approved*
298	Ambulatory Visit Groups/ Ambulatory Procedure Groups	*Approved as Amended*
299	Published Annual Cap for Drug Expenditures	*Approved as Amended*

Committee on Resolutions

291	Retirement of University of North Texas Health Science Center Presiden	*Approved*
277	Recognition of Henry B. Pace, Ph.D.	*Approved as Amended*

If a particular resolution is of interest to you, the TOMA office has complete copies of all the resolutions and would be willing to send or fax it to any TOMA member.

Texas' Poison Control Centers Offer Emergency Assistance, Information

For emergency assistance or information regarding poison exposure, Dennis Perrotta, chief of the Bureau of Epidemiology at Texas Department of Health, says, "Call 1-800-POISON-1." That toll-free number will link a caller anywhere in Texas to a regional Poison Control Center.

For more than five years, the centers — set up by the Texas Legislature at sites in Amarillo, Dallas, El Paso, Galveston, San Antonio and Temple — have been supplying assistance and information to people whose poison problems include everything from over-the-counter and prescription drugs to paints, pesticides, chemicals, plants, snake and insect bites.

Callers do not even need to know where their regional office is, Perrotta said. "The system automatically routes the caller to the closest center. But if that center is busy, the call is rolled to another. Callers just need to hang on. They will not get a busy signal."

That's good news to the more than 350,000 callers the system serves yearly, more than half of whom have poison exposure problems. There were 717 poisoning deaths in Texas in 1997, the last year for which complete statistics are available. The question sometimes arises, then, of whether to call the poison control hotline and or dial 9-1-1 for emergency services. "Both will work," Perrotta said.

"If the person is unconscious," Perrotta said, "get emergency help right now." Otherwise, he said, phone 1-800-POISON-1 (1-800-764-7661). "These are the poison experts. They will know if someone needs to go to a hospital." For the best help, be able to tell the age and weight of the victim, the substance involved, how much was taken, when the exposure occurred, symptoms, any existing health conditions and your name, telephone number and location. "The poison specialist can refer the caller to the nearest hospital, if needed, and then call that hospital with the necessary information," Perrotta said. "If the person is treated at home, the center specialist calls back, often as many as three times, to check on the patient."

The main drug exposure calls are about pain relievers such as aspirin, cold and cough preparations, ointments, sedatives and vitamins. Household cleansers, cosmetics, bites, plants and foreign objects bring the most calls about general poison concerns. Other problems arise from common household items such as perfume and after shave, cosmetics, eye drops, furniture polish, laundry soap, alcoholic beverages and broken plaster.

Although many calls concern children, others come from people who may have been bitten or come in contact with a poison themselves or are calling about an elderly person. Information also is available in several languages and for the hearing impaired.

The Texas Poison Control Network, a joint effort by TDH and the Advisory Commission on State Emergency Communications (also known as the 9-1-1 Commission), is funded through a surcharge on long-distance telephone calls within Texas. The specially trained team at each site includes, along with nurses and pharmacists, paramedics and medical toxicologists on call to provide up-to-date information and education.

About 80 percent of the time the victim does not need to go to the emergency room. According to Perrotta, "Estimates show that for every $1 spent on the poison control center, about $7 in treatment cost is saved."

Immediate Emergency Action for Poisoning

—Inhaled poison

Immediately get the person to fresh air. Avoid breathing fumes. Open all doors and windows. If victim is not breathing, start CPR.

—Poison on the skin

Remove contaminated clothing and flood the skin with water for 10 minutes. Then wash gently with soap and water and rinse.

—Poison in the eye

Flood the eye with lukewarm (not hot) water poured from a large glass held about 3 inches from the eye. Repeat for 15 minutes. Have the person blink as much as possible while flooding the eye. Do not force the eyelid open.

—Swallowed poison

Medicines: Do not give anything by mouth until you have called for professional advice.

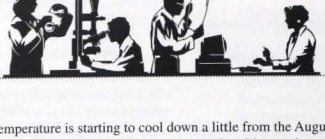
Chemicals or household products: Unless the person is unconscious, having convulsions or cannot swallow, give a glass of water immediately. Then call for professional advice about whether the person should vomit. Have the label ready when you call.

