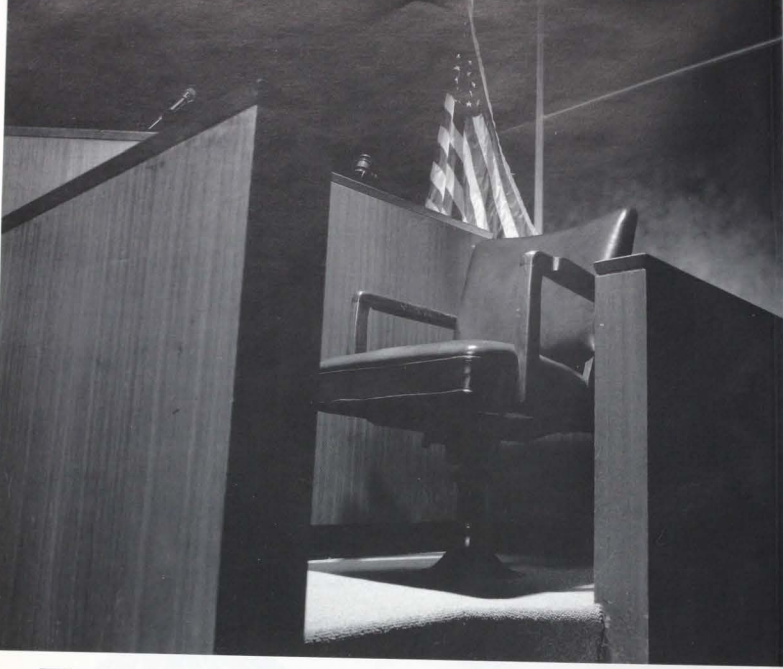
TEXAS D.O.
The Journal of the Texas Osteopathic Medical Association

Volume LVI, No. 1 January 1999



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Inside This Issue

Articles in the ***Texas D.O.*** that mention the Texas Osteopathic Medical Association's position on state legislation are defined as "legislative advertising" according to Texas Gov't Code Ann §305.027. Disclosure of the name and address of the person who contracts with the printer to publish the legislative advertising in the ***Texas D.O.*** is required by that law: Terry R. Boucher, Executive Director, TOMA, 1415 Lavaca Street, Austin, Texas 78701-1634.

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

JANUARY 1999

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

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

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

Published by the Texas Osteopathic Medical Association, Volume LVI, No. 1, January, ISSN 0275-1453.

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

Publication Design and Layout
Sherry Dalton

CALENDAR OF EVENTS

FEBRUARY

5-9

"Ninth Annual Update in Clinical Medicine for Primary Care Providers"
Sponsored by the University of North Texas Health Science Center at Fort Worth
Location: Embassy Suites Resort
South Lake Tahoe, CA
CME: 20 CME hours
Contact: UNT Health Science Center
Office of Continuing Medical Education
817-735-2539 or 800-987-2CME

12-14

"43rd MidWinter Conference/Legislative Symposium"
Sponsored by the Texas Osteopathic Medical Association
Location: Fairmont Hotel, Dallas, TX
CME: Approx. 17 1-A CME hours
Contact: TOMA, 800-444-8662; 512-708-TOMA
Fax: 512-708-1415

21-26

"Ski & CME Midwinter Conference"
Sponsored by the Colorado Society of Osteopathic Medicine
Location: Keystone Lodge & Resort
CME: 39 AOA 1-A hours
Contact: Patricia Ellis, 50 S. Steele St., #770
Denver, CO 80209
303-322-1752 or 800-527-4578
Fax: 303-322-1956

25-28

"Annual Convention"
Sponsored by the Florida Osteopathic Medical Association
Location: Hyatt Regency Pier 66 Hotel
Ft. Lauderdale, FL
CME: Approx. 30 hours 1-A CME
Contact: Florida Osteopathic Medical Association
2007 Apalachee Parkway
Tallahassee, FL 32301
850-878-7364

APRIL

6-9

"12th Annual Texas HIV/STD Conference"
Sponsored by the Texas Department of Health Bureau of HIV & STD Prevention
Location: Austin Convention Center
Contact: Dan Warr: 512-490-2535; Fax: 512-490-2538

16-17

"13th Annual Spring Update for Family Practitioners"
Sponsored by the University of North Texas Health Science Center at Fort Worth
Location: Columbia Medical Center/Dallas Southwest
Dallas, TX
CME: 12 CME hours
Contact: UNT Health Science Center Office
of Continuing Medical Education
817-735-2539 or 800-987-2CME

22-25

"97th Annual Spring Convention"
Sponsored by the West Virginia Society of Osteopathic Medicine
Location: Glade Springs Resort, Daniels, WV
Contact: 304-345-9836

APRIL 29 - MAY 2

"102nd Annual Convention"
Sponsored by the Indiana Osteopathic Association
Location: Radisson Hotel at Star Plaza, Merrillville, IN
CME: 30 1-A hours anticipated
Contact: Indiana Osteopathic Association
800-942-0501 or 317-926-3009

JUNE

17-20

"100th Annual Convention"
Sponsored by the Texas Osteopathic Medical Association
Location: Hotel Inter-Continental, Dallas, TX
CME: 26 Category 1-A hours
Contact: TOMA, 800-444-8662; 512-708-TOMA
Fax 512-708-1415

20-24

"Basic Course in Osteopathy"
Sponsored by The Cranial Academy
Location: Wyndham Emerald Plaza, San Diego, CA
CME: 40 Category 1-A hours anticipated
Contact: The Cranial Academy, 317-594-0411

23-27

"19th Annual Primary Care Update"
Sponsored by the University of North Texas Health Science Center at Fort Worth
Location: Radisson Resort, South Padre Island, TX
CME: 24 CME hours
Contact: UNT Health Science Center Office
of Continuing Medical Education

GET SET FOR THE 76TH TEXAS LEGISLATIVE SESSION

Although the 75th Texas Legislative session officially ended June 2, 1997, it will long be remembered as an extremely productive and progressive session in terms of patient care and patients rights, as well as physician rights. With the passage of a sweeping package of managed care reforms, Texas was thrust into the national limelight as the first state to hold managed care organizations liable for medical malpractice.

As this issue of the *Texas D.O.* goes to press, Texas legislators have been preparing for the opening session of the 76th Texas Legislature, January 12, 1999. It has been estimated that Texas' 181 lawmakers will file more than 5,000 bills to be considered during the 140-day legislative session.

Once again, TOMA will be monitoring legislation of interest to the profession and will keep the membership informed of any action that may need to be taken on specific bills.

The following is a synopsis of prefiled bills relating to the practice of medicine in Texas:

HB 27 relates to the medical records of physicians' patients. The Medical Practice Act would be amended to stipulate that on receipt of a written request by a subsequent or consulting physician of a patient, the requested physician shall 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.

A new section would be added whereby the board, by rule, would establish conditions under which it may temporarily or permanently appoint a person or entity as a custodian of a physician's medical records. The rules would consider the death of a physician, the mental or physical incapacitation of a physician and the abandonment of medical records by a physician.

HB 36 relates to the regulation of abortion. The Health and Safety Code would be amended by adding a new chapter legislating that the abortion of a fetus age 16 weeks or more may be performed only at an ambulatory surgical center or hospital licensed to perform the abortion.

The bill also addresses voluntary and informed consent, except in the case of an emergency, whereby the physician must inform the woman of the risks of abortion; risks associated with carrying the child to term; and medical assistance benefits which may be available for prenatal care, childbirth and neonatal care. The physician shall also make available printed information on public and private agencies who provide pregnancy prevention counseling, adoption options and other alternatives to abortion; and information relating to the characteristics of the unborn child, to include color pictures representing the development of the child at two-week gestational increments. The printed materials are to be provided by the Texas Department of Health.

HB 44 relates to limiting the liability of certain health care professionals who provide free health care services. The Civil Practice and Remedies Code would be amended through the addition of a new chapter specifying that a health care practitioner is not liable for damages arising from an act of omission relating to the provision of the services if the services are: 1) provided without expectation of remuneration; 2) free to the recipient; 3) those the health care professional is qualified to perform; and 4) provided in a manner that does not constitute gross negligence or an intentional tort. The bill would apply to physicians, registered nurses, licensed vocational nurses and physician assistants.

HB 62 relates to exempting certain purchases of machinery and equipment used for research and development from sales and use taxes. The Tax Code would be amended to exempt machinery, equipment or replacement parts that are used directly in the research or development of inventions, products, processes or new technology to include persons primarily

engaged in the performance of scientific or technical services.

HB 70 relates to the establishment of the West Texas Diabetes Center in El Paso. The center would specifically target the health needs and concerns of those residents in West Texas and along the Texas/Mexico border, where there is a high incidence of diabetes. The center would be under the direct supervision of the Texas Council on Diabetes.

HB 75 relates to the use of automatic external defibrillators for cardiopulmonary resuscitation. The Health and Safety Code would be amended to add a new chapter whereby persons may use automatic external defibrillators for the purpose of saving the life of another in cardiac arrest, however, such persons must have successfully completed a course of training. Upon use of the device on another person, either 911 or other appropriate emergency assistance must be alerted. Persons possessing the device would be encouraged to register the existence and location with their local provider of emergency medical services.

HB 96 relates to access to specialty health care services under a health benefits plan. This would amend the Insurance Code by stipulating that a health benefit plan that does not include a properly credentialed specialist who participates in the plan and within whose professional specialty practice an enrollee's disease or condition falls must: 1) permit an enrollee to select the proper specialist outside the plan; and 2) provide benefits for the services of the specialist at the same level as would be provided for these services of a participating physician.

HB 110 relates to public access to certain information regarding medical practitioners. The Medical Practice Act would be amended to mandate that 30 days after the initial conviction of a physician of any offense not punishable by fine only, such information would be sent not only to the Department of Public Safety, but the Texas State Board of Medical Examiners as well.

Additionally, a new section relating to physician profiles would be added, under which the board shall create a profile of each licensed physician to be made available electronically and on the Internet to the public. The profile would contain such information as medical school data and date of graduation; graduate medical education; specialty certification; hospitals at which physicians have privileges; the primary practice location; whether the physician provides any language translating services; a description of any conviction for an offense constituting a felony or a serious misdemeanor; a description of any revocation of or involuntary restriction of longer than 30 days of the physician's hospital privileges; and a description of any final disciplinary action against the physician by a medical licensing board of another state during the 10-year period preceding the date of the profile. The profiles would be updated annually.

HB 181 creates an act relating to the time at which life begins. This act would define the moment that life begins by stating that the life of an individual human organism begins at the moment of fertilization. An unborn human organism is alive and is entitled to the rights, protections and privileges accorded to any other person in this state.

HB 190 relates to a prohibition on certain restrictions imposed by insurers on the performance of professional health care services by health care practitioners. A new chapter would be added to the Insurance Code, such language to stipulate that health benefit plans may not include in a contract with a health care practitioner any provision that penalizes the health care practitioner for 1) referring enrollees for additional diagnosis or treatment by a specialist; or 2) using the practitioner's best professional judgment in prescribing a particular medication, treatment or device for use by an enrollee.

HB 213 relates to certain claims for health care services. This bill would amend the Civil Practice and Remedies Code by adding new language whereby a health care service provider shall bill a patient or other responsible person for services provided the patient no later than the first day of the 11th month after the date the services are provided. Violation of the section would result in the health care service provider not recovering from the patient any amount which the patient would have been entitled to receive as payment or reimbursement under a health benefit plan.

HB 266 relates to the availability of certain specialists under a health care plan offered by an HMO. The Texas Health Maintenance Organization Act would be amended by the addition of language specifying that HMO enrollees may select an out-of-network specialist to provide health care services. The HMO shall pay the out-of-network specialist an amount equal to the amount that would be paid to a network specialist for the same services. However, the enrollee who selects an out-of-network specialist is responsible for any amount charged for the service that exceeds the amount paid by the HMO. In such situations, the enrollee would still need referral from the primary care physician and/or prior authorization or precertification as required under the HMO rules.

HB 272 relates to consent for emergency care. This legislation amends the Health & Safety Code which gives the particulars under which consent for emergency care is not required. Consent is not required if the individual objects to emergency care and a licensed physician has informed the person providing the care that the individual is likely to be suffering from a life-threatening injury or illness.

Consent for emergency care of an individual is required if 1) the individual has executed a directive relating to medical or emergency care, the provision of emergency care is in conflict with the directive, and the person providing the care knows of the directive; or 2) the individual has stated or implied an objection based on religious reasons to the provision of emergency care.

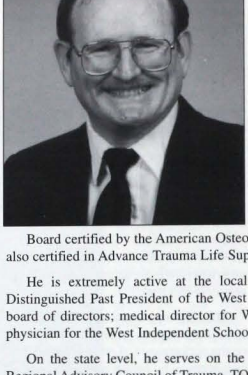
HB 342 & **343** and **SB 27** & **30** all relate to the requirement of parental notification before abortion may be performed on a minor and provide for criminal penalties. Basically, a physician may not perform an abortion on a minor unless he gives at least 48 hours actual notice, in person or by telephone to the parent or guardian of the minor.

HB 348 relates to the liability of certain health care providers. This legislation would amend the Civil Practice and Remedies Code by adding the term "volunteer health care provider" to the definition of volunteer. Volunteer health care provider means an individual who voluntarily provides health care services without

compensation or expectation of compensation and includes physicians, physician assistants, registered nurses, licensed vocational nurses, pharmacists, podiatrists and dentists. The bill would hold volunteer health care providers serving as direct service volunteer of charitable organization immune from civil liability for any act or omission resulting in death, damage or injury to a patient if: 1) the volunteer was acting in good faith and in the course and scope of the volunteer's duties or functions within the organization; 2) the volunteer commits the act or omission in the course of providing health care services to the patient; and 3) the services provided are within the scope of the license of the volunteer.

SB 65 relates to informed consent to the performance of an abortion. Except in the case of an medical emergency, a physician may not intentionally or knowingly perform an abortion without the voluntary and informed consent of the woman. Consent to the abortion is voluntary and informed only if 1) at least 72 hours before the time the abortion is to be performed, the woman is orally informed of the abortion procedure to be used; the medical risk associated; medical risks of carrying a child to term; possible psychological effects of an abortion; and alternatives to the procedure, including adoption. The woman is also to be provided with informational materials provided by the TDH.

Introducing the Program Chair for TOMA's 43rd MidWinter Conference and Legislative Symposium



George N. Smith, D.O., assumes the responsibility of program chair for TOMA's 43rd MidWinter Conference and Legislative Symposium, to be held February 12-14 at the Fairmont Hotel in Dallas.

Dr. Smith is a family physician at the West Medical & Surgical Clinic Association in West, and also serves as a clinical associate professor in the Department of Family Medicine at the Texas College of Osteopathic Medicine. He is a 1974 graduate of the University of Health Sciences College of Osteopathic Medicine in Kansas City, Missouri, and interned at Lakeside Hospital, also in Kansas City.

Board certified by the American Osteopathic Board of Family Practice, Dr. Smith is also certified in Advance Trauma Life Support; and a Certified Medical Director.

He is extremely active at the local and state levels. Locally, Dr. Smith is a Distinguished Past President of the West Kiwanas Club; serves on the West Hospital board of directors; medical director for West Rest Haven, DMS, West Fest; and team physician for the West Independent School District.

On the state level, he serves on the executive committee of the Heart of Texas Regional Advisory Council of Trauma. TOMA service and activities include president of TOMA District 18; member of the TOMA House of Delegates for 10 years; alternate delegate to the AOA House of Delegates for two years; vice chair of the Convention Committee; and member of the Professional Liability Insurance Committee.

Medicaid HMOs Selected for Dallas Area

The Texas Department of Health (TDH) and the Texas Health and Human Services Commission (HHSC) have announced the selection of four HMOs to provide healthcare services for Medicaid recipients in the Dallas area.

The organizations selected include Americaid Texas, Inc.; AmeriHealth HMO of North Texas; Rio Grande HMO, Inc., doing business as HMO Blue; and Parkland Community Health Plan, Inc.

The organizations were selected by TDH to provide medical services to a projected 85,000 Medicaid clients in Collin, Dallas, Ellis, Hunt, Kaufman, Navarro and Rockwall counties, beginning in July, 1999.

The Dallas area is the seventh in the state to be switched from a traditional Medicaid system to a managed care approach. Managed care systems were previously implemented in the Austin, Beaumont, Fort Worth, Houston, Lubbock and San Antonio areas.

With the switch, Medicaid recipients in the Dallas area will be able to choose a primary care provider from among the four HMO plans or from the Texas Health Network, a primary care case management (PCCM) plan administered by the state. Under the PCCM system, individual physicians contract directly with the state and bill the state for medical services provided.

Other Texas areas scheduled to switch to managed care this year include El Paso and the Fredericksburg-Hill Country area.

Medicaid managed care was approved on a pilot basis in 1993 by the Texas Legislature. In 1995, the legislature directed HHSC to begin implementing the program, now called the STAR Program, statewide.

Source: TDH

HEALTH NOTES

Prostate Cancer Biopsy Advised for High-Risk Patients

A new study presented at the annual meeting of the Radiological Society of North America, notes that waiting for blood tests to reveal prostate cancer could prove fatal for men at high risk for the disease.

Men with abnormal levels of a blood substance called prostate specific antigen, or PSA, should not wait several months for a new test, as is generally suggested. Instead, they should consider a biopsy technique in which ultrasound is used to target suspicious areas.

A large-scale study shows the method detects cancer better than standard biopsies and should be used early.

