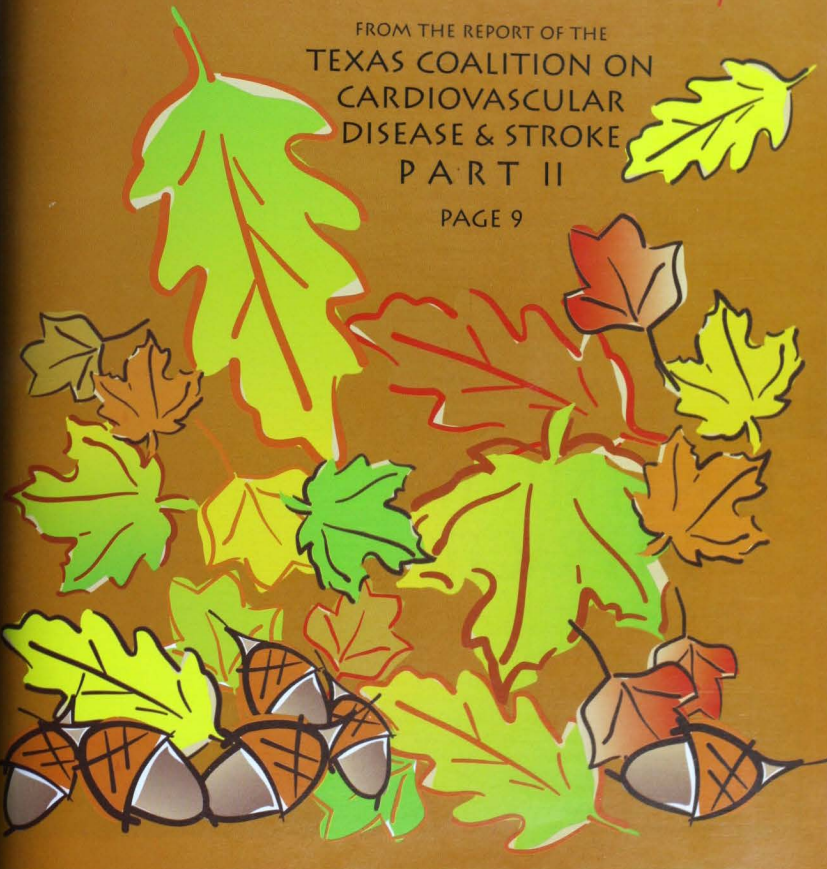
TEXAS D.O.
The Journal of the Texas Osteopathic Medical Association
Volume LV, No. 10
November 1998

FROM THE REPORT OF THE

TEXAS COALITION ON CARDIOVASCULAR DISEASE & STROKE PART II

PAGE 9



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

NOVEMBER 1998

Terry R. Boucher, MPH
Executive Director · Editor

Paula Yeamans
Associate Executive Director

Vanessa Kemper
Meeting Planner

Lucy Gibbs
Membership Coordinator

Mary Waggoner
Administrative Assistant

Jessie Cederburg
Receptionist

Lydia Hedges
Writing Consultant

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

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CALENDAR OF EVENTS

DECEMBER

4-6
"17th Annual Winter Update"
Sponsored by the Indiana Osteopathic Association
Location: University Place Conference Center and Hotel, Indianapolis, IN
CME: 20 hours category 1-A anticipated
Contact: IOA, 3520 Guion Rd., Suite 202 Indianapolis, IN 46222 800-942-0501 or 317-926-3009

5-6
"OMT Workshop"
Sponsored by the Texas ACOFP
Location: Arlington Hilton Hotel, Arlington, TX
CME: 15 hours category 1-A
Contact: Janet Dunkle, Texas ACOFP Executive Director 888-892-2937

1999

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 (8662) 512-708-1415 Fax

FEBRUARY continued

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

IN BRIEF

PRODUCTION PROBLEMS MAY DELAY FLU SHOTS

Due to production problems, there may be a slight delay in getting out flu vaccine this fall. Wyeth-Lederle, one of four U.S. manufacturers, experienced difficulties in growing two of the three strains of flu virus that go in this year's vaccine. Thus, the company will be producing 30 to 40 percent less vaccine than it intended.

Three other manufacturers, however, have increased production. The U.S. Centers for Disease Control and Prevention expects at least 80 million doses to be produced, enough for those who usually get a flu shot. Health experts expect all the doses to reach physicians' offices and clinics by sometime in November.

COMMITTEE WORKING TO CLARIFY MEDICARE POLICY ON LAB TESTS

A special committee is working to set clear national policy on what Medicare lab tests are covered and how. The committee, representing government, physicians, labs and other interests plans to be finished early next year. They will also develop national administrative standards for testing.

Issues under consideration by the committee include: coding guidelines for lab services; beneficiary information required on lab claims; medical documentation required with a claim; the medical conditions for which a "priority" list of tests are covered, and frequency limits for covered tests; and what patients records must be kept, by whom and for how long.

AIDS NO LONGER AMONG TOP 10 KILLERS

Deaths from AIDS dropped 47 percent in 1997, moving it from the number eight killer in the nation to number 14, according to a report released by the Centers for Disease Control and Prevention's Center for Health Statistics. This marks the first time the disease has been out of the top 10 killers since 1990.

Health and Human Services Secretary Donna Shalala called the "tremendous decline" in AIDS deaths "particularly striking." The decline is attributed to powerful new AIDS drugs that have come onto the market in recent years.

Dr. Robert T. Schooley, who leads the executive committee of the federal government's AIDS Clinical Trials Group, noted "What this says is that the benefits of the research effort that has been ongoing for the last 15 years is clearly paying off for patients. This is why we do the research, and it's really gratifying to see these improvements show up so dramatically. I would challenge anybody to come up with any single disease that has had such a dramatic change in mortality in such a short period of time."

NURSE-MIDWIVES WANT HIGHER PAY

The American College of Nurse-Midwives is lobbying to be paid at 95 percent of the Medicare fee shedule for physicians for deliveries its nurse members perform for beneficiaries.

Although 85% of physician payment is allowed for physician assistants and nurse practitioners, the group says that nurse-midwives have higher liability premiums and debt loads. Nurse-midwives currently receive 65 percent of what physicians receive for deliveries to women with chronic medical conditions who qualify for Medicare benefits.

STUDY WILL TRACK HEALTH OF HISPANICS IN VALLEY

A study funded by a four-year, $1.4 million National Institutes of Health grant will track the mental and physical health of Hispanics in the Rio Grande Valley. Eight hundred participants ages 45 and older will be randomly selected and followed for four years.

Researchers say this is the first long-term study of the Valley's aging population.

Texas ACOFP Update

By Joseph Montgomery-Davis, D.O.
Texas ACOFP Editor

For those Texas ACOFP members who missed the news, U.S. District Judge Vanessa D. Gilmore upheld the patients' right to sue health maintenance organizations for quality of care. However, she ruled that the independent review process for patients who have disputes with their HMOs conflicts with the federal Employee Retirement Income Security Act, or ERISA.

Aetna Life & Casualty Co. wants to salvage the independent review process and has joined the state attorney general's office in seeking to delay implementation of Gilmore's ruling. The independent review process was established to require people who believe they might suffer injury because of a dispute with their HMO to attempt resolution through state-overseen mediation.

More than 200 cases have been forwarded to the Texas Medical Foundation, the independent review organization that was contracted to review complaints in conjunction with the state's HMO liability law last November. Of the 183 reviews completed, 48 percent were decided in the patient's favor and 52 percent upheld the HMO's original judgment.

More than 11 million Texans are HMO members or are covered by some other form of managed care. About 60 percent of the people who have health insurance are enrolled in ERISA plans.

The irony of Judge Gilmore's ruling was that the part of the law struck down was the portion the health care companies in Texas had insisted upon - the independent review process.

At this time, I want to highlight a few provisions on medical records issued by the Texas State Board of Medical Examiners.

A licensed physician shall maintain adequate medical records of a patient for a minimum of seven years from the anniversary date of the date of last treatment by the physician.

If a patient was younger than 18 years of age when last treated by the physician, the medical records of the patient shall be maintained by the physician until the patient reaches age 21 or for seven years from the date of last treatment, whichever is longer.

The requested copies of medical records for a summary or narrative of the records shall be furnished by the physician within 30 days after the date of the request and fees for furnishing the information shall be paid by the patient or someone on behalf of the patient.

The physician responding to a request for such information shall be entitled to receive a reasonable fee for providing the requested information. A reasonable fee shall be a charge of no more than $25 for the first twenty pages and $.15 per page for every copy thereafter. In addition, a reasonable fee may include actual costs for mailing, shipping, or delivery.

The physician responding to a request for copies of film or other static diagnostic imaging studies shall be entitled to a reasonable fee for providing the copies. A reasonable fee shall be no more than $8 per copy. In addition, a reasonable fee may include actual costs for mailing, shipping, or delivery.

The physician providing copies of requested medical records or a summary or a narrative of such records shall be entitled to payment of a reasonable fee prior to release of the information unless the information is requested by a licensed Texas health care provider or a physician licensed by any state, territory, or insular possession of the United States or any State or province of Canada if requested for purposes of emergency or acute medical care. In the event the physician receives a proper request for copies of medical records or a summary or narrative of the medical records for purposes other than for emergency or acute medical care, the physician may retain the requested information until payment is received. In the event payment is not routed with such a request, within ten calendar days from receiving a request for the release of such records for reasons other than emergency or acute medical care, the physician shall notify the requesting party in writing of the need for payment and may withhold the information until payment of a reasonable fee is received. A copy of the letter regarding the need for payment shall be made part of the patient's medical record. Medical records requested pursuant to a proper request for release may not be withheld from the patient, the patient's authorized agent, or the patient's designated recipient for such records based on a past due account for medical care or treatment previously rendered to the patient.

In response to a proper request for release of medical records, a physician shall not be required to provide copies of billing records pertaining to medical treatment of a patient unless specifically requested pursuant to the request for release of medical records.

Now, I want to update the membership on a couple of TWCC issues.

TOMA Executive Director Terry Boucher has indicated that he will ask the TWCC to consider a rule change to restore manipulation to appropriate Lower Extremity Treatment Guideline tables. A TWCC review of the Upper Extremity Treatment Guideline tables using new statistical methods resulted in manipulation being restored to five of nine treatment tables from which it had been previously deleted.

I hate to be the one to break the bubble on the fallacy of physician freedom of choice in selecting the patients they serve in Texas. However, there is a provision on the books requiring Texas physicians to fill out paperwork for Workers' Compensation even though the physician does not participate in the program. This is a retroactive situation when a patient is seen and treated as a private pay patient, only later to be identified as a Workers' Compensation case. I don't know how the provision got

on the books but it should be removed. TOMA is aware of the situation, and the place to restore freedom of choice for Texas physician is the 1999 Texas Legislative session. This is an important issue because there is a potential for sanctions if a Texas physician does not comply with Texas law.

Something occurred during the 1998 baseball season that has to be a one-of-a-kind phenomenon. No, it was not the 70 homeruns bit by Mark McGuire. It was the sudden end to the consecutive baseball games played by Cal Ripken at 2632 games. On his own initiative, Cal sat out a ballgame and gave a younger ballplayer an opportunity to play at the Major League level.

Cal Ripken did not let chance enter into his decision to sit out a baseball game and end his consecutive game streak. The streak was not a victim of a serious injury, ill health, or death. It was a victim of a class act by a class individual for the good of his team. I guess my Baltimore Oriole and Marylander bias is getting the best of me! Time moves on and change is inevitable.

I have decided that my time with the Texas Society of the ACOFP should come to a halt. The future belongs to the younger members of the Texas osteopathic profession. I want to assure the younger members that there is plenty of room at the top of this organization. There is unlimited opportunity to improve the osteopathic medical profession and new ideas are always welcome - just get involved!

Now that my active involvement in the Texas ACOFP has ended, I leave with fond memories. I want to wish the organization success in its future endeavors. I intend to focus more of my time and energy on TOMA issues. My Dad was right! A job worth doing requires a 100 percent effort; it should never be short-changed.

On behalf of the Texas ACOFP Board of Governors, I want to wish everyone a very happy Thanksgiving holiday. There is much to be thankful for here in Texas.

Flu Season is Here

Immunize Your Patients!

An outbreak of influenza A in July and August spoiled vacation plans for many senior citizens traveling to Alaska and the Yukon Territory. While Texas was not directly affected, the early appearance of the flu is a wake-up call to be vaccinated, according to Robert D. Crider, director of the Immunization Division of the Texas Department of Health.