—Syrup of ipecac

Always keep a 1-ounce bottle of syrup of ipecac on hand for each child in the house. Use only on advice of the poison control center, emergency medical service or physician.

Call 1-800-POISON-1 (1-800-764-7661) after these steps.

Self's Tips & Tidings



By Don Self

Dear TOMA Member:

It's September - the temperature is starting to cool down a little from the August heat; Medicare is making some changes in the next few months; Texas Workers' Comp is increasing this month; and the year 2000 is only a few short months away. It's an exciting time to be alive in the healthcare field, enjoying the blessings you have been given. This month's article is going to deal with coding, Y2K, Medicare, managed care and several collections tips.

I've told you for months now to start getting ready for Y2K because I believe you'll see either a slowdown or a cessation of Medicare, Medicaid and managed care checks, as well as a loss (hopefully temporary), of utilities coming in January. Some would call me an alarmist while others say that I'm being too conservative in my views of the effects of Y2K. The truth is that no one - and that means not one person on the face of this earth - knows exactly what Y2K will bring. It's kind of like driving your car to work every morning. You hope you get to work without incident, but you still put on a seatbelt and you still have insurance on your car. My advice to you is this - make the same preparations you would make if you knew you would have to live and work without utilities, banks or grocery stores for four weeks. That way, if nothing happens, you won't be shopping as much next January. If something does happen, you won't make the problem worse by not having prepared.

Here are a few answers to questions you have asked over the past month:

Q. I am confused about what I can or can not bill with an office visit. For example, I have a patient come in for a headache and I treat them with injections of Toradol and Vistaril. Can I bill a regular office visit and the injections? Do I need to append a modifier 25 to my office visit code?

A. Yes, you can bill both injections and the appropriate level of office visit, without a modifier, because the injections do not have global fee periods and the visit is separately payable.

Q. I have a patient come in with a complaint of arthritis and I give her a prescription. At the same time, the patient receives her regular injection of B-12 for fatigue. What can I bill?

A. You can bill Medicare for the office visit, but since the B-12 injection is not for pernicious anemia or Vitamin B-12 deficiency, you'll need to have the patient sign the ABN (Advanced Beneficiary Notice) waiver prior to giving the injection or you will not be allowed to bill anyone for that injection.

Q. My wife joined my practice two years ago. Since all of our money goes into the same account and we share liability, we have never bothered with getting her a provider number from Medicare. We bill all of the services she does to Medicare using my provider number. My office manager attended a seminar you taught in Florida and tells me that we can get into trouble billing like this. Is she correct?

A. Medicare requires all physicians billing Medicare to obtain a Medicare provider number. The only exception would be for temporary conditions when one physician has someone covering for another during a vacation or illness, which cannot exceed 60 days' coverage. By billing under your number for the services your wife provides, you are probably risking fines and penalties for Medicare fraud. We recommend that you obtain a group provider number from Medicare, with each physician in the group billing under their own number within the group.

Q. I'm now seeing all of the patients I can handle and I've been thinking about adding a Physician Assistant to my practice. My question is whether a PA can see my hospital and nursing home patients?

A. Medicare rules in billing under "incident-to" provisions limit the services of the PA (or Nurse Practitioner) to the place of service office only. Consequently, we do not recommend you hire a PA or NP for out-of-office services. Now, if you were to ask whether hiring a PA or NP would be profitable for your office services, my answer would be a definite yes, if you were booked solid right now. In every office in which I have reviewed the profitability of adding a non-physician practitioner, I have found it to be highly rewarding and wholeheartedly recommended it.

Q. Don, in one of your articles, a reader mentioned an E&M documentation sliderule they purchased at your seminar. What is this sliderule and how can we get one?

A. The sliderule referenced is the simplest tool we have found in helping you determine which level of evaluation and management service to bill. In fact, at every seminar in which we have taught documentation to physicians using this $9.50 sliderule, we have had multiple physicians tell us they had been undercoding visits and the sliderule helps them to code properly. You can order them by calling (888-DONSELF) or faxing (903-839-7045) our office.