Counseling Patients Against Smoking Would Not Overburden Physicians

A study conducted at the School of Medicine and Biomedical Sciences at the University of Buffalo and published in the Journal of Family Practice, says that family physicians would only add about 11 minutes to their work day if they counseled every patient who smokes to quit. Carlos R. Jaen, M.D., Ph.D., lead investigator of the study, noted "One of the reasons given for not doing this is time, but we've shown it takes an average of 90 seconds per patient."

Alzheimer's Disease and Bacteria

As noted in Microbiology and Immunology, Vol. 187, No. 1, scientists at the Wayne State University School of Medicine discovered a link between Alzheimer's disease and Chlamydia penumoniae, a common respiratory pathogen. The study showed that 17 of 19 patients with advanced Alzheimer's disease had the bacterium present in the areas of their brains affected by the disease.

FDA Recommends New Kind of Painkiller

Advisors to the Food and Drug Administration unanimously recommended that Searle Corp.'s Celebrex be allowed to be sold by prescription for arthritis relief. Celebrex is expected to be the first in a new class of painkillers called "cox-2 inhibitors" to hit the U.S. market. This new class of painkillers is expected to relieve aches and inflammation with little damage to the stomach.

The FDA advisers said Celebrex may help arthritis sufferers, but it stopped short of recommending the drug's use for other kinds of pain.

FDA Acts to Make Drugs Safer for Children

The FDA announced final regulations to provide health care practitioners with specific information on the safe and appropriate use of new drugs and biologics in children. The regulations require that new drugs and biologics that are therapeutically important for children, or will be commonly used in children, have labeling information on safe pediatric use.

Every year more than half of newly approved drugs and biologics that are likely to be used in children lack information to permit safe and effective use. Without adequate information, physicians may be reluctant to prescribe certain drugs for their pediatric patients, or they may prescribe them inappropriately. The new rule makes it more likely that children will receive improved treatment because doctors will have more complete information on how drugs affect children and what age-appropriate doses are needed.

The rule also allows FDA to require pediatric testing of already-marketed products in certain compelling circumstances, such as when a drug is commonly prescribed for use in children, but the absence of adequate labeling could post significant risks.

However, the pediatric study requirement can be waived entirely if the FDA finds that the product is likely to be unsafe or ineffective in pediatric patients; pediatric studies are impossible or highly impractical; or reasonable efforts to develop a pediatric formulation have failed.

HOW YOU GOING TO KEEP THEM DOWN ON THE FARM?

By Terry R. Boucher, M.P.H., Executive Director

Most osteopathic physicians have become very familiar with managed care in the past several years. Urban physicians contend with it on a daily basis and their rural counterparts, occasionally. Now, imagine a system that preserves local control over the managed care system of contract negotiations, provider networks, paper work, reimbursement issues - in almost all rural areas of Texas. Senate Bill 1246, authored by Senator Frank Madla, Jr. (D-San Antonio), will allow rural physicians faced with the encroachment of urban managed care into their practices to fight back. Senator Madla's bill establishes the one-of-a-kind Rural Community Health System.

The Rural Community Health System (RCHS) legislation, supported by the Texas Osteopathic Medical Association, Texas Medical Association, Texas Society of Osteopathic Family Physicians, Texas Academy of Family Physicians, Texas Organization of Rural and Community Hospitals, and Texas Hospital Association, among others, was developed to provide rural communities an alternative to urban-based HMOs now operating in rural Texas. Managed care's influx into rural communities portends significant changes for rural health care delivery. With the state's rapid conversion of Medicaid patients to managed care, rural providers already report network exclusion, declining reimbursement, and the loss of patients to urban health care centers - all factors which threaten the long-term viability of a fragile health care infrastructure. Unfortunately, these trends are likely to continue as more rural Texans enroll in managed care plans.

Texas' rural health care system is a vital asset to the state. Not only is it necessary to ensuring the health of rural Texans, but also in upholding and promoting strong rural economies. Given commercial health plans steady migration into rural areas, and the increasing prevalence of Medicare and Medicaid HMOs, many rural providers recognized a need to establish a new managed care model

that will allow them to compete in a changing health care environment while remaining responsive to the challenges of rural medicine.

SB 1246 became effective September 1, 1997. The RCHS board of directors, which will establish policy for the system, held their initial meeting on February 27, 1998. The RCHS will provide administrative, financial and technical support to locally organized systems. The local community health networks establish and retain control over the local health care system. This arrangement allows local physicians, hospitals and pharmacists to manage the actual delivery of care without the expense of setting up a local HMO.

KEY PROVISIONS

* The law creates a private, non-profit health system governed and managed by rural physicians, hospitals, and community leaders, including employers and consumers of health care. The RCHS will operate exclusively in counties with 50,000 or fewer inhabitants or that are designated as nonurbanized. The commissioner of insurance may also designate other rural areas as necessary.

* Members of the organization will include county hospitals, county hospital authorities, hospital districts, municipal hospitals, and municipal hospital authorities located in rural areas. However, governance of the RCHS is equally distributed among hospitals, physicians, and community leaders.

* The RCHS will be a licensed HMO that will contract with locally-developed community health plans, such as 5.01(a) networks or physician-hospital organizations. The RCHS will be responsible for functions such as licensure, reinsurance, information management, claims processing, marketing, and actuarial analysis. To reduce administrative costs to the local plans, the RCHS will also offer centralized network management and administrative support services to the local health plans.

* An 18-person board of directors will manage the RCHS. Six directors, selected by the participating hospital members, will represent community hospitals. The governor appointed the remaining 12 directors - six rural physicians and six rural community leaders. Of the community leaders, two seats each will be allocated to employers, consumers of health care, and local government. The board may appoint a six-member executive committee, comprising two members from hospital, physician, and community representatives, to transact the business of the RCHS.

* To ensure appropriate, timely input from other health care providers, the board must also appoint at least one advisory committee comprising allied health professionals, rural health clinics, specialty centers, and for-profit facilities.

* The law guarantees the RCHS one of the Medicaid managed care contracts for rural Texas, so long as it satisfies the state's managed Medicaid contractual and licensure requirements. Also, if the state's 1115 Medicaid waiver is approved by the federal government, the RCHS has the option of contracting with the regional

funding entities to provide health care services for newly eligible Medicaid children living in rural communities. Alternatively, the RCHS may become a Medicaid funding entity itself. If the RCHS opts not to provide funds for the 1115 Medicaid waiver, then the other funding entities operating in rural Texas must contract with health care providers who reside and practice in rural communities.

* The RCHS is not limited to Medicaid managed care. It may also contract with private insurers and other public sector health insurance programs, including Medicare.

* Composition and design of the locally developed community health plans with which the RCHS may contract are not specifically addressed within the legislation, with the exception of a network's size: community health plans may not be comprised of more than 19 counties.

* A funding proposal to capitalize the RCHS start-up expenses is under development and probably will be introduced during this legislative session. The RCHS may accept gifts or grants (monetary or in-kind). The RCHS will become self-sustaining as it receives funds for medical services.

GUIDING PRINCIPLES

While the RCHS legislation did not prescribe the design or scope of local networks, the following are fundamental criteria for this model:

* RCHS preserves local physician and hospital control of medical and quality management. Locally developed community networks, also governed equally by physicians, hospitals, and community leaders, will retain control over functions such as quality assurance, utilization management, credentialing, and resource allocation. For instance, any savings generated by the local network will be reinvested in the local health care system or health-improvement initiatives.

* The system ensures patients' access to the spectrum of services available within their community. Each local community health plan will deliver the scope of locally available health services, with emphasis on primary and preventive care. Services not available within the community, such as subspecialty or tertiary care, will be externally contracted. The local community health plan will include all local providers who wish to participate, including for-profit and non-profit hospitals, allied health professionals, and rural health clinics.

* The legislation keeps health care dollars within rural communities rather than redirecting them to urban centers, thus sustaining not only rural communities' health care systems, but also local economies and jobs.

The RCHS gives rural physicians the unique opportunity to contribute to their own community's health system. TOMA members need to work with their local hospitals and other community leaders to develop a community health plan. If there already is one, you need to become knowledgeable and find out what stage of development it is in. Be an active participant in the RCHS and do the things that are needed to give it an effective voice. Physicians need to work to inform other physicians and community leaders about the RCHS. You should start talking to local employers, school administrators, mayors, county officials and other community residents about the benefits of developing a community health plan that can participate with the RCHS. Physicians can play a critical role in bridging the gap between medicine and business. Local employers need to understand how their participation in the RCHS could affect the economic viability of their community.

For more information on how to become involved in the RCHS, call Harold High, MD, President, RCHS at (512) 275-3505; or Victoria Ford in the office of Senator Frank Madla, (512) 463-0119.

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* = *Elected to the RCHS Executive Committee*

Law Limits How Much "Non-Participating" Providers of Care Can Bill TRICARE Patients

Health care providers who provide services to TRICARE patients, but who don't "participate" (also known as "accepting assignment") in TRICARE, are limited by federal law in how much they can charge TRICARE patients for the services they provide.

Non-participating providers may charge no more than 15 percent above the TRICARE allowable charge for their services.

NOTE: Providers who do participate in TRICARE accept the TRICARE allowable charge as the full fee for the care they provide. They also file the claims on behalf of their TRICARE patients.

The billing restriction for non-participating providers was contained in Section 9011 of the Department of Defense Appropriations Act of 1993 (Public Law 102-396), and was effective on November 1, 1993. The restriction has been included in all subsequent Department of Defense Appropriations Acts. The billing limitation is the same as that used by Medicare.

Providers who were exempt from the limit are no longer exempt from this billing limit, as of January 1, 1999. These included pharmacies, ambulance companies, independent labs, durable medical equipment and medical supply companies, mammography suppliers, and portable x-ray companies.

The removal of the exemptions for the providers listed above is found on page 4844 of a Federal Register notice dated September 10, 1998. This notice says that Section 731 of the National Defense Authorization Act for Fiscal Year 1996 - which provides the legal basis for limiting the billing of TRICARE-eligible persons for the balance of the charges for their medical care - extends the billing limit authority to these providers.

A TRICARE patient who has been charged in excess of these limits by a provider of care should make sure the provider has a copy of the TRICARE contractor's Explanation of Benefits (EOB), so the provider may calculate the amount of the refund that's required, or the amount he or she may legally collect from the patient.

A patient who can't resolve the situation with the provider may write a letter of complaint to the TRICARE claims processing contractor for the state in which the patient lives. The contractor will send the provider a letter that explains the legal requirement and ask that the provider refund any charges in excess of the limits to the patient within 30 days.

If the provider doesn't respond to the contractor's letter by complying with the law, and the patient complains to the contractor about the non-compliance, the contractor notifies the TRICARE Management Activity's Program Integrity Branch. Program Integrity sends a stronger letter to the provider, which details the legal requirements and states the penalty for failure to comply.

A provider who doesn't comply with the refund request may ultimately have his or her authorization to provide services to TRICARE patients withdrawn. What this means to TRICARE-eligible patients is that they could still use such a provider, but they would have to pay the full bill for any services they might receive; there would be no government reimbursement of any part of the cost.

Notification of a provider's exclusion from the TRICARE program is sent to other government programs, such as Medicare and Medicaid, and the Federal Employees Health Benefits Program (FEHBP).

In special circumstances, the billing limit may be waived by the regional TRICARE contractor, if such a waiver is requested by a TRICARE-eligible person. Each waiver request is evaluated based on the specific facts provided by the person who requests the waiver. If the person who requests the waiver is willing to pay the non-participating provider his or her billed charges, the requester must send a signed statement to that effect, to the contractor, and the waiver will be granted. The statement must say that the requester is aware that the provider's billed charges are above the legal limit of 15 percent above the TRICARE allowable charges, that the patient feels strongly about using that provider, and is willing to pay the extra charges. The waiver request may be sent in by the patient, along with the claim.

An approved waiver request applies only for the requesting patient, and only for that specific episode of care. Other instances of treatment for that patient, and for other TRICARE-eligible patients, by the non-participating provide in question, will again fall under the legal billing limits. If the provider's charges are above the legal limits in these other treatment episodes, complaints might be filed by any of the patients involved, which could result in termination of the provider's authorization to provide services to TRICARE patients, and to be reimbursed by the government for those services.

Waiver requests should be sent to the patient's regional TRICARE contractor. A decision by the contractor to waive - or not to waive - the legal billing limit is not subject to appeal.

THE TEXAS COALITION ON CARDIOVASCULAR DISEASE & STROKE

PART III

THE TEXAS COALITION ON CARDIOVASCULAR DISEASE & STROKE was established to explore ways to reduce the health and economic burdens imposed on Texas and the nation from CVD and stroke. Together, CVD and stroke claimed the lives of over 52,000 Texans in 1996.

The coalition, whose members include the American Heart Association, Texas Osteopathic Medical Association, Texas Medical Association, some of the state's major health plans and other representatives of the health care industry, concluded that while primary and secondary prevention can effectively reduce the rate of CVD and stroke, resources for research, education, prevention and treatment are insufficient and uncoordinated. In order to ensure that all communities in Texas have access to effective primary and secondary prevention programs, there is a tremendous need for coordination at the statewide level. The coalition report noted that there is no current targeted state funding to evaluate and address the burden of CVD in Texas. Also lacking is surveillance information to evaluate the effectiveness and health outcomes of different programs. The public and private sectors must work together in a partnership if Texas is to achieve meaningful reductions in CVD and stroke.

For informational purposes, the Subcommittee on Cardiovascular Disease has been conducting an interim study for the Texas House Committee on Public Health. The charge is to study the effects of cardiovascular disease in Texas and assess the potential to reduce the health, social and economic impacts through affirmative programs on prevention, care and treatment, with the ultimate hope of filing a bill dealing with these issues during the current legislative session.

HOW OTHER STATES ARE ADDRESSING CVD

The coalition assessed the efforts of several other states' plans and programs in dealing with CVD in order to gauge their effectiveness. (Excerpted from the report of the Texas Coalition on Cardiovascular Disease and Stroke.)

North Carolina

In 1995, the North Carolina General Assembly established and appropriated funding for the North Carolina Heart Disease and Stroke Prevention Task Force. The Task Force was charged with establishing a profile of heart disease and stroke burden, publicizing this profile, and adopting and promoting a comprehensive statewide plan to reduce the impact, both economic and emotional, of CVD.

The task force is the first in the nation to be legislatively appointed and funded. It has 27 members and meets quarterly or at the call of the chair. Four subcommittees have been created: Prevention of Risk Factors, Management of Risk Factors, Public Awareness, and Legislation and Resource Development.

Goals

1) Reduce the proportion that smoke
2) Increase physical activity
3) Increase the proportion who eat high fiber, low-fat diets
4) Increase the proportion of those with high blood pressure who keep it under control
5) Reduce the proportion with high cholesterol
6) Reduce the proportion that is overweight

Process

Bring together community organizations and build coalitions
Assess the community's health needs
Select and implement strategies for reducing risk factors
Evaluate
Sustain

Three primary intervention channels were used. Each was oriented to specific population segments and delivered through multiple channels such as schools, work sites and churches.

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Media
Social marketing, advocacy

Recommendations
* Establish an infrastructure to support media work on CVD prevention.
* Obtain leadership buy-in.
* Technical assistance.
* Consultation and continuing education to local groups.
* Academic preparation for future generations of public health professionals.
* Marketing database

Policy
Organizational policy change, public policy change

Recommendations
* Have the K-12 curriculum in schools emphasize lifetime physical activities rather than just sports.
* Change zoning requirements to encourage more parks and greenways.
* Change the building code to make stairways more prominent and encourage people to use them.
* Allocate public funds for alternative travel such as bikes.
* Require heart-healthy options on menus.
* Get insurance companies to reimburse dietary counseling.

Program Services
Education, clinical

Recommendations
* Develop resource/networking list.
* Develop and promote uniform standards and guidelines for all providers in the community.
* Develop and provide targeted, culturally sensitive and low-literacy educational materials.
* Intervene at school and work sites.
* Provide behavior change training.

In addition, risk-factor specific recommendations were developed.

California

In response to the prevalence of CVD in California, the California Department of Health Services and the Institute of Health and Aging at the University of California, San Francisco, established the Cardiovascular Disease Outreach, Resource & Epidemiology Program (CORE). Its mission is to prevent and control CVD among all Californians through a variety of activities: epidemiologic surveillance, the California Cardiovascular Disease Prevention Coalition, and a geographic variation study.

The CORE program is the principal unit within the California Department of Health Services for the assessment, analysis, interpretation and dissemination of CVD data. In June of 1995, this group published a study entitled, "Californians' Attitudes Towards and Knowledge of Cardiovascular Diseases." The objectives of the study were:

* Identify Californians' priority health conditions and diseases.
* Assess knowledge of the leading causes of death in the state.
* Investigate levels of concern regarding high blood pressure, stroke and heart disease.
* Determine level of confidence in the effectiveness of CVD risk reduction measures.

Based on CORE's identification of California counties at high risk for CVD, ten communities have receive $75,000 to expand local CVD efforts. Examples of programs developed include cooking classes, screening programs with follow-up, educational programming on public access television, and student-produced and acted theater skits that promote healthy eating, physical activity and no smoking.

Despite the limited resources available, CORE has initiated opportunities by promoting partnerships between local health departments and non-profit hospitals. It also provides technical assistance and regional workshops.

The California Cardiovascular Disease Prevention Coalition comprises over 30 statewide organizations including state and local health departments, academia, physicians and voluntary organizations. Its goals are to enhance the positioning of CVD as an important public health issue through advocacy and education; promote healthy lifestyle changes with an emphasis on physical activity and healthy food choices; advance CVD prevention as an integral piece of health care delivery systems at all levels; and to support and protect anti-tobacco policies and activities.