The flu season usually lasts from October through April. "Since it takes about two weeks for the vaccine to reach full effect, it is best to get a flu shot even before flu season begins," said Crider. This is particularly true for people in high-risk groups.

People with diabetes are about three times more likely to die from complications of influenza and pneumonia, yet fewer than half get an annual flu shot. Each year 10,000 to 30,000 people with diabetes die from complications of the flu and pneumonia. During a flu epidemic, deaths among people with diabetes rise five to 15 percent, according to the Centers for Disease Control and Prevention (CDC).

In addition to those with diabetes, people aged 65 or older are at higher risk of serious illness or death resulting from influenza-related complications. More than 90 percent of the deaths from pneumonia and flu occur in people aged 65 or older yet 32 percent of people in this age group failed to get an annual flu shot in 1997, according to TDH figures.

People with weak immune systems, including those with kidney disease and blood problems, transplant recipients and people with AIDS should be vaccinated. Others in high risk groups include people with chronic heart or lung disease, including children with asthma; pregnant women; international travelers and children on long-term aspirin therapy.

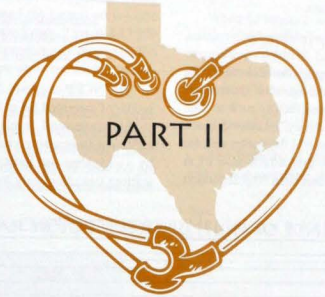
Each year the CDC estimates what strains will cause problems for the following year. This year's vaccine combats the A/Sydney, which afflicted the tourists in Alaska, the A/Bejing and the B/Bejing. The vaccine offers some protection against other strains as well.

Source: TDH Accent on Health, September 23, 1998

Upon request, TOMA members may receive flu shot reminder postcards to send to patients. Call TOMA at 1-800-444-8662 to place your order.

THE TEXAS COALITION ON CARDIOVASCULAR DISEASE & STROKE

Excerpts from the *Report of the Texas Coalition on Cardiovascular Disease and Stroke*



The Texas Coalition on Cardiovascular Disease and Stroke was formed to explore ways to reduce the tremendous health and economic burden imposed on Texas and the nation from CVD and stroke. As the number one and number three causes of death for all Texans, CVD and stroke are also the biggest drain on our health care resources with an annual estimated cost of over $9 billion in direct health care costs alone.

RISK FACTORS DRIVING HEART DISEASE AND STROKE

FACT: Tobacco use is the single largest cause of preventable death and disease in Texas.

FACT: A reduction of at least 10% in total cholesterol yields a greater than 20% reduction in coronary heart disease risk in the medium term, and 30% in the long term.

FACT: People with uncontrolled high blood pressure have four times the risk of developing heart disease.

FACT: Physical activity decreases the incidence of CVD.

FACT: Even a modest weight loss of 5-10% of body weight can significantly decrease the risk of heart disease.

Several factors increase the risk of heart disease and stroke. The major non-modifiable risk factors are heredity, male sex and increasing age. The modifiable risk factors are smoking, high cholesterol, high blood pressure, physical inactivity and obesity. Other risk factors that contribute to one's risk of developing CVD include diabetes and stress.

SMOKING

Tobacco use is the single largest cause of preventable death and disease in Texas. Smokers generally have a twofold increased risk of heart disease. Equally important, smoking is the most reversible risk factor for heart disease and stroke. Studies show that two to five years after people quit smoking, regardless of how long or how much they have smoked, their risk of heart attack drops to that of non-smokers. Smoking cessation is particularly important because it not only reduces risk of CVD, but also helps prevent cancer and chronic lung disease.

The Texas Behavioral Risk Factor Surveillance System (BRFSS) has been collecting risk factor prevalence data since

1987. Based on survey responses, almost three in every 10 adult Texans classified themselves as smokers. Overall smoking prevalence in Texas has remained unchanged since 1987, with a prevalence of 23.7%. By age group, the 35-44 year old age group had the highest percentage of smokers (30%). The 18-24 year old group showed a smoking prevalence increase of 7.9%. Further breakdown reveals that the 18-24 year old males made the greatest contribution to increasing rates. Smoking prevalence for whites was 24.5 % , 27.2% for blacks, and 19.6% for Hispanics.

The average age of first cigarette use is 12 years. The average age for chewing tobacco is 10 years. In fact, the American Journal of Public Health reported that in Texas, the estimated number of smokers 12-18 years of age is 202,871. This statistic ranks Texas second, only behind California.

CHOLESTEROL

High blood cholesterol is a major modifiable risk factor for heart disease. The cholesterol level in the blood is determined partly by inheritance and partly by acquired factors such as diet, calorie balance and level of physical activity. Increased blood cholesterol, specifically high LDL cholesterol, increases risk for heart disease. Epidemiologic data show that a reduction of at least 10% in total cholesterol yields a greater than 20% reduction in coronary heart disease risk in the medium term, and 30% in the long term.

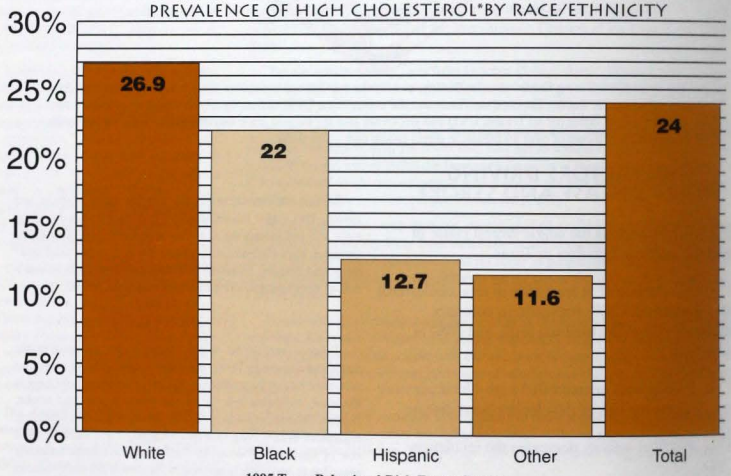
Conversely, high levels of HDL cholesterol protect against heart disease, irrespective of total cholesterol. Available evidence shows that for every 1 mg/dl decrease in HDL cholesterol the risk for heart disease increases by 2-3%.

BRFSS survey data from 1995 reported 24% of Texans as having high cholesterol. While the rates varied by race (whites at 26.9% versus Hispanics at 12.7%), the rates were fairly consistent by gender.

The National Cholesterol Education Program (NCEP) recommends the following levels:

Total cholesterol	<200mg/dl
HDL cholesterol	>35mg/dl
LDL cholesterol	<130mg/dl

The NCEP suggests dietary modifications such as reducing intake of saturated fat as the first intervention for treating undesirable cholesterol levels. When dietary modifications are not sufficient in reaching cholesterol goals, medications as advised by a physician are indicated. While cholesterol-lowering medications can effectively lower total and LDL cholesterol, few are



1995 Texas Behavioral Risk Factor Survey

* High cholesterol defined as individuals age 18 and older having ever been told by a health care professional that their blood cholesterol is high.

Source: Behavioral Risk Factor Surveillance System, Bureau of Chronic Disease Prevention and Control, Texas Department of Health. Prepared by the Health Information Research Team, Bureau of State Health Data and Policy Analysis, Texas Department of Health, May 1998.

able to raise levels of HDL cholesterol. Physical exercise is one effective way of raising levels of protective HDL cholesterol.

HIGH BLOOD PRESSURE

Often cited as the silent killer because of its lack of symptoms, high blood pressure is a significant risk factor for heart disease and stroke. People with uncontrolled high blood pressure have four times the risk of developing heart disease and as much as seven times the risk of developing stroke, compared to those with normal blood pressure. The Joint National Committee on Detection, Evaluation, and Treatment of High Blood Pressure (1993) has established <130/85 as ideal.

Nearly 24% of those surveyed in the BRFSS reported having high blood pressure. Blacks demonstrated the largest prevalence at 38.5% while white and Hispanics were lower, 25% and 17.2% respectively. Also, age is a significant predictor of hypertension prevalence with the higher age groups showing higher prevalence.

Most cases of high blood pressure can be prevented or treated with simple lifestyle modifications such as sodium restriction, exercise and weight loss. For those with significantly high blood pressure (>160 systolic and/or >100 diastolic), or who do not respond to diet and exercise intervention, blood pressure medications when advised by a physician are very effective at controlling high blood pressure.

DIET

Dietary factors and sedentary lifestyle account for at least 300,000 deaths in the United States each year. Diet plays a significant role in diabetes, cancer, cardiovascular disease, and its risk factors. Eating a healthy, low-fat diet with a maximum of 30% of total calories from fat could reduce heart disease rates by 5-20%. Nutrients found in fruits and vegetables can counteract the atherogenic effects of free radicals in the body, but most Americans do not eat enough fruits or vegetables for this protective benefit.

When fat intake is analyzed, age, sex and education were all independently related to a person's reported fat intake. Younger respondents reported higher fat intake than older respondents did. Women in all age groups eat a healthier diet of less fat and more fruits and vegetables than men.

PHYSICAL INACTIVITY

The benefits of regular physical activity are well-established, and emerging studies continue to support an important

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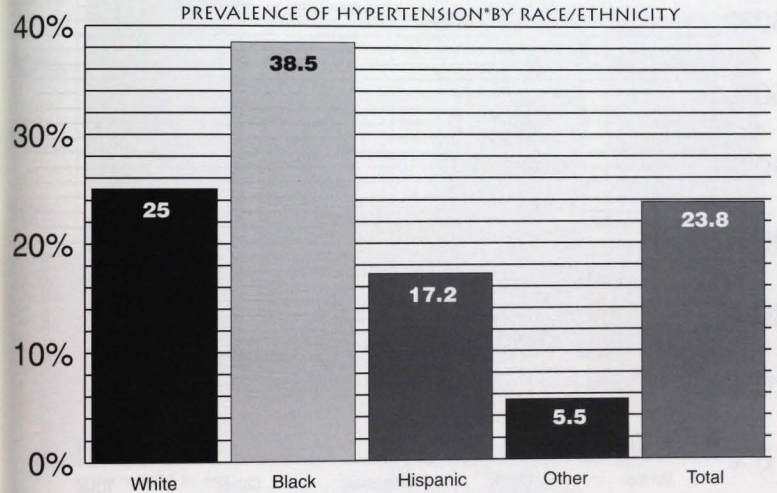


1995 Texas Behavioral Risk Factor Survey

* High blood pressure defined as individuals age 18 and older having ever been told by a health care professional that their blood pressure is high.

Source: Behavioral Risk Factor Surveillance System, Bureau of Chronic Disease Prevention and Control, Texas Department of Health. Prepared by the Health Information Research Team, Bureau of State Health Data and Policy Analysis, Texas Department of Health, May 1998.

role for habitual exercise in maintaining overall health. Physical activity decreases the incidence of CVD, lowers total cholesterol and increases HDL cholesterol, lowers high blood pressure, reduces risk of developing type II (adult onset) diabetes, and increases longevity. Quantitative estimates indicate that sedentary living is responsible for about one third of deaths due to heart disease, colon cancer and diabetes - three diseases for which physical inactivity is an established risk factor.

Fortunately, it is becoming increasingly clear that physical activity does not need to be highly structured or regimented to yield health benefits. Furthermore, the threshold of intensity necessary for the health benefits of exercise is lower than previously thought. The American College of Sports Medicine and the Centers for Disease Control and Prevention suggest that all Americans should accumulate at least 30 minutes of moderate-intensity physical activity on most, preferably all, days of the week.

Despite this overwhelming data, only 22% of adult Americans are currently active enough to derive health benefits; 53% are somewhat active while 25% are completely sedentary. In fact, recent trends over the past several years indicate that rates of sedentary lifestyles may be increasing.

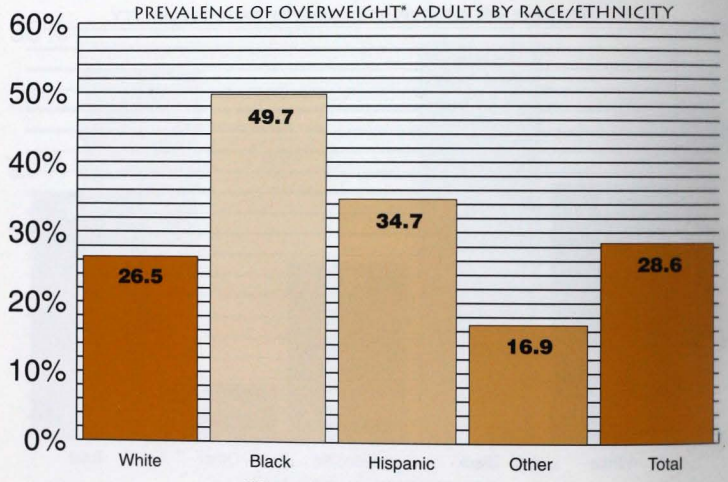
According to 1994 BRFSS data, sedentary lifestyle was more prevalent among Texans with less education or lower household income. Further, those without health care coverage were more likely to be sedentary than their insured counterparts (71% versus 53% respectively).