Billing a Handling Charge

CPT Code 99000 is for handling and conveyance of a lab specimen to the lab or pathologist. You have some basic costs associated with this service, such as: for blood, this is spinning and refrigeration; for cultures, it's collecting and placing in appropriate containers; for lesions, etc, it's storing properly to ensure viability at the time the lab receives it. So, we recommend you use this code and assess a charge for the service, even if the lab sends a runner to your office to pick up the specimen.

Guess Who's Coming to Your Town?

Here's Don's speaking schedule for the next few months. If you send your staff, you will increase your monthly income while reducing your audit potential.

September 17 - Savannah, GA
PAHCOM Convention
September 30 - Houston
Reimbursement/Coding Workshop
October 7 - Corpus Christi
Reimbursement/Coding Workshop
October 28 - Fort Worth
Reimbursement/Coding Workshop
November 18 - El Paso
Reimbursement/Coding Workshop
December 3 - Austin
Reimbursement/Coding Workshop
December 9 - Denton
Reimbursement/Coding Workshop

How to Collect from the HMO

I read an article, published by the AMA, about a couple of D.O.s in New Mexico who filed a claim in small claims court against an HMO to get payment on a $260 insurance claim. That started me thinking and I've talked to dozens of professionals about it. One of those professionals told me that she sends past due accounts to a collection agency that, in turn, sends collection letters to the HMO. Another said that he has his attorney draft up a short letter threatening court action. Both said they were successful in getting the claims paid faster than if they had gone through the regular appeal method (call, leave message, fax a message, write letters, get a return call from someone named Biff at the HMO who has no idea what you're talking about or what a HCFA 1500 claim form is, etc.)

Think about using creative methods to get paid on those past due and delinquent HMO and insurance claims.

An Alternative to Losing Money on Medicare Injections

I walked into a physician's office recently, and overheard a patient at the window explaining to the receptionist that she could not get an injection at her regular physician's office because Medicare pays only $3.20 and the drug costs the physician $18.00. She said, "I told the doctor I'd pay for it myself, but he told me that Medicare would not allow it." When the receptionist recognized me, she asked if it was true and I confirmed it was true. A participating physician cannot have the Medicare patient pay for a covered injection or service more than the co-pay, and cannot have the patient sign a waiver agreeing to pay if the service will be covered by Medicare.

There was one option that the patient's regular physician had not thought of, though, that would make everyone happy, so I shared it with them. If you have a patient who needs a certain injectable and Medicare's payment is so low that you cannot afford to or you choose not to lose money on the service, you can give the patient a prescription. The patient then goes to the pharmacy, gets the prescription filled (out of their own pocket) and brings it back to your office to be injected. That is legal and perfectly understandable. It is not reasonable for Medicare, Congress or the patient to expect you to be paid less for a supply than it costs you to obtain it. There is no business in this country that can stay open for long doing that. When the patient returns with the injectable drug, we don't recommend billing another office visit for the injection administration.

When Should You Bill for the Lesion Removal?

You remove a lesion to send to the pathologist to ensure it is not malignant. The patient starts to leave your office and stops by the payment window. How do you bill for the lesion removal, since you don't know if it is benign or malignant and there is a difference in CPT codes for each? We strongly recommend that you not bill for the removal until you receive the report back from pathology, so you will know whether it was benign or malignant

A Tip to Help You Increase Your Collections and Reduce the Time Your Staff Spends on Insurance Verification

I have decided to recommend the CheckPointe system to every client we work with for the following reasons:

1. Instead of your staff spending valuable time on the phone verifying insurance or deductible amounts, the Checkpointe system can do it in 45 seconds over the phone line.
2. The system allows you to accept checks by phone, thereby allowing you to decrease some of the older past due accounts.
3. The system permits you to automatically debit a patient's credit card a set amount each month until the overdue balance is paid off, thereby increasing collections.

We recommend you give Greg Hightower a call at (214) 522-6601 and have him show you the system we're recommending. (No, I don't get one penny for endorsing it.)

Why Do You Sign a Contract With an "All-Products" Clause?