Most recently, the Coalition was awarded $300,000 to conduct and cosponsor, along with the National Heart, Lung and Blood Institute, its first national conference entitled, "Cardiovascular Health; Coming Together for the 21st Century."

In addition to these activities, the CORE Program, the Physical Activity and Health Initiative, and the California Healthy Cities Project created the Heart Smart Cities Project grants, with awards of $30,000 and an additional $30,000 required match from a local non-profit hospital. The purpose of the Heart Smart Cities Project is to initiate a citywide CVD educational campaign. Several examples include the Walk-a-Cop program, AHA's Heart Power in schools, and utilizing city public services to distribute educational materials.

HOW TEXAS IS ADDRESSING CVD: A LIMITED INVENTORY OF TEXAS RESOURCES

Public Sector

Texas Department of Health

The Texas Department of Health's Bureau of Chronic Disease Prevention and Control collects, interprets and disseminates data relating to behavioral risk factors, cancer and other chronic conditions. In addition, it also provides health information and education related to tobacco use prevention, nutrition, physical activity, diabetes and other chronic disease risk factors. And, it provides technical assistance and consultation to support development of environmental and policy changes related to tobacco use, physical activity and nutrition within worksites, restaurants, schools, communities and health care organizations. It is both state and federally funded. FY 98: $17,875,180.28

Strategies
1) Epidemiology/surveillance
2) Health education/community out reach
3) Improve provision of clinical preventive services

4) Community/worksite environmental changes

Adult Health Program - Promotes and supports the practice of prevention in clinical settings and encourages environmental changes for healthier behaviors in communities. The program provides consultation and technical assistance for implementing a comprehensive clinical prevention system which emphasizes case management of the individual patient.

Within this program are several components:

* Alzheimer's Disease Program (FY 98: $101,206)
* Osteoporosis Awareness and Education Program (FY 98: $195,324)
* Prostate Cancer Education Program (FY 98: $20,028)

Clinical Preventive Services Program

- Supports the incorporation of preventive services into clinical settings throughout the state by promoting the use of the federal Put Prevention into Practice (PPIP) model. PPIP helps clinical staff conduct the system changes necessary to make risk assessment and counseling a routine part of the services provided. Currently, PPIP has funded 26 sites, directly worked with 120 clinical sites, and has provided materials to 1,100 sites. The clinical specialist is usually a nurse, and there is one staff person per region (11 regions). It is completely federally funded. FY 98: $658,958.

Chronic Disease Community and Worksite Wellness Program

- Promotes increased physical activity and proper nutrition choices to prevent heart disease and cancer using population-based approaches for healthier lifestyle choices. The program provides technical assistance and consultation to support development of environmental and policy changes. Staff consists of 3-4 employees per health region (11 regions). Federal and state funding. FY 98: $2,507,139.28.

Behavioral Risk Factor Surveillance System (BRFSS)

- Ongoing random digit dial telephone survey of adult Texans to assess the prevalence of lifestyle risk factors that contribute to the leading causes of premature death and disability. In 1997, 3,000 interviews were conducted with an estimated 5,000 to be conducted in 1998. The program produces Texas Risk Factor Report newsletter and an annual surveillance poster. Funded through CDC. FY 98: $231,868.

Texas Diabetes Program/Council

- Coordinates and implements programs aimed at preventing diabetic complications through patient and professional education and increased awareness. Current programs funded by the Council include the Texas Diabetes Institute in San Antonio, Information/Media Campaign, Walk Texas!, and CATCH. State and federal funding. FY 98: $3,731,145.77.

Office of Tobacco Prevention and Control (OTPC)

- Established in 1986 with funding from the Texas Cancer Council to prevent and reduce tobacco use, particularly among youth. In partnership with the Texas Cancer Council and the American Cancer Society, a medical campaign was developed. State and federal funding. FY 98: $1,424,520.58.

Comments

While TDH has no programs that specifically target cardiovascular disease, it has many programs that address particular risk factors. TDH feels that its endeavors are being utilized and are successful. It envisions developing a program based on facets of the others that strictly focuses on cardiovascular disease. In addition, it wants to augment its present programs to focus more on cardiovascular disease since it is a major public problem.

* TDH has no funding for public awareness campaigns. Only anti-smoking programs have dedicated funding to public awareness campaigns. Public awareness is the cornerstone of prevention.

* Staff is very limited. PPIP and Community program share a maximum of four people per region. There are only 11 regions, so there is considerable strain on existing manpower.

* TDH feels that increased funding is needed for the Community and Worksite program. Although successful, this program cannot impact to the degree envisioned given the present budget.

* Increased surveillance on risk factors for CVD and morbidity data is needed. Data from the Texas Health Care Information Council (THCIC) will help, but more specialized data and a mechanism to track its own programs is required.

Voluntary Sector

American Heart Association

The American Heart Association has many programs to address heart disease and stroke. Multiple educational resources for each risk factor are available, ranging from organized programming and take home brochures to cookbooks and videotapes. Three resource booklets are available that cover all the programs, one for healthcare providers, another for the public at large and one specifically for youth.

The American Heart Association has borne the cost of research and development, and continues to improve upon their materials as new information is discovered. The shelf life of some materials can be as little as two years.

Several major programs are:

HEARTPOWER - Age-specific school curriculum (grades Pre-K to 8) covering nutrition, physical activity, living tobacco-free and the cardiovascular system. Also available in Spanish, the complete kit contains a teacher resource book, posters, activity cards, audiotapes and two stethoscopes. ($95-120)

HEART AT WORK - Cost-effective cardiovascular health promotion program for employees consisting of seven binders in a red cardboard cabinet. Each binder is sold separately and covers a different topic. ($365 for entire kit, $45 for each activity kit)

ANSWERS BY HEART - 53 brief, simple patient information sheets on cardiovascular disease conditions, treatments, tests and risk factors. ($5 for 50 of each sheet)

STROKE CONNECTION - Packet for stroke families in need of information and support. Contains several pamphlets on stroke. ($3)

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Comments

The AHA has neither the staff nor the organizational framework to implement comprehensive program public awareness and subsequent surveillance for outcome studies. Thus, these programs rely on institutions such as schools and businesses to find their own program facilitators for continued operation. In Texas, there are staff in only 20 cities, and 14 of those cities are staffed by only two people.

AHA lacks adequate funding to manage these programs, track the outcomes, and provide follow-up.

American Cancer Society

Over the 21 year history of the Great American Smokeout in Texas, a rich tradition of success has been built that resulted in assisting 500,000 Texas smokers to quit because of the Smokeout. Nationally, for 20 years, 100 million people did not smoke on Smokeout day, and 10 million people quit because of Smokeout.

Of the 238 Texas American Cancer Society units, more than 148 units participated in the Great American SmokeOut - Great American SmokeScream. An estimated audience of over 1.7 million was reached with educational program resources distributed to worksites, school districts, educational service centers and individual school campuses. A total of 4,226 Texans signed the Movie Industry Petition which objects to the increase in smoking seen in film productions.

Private Sector

Texas Medical Foundation

The Texas Medical Foundation (TMF) is the Quality Improvement Organization (QIO) (formerly called Peer Review Organization) for Medicare for the state of Texas. As an agent of the Health Care Financing Administration (HCFA), TMF is obligated to assess and assure the quality of care received by Medicare beneficiaries within the state. Since 1993, TMF has assessed and assured quality through the Health Care Quality Improvement Program (HCQIP). HCQIP is a population-based quality improvement program that focuses on improving the quality of care for diseases of high prevalence or burden of suffering, in which medical science indicates that there are interventions that will reduce morbidity and/or mortality, and in which unintentional variations exist in the application of these interventions. Since 1993, TMF has implemented approximately 60 quality improvement projects throughout the state.

In 1992, the diagnosis of acute myocardial infarction was the second leading cause of hospital admissions, affecting over 35.6 million Medicare beneficiaries in the U.S. AMI accounted for over 15% of all Medicare expenditures for short-stay hospitalizations with an average cost of $11,650. In Texas, there were 19,725 discharges with a principal diagnosis of AMI in 1996.

"IN 1996, CONGESTIVE HEART FAILURE (CHF) WAS THE LEADING CAUSE OF MEDICARE HOSPITAL ADMISSIONS IN TEXAS, ACCOUNTING FOR 35,129..."

The Cooperative Cardiovascular Project (CCP), a nationally-based project coordinated by HCFA and implemented by QIOs in every state, was designed to increase the utilization of interventions that have been shown to reduce the morbidity and mortality of patients with AMI. In Texas, the CCP project received improvement plans from 181 acute care facilities affecting over 80% (15,859) of the total statewide AMI discharges. In ideal patients (i.e., patients with no contraindication to treatment), appropriate administration of aspirin during hospitalization, and aspirin, beta blockers, and angiotensin converting enzyme (ACE) inhibitors at discharge increased as a result of the CCP project.

The percent improvement noted in Texas is similar to improvement noted in a four state pilot study that also evaluated the impact of the CCP project on mortality. In this study, there was a clinically relevant and statistically significant decrease in mortality rates.

In 1996, congestive heart failure (CHF) was the leading cause of Medicare hospital admissions in Texas, accounting for 35,129 acute-care admissions. In addition to being the leading reason for hospitalization, CHF has been reported as being the only major cardiovascular disorder that is increasing in incidence, prevalence and mortality. TMF completed a Congestive Heart Failure pilot project with acute care facilities that focused on improving administration of ACE inhibitors in patients with CHF. This pilot study resulted in an improvement of the use of ACE inhibitors from 65.7% to 71.2%. Based on the success of this project, TMF has recently implemented a large scale CHF project with 99 acute care facilities. These facilities treat over 29% of patients discharged statewide with a principal diagnosis of CHF.

Routine right heart catheterization, as part of a bilateral procedure for coronary artery disease, is a procedure without scientific support of its benefit. TMF, in collaboration with 15 acute care facilities with the highest rates of bilateral catheterization in the state, and utilizing guidelines developed by the Committee on Cardiovascular Diseases of the Texas Medical Association, implemented a Right Heart Catheterization project. The project resulted in a statewide reduction in the rates of right heart catheterization from 32.7% in 1993 to 19.8% in 1997. In 1997, the cost savings, realized from the reduction of unnecessary right heart catheterization in the 15 participating facilities, was over $450,000.

Patients with atrial fibrillation are nearly six times more likely to develop a stroke as compared to similar patients with normal heart rhythm. In 1997, there were 7,700 Medicare discharges with the principal diagnosis of atrial fibrillation. TMF developed an Atrial Fibrillation pilot project designed to improve the administration of warfarin at discharge for patients with atrial fibrillation. The pilot study resulted in a 22.7% increase in warfarin administration. Due to the success of the pilot project, TMF has recent-

ly implemented a large scale project that will impact over 25% of the statewide Medicare discharges for atrial fibrillation.

The prevalence of diabetes approaches 15% in the over-65 population. While this number is high, it significantly underestimates the prevalence of diabetes in Blacks and Hispanics. It is important to consider the impact of diabetes on a population when discussing CVD, since CVD is the leading cause of death within the diabetic population.

TMF has developed and implemented the Primary Care Diabetes project which is based on the Texas Diabetes Council minimum standards of care for diabetes under managed care in Texas. This project focuses on improving the utilization of interventions that have been shown to reduce morbidity and mortality (such as blood pressure checks, lipid level checks, eye exams, foot exams) in diabetic patients. While this project is ongoing, and final results of its impact will not be available for approximately one year, it is important to note that there is significant underutilization of these interventions.

Texas Medical Association

The Texas Medical Association has enjoyed a successful partnership with the American Heart Association, Texas Affiliate, for several years in development and coordination of the TMA Stroke Project (TMASP). During the first quarter of 1998, TMASP provided 403 CME hours to 221 physicians and five nurses in five locations across the state. Currently, a three-hour program, a fourth hour related to treatment of stroke as an emergency, is being developed.

Merck & Co., Inc.

Bringing the delivery of care for heart disease patients closer to national guidelines is the goal of Heart Care Partnership. Heart Care Partnership is designed to improve risk factor management in patients with heart disease through physician education, participation, and consensus development, along with practice improvement processes and patient education. Development and implementation of Heart Care Partnership in Texas was a joint effort of Merck & Co., Inc.; the American Heart Association, Texas Affiliate; and the Texas Medical Association. The program helps hospitals improve quality of care and outcomes for patients with heart disease. Resources included in the program are educational workshops, quality improvement processes and patient education materials. Heart Care Partnership workshops address the treatment gap, define optimal care and help hospitals develop individual plans for treating heart disease. The quality improvement processes provide hospitals with baseline treatment data and tools to improve and measure outcomes over time.

Education/Research

Cardiovascular Research Institute

The Cardiovascular Research Institute seeks to integrate research, training and clinical practice focusing on the heart and blood vessels. The Institute represents a cooperative venture between Texas A&M Health Science Center College of Medicine, Scott & White Hospital, the VA hospital, and Driscoll Children's Hospital with participating sites in College Station, Temple and Corpus Christi. The existing vascular research program has generated $30 million in grant funds and is recognized both nationally and internationally as a leading center of blood vessel research. A heart research program and a consortium of over 50 cardiovascular physicians from participating clinical institutions work together to achieve a broad approach to cardiovascular functions and diseases.

Goals

1) Foster research as the key to gaining a understanding of the mechanisms of human cardiovascular disease and to developing new therapies for these disorders.

2) Provide a forum for exchange of ideas and solutions to problems.

3) Increase the ability of basic and clinical researchers to access human tissues and patient populations.

4) Bridge the gap between research and clinical practice through translational research (i.e., lab bench to bedside).

5) Position TAMUSHSC and its clinical partners for a more aggressive approach to competing for expanding research funding.

6) Stabilize, strengthen, and expand subspecialty training programs in cardiovascular medicine and surgery.

7) Provide a strong academic environment for training of undergraduates, medical students, graduate students, postdoctoral fellows and residents in the cardiovascular field.

Business

Health Plans

The Texas Association of Health Plans represents 60 health plans. In a survey of their members, each one actively participates in cardiovascular disease management programs. While some focus their efforts on their members, many provide community outreach programs. One such example is NYLCare of Dallas. Each year, NYLCare is the corporate sponsor for Women's Health Walk to promote CVD awareness. In addition to providing publicity, NYLCare contributes about $25,000 to this project annually.

Corporations

Many businesses and corporations offer some form of health promotion programming for their employees. An example is the 3M Corporation which offers programs and resources that help 3M employees better balance work and family issues; contribute to overall job satisfaction and enhance productivity and job performance. The following areas of well being are focused upon: mental, physical, social-emotional and spiritual. Programming is provided through seminars, on-site fitness activities and special events.

Community Initiatives

The San Antonio Stroke Awareness Initiative Task Force

A consortium of various community organizations and medical organizations has teamed up with the American Heart Association on a new aggressive pilot stroke program. San Antonio is one of five cities participating in the year-long pilot program with the single purpose of educating San Antonians about stroke. The task force comprises various community organizations and medical organizations.

Two overriding messages drive this initiative. The first message is "know the

continued on next page

warning signs of stroke." The second message is "stroke is a medical emergency, call 911." Some of the activities of the Task Force include health fairs, community events, stroke screenings, partnerships with local community service organizations, partnerships with community business and employee health programs, and professional education programs.

Three subgroups are:

Community Awareness Subgroup
- focus on the warning signs of stroke and recognition of stroke as a medical emergency

Medical Professional Awareness Subgroup
- increase awareness and action to work within the medical community

Public Relations Subgroup
- general city-wide awareness campaign.

The Dallas Area Coalition to Reduce Diabetes and Heart Disease

This coalition seeks a healthier community through collaborative efforts by making the entire community aware and involved in managing and reducing the incidence of diabetes and heart disease, resulting in a national reputation for healthy citizenry and workforce. So far, this coalition has created a database of community programs and resources for prevention and treatment of diabetes and heart disease. The database is divided into categories such as school, workplace, community, public awareness, health care sites, target population, and at-risk population so that trends and pockets where services are lacking can be easily identified.

Goals

1) Lower rates of illness, deaths and cost
2) Improve education in adults and youth, leading to better lifestyle patterns
3) Increase knowledge of signs and symptoms of diabetes and heart disease for the medically "at-risk" populations
4) Increase access to a continuum of education-prevention-intervention support systems.

America's Children and Heart Disease

Because heart disease begins early in life, one of the recommendations of the Texas Coalition on Cardiovascular Disease and Stroke is to educate the Texas Education Agency and local school districts about the positive long-term benefits of a public school curriculum that includes physical education, nutrition, and health education and their relationship to CVD and stroke prevention.

The following facts are credited to HeartMemo, a National Heart, Lung, and Blood Institute publication.

* About one percent of U.S. children and adolescents have high blood pressure.

* Average blood pressures tend to rise with age - slowly before adolescence and faster after puberty.

* Children's high blood pressure tends to persist into adulthood, even for children with high-normal pressure.

* Average blood cholesterol levels in American children and adolescents are too high.

* Children and adolescents with elevated blood cholesterol levels are more likely to have elevated levels as adults.

* Children typically start smoking cigarettes in grades 5 and 6.

* Eleven percent (or 4.7 million) of those ages 6 to 17 are overweight - more than double the percentage of a decade ago.

* Up to 20 percent of overweight children remain so throughout life

* Most children accumulate at least one hour of physical activity daily, but a sizable percentage do not get frequent, vigorous, continuous activity.

* Of high school students, only about half of boys and a quarter of girls do vigorous physical activity three or more times a week.

* Activity levels of girls are below those of boys and tend to decline with age.

(Next Month: "Emerging Risk Factors" and excerpts of reports on CVD and stroke from the November meeting of the American Heart Association.)