OBESITY

The American Heart Association has recently promoted obesity to the rank of a major risk factor for heart disease. Some of the negative health consequences of obesity include glucose intolerance and diabetes, high blood pressure, decreased levels of HDL cholesterol, increased LDL cholesterol levels, and increased mortality from all causes.

About 54% of Americans are overweight, according to recently revise standards, and more than 22% are medically obese. Nearly 30% of Texans surveyed in the 1995 BRFSS survey reported being overweight.

The reason for the shamefully high rates of obesity in America is simple: we eat far more than we need and we exercise far less than we should. We have too much food available, restaurants compete by offering bigger servings, and technology has made it increasingly possible to avoid physical activity. The good



1995 Texas Behavioral Risk Factor Survey

* Overweight defined as individuals age 18 and older with Body Mass greater than 27.3 for women and greater than 27.8 for men.

Source: Behavioral Risk Factor Surveillance System, Bureau of Chronic Disease Prevention and Control, Texas Department of Health. Prepared by the Health Information Research Team, Bureau of State Health Data and Policy Analysis, Texas Department of Health, May 1998.

news is that even modest weight loss of 5-10% of body weight (just 20 pounds in a 200-pound person) can significantly decrease the risk of heart disease.

As a special note, with all of the risk factors, higher educated respondents usually led healthier lifestyles.

Recommendations from the American Heart Association for comprehensive risk factor reduction is presented in the "*Guide to Comprehensive Risk Reduction for Patients With Coronary and Other Vascular Disease.*" (See page 16) The AHA has also developed specific actions for patients, providers and health care organizations to increase compliance with prevention and treatment recommendations; these are also presented in the chart.

PREVENTION INITIATIVES

Primary prevention is defined as the modification of risk factors and prevention of CVD in persons with no known disease, i.e., targeting risk factors before they cause disease. The best approach is the one that is able to positively influence the behavior of its target population. Therefore, no single approach can be described as best because the ability of an approach to reach its target population depends on factors such as disease prevalence, cultural influences, and community resources. Further, no single approach by itself can elicit permanent changes in behavior in any given populations. Following are examples of successful primary prevention initiatives.

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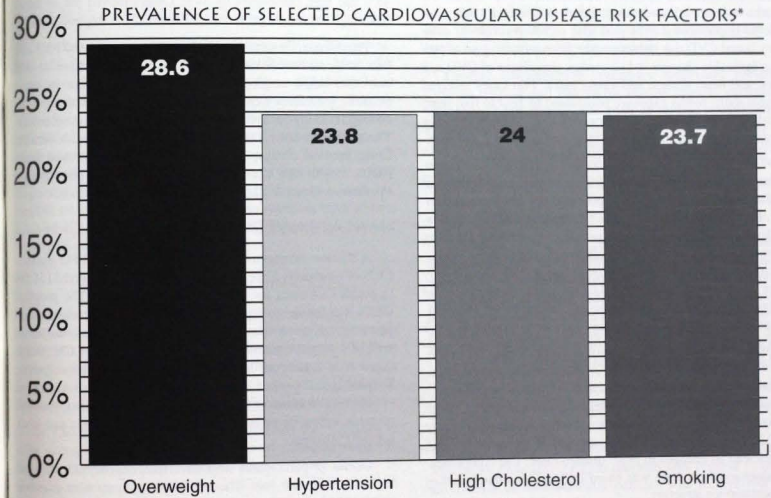

1995 Texas Behavioral Risk Factor Survey

* Risk factors defined as:

1. Overweight: Individuals age 18 and older with Body Mass Index greater than 27.3 for women and greater than 27.8 for men.
2. Hypertension: Individuals age 18 and older ever told that their blood pressure is high.
3. High Cholesterol: Individuals age 18 and older ever told by a health care professional that their blood cholesterol is high.
4. Smoking: Individuals age 18 and older ever smoked 100 cigarettes and currently smoke every day or some days.

Source: Behavioral Risk Factor Surveillance System, Bureau of Chronic Disease Prevention and Control, Texas Department of Health.
Prepared by the Health Information Research Team, Bureau of State Health Data and Policy Analysis, Texas Department of Health, May 1998.

COMMUNITY APPROACHES

Stanford Three-Community Study - A two-year mass media cardiovascular health education campaign was implemented in two communities from January 1973 through the summer of 1975. In the last year of the campaign (1975), the media effort was reduced by one-half. The campaign was bilingual and delivered through various media: TV, radio, newspapers and billboards. Pamphlets and cookbook were mailed to the participants. Some participants received small-group instructions.

Although plasma cholesterol increased in all towns, the increase was greater in the control group. Both men and women in the treatment towns reported reductions in dietary cholesterol (23 to 34%) and saturated fat (25-30%). Although this project was effective in stimulating behavior change, these changes were temporary. Pairing the mass-media campaigns with face-to-face intervention was more effective in creating long-term behavioral changes.

Stanford Five-City Project - Researchers at the Center for Research in Disease Prevention at Stanford University School of Medicine implemented a 14-year trial of comprehensive, community-based CVD risk reduction education with the goal of producing favorable changes in knowledge, prevalence of CVD risk factors, and heart disease and stroke rates. Two cities received continual multi-media exposure punctuated by four to five separate risk factor education campaigns each year. Spanish language programming was also utilized. In addition, special programming targeting grades 4, 5, 7 and 10 was implemented.

Knowledge of CVD risk factors was significantly greater at follow-up in the communities exposed to the educational campaign. Participants achieved a significant net decrease in cholesterol level (about 2%) and blood pressure (about 4%). Declines in tobacco use in treatment cities always exceeded those in control cities by about 13%. Treatment cities had significantly greater decreases in estimated all-cause mortality (about 15%) and significant falls in heart disease risk (about 16%). The organizational and educational programs were administered at a per capita cost of $4 per year. This cost represents 4% of the estimated annual per capita expense on cigarettes.

North Karelia, Finland - Launched in 1972 in response to a local petition to reduce the burden of heart disease in North Karelia, this study explored whether it was possible to influence risk factor levels in the populations and if so, whether such changes lead to changes in heart disease rates. The comprehensive educational program was based on local community action and local service structure.

From 1972 to 1987, the percentage of residents with no risk factors increased from 12.2% to 28.9%. Further, the percentage of people who had any one risk factor increased from 31% to 41.8%. The number of high-risk men and women decreased from 56.9% to 29.2% and 36.6% to 13.5%, respectively.

West of Scotland Coronary Prevention Study (WOSCOPS) - This study evaluated over 6,500 men of average age 60 years with high cholesterol and no history of heart attack or heart surgery. Patients received either pravastatin, a similar cholesterol-lowering drug, or placebo for five years. Mortality and morbidity from heart disease was reduced by 31%, and total mortality by 22% in the pravastatin group.

CORPORATE APPROACHES

The Stay Alive and Well program at Reynolds Electrical & Engineering Company (Las Vegas) cost $76.24 per employee during its first two years of operation. Over half of the 1,600 employees participated. Participants significantly lowered cholesterol levels, blood pressure and weight and experienced 21% lower lifestyle-related claim costs than non-participants. Resulting savings were $127.89 per participant with a benefit to cost ratio of 1.68 to 1.

With medical costs per employee at $6,000, nearly twice the national average, Union Pacific Railroad implemented "personal health management" for its 28,000 employee, mostly union and blue collar, in 19 western and southern states. The program achieved a net savings of $1.26 million. In addition, employees who participated lowered their risk of high blood pressure by 45% and high cholesterol by 34%. Others moved out of the at-risk range for weight problems (30%) and 21% stopped smoking.

Providence General Hospital saved an estimated $1.5 million, or a cost-benefit ratio of 1 to 4.24 over the three years of an outcomes-based employee health benefits program in which financial incentives were offered to employees who demonstrated responsibility for their health and fitness based on set criteria. The program showed reductions in the use of health benefits, lower medical claims, less absenteeism, and improved health habits. Health care claims were 33.6% lower for employees at Providence General than at nine other similar hospitals.

MANAGED CARE APPROACHES

A disease management program run through PPO operator CCN (Community Care Network) saved an estimated $158,600 in health care costs for three Chicago employers. The program, which was limited to high-risk patients, included worksite-based smoking cessation classes and reimbursement incentives for weight loss and exercise programs. Additionally, CCN coordinated with it network hospitals to provide worksite screening, hospital-based cardiac rehabilitation, and exercise classes at community recreation centers. Hospital staff also provided monthly follow-up calls to help participants set goals and monitor their progress.

Of the 73 participants who were tracked, only 27 were still high-risk after one year. The number of patients who exercised climbed from 2 to 53, and 10 of the 30 smokers quit. Almost half of those with high blood pressure were able to lower their blood pressure to moderate or low risk, and the number of overweight patients dropped from 61 to 49, with all patients losing an average of 11 pounds each.

Health plan members, employers and network physicians joined efforts with CIGNA HMO to promote cardiovascular health at the worksite and in the physician's office. Following a worksite health screening and lifestyle survey, results were compared to Healthy People 2000 goals. Groups could earn additional capitation by submitting intervention strategies designed to

improve areas falling short of Healthy People 2000 goals. Four groups were approved for interventions focusing on fitness, weight management and nutrition. The lifestyle survey was to be repeated in 1998 to see if any improvement had occurred.

SCHOOL-BASED APPROACHES

The National Heart, Lung and Blood Institute's Child and Adolescent Trial for Cardiovascular Health (CATCH) curriculum covers nutrition, physical education and smoking for 3rd and 5th graders with related family activity packets and comprehensive training materials for school food service and physician education. It is available for less than $300. It was proven effective in reducing risk factors and improving awareness in individual children and schools.

Other programs with useful components include the AHA's HeartPower schoolsite program, USDA's Team Nutrition, National School Lunch and Breakfast Matters, Fit for Life, Shape Up America! and CRAVE to Be the Best.

CHURCH-BASED APPROACHES

Churches are an appropriate community setting for prevention initiatives. As an example, Grant/Riverside Methodist Hospital of Columbus, Ohio, implemented an eight-week heart risk assessment and educational program through local churches with a focus of overall risk factor awareness and modification. Included in each session was a 30-minute exercise session and health education. From June 1995 to June 1997, 653 individuals participated in the program, and outcomes included 46 newly diagnosed hypertensive, 102 abnormal lipid analysis, and 222 medical referrals. The church provides an excellent environment to assist and support individuals in establishing and maintaining healthy lifestyles.

SECONDARY PREVENTION

Secondary prevention is defined as the modification of risk factors and prevention of subsequent events in persons with established cardiovascular disease. These are patients who have already suffered a cardiac event such as heart attack or stroke or have been diagnosed through tests such as angiography. Following are examples of secondary prevention initiatives.

Dr. Dean Ornish's Lifestyle Heart Trial was the first study to offer strong scientific evidence that lifestyle changes alone can actually reverse the progression of atherosclerotic plaques in coronary arteries. The researchers reported that 82% of the 28 patients in their experimental group - who followed a strict program of a low-fat vegetarian diet, smoking cessation, stress management training, moderate aerobic exercise and group support - showed plaque regression. This program showed that high cholesterol can be reduced with intensive lifestyle changes and that these change can begin to reverse even severe coronary heart disease after only one year, without the use of cholesterol-lowering drugs.

The Scandinavian Simvastatin Survival Study (4S) examined 4,444 men and women with high cholesterol and a history of heart disease who were maintaining a cholesterol-lowering diet. Patients received either simvastatin (a cholesterol-lowering drug) or placebo for 5.4 years. Mortality from further heart attacks in the simvastatin group was reduced by 42%, occurrence of non-fatal heart attacks by 34%, heart surgery by 37% and total mortality by 30%. Further, the simvastatin group had a 28% reduction in stroke and transient ischemic attacks.

The Stanford Coronary Risk Intervention Program (SCRIP) demonstrated a 50% slowing in rate of progression of heart disease with combination of lifestyle changes (diet, exercise, weight loss, smoking cessation, counseling) plus appropriate use of medications. For this study, 259 men plus 41 women were randomly assigned to the SCRIP program, and 155 to "usual care" at another medical school. At the conclusion of four years, SCRIP participants showed a 40% reduction in cholesterol consumption, 23% reduction in LDL cholesterol, 20% increase in exercise, and 12% increase in HDL cholesterol.