No businessperson that I know of would sign a contract with a clause that says "Not only will I deal with all of the products you now carry, but I'll also handle any other products you decide to carry in the future." Yet, physicians do it all the time in the managed care contracts they sign. When you sign a contract like this, you're giving the managed care plan permission to adopt, change and revise any products as they see fit and to dictate to you what the conditions, coverage, payment and restrictions are. Would you sign a home lease like this or an open-ended contract for a new car like this? I think not, yet why do you sign a business contract like this in your medical practice? More than 75% of the contracts we have reviewed in this past year had that clause. We marked it out before we returned the contract to our client to sign. If you're using an IPA, they should be doing the

same thing. If they're not, you're in the wrong IPA, in my opinion.

What are Your Contingency Plans?

OK, you don't believe Y2K will knock out your computer system and, regardless of the fact that multi-billion dollar companies and the Red Cross are buying thousands of generators to be delivered before December 31, you don't believe you'll lose electricity. So you think it is foolish that multi-billion dollar companies are setting aside enough cash to pay employees for six months, thereby giving up interest and buying power with that money. You haven't noticed the overflights of military aircraft or noticed the United Nations blue and white highway signs on our interstate highways, so you're not worried about the year 2000 at all.

But, have you made any contingency plans in case you're wrong? Do you have a pegboard, ledger cards, day sheets or one-write NCR superbills just in case your computer supplier lied or the power company forgot one microprocessor that uses a date dependent chip? Do you have some way to keep track of your accounts receivable, daily charges and deposits if there is one date dependent microchip in the building where your office is or on top of one of the thousands of relay poles in your town? Yes, making a paper copy of your accounts receivable every single week is a good idea, but it's not enough. We recommend you call us at 1-888-DONSELF and order a backup pegboard system soon before they become as hard to get as generators. You have insurance on your car, home and office even though you don't expect any of them to burn down this month. Why not have insurance on your accounts receivable and accounting?

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<www.donself.com/news.html>

New Projections Show National Health Spending to Grow More Slowly than Projected

Projected growth of national health spending over the next decade has been revised downward since last year's projections, according to a new study by the Health Care Financing Administration. The new projections show the rate of growth slows to an average of 6.5 percent for 1997-2007, compared to last year's projection of 7.0 percent. National health spending is still projected to double in level by 2008. This downward revision reflects slower than expected growth in Medicare spending in 1998, and slower projected growth for both private and Medicare spending in the latter half of the projection period.

The study projects the nation's total health spending will reach $2.2 trillion in 2008 and 16.2 percent of Gross Domestic Product (GDP), up from $1.1 trillion and 13.5 percent in 1997. In last year's projection health spending was projected to reach 16.6 percent of GDP in 2007. "These figures show that our efforts, such as our waste, fraud and abuse initiatives, have helped control health care costs in the United States," HHS Secretary Donna E. Shalala said. And President Clinton's plan to strengthen Medicare will continue to control health care spending while making sure that Americans maintain their access to high-quality, affordable health care into the 21st century."

The annual study by HCFA's Office of the Actuary, "The Next Decade of Health Spending: A New Outlook," was published in the July/August 1999 issue of *Health Affairs*. Last year's projections were published in the September/October 1998 issue of the national health journal.

The report indicates that national health spending growth will accelerate from 1998 through 2000, due mostly to an acceleration in private sector health spending growth. During this period, private sector health spending growth will outpace public sector health spending growth, reversing the current trend. This reversal is expected to be more significant than anticipated last year.

HCFA actuaries project Medicare spending will grow just 4.5 percent on average over the 1997-2000 period compared to 5.1 percent over the same period in last year's projection. This slower growth is the result of the Balanced Budget Act (BBA) of 1997 and fraud, waste and abuse initiatives.

"While it's encouraging to see that we are protecting the Medicare Trust Funds, we must be vigilant to protect beneficiaries at the same time," HCFA Administrator Nancy-Ann DeParle said. "The provisions of the BBA expire in 2003 and we must be certain that any new actions we take will protect Medicare from a return to unsustainable growth rates."