Policy Change in Procedures for Obtaining Disabled Person License Plates

House Bill 580 created several changes in the procedures for obtaining disabled person license plates and/or placards. One of the changes was the requirement of a notarized signature of a physician licensed to practice medicine in this state or a written original prescription from the licensed physician signing the Application Form for Disabled Person License Plates and/or Placards, Form VTR-214.

It was previously noted that if the physician provided a written prescription for their disabled patient, they would still need to sign the Form VTR-214.

According to the Texas Department of Transportation, "Upon subsequent review of our rules adopted in May, we determined that we could revise the existing policy to make it more customer-friendly. Effective immediately, if a physician provides a written prescription in lieu of a notarized signature on the Form VTR-214, the physician does not need to sign the Form VTR-214. The physician's written prescription must contain the physician's name, address, professional license number, the disabled person's name, and a statement indicating that the disability is either temporary or permanent."

Physicians can direct any questions to David Linzey, Director, Headquarter Operations, Vehicle Titles and Registration Division of the Texas Department of Transportation, at 512-465-7719; or Ms. Claudia Woods, Chief of Registration, at 512-465-7923.

Dr. Bill Hospers and his wife, Chuckie, visit with Dr. David Gouldy at Mercado Juarex.

Below: Drs. Joseph Del Principe and David Grice in conversation at the October district meeting.

District XV members and guests enjoy the evening's ambiance.

Drs. Craig Whiting and David Gouldy take a break during the October meeting.

Joseph Del Principe, D.O., TOMA District XV President, presents the NOM Week Proclamation during a District XV meeting.

TOMA District XV

TOMA District XV met on October 14, 1998, at Mercado Juarez for a social meeting. During this meeting, Joseph Del Principe, D.O., presented the district with a proclamation for National Osteopathic Medicine Week (see related articles on NOM Week on pages 20 through 22).

Other business on the agenda included a discussion on early voting and the TOMA-PAC endorsements. The subject of record-keeping of prescription drugs also elicited a fair amount of discussion.

Also during the meeting, plans were made for the District XV presidential visit on November 18, 1998, to be held at the Piccolo Mondo in Arlington.

District News

TOMA District X

Patrick J. Hanford, D.O., of Lubbock, was quoted in a lengthy article in the Lubbock Avalanche-Journal, in which he spoke about osteopathic medicine's beginnings, its techniques and philosophy, the training of osteopathic physicians and the profession in general. The following are excerpts from that article:

"The difference [between D.O.s and M.D.s] is that we have a holistic approach to medicine, and much stronger emphasis on musculoskeletal diseases because muscles, joints and tendons are directly related to most disease processes. For example, when you have the flu you have body aches; you hurt all over. With osteopathic manipulation we can help decrease body aches without necessarily having to use medications. In other words, we do manipulations of muscles and joints to help decrease pain."

"D.O.s are trained to be doctors first and specialists second," Hanford said. "The majority are family-oriented, primary care physicians...because one of the osteopathic philosophies has always been a strong emphasis on primary care, as opposed to the M.D. schools, which are just beginning to recognize the importance of primary care."

Hanford added, "And the importance of primary care is in the continuity of care afforded the patient, and the continual monitoring of their health or illness by their doctor."

The article noted that "many people are still unsure about osteopathic medicine simply because its practitioners are rare in many parts of the nation, comprising less than 10 percent of all physicians in the United States."

Dr. Hanford replied, "So we're definitely a minority and when it comes to competing with the recognition allopathic physicians enjoy, we haven't been able to send out enough information to the public concerning what we do and how we treat patients. The problem is not public acceptance, but rather public awareness. I have patients coming in daily asking to be seen by a D.O., whether it was because they were treated by one before, or have a family member or friend who was treated by one."

He concluded, "We're hoping the public will recognize osteopathic medicine in Lubbock County; that it's available as an alternative to allopathic medicine."

OSTEOPATHIC PHYSICIANS

WOMEN'S HEALTH

NATIONAL OSTEOPATHIC MEDICINE WEEK

November 1-7, 1998

National Osteopathic Medicine Week, celebrated November 1-7, 1998, focused on informing post-menopausal women of the many potentially serious medical conditions and problems that can develop without adequate preventive care.

In 1998, nearly 40 million women were post-menopausal and this number is increasing rapidly as the "baby boomer" generation matures. Thus, as the number of post-menopausal women continues to increase, it will be more important than ever that they receive the best health care. As women hit menopause they are at a higher risk for cardiovascular disease, osteoporosis and arthritis. Many post-menopausal women may experience sexual problems. Some women may consider hormone replacement therapy to replace estrogen lost during menopause, thus reducing the risk of osteoporosis, cardiovascular disease and helping sexual problems.

Whether it's helping a woman cope with cardiovascular disease or deciding if hormone replacement therapy is right for her, D.O.s are equipped to treat issues surrounding post-menopausal women and provide advice in the context of a woman's lifestyle and medical history.

WHO ARE POST-MENOPAUSAL WOMEN?

* Women usually become post-menopausal in their late 40s to their early 50s.

* Rapid growth in the number of post-menopausal women started in the early 1990s and will continue until the early 2010s because of the "baby boomer" generation.

* According to the Census Bureau, in 1998 there were an estimated 39.7 million women over the age of 50 in the United States, compared to 1992s estimated 36.3 million. That is a nine percent increase in six years.

WHO LIVES LONGER?

* While in 1998 there were an estimated 39.7 million women over the age of 50 in the United States, there were only a estimated 32.3 million men.

* Beginning at age 30, women begin to outnumber men and the female edge keeps getting larger with age. At age 85 there are 100 women for every 39 men.

Number of Post-Menopausal Women per 1,000 in 1994 with Chronic Conditions Affected by Menopause

CONDITION	45-64 years	65-74 years	75 years & older
Arthritis	297	513.6	604.4
Heart Disease	111	250.8	361.4
Hypertension	224.5	378.7	417.5

The Number of Days in Which Usual Activities Were Restricted Due to Chronic and Acute Conditions Increases with Age

AGE	AVERAGE NUMBER OF DAYS MISSED EACH YEAR
Women 25 to 44 year old	16
Post-menopausal women 45 to 64 years old	24
Post-menopausal women 65 and older	37

Leading Causes of Deaths Among U.S. Women Over 50 Years Old

Cardiovascular Disease	54 %
Other Cancers	18%
Breast Cancer	7 %
Accidents	5 %

WOMEN'S HEALTH AND HEALTH CARE FACTS

* Post-menopausal women age 45 to 64 have eight contacts per year with physicians, while women age 65 and older have 12 contacts per year in comparison to women age 25 to 44 who have six contacts a year.

* One in seven women age 45 to 64 has some form of cardiovascular disease. The number increases to one in three women over age 65.

* Post-menopausal women suffer 2.7 million bone fractures, with 41 percent dying in premature deaths caused by fractures.

* After menopause, a woman's body stops making 80 percent of her pre-menopausal estrogen.

* 75 percent of bone loss that occurs in women the first 20 years after menopause is caused by estrogen deficiency rather than aging.

* By 2020, it is estimated that the cost of medical procedures related to hip fractures will increase six times in the U.S.

NOM WEEK ACTIVITIES IN TEXAS

Auxiliary to the Texas Osteopathic Medical Association

Mary Eileen Del Principe, ATOMA Public Health chair, reports that ATOMA members throughout the state worked on getting NOM Week proclamations for their cities. Mayoral proclamations were made for the cities of Amarillo, Arlington, Fort Worth and Dallas. The city of Lubbock also had a billboard proclaiming NOM Week.

The week ended with an ATOMA Board meeting at Colonial Country Club on November 7, 1998. ATOMA sends a special thanks to Dr. David and Merilyn Richards for the lovely lunch where 20 members of the ATOMA board were present. Every D.O. and spouse should thank the active Auxiliary members who helped make NOM Week successful, and for their support throughout the years.

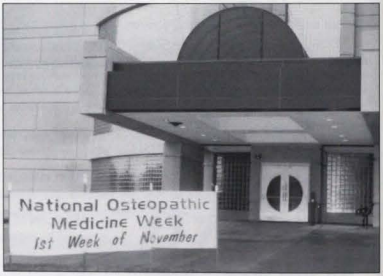
Additionally, one of the TCOM residents, Dr. Marcy Fitz-Randolph, of the manipulative medicine clinic, was an invited speaker at the Southside Lions Club on "What is Osteopathic Medicine?"

Finally, the medical students held a Health Fair on November 1 at the Northside Family Medicine Clinic, where more than 160 individuals received health screenings. The fair provided free blood pressure checks, flu shots, mammogram checks, blood glucose checks and health literature.

The University of North Texas Health Science Center at Fort Worth celebrated NOM Week with a variety of activities

A proclamation was obtained from the City of Fort Worth and Tarrant County declaring November 1-7 as National Osteopathic Medicine Week, and public service announcements were sent to all the radio stations and the local daily and weekly newspapers.

Pictured with NOM Week proclamation, from left to right are: Jay Sandelin, CEO and Chairman of the Board of Osteopathic Health System of Texas; Pam Adams, ATOMA District II President; and Bob Adams, D.O., Chairman and Associate Professor in the Department of OB/GYN at the University of North Texas Health Science Center at Fort Worth. The three made a presentation before the Fort Worth City Council in November.



In a move designed to generate a lot of publicity, a banner was displayed in front of the Patient Care Building during the entire week.

TOMA Accepting Nominations for Awards

The TOMA Board of Trustees is currently accepting nominations for three awards

Distinguished Service
Meritorious Service
Outstanding Community Service

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

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

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

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

TOMA districts that wish to nominate persons for these awards should complete a nomination form, available from Paula Yeamans in the TOMA office, and include pertinent biographical data about the individual as well as information about the person's accomplishments that make him/her deserving of the award. The nomination form must have at least five signatures of TOMA members in good standing; however, no member holding an elective office in TOMA is eligible to sign the nomination. The completed nomination form should then be sent to the TOMA Executive Director, no later than March 15, 1999, who will forward it to the TOMA Awards and Scholarship Committee for consideration.

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

Recipients will be notified by the Board of Trustees and requested to attend TOMA's annual convention, at which time the award will be presented by the TOMA president or master of ceremonies during the President's Banquet on Saturday night.

Not more than one of each award will be granted in any one year. Additionally, these awards are not necessarily annual awards.

National Osteopathic Foundation

Changes Name to

American Osteopathic Foundation

The National Osteopathic Foundation has officially become the American Osteopathic Foundation (AOF), dedicated to supporting education, research and the osteopathic profession.

Additionally, the AOF recently relocated from Atlanta to the American Osteopathic Association headquarters in Chicago, Illinois.

The AOF can be reached at 312/202-8234, 800/621-1773, or by e-mail at aof@aoa-net.org.

Since 1949, the Foundation has been instrumental in fostering a better understanding of osteopathic principles and practice. AOF is the philanthropic affiliate of the AOA and serves the osteopathic medical profession and the public to improve the quality and availability of cost-effective health care. AOF provides loans and scholarships to osteopathic medical students and administers research grant programs for scientific and clinical osteopathic research.

Self's Tips & Tidings

By Don Self

E&M & OMT Symposium Last Month

I'm happy to report that Janet did an absolutely wonderful job of putting together the first OMT & Coding Workshop. It seems that every office manager who attended the coding workshop and every physician who attended the E&M Documentation workshop left satisfied. In fact, every physician who attended the documentation workshop purchased a documentation slide rule. These slide rules have really made a hit with doctors because they simplify the task of choosing which level office visit. One question we found very interesting was asked by one of the physicians attending the workshop. "Don, using this tool reveals that I've been undercoding most of my visits. Is there anything I can do about my past claims?"

Yes! You can appeal those claims up to six months after they have been paid. All you have to do is pick up the phone, call Medicare at 1-903-463-4886 and tell them you want to change the fee and code on the claim. They will do so and issue a new EOMB on the claim.

If you want to receive one of the **1998 Documentation Slide Rules**, send a check for $8.50 to Don Self at P.O. Box 1510, Whitehouse, TX 75791. So far, I've taught these slide rules to doctors at three different seminars and every seminar resulted in every doctor buying at least one. That says something about them.

Medicare + Choice = No Choice

Last November, Congress required that all Medicare patients be made aware of the new plans that would be in effect in 1999. HCFA did a mailout to 39 million beneficiaries telling them about the seven different Medicare plans, and Medicare and consultants have told the providers about all of the plans ranging from HMO, PSO, PPO, PFFO, MSA, etc. There's only one little bitty problem. In order to have the plans, you have to have companies, carriers, financial institutions, etc., willing to administer the plans. As of the date of this writing, only two companies have applied and both companies have limited coverage areas (Northeastern U.S.).

To the best of our knowledge, no companies have stepped forward to meet the stringent governmental requirements to administer the Medicare Savings Accounts, no insurance companies have stepped forward to meet the requirements to offer PFFO plans, and I haven't seen anyone apply to meet the requirements in the Southern U.S. to be a PSO.

What does all of this mean? It means your patients will be carrying these Medicare & You pamphlets into your office asking which plan they should switch to, and you'll be telling them that there are no plans they can switch to. Look out, though, because in the next few months, new plans may be popping into the picture and your patients may be switched when they show up. This is something you and your staff have to stay on top of.

Global Fees - No Pre-Op Included

For years, you've heard that the surgery global fee periods (also called the package) includes the pre-op, surgery and post-op. If this is what you've believed, you've been half-right. If you're talking about the Medicare global fee package, then the pre-op (1 day prior to surgery if the surgery carries a 90 day global) is included in the package price for the surgery. If you're talking about a non-Medicare patient, then you need to re-read your CPT book. Per the definition of "package" in the CPT book, the surgery and the routine post-op is included in the package (global fee period), but the pre-op is not included. This means you may charge separately for the admit, for the office visit on the day prior to the major surgery. Yes, this means you may charges separately for the hospital visit or emergency room visit prior to a surgery, according to the CPT-4 guidelines.

Now, does this mean that all private carriers will automatically pay for it? Nope, that depends on the carrier, but using the definitions found in the CPT-4 code book will give you some great ammunition to get them to pay on appeal! BTW - If you were receiving our monthly 8-12 page newsletter, you would have known about this months ago. Perhaps you should check out the newsletter.

Collecting at the Time of Service

Some seminars you attend will tell you that it is illegal to collect the 20% of the Medicare allowed amount from a Medicare patient at the time of service. I'm here to tell you that unless the patient has a good supplemental or Medigap plan, you're foolish if you do not attempt to collect it from the patient at the time of service. Unless you're using a patient statement service (such as the one we offer), you're currently paying anywhere from 75 cents to $1.40 per every patient statement you send each month. You may ask, "But all I'm spending is 32 cents postage; why do you say 70 cents to $1.40?" It's simple math when you consider the cost of your paper, printer maintenance, toner or ink, envelope, postage and, most important of all, the hours and hours your staff spends on this tedious duty each month. So, my question to you is: *why spend it if you don't have to?* No, I'm not trying to convince you to use our electronic patient statement service, but I am trying to convince you to collect from the patient at the time of service. If your patients are not willing to pay at the time of service, you haven't done a good job of training them and you need to spend some time training your staff on how to train the patient.

Credit Cards

I was talking with a physician this week about accepting credit cards. The doctor told me he didn't want to take credit cards because he didn't want to have to pay the 4% the bank wanted for their fee. I explained to the doctor some basic fundamentals. First, the moment the patient walks out the door, your chances of collecting your full fee just dropped to 84% - meaning that you lost a 16% chance of collecting your full fee.

Now, assuming your average patient encounter is $50, you just lost $8.00. This same patient who left their checkbook at home or used their last check at the grocery store probably has a credit card. If you accepted them, that would have given your staff one more means to collect and even if you paid 4%, your cost to collect would have only been $2.00. You may be one of those that dispute the 16% loss figure and if so, that's okay. But think about this: what does it cost you to send a statement to the patient? Only you know that one.

Managed Care Plans - Do More than Read Them

This past week, we reviewed seven different plans submitted to physicians by managed care companies. I'm still completely amazed at the number of doctors who sign these contracts without first reading them, negotiating them or having a qualified attorney read them. Let me clarify what I mean when I say "qualified" attorney. This is not the same attorney that handled your will, your divorce or the purchase of that time share property. That would be equivalent to me going to my family physician and asking him to personally perform a hip replacement surgery on me.

There are some excellent health care attorneys throughout the United States and I recommend wholeheartedly that you find one you trust and have him or her review your contracts. I also suggest you visit the website called home.earthlink.net/~austintxmd on the internet before you sign any managed care contract. There is an excellent site there by an Austin physician who goes by the alias of Ben Dover, M.D. When reviewing the contract yourself, check to make sure:

1. You can exit or withdraw from the program with only a 60 day notice.
2. You may divorce patients on their plan for the same reasons you can divorce non-plan patients (non-adherence, no shows, failure to pay co-pays, rudeness, etc.).
3. The plan must give you 60 day written notice prior to reducing or altering plan payment amounts.
4. The claim filing deadline for claims is not less than 90 days.
5. The plan agrees to pay clean claims within 30 days or they agree to pay your usual fee rather than the reduced plan amount.
6. The claims appeal period is no less than 180 days from the day the claim is processed.
7. The payor agrees to honor and recognize current year CPT and ICD-9 codes.
8. You do not agree to refer patients only to plan physicians or clinics.
9. At no time in the contract do you agree to see or treat the plan patients within 48 hours of the patient requesting an appointment.
10. Make sure you stipulate no patient-physician relationship exists until the patient has been personally examined by the physician.
11. Make sure there is no verbiage that states you can't notify the patient of a disputed claim.