Merck Pharmaceuticals has implemented a program called Heart Smart to address cholesterol-lowering therapy as secondary prevention. Included in the program are treatment protocols, chart audit forms and patient education materials. In addition, through Pittsburgh Health Research Institute, Heart Smart tracks cardiovascular risk management.

Cardiac Rehabilitation comprises supervised prescriptive exercise training and risk factor modification in patients with established heart disease. The goals of cardiac rehabilitation are to improve functional capacity, alleviate or lessen anxiety-related symptoms, reduce disability, and identify and modify risk actors in an attempt to reduce subsequent morbidity and mortality due to cardiovascular illness. Outpatient programs are currently provided by approximately 2,340 U.S. hospitals and another 700 independent clinics.

Favorable outcomes of cardiac rehabilitation, measured by controlled clinical trials, include reduction in the frequency and duration of subsequent rehospitalization, reduction in total and cardiac-related mortality, reduction of symptoms, improvement in risk factor profile, and improvement in quality of life. The known economic benefits of cardiac rehabilitation are derived primarily from reduced secondary utilization of inpatient medical resources. Unfortunately, of the several million patients with heart disease in the U.S. who are candidates for cardiac rehabilitation, only 11-38% participate in cardiac rehabilitation programs.

Baylor Health Care System's LEAP (Lifestyle Education Awareness Program) for Life program was created to increase the number of cardiovascular patients who receive risk factor education and guidance in secondary prevention. This program was created in response to the fact that while risk factor education is necessary, nationally only 10-11% of cardiovascular patients participate in cardiac rehabilitation services. The program's multidisciplinary team includes physicians, nurses, exercise specialists, dietitians, pharmacists, social workers and chaplains. Topics include understanding heart disease and medications, stress management, healthy eating and exercise. Participants are tracked at three, six and twelve months post-attendance to measure hospital readmissions, effectiveness of education and compliance.

continued on next page

Results from the first full year of outcomes show that 15% of angioplasty patients had a cardiac readmission compared to national statistics which show that approximately 20% of angioplasty patients undergo repeat angioplasty and 5% require bypass surgery within one year of original intervention. In addition, 89% of participants contacted one year following workshop participation knew their individual risk factors for heart disease.

To summarize, secondary prevention effects a greater impact on morbidity and mortality in a shorter period of time compared with primary prevention. However, both approaches are necessary to address cardiovascular disease. In fact, prospective studies have shown that secondary prevention is almost always cost-effective, as is primary prevention.

The January issue of the "*Texas D.O.*" will feature "How Other States are Addressing CVD" and "How Texas is Addressing CVD: A Limited Inventory," excerpted from the report of the Texas Coalition on Cardiovascular Disease and Stroke.

GUIDE TO COMPREHENSIVE RISK REDUCTION FOR PATIENTS WITH CORONARY AND OTHER VASCULAR DISEASE*

Risk Intervention	Recommendations
Smoking Goal: Complete cessation	Strongly encourage patient and family to stop smoking. Provide counseling, nicotine replacement, and formal cessation programs as appropriate.
Lipid Management Primary Goal: LDL <100 mg/dL Secondary Goal: HDL >35 mg/dL; TG <200 mg/dL	Start AHA Step II Diet in all patients <30% fat, <7% saturated fat, <200 mg/d cholesterol. Assess fasting lipid profile. In post-MI patients, lipid profile may take 4 to 6 weeks to stabilize. Add drug therapy according to the following guide: LDL <100 mg/dL: No drug therapy LDL 100 to 130 mg/dL: Consider adding drug therapy to diet, as follows: LDL >130 mg/dL: Add drug therapy to diet, as follows: HDL <35 mg/dL: Emphasize weight management and physical activity. Suggested drug therapy TG <200 mg/dL: Statin, Resin, Niacin TG200 to 400 mg/dL: Statin, Niacin TG >400 mg/dL: Consider combined drug therapy (niacin, fibrate, statin) Advise smoking cessation. If needed to achiever LDL goals, consider niacin, statin fibrate. If LDL goal is not achieved, consider combination therapy
Physical Activity Minimum goal: 30 minutes 3 to 4 times per week	Assess risk, preferably with exercise test, to guide prescription. Encourage minimum of 30 to 60 minutes of moderate-intensity activity 3 to 4 times weekly (walking, jogging, cycling, or other aerobic activity) supplemented by an increase in daily lifestyle activities (eg; walking breaks at work, using stairs gardening, household work). Maximum benefit 5 to 6 hours a week. Advise medically supervised programs for moderate to high risk patients.
Weight Management	Start intensive diet and appropriate physical intervention, as outlined above, in patients >120% of ideal weight for height. Particularly emphasize need for weight loss in patients with hypertension, elevated triglycerides, or elevated glucose levels.
Antiplatelet Agents/ Anticoagulants	Start aspirin 80 to 325 mg/d if not contraindicated. Manage warfarin to international normalized ratio = 2 to 3.5 post-MI patients not able to take aspirin.
ACE Inhibitors Post-MI	Start early post-MI is stable high-risk patients (anterior MI, previous MI, Killip class II [S_3 gallop, rales, radiographic CHF]). Continue indefinitely for all with LV dysfunction (ejection fraction ≤40%) or symptoms of failure. Use as needed to manage blood pressure or symptoms in all other patients.
Beta-Blockers	Start in high-risk post-MI patients (arrhythmia, LV dysfunction, inducible ischemia) at 5 to 28 days. Continue 6 months minimum. Observe usual contraindications. Use as needed to manage angina, rhythm, or blood pressure in all other patients.
Estrogens	Consider estrogen replacement in all postmenopausal women. Individualize recommendation consistent with other health risks.
Blood Pressure Control: Goal: <140/90 mm Hg	Initiate lifestyle modification – weight control, physical activity, alcohol moderation, and moderate sodium restriction – in all patients with blood pressure >140 mm Hg systolic or 90 mm Hg diastolic. Add blood pressure medication, individualized to other patient requirements and characteristics (ie; age, race, need for drugs with specific benefits) If blood pressure is not less than 140 mm Hg systolic of 90 mm Hg diastolic in 3 months or if initial blood pressure is >160 mm Hg systolic or 100 mm Hg diastolic.

ACE indicates angiotensin-converting enzyme; MI, myocardial infarction; TG triglycerides; and LV, left ventricular.

* *Consensus Panel Statement*
Preventing Heart Attack and Death in Patients with Coronary Disease. Circulation, 1995; 92:2-4

Texas Hospitals Introduce New Interns and Residents

Continuing from last month's issue, the following are among new interns and/or residents training for the 1998-99 year in Texas hospitals and medical centers.

BROOKE ARMY MEDICAL CENTER (FORT SAM HOUSTON)

Cynthia Ball, D.O.
Intern
UNTHSC/TCOM

George R. Collins, D.O.
Pathology Resident
WVSOM

Donald M. Crawford, D.O.
Intern
PCOM

Marc R. Happe, D.O.
Intern
LECOM

Brent L. Lechner, D.O.
Pediatrics Resident
NYCOM

Karen B. Looman, D.O.
Intern
KCOM

Michael H. Luszczak, D.O.
Emergency Medicine Resident
COMP

Anthony C. Manilla, D.O.
Otolaryngology Resident
PCOM

John S. Peters, D.O.
Dermatology Resident
WVSOM

Robert K. Russell, D.O.
Intern
UOMHS/COM

Beth A. Schulz-Bubulis, D.O.
Intern
OUCOM

Charles A. Stillman, D.O.
Radiology Resident
KCOM

David E. Thomas, D.O.
Emergency Medicine Resident
UOMHS/COMS

Wendy Whitford, D.O.
Radiology Resident
UOMHS/COMS

Brian P. Wilson, D.O.
OB/GYN Resident
KCOM

Jeffrey L. Wolff, D.O.
Gastroenterology Fellow
UNTHSC/TCOM

COLUMBIA MEDICAL CENTER DALLAS SOUTHWEST (DALLAS)

Rory L. Allen, D.O.
Intern
UNTHSC/TCOM

Karen S. Birdy, D.O.
Intern
UNTHSC/TCOM

Michelle R. Clay, D.O.
Intern
OUCOM

Elizabeth S. Karashin, D.O.
Intern
UNTHSC/TCOM

Cecilia N. Okafor, D.O.
Intern
UNTHSC/TCOM

Charles Roberts, D.O.
Intern
UNTHSC/TCOM

Thomas B. Shima, D.O.
Intern
UHS-COM

DOCTORS HOSPITAL (GROVES)

Tiffany Beggs, D.O.
Resident
UOMHS/COMS

Russell Carlisle, D.O.
Resident
WVSOM

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

David Frick, D.O.
Resident
UHS-COM

Gary Hillman, D.O.
Intern
UOMHS/COMS

Paul Hunt, D.O.
Resident
Western U

Robert McClimans, D.O.
Resident
KCOM

Kathryn S. Williamson, D.O.
Resident
UOMHS/COMS

SCOTT & WHITE MEMORIAL HOSPITAL (TEMPLE)

Lenore C. DePagter, D.O.
Resident
UNTHSC/TCOM

Grady F. Miller, D.O.
Family Practice Resident
OSU-COM

Binh D. Nguyen, D.O.
Pediatric Resident
UNTHSC/TCOM

Ann-Margaret Ochs, D.O.
Internal Medicine Resident
KCOM

Erik C. Petersen, D.O.
Resident
UHS-COM

Steven C. Strength, D.O.
Internal Medicine Resident
UNECOM

Michael A. Wagnon, D.O.
Pediatric Resident
UHS-COM

METHODIST HOSPITALS OF DALLAS

John Denning, D.O.
Primary Care/Sports Medicine
Resident

Mark Sij, D.O.
Internal Medicine Resident
UNTHSC/TCOM

Anjali Varde, D.O.
Family Practice Resident
UNTHSC/TCOM

Stephanie Waterman, D.O.
Family Practice Resident
UNTHSC/TCOM

J. Steve Welch, D.O.
Family Practice Resident
UNTHSC/TCOM

TEXAS TECH HEALTH SCIENCES CENTER AT ODESSA

Michael Van McGee, D.O.
Family Practice Resident
UNTHSC/TCOM

Jack P. Short, D.O.
Family Practice Resident
UNTHSC/TCOM

ST. MARY'S HOSPITAL/ST. ELIZABETH HOSPITAL (BEAUMONT)

Arnold Carothers, D.O.
Family Practice Resident
UNTHSC/TCOM

Danny Hall, D.O.
Intern
UNTHSC/TCOM

Rick Leggett, D.O.
Family Practice Resident
UNTHSC/TCOM

Monica Medrano, D.O.
Intern
UNTHSC/TCOM

Tim Schiller, D.O.
Family Practice Resident
UNTHSC/TCOM

TRI-CITY HOSPITALS (DALLAS)

Photo not available

Chandi Bankston, D.O.
Intern
UNTHSC/TCOM

Donald Brock, D.O.
Intern
UHS-COM

Daniel Hua, D.O.
Intern
KCOM

Tracy Kidwell, D.O.
Intern
OSU-COM

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

Denny Parton, D.O.
Intern
OSU-COM

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

Vera Robert, D.O.
Family Medicine
Resident
NYCOM

Patricia Roberts-Harris, D.O.
Family Medicine Resident
UNTHSC/TCOM

Paul Robinson, D.O.
Intern
UHS-COM

Steve Vacalis, D.O.
Family Medicine
Resident
UOMHS/COMS

Soledad Wang, D.O.
Intern
OSU-COM

Kin Wong, D.O.
Intern
UNTHSC/TCOM

Camille Ziomek, D.O.
Family Medicine
Resident
COMP

THE UNIVERSITY OF TEXAS HEALTH SCIENCE CENTER AT SAN ANTONIO

Nathan B. Green, D.O.
Internal Medicine
Resident
UOMHS/COMS

THE INDEPENDENT

INVESTOR

DEAN, JACOBSON FINANCIAL SERVICES, LLC

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10. I feel secure putting my hard earned life savings in a mailbox and sending it to total strangers.

9. I prefer the service I receive from faceless clerks at 800 numbers to a local investment professional.

8. I have plenty of time to read financial journals, investment magazines and newsletters.

7. I believe that publications which depend upon advertising revenue from no-load funds can render impartial and objective investment advice.

6. I prefer being thought of as computer entry rather than as a person.

5. I feel that fund companies which sell to a mass market care about me and understand my specific financial goals, time horizons, and risk tolerance.