Private sector growth is projected to average 7.3 percent annually over the 1997-2000 period, compared to 6.7 percent for the same period in last year's projection. Thus the private sector growth is projected to be 2.8 percentage points higher than Medicare growth between 1997 and 2000. The main reasons for the faster anticipated growth in the private sector is a sharper projected acceleration in private health insurance premiums for 1999-2000 and faster projected growth of drug spending.

For the years 2001 through 2008, both public and private sector spending growth is projected to be slower than was expected last year. Public sector spending growth, particularly Medicare, is affected by slower expected input price increases for hospitals, physicians, home health, and skilled nursing services and reduced hospital case-mix updates. Slower private sector spending results from a faster than expected rise in the uninsured population, slower than expected input price increases, and a general shift in managed care toward arrangements that more effectively control costs.

The HCFA economists and actuaries project revised patterns of growth across types of services. Drug spending is projected to grow faster than projected last year in part due to upward revisions to historical drug spending, new drug introductions, and recent evidence of increasing drug prices. Hospital spending growth is also expected to accelerate faster as the recent trend towards rising occupancy rates continues. And spending on nursing home and home health care will grow more slowly than projected last year.

Detailed information on the forecasts, both by type of service and source of funds, is available on the HCFA home page at: <http://www.hcfa.gov/stats/NHE-Proj/>.

SAA Update

by Ann Costello, SAA President

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

The month of June was spent attending the TOMA Annual Convention and planning the calendar and budget for the upcoming year. Ann Costello, Melissa Smith, and Mandy Sutterer were able to be present at the convention in Dallas and enjoyed meeting the physicians and their spouses as well as learning more about TOMA and ATOMA. SAA was able to raise some funds for our book covers and help with the ATOMA silent auction and T-shirt sales. After convention, we set our budget and scheduled our service, social, and educational events for the year.

In July, SAA was very busy ordering, counting, and sorting over 300 lab and clinic coats for the students at UNTHSC/TCOM. This year, TOMA purchased a coat for each incoming TCOM student through the SAA. This is our biggest fund-raiser and with our experience it has become more successful each year. Other fundraising activities included organizing a raffle for a "Journey's End" trip to Dr. George and Linda Cole's lake home and making bell wreaths to sell at the AOA Convention in San Francisco, October 25-29.

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

Toward the end of August SAA looks forward to the annual pool party hosted by Dr. Mark and Rita Baker. The Bakers continually provide support to the Student Associate Auxiliary, and we appreciate everything they do. In September we have planned our annual Freshman Brunch and the SAA pizza party. These events are a fantastic way to meet and get to know the new spouses and significant others.

The Student Associate Auxiliary is a strong organization because of the time its members devote to our various events and projects, and because of the support provided by ATOMA, TOMA, AAOA, OHST, and UNTHSC/TCOM. We hope to continue to be strong and support osteopathic medicine as we move into the new century.

Texas Medical Foundation's Clinical Credentialing Service Bureau Receives National Committee for Quality Assurance Certification for 10 out of 10 Verification Services

The Texas Medical Foundation's Clinical Credentialing Service Bureau (CCSB) is fully certified by the National Committee for Quality Assurance (NCQA) for 10 out of 10 verification services.

Certification is awarded to participating organizations on the basis of individual credentials elements. Organizations may be certified for all, some, or none of the 10 credentials elements addressed in the NCQA Standards.

These elements are:

- License to practice
- Hospital privileges
- DEA/CDS certification
- Board certification/residency completion/medical school graduation
- Malpractice insurance
- Malpractice claims history
- National Practitioner Data Bank
- Sanctions against state licensure
- Medicaid/Medicare sanctions
- Application processing

Certification in these 10 areas enables CCSB to add managed care organizations to the large market of providers that it currently serves as a credentials verification organization. Currently, CCSB holds 33 credentials verification contracts with providers in Texas and several other states.

NCQA certification for 10 out of 10 verification services is valid through March 17, 2001.

The National Committee for Quality Assurance is an independent, non-profit organization that certifies credentials verification organizations, and accredits managed care organizations.

TRICARE News

On the heels of the first White House Conference on Mental Health, the Department of Defense (DoD) has launched two new initiatives aimed at reducing stress and suicide among service members and their families.