Once you make these changes to the contract and submit them to the plan, it's your call. If they reject all the changes, you're letting them stack the deck in their favor. That's not good business.

Stress Tests in the Hospital

When you go to the hospital to perform a stress test on your patient, you have a choice as to how to bill for it. If you're billing a private insurance patient, my advice is to use 93015. If you're billing a Medicare patient, we recommend you bill for codes 93016 and 93018. If you're not present when the stress test is taking place, but you're providing the interpretation and report, bill only code 93018. Of course, if you provide the service in your office, bill 93015.

Notification of Seminars

In the months of January through March, Don will be in or near your town teaching seminars. If you want to be notified via fax or email of the seminars on coding, documentation requirements, collections or others, it's up to you to be placed on Don's notification list. If you have email, then email Don at: donself@donself.com If you want to be notified by fax, then fax him a request to be added to the notification list at 903-839-7069. If you do nothing, you may not even be aware of when he's in your area.

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Dallas/Fort Worth Medical Center is NOT on the Market

The board of directors of the Grand Prairie-based Dallas/Fort Worth Medical Center has turned down Houston-based Healthplus Corp.'s offer to buy the hospital. Although hospital officers had signed a letter of intent in July to sell, officials now say that the hospital is doing well on its own and a sale is no longer being considered.

"Since 1996, when the board first began to consider sale options, the medical center has experienced tremendous turnaround," said Chairman Michael Grace.

The hospital's turnaround includes a $100,000 renovation of its third and fourth floors, updated equipment and services in the new cardiology department and a new community outreach van.

"After much consideration, the board does not see a need at this time to join with another health care corporation and feels that the local community can best be served by continuing operations as they are now," Grace said.

Texas Osteopathic Medical Association's

43rd MidWinter Conference and Legislative Symposium

George Smith, D.O. - Program Chairman

16.75 Category 1-A Hours Available

Friday - February 12, 1999

4:30 pm – 8:30 pm	Registration Open
5:00 pm – 6:00 pm	Reception with Exhibitors
5:00 pm – 8:30 pm	Exhibit Hall Open
6:00 pm – 7:00 pm	New Approaches to Smoking Cessation ***Sponsored by McNeil***
7:00 pm – 7:30 pm	Hormone Replacement Therapy Steve Buchanan, D.O. ***Sponsored by Wyeth-Ayerst***
7:30 pm – 8:00 pm	Pharmaceutical Update with Exhibitors
8:00 pm – 9:00 pm	OMT for Carpal Tunnel Syndrome Conrad Speece, D.O.

Saturday - February 13, 1999

7:30 am – 8:00 am	Breakfast with Exhibitors
7:30 am – 4:00 pm	Exhibit Hall Open
7:30 am – 5:15 pm	Registration Open
8:00 am – 9:00 am	Jay Butterman, D.O. ***Sponsored by Eli Lilly***
9:00 am – 10:00 am	Compass 21 New Medicaid Software
10:00 am – 10:45 am	Pharmaceutical Update with Exhibitors
10:45 am – 11:45 am	Cardiac Electrophysiology 1999 Larry Price, D.O.
11:45 am – 12:15 pm	TSBME 1999 Larry Price, D.O.
12:15 pm – 1:30 pm	Legislative Luncheon - Sen. David Sibley
1:30 pm – 2:30 pm	New Advances in Arthritis Therapy: Selective Cox II Inhibitors Bernard Rubin, DO ***Sponsored by Searle***
2:30 pm – 3:30 pm	Pharmaceutical Update with Exhibitors
3:30 pm – 4:30 pm	Forensics in the Branch Davidian Compo David Pareya
4:30 pm – 5:30 pm	Ethics Russell Thomas, D.O.

Sunday - February 14, 1999

8:00 am – 9:00 am	Medical Malpractice Monte Mitchell, D.O.
9:00 am – 10:00 am	Virtues Monte Mitchell, D.O.
10:00 am – 11:00 pm	End of Life Decisions Peggy Russell, D.O.
11:00 am – 1:00 pm	Fraud & Abuse Teresa Habel

Hotel Information

This year's conference will be held at the Fairmont Hotel in the Dallas Arts District, 1717 N. Akard St., Dallas, TX 75201. Reservations must be made no later than January 18, 1999, to receive the discounted group rate of $119 single/double. Call the hotel directly to make reservations 800/527-4727 or 214/720-2020. Be sure to mention you are with TOMA to receive the discounted rate.

Registration Form

Name_____

Address_____

City_____ State_____ Zip_____

Phone (____)_____ Fax (____)_____

AOA #_____ College_____ Grad. Year_____

	Registration Postmarked on or before 2/5/99	Registration Postmarked after 2/5/99
TOMA Member	$175	$250
Non-Member	$275	$350

Please reserve me _____ additional ticket(s) to the Legislative Luncheon on Saturday for $25 each. (One ticket is included with the registration fee.)

Regisration Fee $_____

Luncheon Ticket(s) $_____

TOTAL ENCLOSED $_____

Return this form with payment in full to:
TOMA
1415 Lavaca Street
Austin, TX 78701-1634

Refund Policy:
Requests postmarked on or before 2/5/99 will receive a refund minus a 25% administrative fee. All requests must be made in writing. No refunds will be issued after 2/5/99.

New Educational Materials on Diet & Heart Disease Available for Health Care Professionals

The American Medical Women's Association (AMWA) announces the availability of a free educational program and handout for use by health care professionals. "The Guide to Heart Healthy Eating" is a user-friendly patient education brochure outlining the basics of good nutrition, the building blocks for a heart-healthy diet, and is based on dietary guidelines from the American Heart Association and the U.S. Dietary Guidelines for Americans. The "Nutrition and Heart Disease" slide-lecture program is ideal for health care professionals to educate their peers, their patients and their community on the importance of good nutrition for preventing and treating coronary heart disease.

Heart disease is the number one killer of American women, resulting in 500,000 deaths every year, more than all cancers combined. Most people know that heart disease kills thousands of men each year, but many do not know that it is such a significant killer of women. More women than men die each year from heart disease, yet women and their physicians may not be aware of their risk. To address this serious public health issue, AMWA launched its not-for-profit Education Project on Coronary Heart Disease in Women to train practicing physicians in "state of the art" education on risk factors and prevention, symptoms, treatment and diagnostic evaluation of heart disease in women. The benefit of diet and lifestyle modification are dramatic and cost-effective, yet doctors may lack the tools they need to educate and encourage changes in their patients. Over the past five years, AMWA has educated over 7,000 health professionals and a wide range of consumers on these issues.

To broaden the availability of this important information on nutrition and heart disease, AMWA has placed the "Guide to Heart Healthy Eating" on their Web site (http://www.amwa-doc.org).

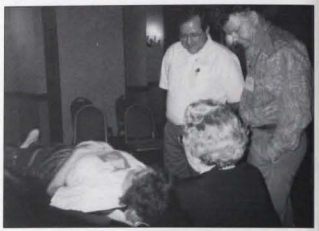
Health professionals interested in presenting information geared toward primary care physicians and their patients on nutrition and heart disease should contact Stephanie Woodfin, CHD in Women Project Manager, at AMWA's National Office (703-838-0500 or email at swoodfin@amwa-doc.org) to receive a free slide-lecture loaner kit.

TEXAS ACOFP HOLDS OMT UPDATE AND REVIEW

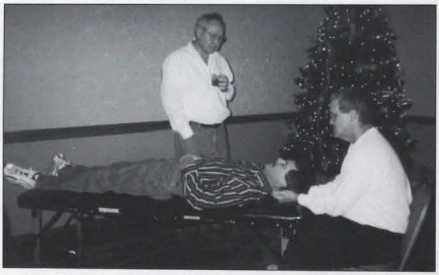
In response to the requests of members of the Texas ACOFP to receive more training in OMT, the Society, under the direction of President Patrick Hanford, D.O., held its 1st Annual OMT Update and Review on December 5-6, 1998, in Arlington, Texas. The seminar began with a four-hour session on Ligametnous Articular Strain, a technique developed by A. T. Still but not taught in medical schools since the 1940s. The program continued with OMT for the Elderly, Cranial Release, Low Back, Shoulder Pain, G/I Disorders and OMT for Otitis Media and Sinusitis.

Carol Browne, D.O., board certified in Family Practice and currently a faculty member of the Department of OMM at the Texas College of Osteopathic Medicine, served as Program Chairperson for the seminar. Speakers included Russell Gamber, D.O., and Scott Stoll, Ph.D., D.O., from the college, as well as members of the Dallas Osteopathic Study Group, a group founded in 1962 by Rollin Becker to study osteopathy. Faculty included T. R. Sharp, D.O., a Past President of ACOFP, Catherine Carlton, D.O., Fort Worth, and Conrad Speece, D.O., Dallas.

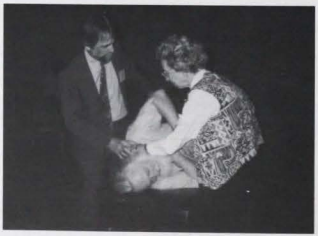
Physicians attending the seminar were extremely excited to receive the opportunity to sharpen their OMT skills in an informal setting. They all received "opearls" (short techniques) for a variety of disorders as well as some new methods being taught in schools. Attending physicians indicated that the weekend was a wonderful experience and urged the Society to offer this program annually.



Treatment for Sinusitis and Otitis Media were just two of the many demonstrated during the OMT Update.



Harold Lewis, D.O., of Austin, observes Robert DeLuca, D.O., of Eastland, performing a technique on TXACOFP President, Patrick Hanford, D.O.



Russell Gamber, D.O. and Catherine Carlton, D.O., demonstrate a technique on Reginald Platt, D.O. of Houston.

TXACOFP NEWS BRIEFS

HALL SCHOLARSHIP FUND

The RICHARD AND MYRTLE HALL SCHOLARSHIP FUND was established in 1996 by the Halls to encourage young people to consider rural health care as a profession. As a family practice osteopathic physician in Eden, Texas for over 25 years, Dr. Hall fought to improve the health care facilities in rural areas and to provide the best possible care to his patients.

The Fund has provided four scholarships of $500 each to Eden high school seniors enrolled in San Angelo State University. After recommendation from the school's principal, these young people are interviewed by the Halls to learn of their career plans.

The Hall Family recognizes and wishes to thank the following individuals and companies who have donated to this Fund:

Dr. Frank Bradley
Mary and Sam Castanuela
Mr. & Mrs. Dail
June Dankworth
Dr. Al Faigin
Dr. Robert Finch
Dr. Jim Froelich
Edward Gates
Dr. Charles Hall
Dr. Richard Hall
Drs. Donna & Wendell Hand
Dr. Patrick Hanford
Mr.& Mrs. Paul Hensley
Drs. Elva & Royce Keiler
Ruth & Lee Kennedy
Mr. L. M. Kirkpatrick
Dr. Richard Lane
Dr. James Linton
Mr. & Mrs. Oehler
Dr. & Mrs. Robert Peters
Patricia & Bob Schneider
Carolyn Sorrell
Bart Truitt
Dr. Stephen Urban
Dr. Brent Wadle
Dr. Arthur Wiley
Dr. & Mrs. Gene Zachary
ATOMA
Eli Lilly
G. D. Searle
Janssen Novartis
Ortho-McNeil
Pfizer
TOMA District II

Donations can be made to
"TXACOFP" Hall Scholarship Fund
1415 Lavaca Street, Austin, TX 78701

TEXAS DELEGATES NEEDED

The Texas ACOFP is looking for members to represent Texas at the ACOFP Annual Convention and Scientific Seminar. This year's Congress of Delegates will meet Friday, March 19 and Saturday, March 20, 1999, at the San Diego Marriott and Marina in San Diego, California.

We are permitted 28 delegates this year and need to know by January 15, 1999 if you are attending. Those who notify us by this date will have a book mailed to them by ACOFP listing all of the resolutions and official business of the national society prior to the meeting.

This is a great way to demonstrate your support of Texas and our society's efforts. Please contact the state headquarters at 888-892-2637 if you will be attending.

LUBBUCK FOUNDATION GRANT

The Lubbock Osteopathic Foundation has provided a grant to TOMA and TXACOFP for the purchase of 10 portable OMT tables. This will enable both associations to easily include OMT as a component of their educational seminars.

The Lubbock Osteopathic Foundation has been a consistent supporter of both associations and its generosity is very much appreciated.

MEMBERSHIP UPDATE

The following physicians were approved for membership at the December 5, 1998 TXACOFP Board of Governors Meeting:

Deborah D. Browne, D.O., Fort Worth
Theresa Boyd, D.O., Eden
James E. Froelich, D.O., Bonham
Nancy G. Faigin D.O., Fort Worth
Jill A. Gramer, D.O., Saginaw
Sylvia J. Herr, D.O., Cleburne
Daniel K. Leong, D.O., Garland
Kristen Pak, D.O., San Antonio
Stephen B. Trammell, D.O., DeSoto
James Waggener, D.O., Fort Worth
Sergio Zamora, D.O., Eagle Pass

We appreciate these physicians and their support of our efforts and programs.

Help on the Net for Dealing with the Millennium Bug

Many websites offer information about dealing with the year 2000 bug. The following are some of the best sources for small businesses.

Small Business Administration Y2K site - www.sba.gov/y2k
This site includes checklists, step-by-step testing instructions, and "business card" links to consultant and vendors that specialize in helping small businesses.

Small Business Advisor site - www.isquare.com/y2k.htm
This site carries to-do lists and how-to's for testing your personal computer's compliance with Y2K.

Y2K Links Database Home Page - www.y2klinks.com/
This links to good sources of information, contacts and even an artificial-intelligence database called Millie that lets you ask questions such as "Is my vendor's software Y2K-ready?" It also offers reviews of software and hardware that address the millennium bug.

Vendor Sites
Vendor sites can offer information about a company's specific hardware and software. Notable sites are Microsoft's Y2K page (www.microsoft.com/industry/tools/y2k.htm) and IBM's Year 2000 page (www.ibm.com/IBM/year2000). Most vendors, including major computer and hardware manufacturers, post Y2K information at their sites. Some vendors also have software you can download to test your PC for Y2K compliance.

Swiss America Trading Corp. Y2Knet (www.y2knet.com/) and Westergaard Year 2000 site (www.y2ktimebomb.com/)
These sites provide ongoing news, articles and commentary.

Peter de Jager's Year 2000 page (www.year2000.com) and the Information Technology Association of America (www.itaa.org/year2000.htm)
These list dozens of Year 2000 consultants and "solution providers," articles, news, and answers to common questions about the millennium bug.

The Year 2000 Journal (www.y2kjournal.com)
This is an online and print magazine dedicated to addressing bug problems, and also offers a list of links to vendors.

Source: Your Company, Oct./Nov., 1998

New Dean Appointed for KCOM

The Kirksville College of Osteopathic Medicine Board of Trustees has approved the appointment of Michael L. Kuchera, D.O., F.A.A.O., a 1980 KCOM graduate, to vice president for academic affairs and dean. He had been acting in the position since February, 1998.

Dr. Kuchera served as the chairperson of KCOM's osteopathic manipulative medicine (OMM) department since 1988 and has been a member of KCOM's faculty since 1981. The son of William A. Kuchera, D.O., F.A.A.O., a KCOM 1958 graduate and emeritus professor of OMM, Dr. Michael Kuchera is a former president and a fellow of the American Academy of Osteopathy. He is also active in the American Osteopathic Association, having served as chairperson of the AOA Council on Research and Grants and as a member of the AOA Bureau of Research and the AOA Council on International Osteopathic Medical Education and Affairs.

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

* Glenn M. Calabrese, D.O., was notified by the American Board of Emergency Medicine of his successful completion of the examinations in the specialty of emergency medicine, and his certification as a Diplomat of the American Board of Emergency Medicine. In addition, Dr. Calabrese was named a fellow in the American College of Emergency Physicians.

* The United States Transportation Department issued orders for 1990 automobile models to feature shoulder belts in back seats. This came after years of growing concern over injuries received by rear-seat passengers buckled up only by lap belts.

* Texas College of Osteopathic Medicine and faculty members were honored by the Fort Worth/Tarrant County Public Health Department for their volunteer work at the Homeless Health Clinic at the Presbyterian Night Shelter. Honored were David M. Richards, D.O., TCOM President; Francis Blais, D.O.; Gregory Friess, D.O.; Janice Knebl, D.O.; Bernard Rubin, D.O.; Stanley Weiss, D.O.; and Robert Woodworth, D.O.

The Homeless Health Clinic was opened by the Health Department in February, 1988. The physicians honored provided evaluation, diagnosis and basic medical treatment at no charge.

Also honored were eight D.O.s in private practice: Mike Adamo, D.O.; Stephen Taylor, D.O.; James Poplawsky, D.O.; Phil Cohen, D.O.; Michael Bell, D.O.; Ruth Carter, D.O.; William Griffith, D.O.; and Ann Adamo, D.O.

* The American Osteopathic Association's latest fact sheet listed a current total of 28,269 doctors of osteopathic medicine.

Budget Bill Passed by Congress

Congress passed a giant budget bill before going home to campaign for the November elections and the President signed it. The following is information about the bill.

* The Medicare interim payment system for home health services was liberalized. The per-visit limit and the per-beneficiary cap were raised. A 15 percent reduction mandated by the Balanced Budget Act was delayed for a year. The $1.7 billion cost is financed through changes in the tax law related to gambling winnings and by a fiscal year 2002-2003 home health market basket reduction. Half of the funding comes from non-health care sources.

✓ User fees for providers were not adopted. The hospital field had fought off user fees throughout this session of Congress, but had feared that a last minute back-room deal might impose them after all.