4. I have nerves of steel. The 554 point market decline on October 27, 1997 didn't concern me - neither do "bear" markets.

3. I can time the market and make fund switches with laser precision.

2. I don't find the 4000+ no-load fund alternatives overwhelming. By reading 5 prospectuses a day, I'll know them all in about 26 months.

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F.Y.I

HMO Ends Medicare Program

United HealthCare of Texas announced that it plans to withdraw its Medicare product in North Texas, becoming the first large managed care company to withdraw from the Medicare HMO business in North Texas. The move will affect 7,500 Medicare beneficiaries and approximately 3,600 physicians in the Metroplex.

"We did not feel that the Dallas/Fort Worth marketplace could bear the type of changes we were required to make as a result of the Balanced Budge Act of 1997," said Thomas Quirk, president of United HealthCare Medicare Complete in Dallas. "We did not want to unfairly burden either our Medicare beneficiaries with increased out-of-pocket expenses or our providers with an additional decrease in fees."

Provisions in the Balanced Budget Act of 1997 are cutting payments to HMOs more than $20 billion over five years.

The eight North Texas counties affected are Tarrant, Dallas, Denton, Collin, Grayson, Ellis, Kaufman and Rockwall. The company's Medicare contracts will not be terminated until January 1, so members will continue to receive their benefits until that time. They will then be given a list of other companies that have Medicare HMO options.

United began offering its Medicare product in Houston in September. Kelly Knigge, communications specialist for United HealthCare of Texas, said the company will continue in Houston because government reimbursement rates meet the company's needs.

"The only reason we can't stay in certain counties is the HCFA reimbursement. It has nothing to do with our financial alignment," said Knigge.

Texas HMOs Score Well on Quality of Care

A report entitled, "Comparing Texas HMOs 1998," released by the office of Public Insurance Counsel in Austin, marks the first study to survey HMO members directly rather than depend on data gathered by the health plans. The report includes information gathered in a survey of 10,000 members in 34 health plans across Texas and information compiled from other government agencies.

For overall satisfaction, which includes quality of care, Texas HMOs averaged a score of 7.6 on a scale of one to 10, with 10 representing high approval. However, when asked about the helpfulness and customer service on the part of plan representatives, the marks dropped.

Cigna Healthcare of Texas' Dallas division earned the highest overall rating, 7.9, compared with other North Texas plans.

Texas Appeals Ruling on HMO Plans

The state is appealing U.S. District Judge Vanessa D. Gilmore's decision that federal laws pre-empt Texas' independent review of HMO plans, and is asking that the program continue to operate during legal proceedings.

Gilmore's decision came as part of her ruling in the case of Aetna U.S. Healthcare vs. the Texas Department of Insurance, in which she upheld a Texas law that allows HMO members to sue their plans for malpractice. However, she also ruled that the federal Employee Retirement Income Security Act of 1974 (ERISA), pre-empts the review process for most members of health insurance companies in Texas.

Although Aetna, Attorney General Dan Morales' office and the Texas Department of Insurance are working together to ensure that the review process stays intact, there is some disagreement on the issue of whether the review organization's decision should be binding. Insurance Commissioner Elton Bomer and Morales believe the organization's decisions should be binding, while Aetna says it should not.

Medicare Patients Win HMO Suit

Although efforts to establish federal law ensuring patients' rights to appeal HMO decisions seem to have run out of steam in Congress, the nearly six million Medicare beneficiaries enrolled in HMOs have won an important victory in a federal appeals court. The 9th U.S. Circuit Court of Appeals has upheld a lower court ruling that determined that HMOs are "federal actors" in the context of Medicare. That decision gives Medicare patients the right to due process, a constitutional protection under the Fifth Amendment, entitling them to immediate hearings and other protections when they are denied care by HMOs.

The opinion, written by Judge Charles Wiggins, a former Republican congressman from California, stated that many HMOs failed to provide adequate explanations for the denial of benefits and failed to inform patients of their appeal rights. Judge Wiggins said Medicare beneficiaries were entitled to due process because the HMO decisions amount to "government action."

The ruling requires the government to ensure that HMOs make appeal rights and procedures known to enrollees; denial notices must be given no more than five working days after a written or oral request; denial notices must be on a clear, readable form and must clearly explain why the service was refused; plans must render expedited appeals decisions within three working days; and the Department of Health and Human Services must monitor HMO compliance and is prohibited from renewing or entering into Medicare contracts with HMOs that have violated the appeals rules. Additionally, while a case is receiving expedited processing, any disputed care must continue while the case is being resolved.

The original lawsuit was brought against the Department of Health and Human Services on behalf of five Arizona beneficiaries denied services by their HMOs.

Upper Left: Harold Lewis, D.O. and his sponsor Robert Peters, D.O.

Upper Right: Former Texas resident and Grand Marshall, Mary Burnet, D.O.

Left: Jack McCarty, D.O. and his wife, Cindy are congratulated by Dr. McCarty's sponsor, Robert Maul, D.O.

Below: Ray and Edna Stokes with Dr. Lewis and his wife, Peggy.

New ACOFP Fellows

At the 1998 Annual Ceremonial Conclave of ACOFP Fellows Awards Banquet in New Orleans, two of our members received the Award of Fellow. Harold Lewis, D.O. from Austin and Jack McCarty, D.O. from Lubbock received this prestigious award held during the recent A.O.A. Convention.

This award is in recognition of outstanding contributions through teaching, authorship, research, or professional leadership at the state or national level. Any Fellow in the college can nominate one qualified ACOFP member for the Award of Fellow each year. The nominees are reviewed and approved by the Awards Committee and by a majority vote of the ACOFP Board of Governors.

Additional requirements are: a minimum of six consecutive years of dues paying membership on ACOFP and attendance at 50% or more of the AOA Scientific Seminars (registered as a family physician), and the ACOFP Annual Conventions over the last six years.

You are encouraged to speak with a Fellow about sponsorship and the requirements to become a nominee.

Membership Update

The following physicians are TxACOFP members and Fellows:

David Armbruster, D.O., Pearland, TX
Elmer Baum, D.O., Austin, TX
John Bowling, D.O., Fort Worth, TX
John Carter, Jr., D.O., Fort Worth, TX
John Cegelski, Jr., D.O., San Antonio, TX
Samuel Coleridge, D.O., Fort Worth, TX
Marion Coy, D.O., Joshua, TX
Joseph Dubin D.O., Dallas, TX
Robert Finch, D.O., Dallas, TX
Gerald Flanagan, D.O., Argyle, TX
Samuel Ganz, D.O., Corpus Christi, TX
Richard Hall, D.O., Eden, TX
Armin Karbach, D.O., Arlington, TX
Royce Keilers, D.O., La Grange, TX
Arthur Kratz, D.O., Dallas, TX
R. Greg Maul, D.O., Rowlett, TX
Robert Maul, D.O., Lubbock, TX
L. N. McAnally, D.O., Granbury, TX
William Mosheim, D.O., San Antonio, TX
Robert Peters, Jr., D.O., Round Rock, TX
Donald Peterson, D.O., Mesquite, TX
Irvine Prather, D.O., Fort Worth, TX
Harvey Randolph, Jr., D.O., Port Arthur, TX
David Richards, D.O., Fort Worth, TX
Phillip Saperstein D.O., Fort Worth, TX
T. Robert Sharp, D.O., Mesquite, TX
Stephen Urban, Jr., D.O., Fort Worth, TX
John Walton, D.O., El Paso, TX
Craig Whiting, D.O., Fort Worth, TX
Rodney Wiseman, D.O., Tyler, TX
Andrew Roland Young, D.O., Maypearl, TX
Capt. Ben Young, D.O., Lubbock, TX
T. Eugene Zachary, D.O., Fort Worth, TX
Richard Anderson, D.O. Mesquite, TX

The Award is one that strengthens you as a physician and as leader in your profession. Contact the TxACOFP Headquarters at 888-892-2637 for additional information.

New Dues Categories

With 1999 dues statements being mailed this month, please note the three new levels of contribution approved at the 1998 Annual Membership Meeting. The level of President Club permits you to donate an additional $50 with your annual dues, President Gold Club is $75 and the TxACOFP Patron level an additional $100. These levels were designed to give you the opportunity to contribute more to some of the efforts of the Society.

One of the TxACOFP goals is to annually support the Family Practice Chapter at the UNTHSC/TCOM in Fort Worth. We support them with an annual $4000 contribution toward its operating budget as well as send 8 officers and members to the National ACOFP Convention.

The feedback we receive from the students attending this meeting convinces us that attendance makes a lasting impression and encourages them to remain active in the leadership of our profession. We feel that making this investment is making an investment if the future of the TxACOFP and your increased donations can help to ensure our commitment.

OMT Update and Review

In response to your positive feedback on the OMT workshops and lectures offered in Fort Worth this August, we are offering a 15 hour OMT Update and Review at the Arlington Hilton Hotel on December 5 - 6, 1998.

This program will begin with an introduction to the Dr. Sutherland's Ligamentous Articular Strain with emphasis on the Lower Extremities followed by problem based OMT techniques. A lunch lecture to satisfy the medical ethics requirement for 1999 will be included during this program as well as coding for both you and your office staff.

This weekend can also be one for your family as the Arlington Holiday Jolly Jubilee will be in full swing. We have a special room rate of $69.00 at the Arlington Hilton for the nights of December 4 and 5 so treat your family to Six Flags Holiday in the Park and some great shopping!

Registrations will be limited to keep a high quality program so please fax or mail your registrations in early to ensure a space in this workshop.

To learn more about the OMT Update and Review, contact the State Headquarters at 888-892-2637.

THANK YOU JOE!

Since 1988, Joe Montgomery-Davis, D.O. from Raymondville has served as Texas ACOFP Editor. On our behalf, he has conducted research, attended meetings, wrote and edited resolutions, and wrote this monthly update for the *Texas D.O.*

With his position on the TWCC Medical Advisory Committee and as a member of the TWCC Guideline Standardization Committee, his free time has become very limited, resulting in his resignation as TxACOFP Editor.

From everyone he has helped over the past decade, we thank you for your service and dedication to us and our profession.

Blood Bank Briefs for Physicians

By Leland B. Baskin, M.D.
Associate Director, Carter BloodCare

The Benefits, Risks and Indications for Autologous Blood Transfusion

Transfusing an individual's own blood into himself (autologous transfusion) has been available for several years. It was initially advocated as a way of maintaining the blood inventory, but this practice has expanded in recent years as a result of concern about transmitting infectious disease. It is ironic that during this same period, the blood supply has become considerably safer. For example, between 1982 and 1998, the risk of transmission of hepatitis B has decreased from 1:25 to 1:63,000.

Table 1.
Potential Advantages of Autologous Transfusion

Prevention of transfusion-transmitted disease
Prevention of alloimmunization
Prevention of immune-mediated transfusion reactions
Supplementation of the blood supply
Matching blood containing multiple antibodies

The primary component collected for autologous transfusion is packed RBC, however, other components are occasionally collected as well. These include plasma, fibrin glue from cryoprecipitate and platelet-rich plasma. This final product may be collected by apheresis prior to cardiopulmonary bypass and infused after heparin reversal.

Currently, there are at least four different methods by which autologous blood may be collected perioperatively. These are preoperative donation, intraoperative salvage, postoperative salvage and acute normovolemic hemodilution. This discussion will be limited to preoperative donation, the only procedure performed by the blood center. The potential advantages of receiving autologous blood go beyond that of preventing the transmission of viruses and are enumerated in Table 1.

Listed in Table 2 are potential risks in conjunction with autologous donation and transfusion. Because the donor is also the recipient and stands to benefit directly from the transfusion, a greater risk in donation may be accepted than that for the donor of allogeneic blood. Thus, the criteria for accepting donors are less rigid than those for allogeneic donors. Some of the criteria are described below. Because these requirements for autologous donation are relaxed, donor reactions are much more common. Acute loss of as little as one unit of blood significantly increases the risk of myocardial infarction in individuals with existing coronary artery disease. Unfortunately, two of the most serious hazards of transfusion, error in blood administration and bacterial contamination, are not ameliorated by autologous donation. Transfusion of autologous units to the wrong patient or in the wrong order have been reported by approximately 1% of transfusion services each year.

Table 2.
Risks of Autologous Donation and Transfusion

Severe donor reaction, including myocardial infarction (1:150 - 1:17,000)
Administrative error (1:30,000 - 1:50,000)
Bacterial contamination
Iatrogenic anemia
Allergic or anaphylactic reactions to anticoagulant, preservatives or plasticizers
Volume overload

As with any procedure, the decision to perform preoperative donation requires that the benefit must exceed the risk or cost. Recent interest in risk assessment and cost-effectiveness of autologous donation have called into question the extensive use of this practice.