President Clinton announced the new DoD programs June 7. The first is designed to help service members and their families learn to manage stress associated with frequent deployments, family separations and other life issues. The second initiative tackles the issues of suicide.

A new DoD directive requires that all service members and health care providers receive training in combat stress control and assigns a mental health consultant to each unified command surgeon. A reinvigorated suicide prevention program will identify and implement the best practices from among the service departments, integrate the delivery of mental health services between agencies and develop a robust data base to guide program planning and implementation. Both initiatives call for greater support from line commanders.

The two initiatives require similar resources, said Sue Bailey, D.O., assistant secretary of defense for health affairs. She said DoD's goal is to strengthen and unify programs the services already have. Moreover, she added, DoD wants to remove the stigma often associated with mental health difficulties.

"It's an issue for society as a whole. There has been stigma associated with any mental illness or emotional disturbance. Particularly, we're looking at cultural change in the military," Bailey said. Commanders must be involved so troubled people know they can step forward and seek help without threatening their careers, she said.

Increasing peoples' ability to cope with stress requires an openness that could conflict with an individual's need for privacy, Bailey admitted. But it's important commanders and supervisors know if somebody under their command is suffering emotional problems, particularly if that person's job involves individual, organizational or national security, she said.

The services' have programs to help members recover. While in them, service members may need a job change or duty restrictions, but with successful treatment they can usually return to their old jobs, Bailey said.

There is no return from suicide, however. Bailey said she's encouraged by an Air Force prevention plan that has reduced suicides by four-fifths.

"The average suicide rate for the military is 12 per 100,000 people," she said. "In the Air Force program, we found that in the first six months of 1999, the rates came down from about 15 per 100,000 to 3 per 100,000. So we're seeing what we think are real positive results from the program they've initiated."

The Air Force suicide prevention program focuses greatly on community involvement, Bailey said. Mental health professionals counsel and support troubled people, but so does the entire community, including churches, schools, family services and others, by forming a circle of help to rescue somebody from the turmoil of emotional and mental despair, she said.

DoD's program will build on the Air Force's and blend in the best practices of the other services' programs, Bailey said. "We will work together to share our resources, experience and data," she said. Some aspects of the program will be uniform across DoD, while others will be tailored to meet the needs of the specific services or other groups, such as members of different services who deploy together. The program will be fully implemented by the end of 1999, Bailey said.

"National security depends on a military force that is healthy and fit, both physically and mentally," Bailey said. She said she's encouraged by a 1998 health behaviors survey that reveals more service members are finding positive ways to deal with stress.

"The survey indicates that service members are experiencing a greater level of access to programs within the community and through our medical system," she said. "They are also seeking out things such as exercise as a means of coping with stress.

"There's an interesting phenomenon taking place in the military today," Bailey said. "It used to be on a Friday night that people went for happy hour and you couldn't get a parking place at the club. Now, you can't find parking at the gym, because they're looking for happier lives and they're looking the right way."

TRICARE Benefits Expanded to Cover Cancer Prevention Trials

Under Secretary of Defense for Personnel and Readiness Rudy de Leon, Assistant Secretary of Defense for Health Affairs Dr. Sue Bailey, and Director of the National Cancer Institute Dr. Richard D. Klausner recently announced an expanded interagency agreement that enables military beneficiaries to participate in the National Cancer Institute (NCI) cancer prevention trials as a TRICARE benefit.

The Department of Defense has become a wellness pioneer by offering leading-edge cancer prevention programs to its beneficiaries, through the expanded agreement that became effective June 21, 1999. Describing the benefit, Bailey stated, "This agreement will give our at-risk beneficiaries access to some of the most promising advances in cancer research through NCI-sponsored clinical trials throughout the country."

Joining de Leon, Bailey, and Klausner at the announcement in the Pentagon were several cancer survivors and members of cancer survivor support groups. Also attending were representatives from both NCI and DoD. According to Klausner, "This is the first time a health plan has agreed formally to provide coverage for patients to participate in cancer prevention trials. This agreement

will become a model for providing access to the best available health care while ensuring that cancer research can continue to make progress."