✓ $2.5 million in funding was provided for rural critical access hospitals.

✓ Legislative language requires the General Accounting Office to monitor and report on U.S. Attorney's general compliance with false claims act guidelines.

Legislation Introduced in the Closing Days of Congress

Two significant pieces of legislation were introduced in the closing days of Congress. In both cases, the sponsors said they wanted to make the proposals available for review and discussion, and intended to reintroduce them this year in the 106th Congress.

* Senators Robert Bennett (R-UT) and Connie Mack (R-FL) introduced S. 2609, the "Medical Information Protection Act of 1998." The bill intends to protect the privacy of medical information while respecting the needs of providers, insurers, and researchers to have access to patient information under specified circumstances. Existing law specifies that if the Congress does not act by August 1999, the Secretary of Health and Human Services is required to put into place regulations governing health information in an electronic format. The bill addresses both paper and electronic records. Major hospital organizations and the Pharmaceutical Research and Manufacturers of American have applauded the introduction of the legislation.

* Rep. Benjamin L. Cardin (D-MD) has introduced H.R. 4739, the "All-Payer Graduate Medical Education Act." It would establish a trust fund funded by a one percent fee on health care premiums. About one-third of the revenue to the fund would be used to reduce the Medicare program's GME contribution. Direct graduate medical education payments would be based on national average resident salaries and fringe benefits. Hospitals receiving indirect medical education payments would report annually on their contributions to education and other factors. Disproportionate share payments would be redistributed more uniformly nationwide (including to rural hospitals). The Secretary would develop and implement a plan to achieve within five years a limitation on first-year residencies to 110 percent of U.S. medical school graduates. Rep. Fortney "Pete" Stark (D-CA) and Rep. William J. Jefferson (D-LA) are cosponsors of the bill.

Source: AOHA Washington Update

AOA Eye on Federal Agencies

A synopsis of some of the important changes in the Medicare 1999 Physician Fee Schedule Final Rule, published November 2, 1998, in the *Federal Register*

Conversion factor for 1999 dips to $34.7315 from 1998's $36.6873

It's true, the Medicare dollar conversion factor for 1998 will actually be lower than the current rate. However, you must take in to account other factors, such as the geographic adjustment in your area, the service mix your practice performs, and the first set of changes in practice expenses. Here's a look at some procedures, comparing 1998 with 1999 payment rates.

Comparison of 1998 and 1999 Payment Rates for Selected Procedure Codes

CODE DESCRIPTOR	1998 PAYMENT	1999 NON-FACILITY PAYMENT	1999 FACILITY PAYMENT
12031-Layer closure of wounds	$101.31	$117.39	$95.51
88170-Fine needle aspiration	$82.35	$83.36	$83.36
98929-Osteopathic manipulation	$55.44	$58.35	$56.27
98942-Chiropractic manipulation	$40.27	$41.68	$36.82
99203-Office visit-new/outpatient	$68.93	$76.06	$62.17
99283-Emergency visit	$61.16	NA	$93.78

Note: The dollar amounts above are not adjusted for geographic variation. They take into account changes in the conversion factor and in the practice expense values for the listed procedures.

HCFA keeps 1998 "downpayment" rates for four-year transition to resource-based practice expenses

HCFA is sticking to its guns and its June interpretation of the statute which will maintain the 1998 practice expense relative value units (RVUs) as the base value for the transition years. In 1999, practice expense RVUs will be based on a blend of 25% of the resource-based RVUs and 75% of the 1998 RVUs; in 2000 the blend will be 50-50; in 2001 the RVUs will be based on a blend of 75% of the resource-based RVUs and 25% of the 1998 RVUs; and, in 2002, the RVUs will be 100% resource-based. AOA supported HCFA's stance as stated in the proposed rule. Some organizations opposed HCFA's choice, however, commenting that the downpayment figures were intended to be used in 1998 only, and that throughout the transition, HCFA should return to practice expense values used in 1997, or in 1991 at the inception of the fee schedule. This would eliminate gains made by office-based procedures, then slowly phase them back in, creating a "yo-yo effect."

HCFA disagrees that such an effect is what Congress intended. "We have analyzed both the statutory language and the context in which it was found, and we have determined that the best accommodation of the two is to use current 1998 practice expense RVUs as the basis for the transition to the resource-based practice expense system."

HCFA maintains the top-down methodology best serves its purposes

HCFA still believes the top-down methodology proposed in June is the best way to calculate practice expenses. "However," the agency admits, "we agree that a possible weakness of the top-down approach is that it may perpetuate historical inequities in the current charge-based practice expense RVUs." AOA noted this problem in its comments to the agency. HCFA agrees with AOA that "more highly paid physicians would presumably have more revenues that could subsequently be spent on their practices." The agency believes this issue should be discussed during the refinement period.

The American Medical Association's Socioeconomic Monitoring System (AMA SMS) survey chosen as best available data, HCFA says: In our comments on the proposed rule, we alerted HCFA to the fact that:

"HCFA erroneously states that 'the recipients of the [AMA SMS] survey are randomly selected from the AMA's physician master file, which contains current and historical information on every physician in the United States, including nonmembers of the AMA' (emphasis added).

Though the physician master file does contain information on non-AMA members, it only contains information on those physicians who graduated from an allopathic medical school. Therefore, the SMS data contains no information about osteopathic physicians."

HCFA responded that it recognized some specialties are underrepresented and not included in the SMS survey, hence "one of our most important tasks during the immediate refinement period will be to work with the AMA and the medical community to consider possible ways to improve the representativeness of the aggregate specialty-specific data so that sampling error is decreased." However, HCFA is extremely wary about subsequent survey data it may receive, especially that from individual specialty societies. Instead, the agency believes that "it is more appropriate to use data collected at the same time by an independent surveyor for a wide variety of specialties that both gain and lose under the proposal."

Site-of-service differential now shown in two separate values

As proposed (and illustrated in the table on page 34), there will be two practice expense categories for most procedures: non-facility, or office rates, and facility rates. In response, some commenters felt that "the differential will accelerate the shift of some services from facility to nonfacility settings at the expense of patient safety." HCFA disagrees. The agency believes that since the different pricing structure reflects real differences in practice costs, no incentive to move procedures to the office setting, which offers a higher payment, exists. *"We have complete confidence that physicians will continue to exercise their best clinical judgment as to the most appropriate setting for their patients,"* HCFA wrote.

Separate payment for office-based supplies for certain procedure codes will be eliminated

Currently, physicians may bill for separate payment for supplies if the following procedures are performed in a physician's office: closing a tear duct (68761) allows payment for a permanent lacrimal duct implant (A4263); inserting an access port (36533) allows separate payment for an implantable vascular access portal/catheter (A4300); and, performing cystoscopy procedures allows payment for a surgical tray (A4550). Now that a specific payment rate exists for procedures performed in an office setting, HCFA will eliminate separate payment for these supplies. However, this separate payment will be phased-out as resource-based practice expenses are phased-in over the next four years.

All practice expense values will be interim throughout the transition period — 1999-2002

The practice expense values of all codes will be considered interim during the entire four-year transition period, as AOA and many organizations requested. For 1999, 2000, and 2001, HCFA will publish the fully resource-based practice expense values as well as the blended values for the current transition year. However, for codes that are new in 1999 and beyond, HCFA won't provide a transition.

Method HCFA will use to deal with year 2000 disruption of practice expense phase-in uncertain

HCFA understands that "routine updates between October 1, 1999 and April 1, 2000 may need to be delayed because they would occur during a critical time frame...when final Y2K testing and refinements must be accomplished." The agency plans to consult with Congress and physician groups to determine how it can "cause minimum disruption in fee schedule updates," but options under consideration are not noted in the final rule.

Proposal to loosen requirements for physician direction of anesthesia dropped

HCFA will retain current requirements for medical direction of anesthesia services provided by a certified registered nurse anesthetist (CRNA) with a slight change. AOA and other physician groups support current requirements, and opposed HCFA's June proposal to relax them as a risk to patient care. The requirements now state that for each patient the physician must:

* Perform a pre-anesthetic examination and evaluation;

* Prescribe the anesthesia plan:

* Personally participate in the most demanding aspects of the anesthesia plan, including, if applicable, induction and emergence;

* Ensure that any procedures in the anesthesia plan that the physician does not perform are performed by a qualified individual as defined in program operating instructions;

* Monitor the course of anesthesia administration at frequent intervals;

* Remain physically present and available for immediate diagnosis and treatment of emergencies; and

* Provide indicated post-anesthesia care.

Separate payment for interpretation of an abnormal Pap smear approved in all settings

To create a uniform payment for physician services, HCFA will allow separate payment in all settings for interpretation of an abnormal Pap smear, now payable only when provided for hospital inpatients. However, the following criteria must be met, HCFA says: "1) The laboratory's screening personnel suspect an abnormality; and, 2) the physician reviews and interprets the smear."

HCFA to create a model private contract

HCFA plans to create "boilerplate language" that physicians can use in private contracts with Medicare patients. The agency is unable to eliminate the two-year opt out of Medicare required when entering such a contract, as it is a requirement of the Balanced Budget Act of 1997.

Final coverage rules for teleconsultations in rural HPSAs explained

HCFA spelled out the following requirements for teleconsultation:

Eligibility - Medicare patients living in rural Health Professional Shortage Areas (HPSAs) are eligible to receive teleconsultation services. That is, either the site of the consult must be in a HPSA,

Impact of resource-based practice expenses by specialty (percent change) – From HCFA's final fee schedule rule

Specialty	Allowed charges (in billions)	Impact Per Year	June 1998 *Proposed Rule* Cumulative 4-Year Impact	Current Cumulative 4-Year Impact
Physicians (D.O.s and M.D.s)				
Anesthesiology	1.6	0	2	0
Cardiac Surgery	0.3	-3	-14	-12
Cardiology	3.8	-2	-13	-9
Clinics	1.6	-1	-3	-3
Dermatology	1.0	5	27	20
Emergency Medicine	0.9	-3	-13	-10
Family Practice	2.7	2	6	7
Gastroenterology	1.2	-4	-14	-15
General Practice	1.0	1	3	4
General Surgery	2.0	-2	-6	-7
Hematology/Oncology	0.5	2	2	6
Internal Medicine	6.0	0	1	2
Nephrology	0.9	-2	-5	-7
Neurology	0.7	0	0	-1
Neurosurgery	0.3	-3	-10	-11
Obstetrics/Gynecology	0.4	1	5	4
Ophthalmology	3.3	1	11	4
Orthopedic Surgery	2.0	0	-1	-1
Other Physicians*	1.1	0	0	1
Otolaryngology	0.5	2	6	9
Pathology	0.5	-3	-10	-13
Plastic Surgery	0.2	1	5	2
Psychiatry	1.1	0	4	1
Pulmonary	1.0	-1	-3	-4
Radiation Oncology	0.6	-2	-13	-6
Radiology	2.9	-3	-13	-10
Rheumatology	0.2	4	15	16
Thoracic Surgery	0.6	-3	-13	-12
Urology	1.1	1	7	5
Vascular Surgery	0.3	-3	-12	-11
Others:				
Chiropractic	0.4	-2	-2	-8
Nonphysician Practitioner	0.8	0	-1	2
Optometry	0.3	6	36	27
Podiatry	0.9	2	5	9
Suppliers	0.5	-2	-18	-6

* Other physician includes allergy/immunology, oral surgery, physical medicine and rehabilitation, pediatrics, critical care and hematology.

or the patient must demonstrate that he or she lives in a rural HPSA, and Medicare will pay regardless of the site of the consultation.

Scope of coverage - Initial, follow-up or confirming consultations in hospitals, outpatient facilities or physicians' offices delivered via interactive audio and video telecommunications systems will now be covered.

Who can consult and refer - Physicians, physician assistants, nurse practitioners, clinical nurse specialists and nurse-midwives can provide teleconsultations. Physicians, physician assistants, nurse practitioners, clinical nurse specialists, nurse-midwives, clinical psychologists and clinical social workers can refer patients for teleconsultation.

Conditions of payment - The patient must be present during the consultation (not prerecorded) and the examination must be under the control of the consulting practitioner. The referring practitioner or an employee of the referring practitioner may present the patient to a consultant. Registered nurses may not act as presenters during teleconsultations.

Medicare payment policy - A single payment will be made to the consulting practitioner, equal to the payment for a face-to-face consultation. The consulting practitioner gets 75%, the referring practitioner 25% of the fee. The patient is responsible for the 20% coinsurance.

Billing - The consulting practitioner submits a single claim for the service, and provides the referring practitioner with 25% of any payment, including any deductible or coinsurance. A modifier should be attached to the appropriate consultation code to identify the service as a teleconsultation. The referring practitioner cannot bill Medicare for the teleconsultation.

Eleven specialty groups sue HCFA over 1998 downpayment use during transition to resource-based practice expenses

On November 4, two days after publication of the fee schedule final rule, 11 physician specialty organizations filed suit against HCFA in federal district court in Chicago. The suit contends that HCFA illegally used the 1998 practice expense relative value units as the base figures for the 4-year transition to resource-based practice expense relative value units. Plaintiffs charge that adjustments to the 1998 practice expense values authorized by the Balanced Budget Act of 1997 were intended for one year only, and that HCFA cannot extend them against Congress' intent. Values from 1991 should be used instead, the plaintiffs argue. This is a crucial issue for the AOA, as this lawsuit, if successful, would remove for 1999-2001 the 1998 primary care downpayment for which AOA lobbied.

Plaintiffs in the suit are the: American Association of Neurological Surgeons; Congress of Neurological Surgeons; American Academy of Ophthalmology; American Academy of Orthopedic Surgeons; American College of Cardiologists; American College of Gastroenterologists; American Gastroenterological Association; American Society for Gastrointestinal Endoscopy; American Society of Cataract and Refractive Surgery; Outpatient Ophthalmic Surgery Society; and the Society for Excellence in Eyecare.

The Practice Expense Fairness Coalition (PEFC), of which AOA is a member, has already responded to this suit with a letter to the media and members of Congress. The letter states that the lawsuit is based on "an erroneous interpretation of congressional intent and the requirements of the Balanced Budget Act of 1997."

The lawsuit, if successful, could cause a delay in the transition to resource-based practice expenses which Congress mandated as of January 1, 1999. "HCFA would be required to recalculate the PE-RVUs and transition payments for virtually every code, and to impute new PE-RVUs for the more than 2,000 services with codes developed since 1991," the PEFC letter argues. Clearly, HCFA couldn't meet the January 1 mandate if this were the case.

If 1991 values were used as the base for calculating transition values (as the lawsuit contends was Congress" intention), primary care physicians stand to lose $700 million over the next two years. "It would make practice expense payments less fair and rational...services whose PE payments went down in 1998 would go up in 1999 then back down again in subsequent transition years," the PEFC letter explains.

HCFA is confident the suit will not be successful, and that it correctly interpreted Congress" intent. However, AOA will continue to work with PEFC and monitor the progress of the lawsuit.

Harris Methodist Health Plan Pays Penalties to Physicians

Harris Methodist Health Plan has finished reimbursing North Texas physicians $3.4 million in penalties and lost bonuses, according to a letter sent to the Texas Department of Insurance.

The state, in April, had ordered Harris to pay after department attorneys determined that the contracts illegally encouraged physicians to limit necessary medical care. Under the agreement, the insurer did not admit illegal actions and agreed to pay the balance within 30 days.

ATOMA News

By Linda Cole, ATOMA President

Auxiliary to the American Osteopathic Association Annual Convention

The October convention was held in New Orleans with all the dazzle that is reminiscent of the "party city". ATOMA's Rita Baker was responsible for the opening ceremony, which was full of music and fun! In her own enticing fashion, Rita enlisted the help of ATOMA's Merilyn Richards, Susan and Duane Selman, Shirley Bayles, Nancy Zachary and many others in the dancing and bead throwing that is typical of Mardi Gras.

The proposed name change was defeated so that issue was put to rest, for now. **THE YELLOW RIBBON YOUTH SUICIDE PROGRAM** was adopted. This awesome program and our role in partnering with the program is to:

1. Help get a Yellow Ribbon Card to every young person in the world.

2. Get adults to recognize that when a Yellow Ribbon Card is presented to them, they need to respond by making sure that the individual gets the help he or she is seeking.

FACTS

- Suicide kills our kids 3 to 6 times more than homicide!
- Each completed teen suicide represents 100 teen suicide attempts.
- Suicide is the fastest growing killer of youth in America today!
- There are 16 teen suicides a day.
- 95% of all youth suicides are preventable.

(Maryland - after implementation of their suicide prevention plan, suicides dropped from the 5th highest in youth suicides to 45th in the nation.)

WHAT TO DO TO HELP START THE YELLOW RIBBON PROGRAM IN YOUR AREA

1. Order and get cards in the hands of youth. (Contact your auxiliary board for more information).
2. Get the information to adults.
3. Distribute cards/information to: schools, churches, police and fire departments, youth centers, hospitals and health clinics.
4. Call or write to: clergy, doctors, therapists, company human resource and personnel directors, local newspapers, magazines, journals, radio/TV stations, your favorite celebrities, sports stars, magazines, fraternal organizations and lodges, politicians, governors and mayors.
5. Make Yellow Ribbon Cards available: in basket displays so youth can get them without embarrassment, in schools, churches, teen centers, medical offices, libraries, anywhere!
6. Leave Yellow Ribbon Cards: on the table with your tip after dining, and in books as bookmarks from public and school libraries. Put cards on bulletin boards wherever you go.
7. Spread the word on the Internet.

Our kids are not trying to end their life...they are trying to end the pain! The yellow ribbon card is a safe, simple way to ask for help when the words are not there. The cards are pennies; the different it makes is tremendous.