Currently, the indications listed in Table 3 are generally accepted for autologous preoperative donation.

Even though autologous donors do not have to meet the same requirements as allogeneic donors, a few criteria remain in place to protect the donor and others who may be exposed. The donor's blood hemoglobin concentration must be at least 11.0 g/dL. The donor must have no medical condition contraindicative for donating or storing blood. These conditions include those predisposing to bacteremia (indwelling urinary or transdermal catheter) and certain infectious states (confirmed positive anti-HIV, anti-HTLV or HBsAg). Persons with stable coronary artery, valvular or congenital heart disease are acceptable with a release from a physician, preferably a cardiologist. Neither age, weight nor pregnancy disqualify candidates.

Table 3.
Indications for Autologous Preoperative Donation

The operative procedure is associated with excess blood loss and has more than a 10% probability of transfusion.
Example procedures: orthopedic (joint replacement), vascular (aneurysm repair), cardiothoracic (coronary artery bypass), urologic (prostatectomy) and obstetrical (placenta previa, multiple gestation deliveries) procedures
Underlying coagulopathy that may increase the probability of blood loss, such as von Willebrand's disease
Multiple red-cell alloantibodies increasing the difficulty of providing compatible blood

continued on next page

It is recommended that donation be initiated four to six weeks before surgery so that the donor's hemoglobin may be replenished. To aid this, iron supplementation in the form of ferrous sulfate (325 mg tables, three times a day) or ferrous gluconate (325 mg tables, five times a day) may be helpful. Erythropoietin may be used to help stimulate erythropoiesis. The final donation should be at least 14 days before surgery. No donation will be accepted less than three days before surgery.

Donations may be made as often as every three days, if necessary. Using apheresis, two RBC units may be collected at one time. Ideally, an individual undergoing apheresis should weigh 150 pounds and have a hemoglobin over 13.3 g/dL, but at a minimum, the donor's weight must be 130 pounds and the hemoglobin must be 12.0 g/dL.

References:

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Sator LJ. Autologous Blood: Issues for the Hospital Transfusion. 4th Annual Progress in Clinical Pathology 1996:149-175.

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Washington Update

Hospitals Receive Increase to Base Payment Rate

Hospitals began receiving a 0.5 percent increase to their base payment rate on October 1, 1998, under the Medicare prospective payment (PPS) update for fiscal year 1999. The Health Care Financing Administration (HCFA) forecasts a hospital market-basket cost increase of 2.4 percent. Current law mandates a PPS update equal to the market-basket increase minus 1.9 percent, for a total increase of 0.5 percent. Actual payment updates differ due to wage index adjustments, each hospital's case mix intensity as indicated by the diagnosis related groups (DRGs) for which it bills and other factors.

Some Hospital Discharges Treated as Transfers

As mandated by the Balanced Budget Act, certain hospital discharges will be treated for payment purposes as transfers, which receive lower payment than discharges. When a patient whose case is classified in one of 10 specified DRGs is discharged to a post-acute care provider, the discharge will be treated as a transfer. According to the Department of Health and Human Services, the 10 DRGs selected have a high volume of discharges to post-acute care and an exceptionally high use of post-discharge services. They include amputations for circulatory system disorders, hip and pelvis fractures and certain skin grafts.

HCFA Proposes New Outpatient PPS Payment System

HCFA has proposed a new outpatient PPS payment system, as required by the Balanced Budget Act. The plan was to have gone into effect January 1, 1999, but due to year 2000 computer problems, HCFA plans to defer implementation until at least April, 2000. The system classifies services into 347 ambulatory patient classifications (APCs).

Source: AOHA Washington Update

OMCT Invited to Speak at National Health Care Meeting on Patient Satisfaction in Emergency Departments

Reductions in patient waiting times and an increase in overall patient satisfaction in the emergency department at Osteopathic Medical Center of Texas have spawned an invitation to speak at a national meeting of emergency room workers and hospital administrators.

The advisory group of the Institute for Health Care Improvement's Breakthrough Series, a collaborative of 31 health care organizations across the nation that focuses on increasing patient satisfaction and reducing delays in emergency departments, has invited representatives from OMCT to be a major presenter at the national meeting in November. About 1,000 hospital administrators, emergency department physicians and other related workers are expected to gather at the meeting in Orlando, Florida.

OMCT has successfully reduced waiting times in the emergency department by about 1 1/2 hours both for admitted and non-admitted patients. In addition, OMCT's Fast Track (non-acute care) emergency clinic is ranked one of the best in the country, according to the institute. OMCT joined the collaborative in March this year.

"We were invited to present because of the overall performance in our emergency department," said Betty Hunter, R.N. Emergency Department director. "We are very excited and honored to be a part of the national meeting."

Self's Tips & Tidings

By Don Self

Doctors Are Failing the Medicare Pre-Pay Audits

In a recent report, it was revealed that more than 60% of the pre-pay audits performed by Medicare, since they began in January of this year, have failed. The report stated that almost 40% of those audits resulted in the claims being down-coded to match the progress note documentation. In a little over 20% of the audits, the claims for the evaluation and management service were denied completely, due to a lack of proper documentation. Sixty percent is quite alarming, considering the fact that these evaluation and management pre-pay audits are picked at random by Medicare's computers. This indicates that more than 60% of the doctors are not documenting the evaluation and management services to the degree to justify the CPT code the doctor uses, even though this has been required since 1987.

Currently, the Health Care Financing Administration (HCFA) requires physicians to use either the 1994 or 1997 (also referred to as the 95 and 98) documentation guidelines. The HCFA has been "generous" in allowing the auditors to use either the 94 or 97 printed guidelines in the audits with the instructions, "Use whichever is most favorable to the provider (physician)." Medicare and almost every association have taught seminars, prepared videos and written books on this subject. Literally tens of thousands of pages of review, guidelines, charting guides, slide rules, and templates have been published with the requirements, yet more than 60% of the audits failed. This tells me that the majority (60%) of physicians are not taking this seriously, yet it drastically affects their income.

You may be wondering why I'm devoting this entire column to this subject this month. The reasons are two-fold:

1. If Medicare catches you in a pre-pay audit often enough, expect a full scale audit. That doesn't mean they'll just admonish you for over-coding. It means they'll ask for thousands or tens of thousands of dollars in recoupment, plus possible fines, penalties and interest. No, your malpractice or liability insurance won't touch it; it will come out of your pocket.

In a recent case in Colorado, the Office of Inspector General invoked the $10,000 per line item penalty with a total fine of more than $1,000,000. Yes, the two-doctor practice had a good attorney and had it greatly reduced, but it still cost the practice more than $50,000 in attorney fees.

2. We don't know for a fact when HCFA will implement the new guidelines as the only documentation requirements to be accepted, but I believe it will be soon. HCFA is under extreme pressure from the Congress to make good on their promise to cut the Medicare expenditures by more than $12 billion a year. I would not be surprised if HCFA came out with the order to drop the 94 guidelines (which are more favorable to specialists) and accept only the 97 or 99 guidelines as of January 1st. For this reason, we are scheduling workshops for physicians on the documentation requirements in every city we can.

If you are concerned (as you should be), call your local hospital and get them to sponsor our seminar in your city on the evaluation and management documentation requirements. You or your hospital can call us at 1-888-DONSELF or email us at: donself@donself.com If you wait, you may wait too long. We will be teaching this in Arlington on December 5th at a symposium for the Texas Society of the American College of Osteopathic Family Physicians. You can also call Janet Dunkle at the Texas ACOFP (888-892-2637) for more information.

DON SELF & ASSOCIATES
P.O. Box 1510
Whitehouse, TX 75791-1510

(903) 839-7045
Toll Free (888) Don-Self

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Texas Medical Foundation News

Physician Reviewers Needed

The Texas Medical Foundation (TMF) defines its purpose as follows: "to promote, develop, define, and encourage the delivery of high quality medical care and health services to the people of the State of Texas and the general public while promoting efficient, cost-effective health care." As a physician-directed organization, TMF was established in the belief that only physicians should make decisions regarding medical necessity and quality of medical care. TMF believes that licensed, practicing physicians are the individuals best qualified to make these important judgments.

During a spring meeting of the TMF Board of Trustees, discussion centered on the shortage of available physician reviewers in certain medical specialties. The following are the medical specialties under-represented in TMF's physician reviewer resource pool:

Anesthesiology
Pediatric Hematology-Oncology
Dermatology
Pediatric Surgery
Endocrinology
Psychiatry
Infectious Diseases
Psychiatry-Child
Neurology, Pediatric
Rheumatology
OB/GYN, infertility specialist
Surgery, Cardiovascular
Oncology-Hematology
Surgery, General
Oral surgery (dentists)
Surgery, Neurological
Otolaryngology
Surgery, Plastic
Pain Management
Surgery, General Vascular
Pediatrics, Urology
Pediatric Cardiology

TMF physician reviewers must be in the active practice of medicine, must be board certified in a medical specialty, and must meet other qualifications as required by contract or board policy. They are compensated at a rate of between $65 and $100 per hour, depending upon the type of review performed.

If you are interested in becoming a physician reviewer for the TMF, further information can be obtained by contacting Phil Dunne, CEO, or Debra Lovato, Director of Health Services Assessment, at 1-800-725-9216.

TMF Issues Revised TMF Screening Criteria Manual

The Texas Medical Foundation has released the extensively revised TMF Screening Criteria Manual to be used for all reviews performed after August 25, 1998.

A free copy of the TMF Screening Criteria Manual is provided to every Medicare-certified health care facility throughout the state under TMF's Medicare contract obligation. Hospital staff can use the criteria to assist in determining the appropriate level of care and services for a patient based on his or her condition. When used with a flexible screening methodology, the criteria recognize the severity of an illness and acceptable diversity in physician practice patterns. TMF screening criteria do not limit medical practice, but rather establish a baseline for nonphysician review of medical records.

TMF uses the criteria when conducting medical records review for Medicare and other TMF contractors. Nonphysician reviewers apply the criteria to approve cases. Any exception to the criteria requires physician judgment based upon the medical needs of the individual patient. The physician reviewer's judgment, not the screening criteria, is the basis for decisions rendered on cases referred to physicians.

Several levels and types of care area addressed in the TMF Screening Criteria Manual including: admission criteria sets for acute hospitalization; admission criteria sets for swing bed and long-term care; generic quality screens; guidelines for outpatient procedures; surgical/invasive procedure criteria sets; diagnostic procedure criteria sets; and criteria reference materials for psychiatric, substance dependence detoxification, and physical rehabilitation.

The TMF State Review Program Committee is responsible for maintaining the screening criteria for TMF's Medicare and private-review programs. The committee periodically develops new criteria or improves upon existing criteria by researching and soliciting comments from members of the appropriate medical specialty societies. TMF will continuously update and issue revisions to the manual to reflect changes in medical practice and research. This is the first total reissuance of the TMF Screening Criteria Manual since 1991. TMF is happy to consider requests and comments from Texas physicians/providers regarding the screening criteria. Such comments, or any questions, should be directed to TMF Assessment Specialist Crystal Wilkinson at 512-329-6610.

The TMF Screening Criteria Manual is a valuable resource for facility staff members responsible for utilization and quality review. Bound editions of the manual are available from TMF for $50 each. To order a TMF Screening Criteria Manual, please contact Eve Cantu, TMF departmental assistant, at 512-329-6610.

TMF is the medical peer review/quality improvement organization for Texas. Under federal government contracts, TMF is responsible for reviewing the quality and medical necessity of care provided to Medicare beneficiaries. TMF's membership consists of over 6,500 physicians, 16 of whom serve on the board of trustees.

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43rd MidWinter Conference and Legislative Symposium

George Smith, D.O. - Progam Chairman

17.25 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 Repalcement 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	Depression ***Sponsored by Eli Lilly***
9:00 am – 10:00 am	Legislative Topic
10:00 am – 10:45 am	Pharmaceutical Update with Exhibitors
10:45 am – 11:45 am	Cardio Electrophysiology 1999 Larry Price, D.O.
11:45 am – 12:15 pm	Future Directions of TSBME Larry Price, D.O.
12:15 pm – 1:30 pm	Legislative Luncheon
1:30 pm – 2:30 pm	New Advances in Arthritis Therapy: Selective Cox II Inhibitors Bernard Rubin, DO ***Sponsored by Searle***
2:30 pm – 3:00 pm	Lipids ***Sponsored by KOS Pharmaceuticals***
3:00 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	End of Life Decisions Peggy Russell, D.O.
9:00 am – 10:00 pm	Virtues Monte Mitchell, D.O.
10:00 am – 1:00 pm	Risk Management

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 rate 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.