"To underscore our commitment to wellness and prevention, we feel we must provide reimbursement for clinical trials that offer some of the most promising advances in cancer prevention and treatment research," stated Bailey. "For some TRICARE beneficiaries with an increased risk of developing cancer, the experimental DoD/NCI Clinical Trials Demonstration Project offers new choices to minimize chances of developing cancer. It is another way to help keep our troops and their families healthy."

The DoD and NCI first combined forces in 1996 with an agreement known as the DoD/NCI Cancer Clinical Trials Demonstration Project, that allowed military beneficiaries with cancer diagnoses to participate in Phase II and Phase III treatment studies sponsored by NCI. Nearly 12,000 military health system beneficiaries are diagnosed with cancer each year, and to date more than 200 family members have participated in these clinical trials.

Prevention trials are designed to keep cancer from developing in people who have a family history of cancer but do not have cancer, and to prevent a new type of cancer, especially in the early stages where treatment is most effective. Finally, these prevention trials include studies to evaluate ways of modifying cancer-causing behaviors, such as tobacco use, poor dietary and exercise habits.

To obtain additional information about cancer prevention, early detection, or treatment trials covered by the DoD/NCI demonstration, interested persons may contact the NCI Cancer Information, 1-800-4-CANCER (1-800-422- 6237), or the Demonstration Coordinator, 1-800-779-3060. Related websites are located at: <http://www.tricare.osd.mil/cancertrials/> or <http://cancertrials.nci.nih.gov>.

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

- During the quarterly meeting of the Dallas Southwest Osteopathic Physicians, Inc., J. L. LaManna, D.O., was re-elected chairman of the board for a fourth term. Dr. LaManna was also serving his sixth term as chief-of-staff at Dallas Family Hospital in Oak Cliff.

- The Texas College of Osteopathic Medicine held its 12th annual convocation, honoring 113 members of the Class of 1993. TCOM freshman class president David Gray delivered the response to the official welcome of the newest class at TCOM. In addition, Earl C. Kinzie, D.O., of Lindale, received a TCOM Founders' Medal, the highest honor bestowed by the college.

- Student/doctor Kevin R. Stahl was selected as the second recipient of TOMA's Academic Excellence Award, presented during TCOM's 1989 Fall Convocation.

- William H. Voss, D.O., a Jefferson City, Missouri, osteopathic physician, was installed as president of the American Osteopathic Association during the AOA House of Delegate's meeting in Nashville, Tennessee.

- The Centers for Disease Control stated that as of July 30, 1989, 102,621 Americans had been diagnosed with AIDS, with 59,391 of that total dying in the eight-year epidemic. Approximately one million to 1.5 million were believed to be HIV infected. Texas ranked as number five in total AIDS cases, with New York ranking number one; California, number two; Florida, three; and New Jersey, four.

- A law which became effective August 28, 1989, stated that real estate agents must inform prospective homebuyers if the previous occupant had AIDS, HIV-related illness or HIV infection, if the agent had actual knowledge, or if the prospective buyer asked. The law was precipitated by the Texas Association of Realtors over concerns about lawsuits erupting if a buyer found out a former occupant had AIDS. However, due to confusion over enforcement of the law, the Texas Real Estate Commission sought an opinion from Texas Attorney General Jim Mattox. He ruled that requiring agents to inform buyers of the previous owner's HIV status upon request, if the agent has actual knowledge, "contravene the Federal Fair Housing Amendment Act of 1988, and therefore are invalid."

FYI

ESI Lederle is voluntarily withdrawing twenty lots of Gentamicin Sulfate Injection, USP packaged in 40 mg/mL and 80 mg/2mL strengths. While these lots fully comply with all product specifications, a higher than expected number of adverse experiences (pyrogenic-like reactions such as fever, chills, or dyspnea) have been reported coincidental with the administration of these lots. Other lot numbers of these products are not subject to this withdrawal. A full safety notification, including a listing of the involved lots, is available at <http://www.fda.gov/medwatch/SAFETY/1999/gentam1.htm>.