Melissa Brothers and the S.A.A. were responsible for getting 1,500 card in the Fort Worth Independent School Districts. If they can do it, you can do it.

THIS RIBBON IS A LIFELINE!©

It carries the message that there are those who care and will help! If you are in need and don't know how to ask for help, take this card to a counselor, teacher, clergy, parent or friend and say:

"I NEED TO USE MY YELLOW RIBBON"

The Yellow Ribbon Program is in loving memory of Michael Emme

THIS CARD IS A CRY FOR HELP!

- Stay with the person - you are their *lifeline!*
- They may not be able to tell you clearly their needs if they are in severe emotional pain or distress.
- Get them to, or call, someone who can help if you cannot!

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CONFIRMATION OF MEDICAL BENEFITS COVERAGE

(TWCC Advisory 98-06)

The Commission has been notified of incidents where insurance carriers have failed to confirm medical benefits coverage for treatment that does not require preauthorization under Rule 134.600. Particularly problematic is the situation when an insurance carrier informs a health care provider and/or a pharmacy that the insurance carrier will not pay for services because of a prospective dispute regarding the reasonableness or necessity of medical treatment. Other situations involve insurance carriers filing TWCC-21 forms disputing all future medical benefits for reasons other than the compensability of an injury. These actions should not occur and such situations will be considered by the Commission to be potential violations of the Texas Workers' Compensation Act.

If a health care provider or pharmacy contacts an insurance carrier before services are provided, and preauthorization is not required for the specific services, the insurance carrier must confirm whether or not coverage exits and should inform the requester that preauthorization is not required. The confirmation of coverage can be accomplished by informing the requesting person that:

* the insurance carrier will pay for the reasonable and necessary medical treatment if it is related to the compensable injury, or

* a workers' compensation policy (was/was not) in effect for the date of injury.

Unless the specific service or treatment requires preauthorization under Rule 134.600, an insurance carrier shall not file prospective disputes on the reasonableness or necessity of the treatment being requested. Verification of coverage does not bind the carrier or limit the carrier's ability to retrospectively dispute the reasonableness or necessity of treatment after the carrier receives a bill for the services. An insurance carrier should inform a health care provider about a dispute, and the status of the dispute, when the insurance carrier has already filed a TWCC-21 with the Commission which disputes compensability (that an injury occurred in the course and scope of employment or that a particular problem is related to the compensable injury). Medical disputes for treatment already provided should be filed on the TWCC-62 form, Notice of Medical Payment Dispute, after the insurance carrier receives, audits and adjusts the bills for medical treatment.

An insurance carrier may not prospectively inform any health care provider or pharmacy that it will not pay for a specific service, treatment or prescription when the requested service, treatment or prescription does not require preauthorization under the provisions of Rule 134.600. These instructions also apply after an injured employee has been certified to have reached maximum medical improvement. A certification of maximum medical improvement does not mean that medical treatment is no longer necessary. An injured employee remains entitled to reasonable and necessary medical treatment after the date of maximum medical improvement.

An insurance carrier that fails to confirm medical benefits coverage may commit an administrative violation pursuant to Texas Labor Code 415.002(a)(1), 415.002(a)(7), and/or 415.008. If the requested health care treatments or services do not require preauthorization under Rule 134.600, an insurance carrier that files a prospective dispute on the reasonableness or necessity of medical treatment or that informs a health care provider prospectively that it will not pay for health care services may commit an administrative violation pursuant to the sections of the Texas Labor Code cited above.

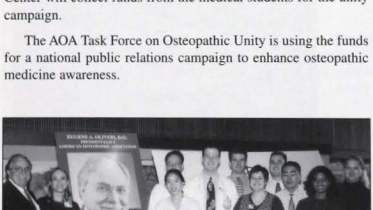
CAMPAIGN
for Osteopathic Unity

On October 27, 1998, Eugene Oliveri, D.O., president elect of the American Osteopathic Association and chair of the AOA Task Force on Osteopathic Unity, visited the Texas College of Osteopathic Medicine.

Dr. Oliveri's visit was designed to signal the kickoff of the Osteopathic Medicine Unity Campaign. He presented the goals of the campaign to TCOM students, which are: to build the awareness about the osteopathic profession, raise its visibility and accentuate osteopathic medicine and doctors of osteopathic medicine's distinctiveness.

TCOM is the first of the 19 osteopathic medical schools in the country to officially open the unity campaign to the student body. Each student pledged to give $5 towards the campaign. The Student Government Association of the UNT Health Science Center will collect funds from the medical students for the unity campaign.

The AOA Task Force on Osteopathic Unity is using the funds for a national public relations campaign to enhance osteopathic medicine awareness.



Eugene Oliveri, D.O., AOA President-elect, visits with the UNT Health Science Center's Texas College of Osteopathic Medicine students in Fort Worth on October 27. Dr. Oliveri's visit signaled the kickoff of the Osteopathic Medicine Unity Campaign at the health science center's medical school.

AOA's New Healthcare Facilities Accreditation Program Offers Hospitals a User-Friendly Option

The American Osteopathic Association recently incorporated their customers requests for a user-friendly hospital accreditation program into an easy-to-use manual that will assist them in complying with accreditation requirements.

The Healthcare Facilities Accreditation Program (HFAP) manual, designed in a new and easy-to-use four column format, allows simultaneous viewing of several items related to each of the requirements. Column one lists the accreditation requirement with which the facility must comply. Column two indicates any explanation required as background to better understand the requirement. Column three indicates what the survey team members will look for in determining the facility's compliance with accreditation requirements including documents to review, interviews to conduct and observations to make. Column four shows scoring criteria for each requirement.

"The new manual integrates the many needs of our accredited medical facilities into a user-friendly guide outlining specific requirements for accreditation," explains George A. Reuther, Director of AOA's Division of Healthcare Facilities Accreditation. "It also helps to ensure that every hospital that regularly uses the manual to perform self-evaluations, will be ready for their accreditation survey."

Crosswalk tables in the manual demonstrate how the AOA accreditation requirements relate to both the Medicare Condition of Participation and the eleven core functions developed by the Health Care Financing Administration (HCFA). In addition, the manual consistently reflects the most current version of Medicare requirements. The AOA Division of Healthcare Facilities Accreditation has incorporated approximately 95 percent of the elements listed in the draft of Medicare Conditions of Participation as published by HCFA and the Federal Register in December, 1997.

"Our goal is to help health care facilities be able to monitor and improve their facility as well as the quality of care they provide to their patients," concludes Reuther. "This user-friendly manual assists facilities in maintaining high quality of care in all areas throughout the year."

The AOA has been accrediting hospitals across the country for more than 50 years, and more than 30 years under Medicare. The AOA Health Care Facilities Accreditation Program is one of only two voluntary accreditation programs in the United States authorized by HCFA to survey hospitals under Medicare and their labs under the Clinical Laboratory Improvement Amendments (CLIA).

For more information about the AOA Health Care Facilities Accreditation Program, please contact George A. Reuther, Director, AOA Division of Healthcare Facilities Accreditation, at 800-621-1773, extension 8060.

THE INDEPENDENT

INVESTOR

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Hedge Funds Teach Us Important Lesson

Hedge funds are not something the ordinary investor usually thinks about when it comes to investing. Primarily used by institutions and the very wealthy, hedge funds are a high-risk investment vehicle. Unlike mutual funds, hedge funds are not regulated by the Securities Exchange Commission and require no disclosures to investors.

Hedge funds borrow large sums of money to make speculative bets on such things as gold, currencies, commodities and equities. They are known for their aggressive trading practices and their highly leveraged market plays. Many of their sometimes huge gains and losses take place shrouded in secrecy.

The veil was lifted last month when the activity of hedge funds suddenly came under close scrutiny. Long-Term Capital Management (LTCM), the Greenwich, Conn. based hedge fund, consists of an all-star lineup of fund managers and researchers - including two Nobel laureates. However, this wealth of talent could not keep LTCM from getting itself into trouble. Due to its very risky holdings, LTCM lost 92% of its holdings in the first nine months of the year.

The Federal Reserve Bank of New York stepped in to help facilitate a 14-company bailout of the beleaguered fund, which Fed chairman Alan Greenspan defended as necessary to avoid potentially damaging results to many economies.

01/99

Why come to the rescue of this particular hedge fund? Greenspan explains, "Had the failure of Long-Term Capital Management triggered the seizing up of markets, substantial damage could have been inflicted on many market participants, including some not directly involved with the firm, and could have potentially impaired the economies of many nations, including our own." [1]

The Federal Reserve acted solely as a "neutral ground" for the bailout negotiations among 14 investment and commercial banks. The Fed's efforts "were designed solely to enhance the probability of an orderly private-sector adjustment," Greenspan explained. "No Federal Reserve funds were put at risk, no promises were made by the Federal Reserve and no individual firms were pressured to participate." [1]

But back to the question at hand: How could a failed fund consisting of some of the savviest investors and wealthiest individuals possibly affect the world economy? The answer lies in the huge amounts of money hedge funds borrow from banks and other financial institutions. If the fund goes under, the banks take a huge loss. They will in turn be tighter with credit, making it more difficult to secure a loan. The credit squeeze slows down the economy, which can potentially harm corporations' earnings and stock prices.

It is important to note that hedge funds, in general, are positive players in the world markets and keep price moves in line.[2] Hunt Taylor, executive director of the hedge fund tracking firm Tass Management Inc., notes that a broadly diversified hedge fund can help protect the investors from risk.

In fact, at least 75 universities, through their endowments, invested last year in hedge funds, including Loyola University in Chicago, Cornell University and Harvard University.[3]

So, good or bad, hedge funds do impact your portfolio. And they teach us a valuable lesson: It is impossible to accurately predict in which direction the markets are moving in the short term. Long Term Capital Management's troubles are just a case in point. That is why it's so important to use asset allocation strategies when financial planning. Determine what kind of investor you are, how much risk you are willing to assume, and the length of your time horizon. And, as always, as financial advisors, we stand ready to help you in this process.

[1] CNNfn, the financial network, October 29, 1998

[2] Bloomberg, Oct. 30, 1998

[3] CNNfn, the financial network. Oct. 2, 1998

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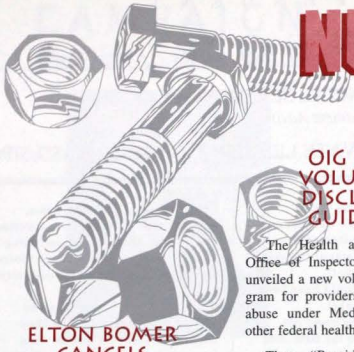


ELTON BOMER CANCELS PUBLICATION OF PROPOSED MANAGED CARE CONTRACT GUIDELINES

A task force formed by Texas Insurance Commissioner Elton Bomer to develop contract guidelines for HMOs and physicians has run out of steam. Disagreement among health industry representatives has led Bomer to cancel the publication of proposed guidelines for physician compensation.

Instead, contracts between physicians and health insurers will be "judged on a case-by-case" basis, Bomer said.

Concerns regarding physician contracts were raised last year during the Insurance Department investigation of the Arlington-based Harris Methodist Health Plan for offering physicians financial incentives. A settlement was reached whereby Harris agreed to pay physicians for penalties and lost bonuses and to rewrite its contracts within 150 days.

The settlement led insurance companies and physicians to ask for specific guidelines to follow when creating contracts. Proposed guidelines were released by Bomer and in October, the task force was created to help establish the specific amount and types of risks.

The task force was unable to agree on key issues such as what percentage of a physician's base compensation he or she should be at risk to lose.

OIG ISSUES VOLUNTARY DISCLOSURE GUIDANCE

The Health and Human Services Office of Inspector General (OIG) has unveiled a new voluntary disclosure program for providers to report fraud and abuse under Medicare, Medicaid and other federal health care programs.

The "Provider Self-Disclosure Protocol" replaces the voluntary disclosure pilot project begun by the OIG under Operation Restore Trust in 1995 and is effective immediately. In contrast to the old pilot program, the new Protocol is available to all providers - the previous pre-disclosure, admission and preliminary qualifying requirements have been eliminated by the OIG. Providers who voluntarily disclose under the new Protocol will not be immune from prosecution under the federal civil or criminal False Claims Act, however, such disclosure could be a mitigating factor in the OIG's recommendations to prosecuting agencies.

The new Protocol can be obtained from the OIG's website at www.dhhs.gov/progorg/oig

WIDER "PATIENT DUMPING" RULE PLANNED

The federal government is warning hospitals against delaying or denying emergency room care just because a patient's health insurance plan requires pre-approval before treatment.

Although a 1986 law prohibits hospital emergency rooms from refusing to examine and stabilize patients who can't pay, government regulators say that delays while emergency room staff consult with health plans to see whether insurance will pay are on the rise. To deter such incidents, the U.S. government will begin applying the patient dumping prohibition, which carries fines of up to $50,000 per incident, to ensure immediate care whether or not insurance pays.

June Gibbs Brown, inspector general of the Department of Health and Human Services, noted, "Despite the terms of any managed care agreements...federal law requires that stabilizing medical treatment be provided in an emergency."

The government plans to issue the policy statement as a special advisory bulletin. The public will then have 30 days to comment on it before it becomes final.

HEALTH CARE SPENDING REVEALS SMALL INCREASE

A report released by the Health Care Financing Administration reveals that health care spending was relatively stable in 1997, with the national bill growing by less than five percent for the third consecutive year. It was the smallest increase since 1960, when the government began tracking spending in comparable terms.

Managed care in the private sector has kept health care spending increases low since the mid-1990s, and now cost controls in Medicare are starting to slow the pace of growth in that program, bringing the overall increase in 1997 to just 4.8 percent.

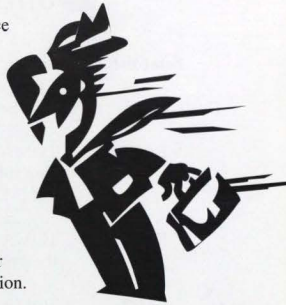
Overall, health care spending in 1997 totaled $1.1 trillion with an average of $4,000 spent per person. However, the government predicts that spending will soon begin to rise, nearly doubling to $2.1 trillion by the year 2007, due to insurance premium increases and a rise in private payments as insurance companies look to compensate for cost controls in Medicare.

Each year's spending is primarily a product of two factors: spending in the private sector and government spending, mainly Medicare and Medicaid.

MEMBERSHIP ON THE MOVE

1999 — *the last year of this century!*

It's also a Legislative year and a strong, vocal, professional presence is more important now than ever.



We know that there are a number of osteopathic physicians who, for whatever reason, are not members of TOMA.

Let's all work together to make improving our membership numbers a priority for 1999.

The best method of recruiting new members is peer to peer. — one physician sharing with another physician his/her reasons for belonging to TOMA and inviting that physician to join the association.

Please start the year off by calling one osteopathic physician who is not a TOMA member. If you are not sure, call the TOMA office and we will check for you. Invite that individual to a district meeting and encourage him/her to support the osteopathic profession by joining the association. As an extra incentive, you will receive $50 off your registration fee for TOMA's Annual Conference, to be held this year June 17-20 at the Hotel Inter-Continental in Dallas.

If you need a non-member physician's address or phone number or would like for the TOMA staff to send a non-members physician a membership form, **call us at 1-800-444-TOMA** and we will be delighted to assist you.

If we all work together, we CAN achieve the goal of EVERY osteopathic physician in Texas becoming a member of TOMA.

Dialysis Provider May Donate Funds for Low Income ESRD Patients

In an advisory opinion issued on November 6, 1998, the Office of Inspector General (OIG) concluded that a dialysis company which owns dialysis facilities may donate funds to be used by needy ESRD patients to a nonprofit charitable organization. The charitable organization may, without restriction, use the funds to assist these patients to pay their Medicare Part B and Medigap premiums, without violating the federal illegal remuneration statute.

The OIG stated in its opinion that the donated funds are not likely to influence a beneficiary's selection of a particular provider due to the following issues: The charitable organization 1) is completely independent of the dialysis company, 2) provides funds to financially needy ESRD patients regardless of the patient's provider, 3) makes its own eligibility determinations, and 4) takes referrals primarily from social workers. It was noted that most patients have already selected a provider prior to receiving the financial assistance. Once they have received the funds, they may select any dialysis facility. The donated funds will actually "expand rather than limit, beneficiaries' freedom of choice of providers."

Texas Osteopathic Medical Association Political Action Committee

Established to protect and promote the interests of osteopathic medicine in Texas.

During the 75th Legislative Session, TOMA had many successes. . .

FACT: TOMA worked with other health care organizations to pass the managed care reform package which provided greater oversight of the operations of HMOs and PPOs.

FACT: TOMA worked with other health care organizations to effectively defeat the property tax bill.

FACT: TOMA worked to amend the law so that after 1999 physicians will no longer be required to use triplicate prescriptions for scheduled drugs.

FACT: TOMA worked to obtain additional funding to increase the number of family practice and primary care residency slots available in Texas.

FACT: TOMA worked to defeat the naturopathic licensure bill.

The above is proof positive of the power of **your** association! As you can see, TOMA has many friends in the Texas Legislature. Campaign season will soon be upon us again and we need your help in replenishing our political war chest.

Your financial support to TOMA-PAC will provide us with the opportunity to develop and continue ongoing relationships with the legislators as TOMA fights for issues relevant to the osteopathic profession.

PLEASE MAKE A COMMITMENT TO SUPPORT YOUR PROFESSION BY CONTRIBUTING NOW!