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TDH REVIEWS COMMENTS ON HIV REPORTING PROPOSAL

The Texas Department of Health (TDH) submitted a proposal this summer which would make HIV infections reportable by name. The proposal, which appeared in the July 31 edition of the Texas Register, would require Texas health care providers to report the names of persons testing positive for HIV infection to the TDH. Names of persons with AIDS and other sexually transmitted diseases are already reported to the TDH.

The health department believes making HIV reportable by name would improve the state's ability to measure the impact of HIV and to respond to the changing trends of the epidemic. "We need a more accurate and reliable way to link populations affected by HIV with preventive and medical services," said Dr. Sharilyn Stanley, chief of TDH's Bureau of HIV and STD Prevention.

TDH currently uses a reporting system in which each HIV case is reported by assigning a unique number rather than using the patient's name. TDH officials indicate that this system has not performed well in the four years since its inception, and estimate that only 26 percent of positive HIV test results are reported through the current system.

Under the proposal, names of persons with HIV infection would be kept confidential. "Information in the reporting system is secure. More than 45,000 cases of AIDS have been reported in Texas with no breaches of confidentiality," said Dr. Stanley.

Some members of the affected communities have expressed concerns that reporting HIV by name will cause persons to avoid testing for HIV and may cause those persons living with HIV to delay seeking treatment. The TDH has been actively consulting with community members to respond to these concerns.

A public comment period ended August 30 and TDH plans to submit the finalized proposal to the Texas Board of Health this November. At the earliest, named reporting of newly diagnosed HIV infections would begin in January, 1999.

Ann Robbins, manager of the Research and Program Evaluation Branch of the TDH Bureau of HIV & STD Prevention, noted in Texas HIV/STD Update, Vol. 3, No. 3, "This proposal has been controversial, and there has been much discussion of the possible effects of moving to named HIV reporting. A preliminary look at the letters, e-mails, and faxes received on this topic reveals a number of major misperceptions about what the Bureau is proposing."

Following are accurate facts about named reporting:

- HIV reports are not public information. The names of HIV-infected persons would not be made public, or released to the media, to insurance companies, to employers, to the Immigration and Naturalization Service, or anyone else. Information on who has HIV is not subject to open records requests, and courts cannot make health department personnel testify or disclose information associated with the HIV infection reporting records. The information in the surveillance system is privileged and totally confidential.

- Anonymous testing will continue to be available. The Bureau will not restrict access to anonymous testing. In fact, we require all contractors providing HIV testing to offer anonymous testing options for clients and we will be enforcing this policy more strictly.

- There will be no retroactive reporting. If the change is made, people who had a positive HIV test before the date HIV reporting becomes effective will not have their names reported through the confidential reporting system.

- HIV reporting information will be secure. This information would go into the same systems which handle AIDS data. Texas has never had a breach of the security of AIDS reporting information. HIV data are treated with the same high level of security.

The proposed change and evaluation of the current HIV reporting system can be viewed online at:
www.tdh.state.tx.us/hivstd/stats/htm.

Questions or comments about HIV reporting may be directed to Ann Robbins at 512-490-2555 or 800-299-AIDS.

Osteopathic Medical Center of Texas Welcomes New Manipulative Medicine Physicians

Two faculty members from the University of North Texas Health Science Center have been welcomed onto the staff of the Department of Manipulative Medicine at Osteopathic Medical Center of Texas.

Russell Gamber, D.O., an associate professor of manipulative medicine, and Richard Koss, D.O., an assistant professor of manipulative medicine, are experts in their field and will serve both the inpatient and outpatient populations at the hospital. Both physicians are board certified in osteopathic manipulative therapy and have backgrounds in family practice.

Both physicians remain on the faculty at the medical school and will conduct research on uses of osteopathic manipulative therapy. Dr. Gamber recently completed a study with Donald Noll, D.O., on 60 geriatric patients suffering from pneumonia. The preliminary results showed that patients who received OMT went home from the hospital 1 1/2 days sooner than those who did not.

Osteopathic Medical Center of Texas Staff Physician Discusses Alternative Treatments on Today Show

OMCT medical staff member Mary Ann Block, D.O., an expert in chronic illnesses, appeared on the New York-regional version of the Today Show on Sunday, September 20 to discuss her new book, *"No More Amoxicillin, Treating Ear and Respiratory Infections Without Antibiotics."*

Dr. Block was also featured on a local show, Positively Texas, discussing her first book, *"No More Ritalin, Treating ADHD (attention deficit hyperactivity disorder) Without Drugs."* The program included an interview with the parents of a child she has successfully treated for symptoms of ADHD.

Dr. Block has just completed her third book, *"Today I Will Not Die,"* which recounts her mother's successful recovery from inoperable, mestastic lung cancer. Her mother attributes her recovery to the care she received from OMCT staff oncologists, Bill Jordan, D.O., and Greg Friess, D.O., and her daughter's protocol to support and enhance the body's immune system. Today, seven years after her terminal diagnosis, her mother is healthy and in complete remission. The book is due out in spring 1999.

Dr. Block competed her internship at OMCT after graduating from the University of North Texas Health Science Center at Fort Worth/Texas College of Osteopathic Medicine. She chose to be an osteopathic physician after a D.O. helped her cure her daughter from a devastating and long-term illness.

Osteopathic Medical Center of Texas Working Toward "Baby-Friendly" Certification

Osteopathic Medical Center of Texas is striving to become recognized as a "baby-friendly" hospital, a UNICEF/World Health Organization designation that only 12 other hospitals in the nation hold.

The recognition will demonstrate OMCT's commitment to breastfeeding and will encompass the following 10 steps:

- Maintaining a written breastfeeding policy
- Training staff to implement the policy
- Informing all pregnant patients about breastfeeding benefits
- Helping mothers start breastfeeding within one hour of birth
- Showing mothers how to breastfeed and maintain lactation, even if they are separated from the baby
- Giving babies no food or drink other than breast milk unless medically indicated
- Rooming-in, to allow mothers and infants to stay together 24 hours a day
- Encouraging unrestricted breastfeeding
- Giving no pacifiers or artificial nipples to breastfeeding infants
- Fostering the establishment of breastfeeding support groups and referring mothers to them on discharge from the hospital

OMCT has already taken steps to promote breastfeeding to new mothers by offering a private breastfeeding room, a commercial-quality breast pump, breastfeeding consultants and rooming-in, to allow mothers to be with their babies any time of the day or night.

"Referencing the latest research, we know without a doubt that breastfeeding is the best source of infant nutrition," said Laura Burnett, R.N., childbirth educator. "We feel it's important to offer mothers the education and support they need to make decisions regarding their infant feeding preference."

The 265-bed Osteopathic Medical Center of Texas is the largest osteopathic hospital in Texas and is the flagship of Osteopathic Health System of Texas, a complete provider of osteopathic health care, with more than 300 physicians, 12 family medicine clinics and a variety of allied health services.

AOA News

Eugene Oliveri, D.O., Named AOA President-Elect

Eugene Oliveri, D.O., was named president-elect of the American Osteopathic Association during the recent AOA House of Delegates meeting held in Chicago, Illinois.

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

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

Dr. Oliveri served as president of the Michigan Osteopathic Association (MOA) from 1991-92, at which time he succeeded in increasing membership. He currently serves as chair of MOA's Council on Government Affairs.

Sydney Olson Named AOA's Director of Government Relations

The AOA has named Sydney Olson the new director of government relations at its Washington, D.C. office. The appointment became effective September 8.

AOA Executive Director John Crosby stated that "An extensive national search for the best candidate was conducted and Ms. Olson's experience in both the public and private sectors made her stand out as uniquely qualified to lead the AOA in advancing its legislative and regulatory initiatives."

Prior to joining the AOA, Ms. Olson served as director of government affairs of the 94,000-member American Speech-Language-Hearing Association (ASHA). Her background also includes serving as assistant secretary for human development services at the U.S. Department of Health and Human Services (HHS) in the Reagan Administration (1987-89); 13 years of service on Capitol Hill as a member of the professional staff for the U.S. Senate Committee on Finance; and in various roles at the U.S. House of Representatives. In addition, she is a member of the Board of Directors of the Barbara Bush Foundation for Family Literacy.

"As director for government relations, Ms. Olson will supervise the efforts of the AOA's Council on Federal Health Programs (COFHP)," according to its chairman, Marcelino Oliva, Jr., D.O., "and also serve as the chief advocate for the osteopathic profession in Washington. Ms. Olson is a much-needed and welcome addition to the AOA team."

American Osteopathic Foundation Announces Executive Director

Leda Hanin has been appointed executive director for the newly named American Osteopathic Foundation (AOF) and officially began her duties on September 8. As the executive director, Ms. Hanin is responsible for establishing the AOF as the key philanthropic organization for the osteopathic medical profession.

"Joining the AOA is an exciting venture, it is in a growth mode and presents great opportunity for the profession," said Hanin. "I look forward to forging new partnerships and enhancing our services and programs for members, friends and sponsors of the Foundation."

Prior to joining AOF, she served as executive director of the Leukemia Society of America's Illinois Chapter. During her three-year tenure with the Leukemia Society, Ms. Hanin oversaw all aspects of the administration for this organization including special events, fundraising solicitations as well as corporate and foundation proposals and grants.

Her past work experience includes prior tenure as associate vice president at DePaul University and several senior staff positions within academic institutions such as the University of Chicago and Carnegie Mellon University. While holding these positions, Ms. Hanin received many local and national awards for projects she supervised or implemented including the Golden Trumpet in 1992 from the Publicity Club of Chicago, recognizing the "Media Relations Program for DePaul University."

Ms. Hanin earned her B.A. in sociology from the University of California at Los Angeles. In addition to receiving her marketing certificate from the University of Pittsburgh, she also earned her Masters of Higher Education Administration there, concentrating in executive education.

TOMA HEALTH AND REHABILITATION HOT-LINE (800) 896-0680

The above telephone number is dedicated exclusively to osteopathic physicians seeking help for alcohol or chemical dependency or for friends/relatives who are concerned about a colleague with a possible problem.

The hot line insures immediate access to help and advice in strict confidentiality. A TOMA Field Representative, who works in conjunction with the TOMA Physician Health and Rehabilitation Committee, will answer the telephone. The hot line is staffed during regular weekday business hours. The TOMA Physician Health and Rehabilitation Committee serves as an advocate for Texas osteopathic physicians with dependency problems.

ASSISTANCE — IN COMPLETE CONFIDENCE — IS ONLY A TELEPHONE CALL AWAY.

TCOM Student Chapter Receives National Grant

By Rick Lin, President
Student Chapter of the College of Osteopathic Healthcare Executives

The TCOM Student Chapter of the College of Osteopathic Healthcare Executives (COHE), also known as the Business and Medicine Club, was awarded a grant from the Foundation for Osteopathic Health Services (FOHS). The two-part grant of $2,500 was awarded to the new student chapter to develop a national model for the COHE student chapters across the country.

The first student chapter of the College of Osteopathic Healthcare Executives was established at the University of North Texas Health Science Center, Texas College of Osteopathic Medicine in the Spring of 1998. The development grant from the FOHS has enabled the COHE student chapter to promote the osteopathic profession by pursuing the following goals in that endeavor. The first is to actively recruit osteopathic medical students to remain within the osteopathic profession by promoting the presence of osteopathic healthcare institutions at TCOM. Efforts are being made to organize a hospital tour for students at the Dallas/Fort Worth Medical Center to introduce this osteopathic hospital to medical students prior to their clinical rotations.

The next goal is to prepare osteopathic medical graduates for practice in the managed care environment. In August 1998, the Business and Medicine Club (COHE) sponsored a Managed Care Awareness seminar titled, "Managed Care Basics: Start Thinking About It Now." The seminar was geared toward medical students of TCOM and was presented by Deborah Blackwell, D.O., TCOM graduate of 1982 and the associate dean for clinical education at UNT Health Science Center. The event drew more than 120 students in attendance. Many participating students commented on the significant educational value of the seminar.

In order to promote osteopathic awareness in the local community, the student chapter has initiated PROMISE, a guest speaker program that provides the osteopathic medical students with an opportunity to teach school children about the osteopathic profession. PROMISE is currently jointly sponsored by seven other student organizations as well as the Office of Multicultural Affairs of the UNT Health Science Center.