TEXAS STARS

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

Abbott Labs Pharmaceuticals
Rene Acuna, D.O.
Bruce Addison, D.O.
Ted C. Alexander, Jr., D.O.
Richard Anderson, D.O.
Sara Apsley-Ambriz, D.O.
David Armbruster, D.O.
Astra Merck
ATOMA
ATOMA District II
Aus-Tex Printing and Mailing
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American Osteopathic Healthcare Association
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For Premium Rates, Enrollment & Information 800/321-0246
TOMA Major Medical Insurance 800/321-0246
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UNTHSC/Texas College of Osteopathic Medicine 817/735-2000
Dallas Metro 429-9120
Medicare Office
Part A Telephone Unit 800/813-8868
Part B Telephone Unit 903/463-4495
Profile Questions 214/766-7408
Provider Numbers
Established new physician (solo) 214/766-6162
Established new physician (group) 214/766-6163
All changes to existing provider number records 214/766-6158
Medicaid/NHIC 512/343-4984
CHAMPUS/General Inquiry 800/406-2833
Texas Medical Foundation 512/329-6610
Toll free 800/725-9216
Texas Osteopathic Medical Association 512/708-TOMA (8662)
in Texas 800/444-TOMA (8662)
FAX: 512/708-1415
E-Mail..... toma@txosteo.org
TOMA Physicians' Health and Rehabilitation Program 800/896-0680
TOMA Med-Search 800/444-TOMA

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

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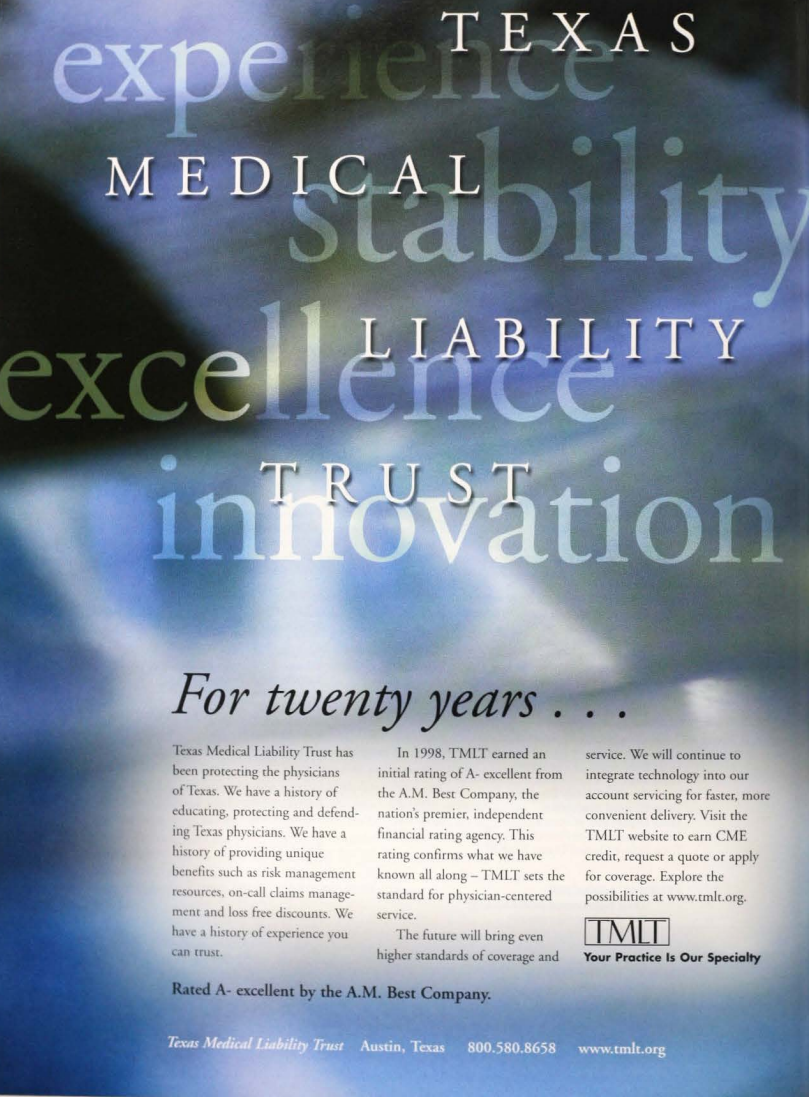

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