SEND CONTRIBUTIONS TO:

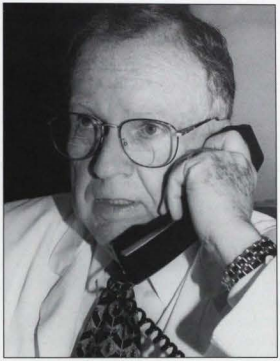
TOMA-PAC
1415 Lavaca Street
Austin, Texas 78701-1634

Terry R. Boucher, MPH, Treasurer

Be sure to include your name, mailing address, occupation and name of employer with your contribution.

NOTE: **TOMA-PAC contributions are not tax-deductible as a business expense. Federal law requires political committees to report the name, mailing address, occupation and name of employer for each individual whose contributions aggregate in excess of $200 in a calendar year.**

UNT Health Science Center President David M. Richards, D.O. to Retire



David M. Richards, D.O., president of the University of North Texas Health Science Center at Fort Worth, has announced that he will retire in December, 1999. Dr. Richards, who has been serving as president since 1986, is one of two presidents in the University of North Texas System.

UNT Chancellor and President Alfred F. Hurley praises Dr. Richards for his leadership in the development of partnerships between the health science center and other health education and health care institutions throughout the country, as well as with business, philanthropic and educational organizations in Fort Worth. Dr. Richards will continue to build upon these and many other accomplishments in 1999 while a nationwide search is conducted to find a new president.

"Dr. Richards has brought national attention to the capabilities of the UNT Health Science Center, especially to its work in primary care medicine and in related research such as its nationally recognized study on cholesterol," Hurley said. "His eventual successor will take the helm of an already highly successful institution, one that has as its centerpiece the leading osteopathic medical school in the United States, plus a growing number of other components, including a newly authorized School of Public Health."

A widely acknowledged leader in his field, Dr. Richards was the first osteopathic physician elected as a member-at-large to the National Board of Medical Examiners, the board which designs the medical licensure tests given to all physicians in the United States. He also was one of the first osteopathic physicians named to the Veterans Administration Special Medical Advisory Group, which advises the VA and Congress. He has previously chaired the board of governors and the council of deans of the American Association of Colleges of Osteopathic Medicine.

A BRIEF BIOGRAPHY

Before coming to Texas, Dr. Richards practiced family medicine in Ohio (1961-81). There, he was elected president of the Ohio Society of Osteopathic General Practitioners. He became the founding chair of osteopathic medicine, and later associate dean for academic and clinical affairs, at the Ohio College of Osteopathic Medicine.

In 1981, he arrived at what was then the stand-alone Texas College of Osteopathic Medicine to take the position of associate dean for academic affairs. Through a series of promotions, he became TCOM's interim executive vice president in 1984, acting president in 1985, and then president in 1986.

In 1993, the Texas Legislature elevated the Fort Worth cultural district's campus, including TCOM, to a health science center. Under Dr. Richards' leadership, the institution's primary component - the osteopathic medical school - has thrived, as have other components. Today, the health science center includes a Graduate School of Biomedical Sciences, five medical research Institutes for Discovery, an Institute for Clinical Research, and a 112-member Physicians & Surgeons Medical Group, Tarrant County's largest multi-specialty group practice. Last fall, the Texas Higher Education Coordinating Board approved the establishment of a School of Public Health at the health science center and a Physician Assistant Program.

Last year, Dr. Richards was named chair of the Health Professions Education Advisory Committee of the Texas Higher Education Coordinating Board. This committee advises the Board on matters related to the education and training of health professionals in Texas.

On the local front, Dr. Richards chaired Fort Worth's Strategy 2000 Biomedical Technology Planning Committee, which led to the 1998 opening of the MEDTECH business incubator. He is active on the Economic Development Group of the Fort Worth Chamber of Commerce, and he is a past president of the American Heart Association of the Fort Worth metropolitan region. He also is a member of the board of directors of the Dallas/Fort Worth Health Industry Council and a member of the Association of Academic Health Centers. In addition, he has served as vice chair of the board of directors for the United Way of Tarrant County.

Dr. Richards is a fellow of the American College of Osteopathic Family Physicians and is certified by the American Osteopathic Board of Family Physicians. He earned his D.O. degree from Kirksville College of Osteopathic Medicine.

The UNT Health Science Center represents an increasingly important economic force in Fort Worth. Its annual community economic impact exceeded $140 million when last calculated in 1996. More than 1,000 men and women hold positions at the center, and some 1,800 additional Tarrant County jobs are filled by those who provide goods and services to the health science center. The rate of growth in the UNT Health Science Center's research budget is the fastest among all Texas health science centers.

Fort Worth Medical Group Appoints Manager

Experienced health care executive, Raymond P. Medina, has been appointed chief operating officer of the Physicians & Surgeons Medical Group, the faculty medical practice of the UNT Health Science Center.

Since 1992, Medina has held a senior management position with the medical group practice at the University of Texas Medical Branch, Galveston. As associate administrator there, he was directly responsible for that group's hospital clinics and outpatient clinic services.

Medina's appointment to the UNT Health Science Center post was jointly announced by Robert C. Adams, D.O., medical director of the Physicians & Surgeons Medical Group and by Sam W. Buchanan, D.O., chairman of its board. They said that Medina's "leadership skills and expertise in health care finance would be put to immediate use in Fort Worth." Medina also has a background in health services contracting, "a critical credential during this rising era of managed care," the physicians said.

Tarrant County's largest multi-specialty group practice, the Physicians & Surgeons Medical Group, is composed of 112 members of the faculty of the Texas College of Osteopathic Medicine. They practice in 24 medical and surgical specialties and subspecialties and have admitting privileges at five Fort Worth-area hospitals. The group manages 176,000 patient visits annually on the center's main campus in Fort Worth's Cultural District and in 11 neighborhood clinics. Group employees at the center number over 300.

Medina, 49, has held administrative positions with the Milwaukee County Medical Complex, Milwaukee, WI; the Good Samaritan Hospital and Health Center, Dayton, OH; and at the Kaiser Permanente Medical Center, Los Angeles. He is a member of the Medical Group Management Association and the society of Ambulatory Care Professionals. A graduate of the University of the Pacific, he earned his master of public health in Health Services Management and Hospital Administration at the University of California, Los Angeles.

From the Texas Health Care Information Council

The Texas Health Care Information Council (THCIC) recently released its first report on the quality of health care providers. For the first time, in 1998 all licensed Texas HMOs were required by law to report more than two dozen of the Health Plan Employer Data Information Set (HEDIS) measures to THCIC. "Your HMO Quality Check-up" contains information about how to choose an HMO and a selection on performance measures chosen from the HEDIS data set. To make the report more useful to consumers, the Council has divided the information into six regional reports.

In addition to collecting data from the HMOs, the Council has begun collecting hospital discharge information from Texas hospitals. This data will be used to produce other reports to assist consumers in making informed decisions about their health care options. Some of the publications on the quality of HMOs and hospitals will be designed to assist employers and purchasers of health care services in making fair comparisons between providers. As representatives of a wide variety of employers, the Council felt that it is important to make trade associations aware of the Council's efforts.

It is the Council's desire to create a partnership with employers and other interested organizations to disseminate the Council's reports to consumers. THCIC is a small State agency with a small budget. With more than 4.5 million families residing in Texas, the cost of providing copies of reports to all those who are interested would be prohibitive.

Their plan is to use the Council's resources to produce high quality publications that will assist Texas consumers in making informed choices about the health care options available to consumers at all levels. The reports are available on their Internet web site (www.thcic.state.tx.us) so that individual consumers can view and download them.

The Council hopes that this information will assist purchasers and providers of health services in working together to improve the quality of health care delivered in Texas.

Technology Efforts Expand at Health Science Center

Molecular biologist Geoffrey Grant, Ph.D., has been named senior manager of research and technology at the University of North Texas Health Science Center at Fort Worth.

Dr. Grant comes to the health science center from CEKA Biotech in California, where he was a biotech consultant, business developer and private entrepreneur for 20 years. Prior to entering the business sector, he served as research assistant professor at the Salk Institute where he worked with Nobel Laureate, Roger Guillemin, on the discovery of specific brain hormones. Dr. Grant also served as CEO of what is now Micrologix Biotech, one of the largest public biotech companies in Canada.

Dr. Grant receive his post-doctoral degree in molecular genetics and cellular biology at the University of California at San Diego and his master of science in microbiology and biochemistry at the University of British Columbia. His research efforts have been published in *Journal of Bacteriology, Immunochemistry, Nature, Biochemistry and Endocrinology*, among others.

Surveillance and Epidemiology Program Debuts Web Site

By Janice Fernandes Jackson, M.P.H.

Have you ever surfed the web for information on the incidence of vaccine-preventable diseases (VPDs) in Texas, information on VPDs, or county immunization rates? Well, now there is a comprehensive web site that contains this information and more.

Located at www.tdh.state.tx.us/immunize/survepi.htm, the Surveillance and Epidemiology (SE) web site was developed to answer frequent customer requests for information and to share important resources available from the SE program.

The SE web site is easy to use and includes a site map with a "Table of Contents." The Texas Department of Health (TDH) search engine is also incorporated into the SE site, so that information can be easily located.

Here are some of the topicscovered by the SE site

- Incidence of VPDs by year, county, and public health region (PHR)
- How to report VPDs and vaccine adverse events
- Statistics from the Perinatal hepatitis B prevention program
- Information on varicella vaccine and the Travis County Varicella Surveillance Project
- Vaccine requirements for children enrolled in Texas schools and child-care facilities
- Immunization rates by state, county and PHR

The SE web site features "hot" maps that you can click on to find out county or PHR statistics such as immunization rates and VPD incidence. Information on the minimum state vaccine requirements for Texas children, as well as case investigation forms for reporting of VPDs are accessible as Adobe Acrobat Reader documents. A link to download the Reader is also available for those who do not have this software. Many links to related web sites are included in the SE site.

Any comments on the web site would be greatly appreciated. Please contact Janice F. Jackson at 800-252-9152.

Source: Texas Department of Health Immunization Division

Governor Appoints J. M. (Mike) Lowrey as Commissioner

J. M. "Mike" Lowrey of Lake Jackson was sworn in as a Commissioner representing employers on the Texas Workers' Compensation Commission on October 1, 1998.

Gov. George W. Bush appointed Lowrey to complete the term of former Commissioner Richard F. Reynolds, whose term will expire on February 1, 2001. Lowrey is the president and chief executive officer of Miken, Inc., a specialty contracting company in Clute.

"Because of his long-standing commitment to safety, Commissioner Lowrey brings a valuable perspective to the Commission. We look forward to working with him to ensure the Commission fulfills its responsibilities of helping to provide safe workplaces for Texans while making sure that workers' compensation benefits are administered equitably," said Commission Chairman Jack Abla.

A graduate of Lamar University, Lowrey is on the board of directors of the Associated Builders and Contractors of Texas Gulf Coast. He also served on the Governing Committee of the Texas Workers' Compensation Insurance Facility. He joins two other Commissioners who represent employers and three Commissioners who represent employees. His appointment is subject to confirmation by the Texas Senate.

Alumni Association Elects Leaders

A new Texas College of Osteopathic Medicine Alumni Association board of directors was elected to lead the 1,941 member organization in 1999.

Fort Worth physician, Jim Czewski, D.O., a 1977 TCOM graduate, is president of the association. He is currently in private practice in Fort Worth at his business, Alpha Ergonomics, specializing in occupational medicine and disability evaluations.

Newly elected board members and their graduating year and location include Dr. David Garza, 1989, Laredo; Dr. Alvin Mathe, 1989, Fort Worth; and Dr. Craig Boudreaux, 1996, The Woodlands. Dr. Boudreaux is also the first physician resident elected to the TCOM Alumni Association.

The Alumni Association provides leadership in the professional development of the medical school's graduates, and seeks to advance osteopathic medicine and the medical school. Board members serve three year terms. TCOM's alums number 1,941 physicians and surgeons across the U.S., with approximately 65 percent practicing in Texas.

"There's real enthusiasm among these association leaders, and I've not seen an eagerness like they have to get to work on a new agenda," said Dr. Czewski. He is the 20th president of the TCOM Alumni Association. "Our priorities include connecting with more of our alumns to ensure their involvement, and offering programs to advance the profession and to support current TCOM students."

Continuing board members are Dr. James Froelich, 1981, president-elect, Bonham; Dr. Jack McCarty, 1978, vice president, Lubbock; Dr. Greg Smith, 1983, immediate past president, Aurora, CO; Dr. Dale Chisum, 1978, Wichita, KS; Dr. Tony Hedges, 1991, Littlefield; Dr. David Hill, 1993, Cuero; Dr. John Jones, 1987, Pomona, CA; Dr. Ray Morrison, 1986, Tyler; Dr. Elizabeth Palmarozzi, 1984, Fort Worth; Dr. Dan Saylak, 1983, College Station; Dr. Rodney Wiseman, 1978, Whitehouse; and Dr. Gary Wolf, 1977, Mansfield.

Texas Board of Health Approves Named-based Reporting of HIV

On November 20, 1998, the Texas Board of Health approved rules that require the names of people testing positive for HIV infection to be included in standard disease reports to state health authorities. The rules took effect January 1, 1999.

Since 1994, Texas has used a reporting system based on assigning each HIV case a unique number. But Texas Department of Health (TDH) officials say the system has failed to generate reliable HIV data. They estimate that as few as 26 percent of positive HIV test results have been reported.

"Named-based reporting will improve TDH's ability to track HIV and direct money and resources where they are most needed," said Dr. Walter Wilkerson, board chairman. "It also will enable us to do a better job of linking patients and their partners with preventive and medical services."

Dr. Wilkerson stressed that names of persons with HIV are confidential and will not be made public. "Reportable does not mean releasable," he said. "The names will only be used for public health purposes. They will not be released to the media, insurance companies, employers or other government agencies. The board would oppose any measure that threatens HIV confidentiality."

Anonymous HIV testing will continue to be available. TDH will continue to require its HIV testing contractors to offer anonymous testing. Results of anonymous testing are not reportable.

Names of persons with AIDS have been reported to the TDH since 1983. Names of infants and children with HIV have been reported since 1994. Dr. Wilkerson said the TDH has never had a security breach in its HIV or AIDS reporting systems.

The move to a named-based HIV reporting system was proposed by the TDH last year. Modifications to the proposal were made following public meetings, written comments and consultations with community members.

Additional information about HIV reporting is available via the Internet at: www.tdh.state.tx.us/hivstd/input.htm.

(For more information, contact Sharilyn Stanley, M.D., Chief, TDH Bureau of HIV/AIDS Prevention, at 512-490-2505; or Doug McBride, TDH Public Information officer, at 512-458-7524.)

Texas Insurance Commissioner Leaves Post This Month

Elton Bomer, Texas Insurance Commissioner, will resign, effective January 15, 1999, to become senior adviser to newly re-elected Governor George W. Bush.

During his years as insurance commissioner, Bomer has implemented patient protection rules, investigated health insurance companies and become known as a change agent in the health care industry.

"Managed care was a new industry in Texas and there were some abuses in the system," he stated. "We had to be fair but firm in breaking new ground." He also noted that there is "still so much work to be done, especially in relationships between doctors and organized doctor groups and managed care companies."

Bomer, who was appointed in February, 1995, says he is proud of the work he did on tort reform, homeowners insurance and auto insurance rates. "I think all they can really ask for is somebody that's fair," he said of his office "We've been fair and we've been diligent."

As of this writing, his successor has not yet been selected.

Research on "Bad Genes" Published in Cancer Journal

Researchers at the University of North Texas Health Science Center are examining the effects of "bad genes" and working to identify how these genes interact in the production and spread of cancer cells. Their work is published in the November 15 issue of the journal *Cancer Research*.

The health science center investigators have been working with a protein (PARP) that is responsible for some of the actions of a known gene (p53). The protein is not new to the scientific world but its regulation of the gene and its role in killing mutated cells is now being documented for the first time by health science center researchers. This research may lead to additional knowledge about the origins of cancer formation and prevention of tumor growth.

The results of the study clarify some aspects of the regulation of this tumor suppressor gene (p53) found mutated in 70 percent of colon cancer, 50 percent of lung cancer and 40 percent of breast cancer patients.

The Fort Worth research team is led by Rafael Alvarez-Gonzalez, Ph.D., associate professor of molecular biology and immunology at the health science center. Dr. Alvarez's research team is the only one in Texas and one of three research groups in the country studying mechanisms of the protein in this study. This discovery opens the door to additional studies at the genetic level in tumor cells, Dr. Alvarez says.

The health science center study, now in its fifth year, was funded by the National Institutes of Health and the Texas Advanced research program. Dr. Alvarez's hope is that this research will reap benefits for cancer patients in the clinical setting within the coming five years. He is currently continuing his research in Heidelberg, Germany, where he was invited to serve as a visiting professor for a six-month sabbatical at the German Cancer Research Center, one of the leading cancer centers in Europe.

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.

Rene Acuna, D.O.
Bruce Addison, D.O.
Ted C. Alexander, Jr., D.O.
Richard Anderson, D.O.
Sara Apsley-Ambriz, D.O.
David Armbruster, D.O.
Astra Merck
ATOMA
ATOMA District II
Aus-Tex Printing and Mailing
Mark Baker, D.O.
Rita Baker
Gordon H. Barth, D.O.
Elmer Baum, D.O.
Kenneth Bayles, D.O.
James Beard, D.O.
Jay G. Beckwith, D.O.
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Catherine Carlton, D.O.
Juanita Carmichael
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Robert DeLuca, D.O.
Doctors Hospital
Iva Dodson
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Eli Lilly & Company
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D. Dean Gafford, D.O.
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Wendell Hand, D.O.
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