Ron Stephen, FCOHE, executive vice president of the Osteopathic Medical Center of Texas, and also the chairman of COHE, is serving as the chapter mentor and advisor. In addition, Robert Adams, D.O., FACOOG, the medical director of the Physicians & Surgeons Medical Group of the University of North Texas Health Science Center, is the clinical advisor for the student chapter.

The upcoming activities for the Student Chapter of the College of Osteopathic Healthcare Executives include Business and Investment seminars to educate the medical students on the basics of personal finance and malpractice considerations. There will also be additional Managed Care Awareness seminars in the areas of Medicaid, healthcare delivery systems and women's health.

Please visit the website of the Business and Medicine Club at: http://www.hsc.unt.edu/departments/committees/ache/main.html.

New Executive Director for TWCC

Leonard (Len) W. Riley, Jr., has been named as the new executive director of the Texas Workers' Compensation Commission (TWCC). He began his official duties August 24.

A resident of Austin, Riley brings 26 years of experience with Texas Instruments, where he served as support operations manager and site director at facilities in Austin and Temple.

"The Commissioners look forward to working closely with Mr. Riley in fulfilling the Commission's important mission of effectively and efficiently serving the needs of all participants in the workers' compensation system," said Jack Abla, chairman of the Commission.

"Mr. Riley brings an extensive business background to this position. This perspective should prove valuable in guiding Commission staff to provide high quality service to the citizens of Texas," Abla said.

"On behalf of the Commissioners, I would like to express gratitude to all Commission staff who worked so diligently during the transition period. This agency was extremely fortunate to have had the expertise of Virginia May as acting executive director and we look forward to her continuing to serve the Commission in a leadership position," added Abla.

The Commission has approximately 1,100 employees who provide services in 27 field and satellite offices throughout Texas.

FYI: NEW NAME FOR TDH STAR HEALTH PLAN; NEW METHOD FOR ADDING PATIENTS

In hopes of minimizing confusion, the Texas Department of Health (TDH) has changed the name of its Primary Care Case Management plan from TDH STAR Health Plan to Texas Health Network. However, the entire Medicaid managed care program is still called TDH STAR (State of Texas Access Reform).

In addition, it will now be easier for physicians to request exceptions to the 1,500 Medicaid patient limit allowed by TDH STAR. Forms for exception requests were sent to physicians this summer by the TDH. After receiving an exception request, TDH's Bureau of Managed Care will mail a decision to the physician. Questions may be directed to D. J. Jones at TDH at 512-338-6911.

Study Concludes In-Flight Medical Events are Rare

The Air Transport Association completed a study earlier this year on the frequency and "mix" of in-flight medical events. The study concluded what has been intuitive but not proven: medical events are rare.

The study was based on 1996 data, which included input from nine airlines that carried more than 90 percent of the 580 million passengers in the U.S. In all, 10,471 events were reported, ranging from mild headaches to myocardial infarction. This works out to just less than one event per 50,000 passengers. Of these events (which were divided into 52 various categories), dizziness/fainting was reported 2,136 times while "heart attack" was reported 141 times. Interestingly, chest pain was the chief complaint 433 times. This implies that one out of three passengers that complained of chest pain were indeed having a myocardial infarction.

Source: Flight Physician, Vol. 1, No. 4

Government Investigations Reveals Questionable Costs Paid by Medicare

A government investigation shows that more than 90 percent of recent Medicare payments to day-treatment mental health centers in five states, went for "highly questionable" or "unallowable" uses.

After sharply increasing costs triggered suspicion, the Health and Human Services Department's inspector general reviewed $252 million in claims sent to Medicare in 1996 and 1997 by 158 community mental health centers in Texas, Florida, Colorado, Pennsylvania and Alabama.

Investigators found that instead of providing psychiatric therapy for the mentally ill, some of the centers were billing Medicare hundreds of dollars an hour for coffee klatches for healthy people recruited from retirement homes.

Texas Center for Music and Medicine Seeking Referrals

The Texas Center for Music & Medicine is seeking interested physicians, psychologists, physical therapists and other healthcare providers to become members of the center's referral network. The center was created to study, treat and prevent musician-related ailments.

Like professional athletes, musicians are required to function at peak capacity under stressful conditions. Until now, if musicians encountered trouble with their hands, back or joints, they were unlikely to find a physician who understood factors underlying the conditions and who could prevent or treat their ailments. These include hearing loss, sleep disorders, injuries from repetitive actions and performance anxiety.

Now both musical and medical resources have been brought together to study, treat and prevent these often career-threatening disorders through the Texas Center for Music & Medicine. Contributing organizations to the center include the UNT Health Science Center and the University of North Texas (UNT) in Denton.

Led by Bernard Rubin, D.O., chief of rheumatology and professor of medicine at the health science center, and Kris Chesky, Ph.D., research assistant professor in the College of Music at UNT, the Texas Center of Music & Medicine capitalizes on the strengths of both institutions to contribute new medical knowledge and services for musicians worldwide.

Plans for the center include establishing an education research and training facility within the College of Music at UNT as well as a clinical services and referral system within the health science center in Fort Worth. Drs. Rubin and Chesky also plan to develop workshops, conferences and other education efforts to inform physicians, musicians and interested observers about the health of musicians.

"In many cases, a musician's ailments and disabilities arise from the specific uses of the body while performing, such as overuse to the hands or arms while playing an instrument," said Dr. Rubin, who will serve as medical director of the center. "Many musicians still have difficulty finding the specialized care they need."

"Musicians need optimum health, strength and stamina to withstand the pressure of performing in today's competitive world and to meet their own high artistic expectations. Training for a career in music is difficult and even the most successful performers may be subject to severe and at times crippling stresses and strains," Dr. Rubin continued. "We're working to increase the amount of knowledge that exists about how, when and why these disorders develop and how to prevent them."

Through the Texas Center for Music & Medicine, research will examine hearing preservation, musculoskeletal and sensory dysfunction associated with overuse and repetitive strain injury, stage fright and performance anxiety, occupational stress and safety, and other work-related physical and psychosocial stresses.

Immediate research at the Texas Center for Music & Medicine includes a major study of clarinet techniques and associated wrist problems, and a study of how certain levels of music exposure affect short-term threshold shifts in hearing. Contact Dr. Rubin at brubin@hsc.unt.edu or at 817-735-5181 for further information on working with the center.

The University of North Texas Health Science Center seeks excellence in medical education, research and patient care. In addition to the Texas College of Osteopathic Medicine, the health science center includes the Graduate School of Biomedical Sciences, a public health program, a physician assistant studies program and nine research Institutes for Discovery. Its 112-member faculty group practice, The Physicians & Surgeons Medical Group, manages the care of 176,000 Fort Worth-area residents yearly.

NEW DIRECTOR NAMED TO WOUND HEALING CENTER

Glenn Hermes has been named the new director of the Wound Healing and Hyperbaric Medicine Center at Osteopathic Medical Center of Texas.

The center treats patients suffering from chronic wounds, just as those caused by diabetes, radiation burns and brown recluse spider bites. Through hyperbaric oxygen therapy, the center can also treat patients with carbon monoxide poisoning and divers with the "bends."

The center boasts the only hyperbaric chamber in Tarrant County that accommodates more than one patient at a time.

PROVIDING A HEALTHIER FUTURE FOR A CHANGING WORLD: THE STUDENT CHAPTER OF THE MEDICINE/PUBLIC HEALTH INITIATIVE

By Tracy L. Lambert, M.P.H. Student
UNTHSC Student Chapter of the MPHI

The University of North Texas Health Science Center Student Chapter of the Medicine/Public Health Initiative was created to provide a forum for student discussion and action related to public health and medical education, practice, and research. The chapter promotes a shared vision of determinants of health and brings together students from each of the three facets of the university: medicine, public health, and biomedical sciences. The chapter is dedicated to furthering the vision of the national initiative: to produce innovative solutions to the health needs of the American people. In the short time the chapter has existed, over 135 students have become involved.

One of the primary goals of the Student Movement is to initiate local community education projects. Students in the chapter work together as a team to promote prevention through programs targeting identified health needs in the community. The first community education project established by the students was HeartWorks!, a cardiovascular disease prevention program designed to inform school-aged children and youth about nutrition and exercise. Student participants developed an interactive program that incorporated discussions, games and handouts on various topics of nutrition and exercise. Partnering with the city health department, the student chapter introduced the program into several Fort Worth elementary schools last spring. Teams of presenters visited students during their physical education classes to discuss HeartWorks! Emphasis was placed on students learning how to make good food and physical activity choices, to develop goals for their health, and to include their families in the health education process. Response to this program was enthusiastic from all involved: the elementary school students, the presenters, and the school system. Plans for the program in the coming year include scheduling more presentations, engaging more participant schools and volunteer presenters, and incorporating stress management into the HeartWorks! curriculum.

In addition to the HeartWorks! project, two other projects began during the inaugural year of the student chapter: HIV/AIDS Outreach and Education, a peer facilitated HIV education program, and Trauma Prevention, a school based injury prevention workshop. Joining these established programs are several new projects scheduled to begin later this year. They are Teen Talk, a Fort Worth guide to preventive medical services for teens, and SmokeOut, a school based tobacco education and avoidance program. These community education programs will continue to allow students within the chapter to develop working relationships with the community, the city health department, local schools, community organizations, health care providers, and other health educators.

As the officially recognized National Headquarters for the Student Movement of the Medicine/Public Health Initiative, our chapter has been busy with efforts to increase awareness of the Initiative and to assist other universities in forming their own student chapters. To date, fifteen other schools of medicine and public health have expressed interest in creating chapters and the second student chapter was recently formed at Tufts University School of Medicine. We are asking for your support of these health care initiatives and your contributions; your tax-deductible donations will aid us in continuing with our objectives and expanding our project ideas.

Please send contributions to:

Student Chapter of the
Medicine/Public Health Initiative
Box 298
University of North Texas Health
Science Center at Fort Worth
3500 Camp Bowie Boulevard
Fort Worth, TX 76107-2699

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.

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

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

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Opportunities Unlimited

PHYSICIANS WANTED

THE DEPT OF OBSTETRICS and Gynecology at the University of North Texas Health Science Center at Fort Worth is Seeking a full-time BE/BC, OB/GYN physician interested in academic medical practice. Position will work with 4 OB/GYNs and 1 Maternal Fetal Medicine Specialist. Salary and benefits commensurate with experience. The University of North Texas Health Science Center at Fort Worth is an EEO/Affirmative Action Institution. Send CV to: Robert Adams, D.O., Chairman, UNT Health Science Center, Department of OB/GYN, 3500 Camp Bowie Boulevard, Suite 536, Fort Worth, TX 76107-2699. (05)

ORTHOPEDIC SURGEON needed in Dallas/Fort Worth for orthopedic consultations. No surgery, no weekends, no call. Contact: Lisa Abell at K Clinic, 1-800-CLINIC K, 972-255-5533 or fax CV to 972-256-0056. (06)

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

ENERGETIC PHYSICIAN WANTED to help cover solo practice while physician on sabbatical. Office located in mid-cities of Dallas/Fort Worth. Competitive payscale. Reply and send resume to: P.O. Box 201887, Arlington, TX 76006-9998. (14)

INTERNAL MEDICINE — Immediate opening for BE/BC Internal Medicine D.O. at 54-bed hospital in Tyler, Texas. Approximately 30-member referral base with multiple specialties. Office space available within medical complex. PHO with approximately 400,000 insured individuals. Hunting, fishing, watersports, country clubs, university, junior college, many recreational facilities, civic and social opportunities. Contact Olie Clem, C.E.O., at 903-561-3771. (16)

DOCTOR NEEDED in various parts of Texas to work small hospital emergency rooms on weekends. Also, full-time/part-time primary care opportunities available. For more information, call Jerry at the Lewis Group at 800-460-8159. (20)

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

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

OFFICE SPACE AVAILABLE

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

MISCELLANEOUS

PRACTICE FOR SALE — Busy, lucrative, solo practice located in the mid-cities area of Dallas/Fort Worth. Good mix of family practice and industrial medicine. Fully equipped office. Take over/purchase this well established practice. Willing to finance purchase. Reply to: P.O. Box 201887, Arlington, TX 76006-9998. (08)

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

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For more information call the TOMA office at 512-708-8662 or 800-444-8662

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Texas Medical Foundation 512/329-6610
Toll free 800/725-9216
Texas Osteopathic Medical Association 512/708-TOMA (8662)
in Texas 800/444-TOMA (8662)
FAX: 512/708-1415
E-Mail. . . . . toma@txosteo.org
TOMA Physicians' Health and Rehabilitation Program 800/896-0680
TOMA Med-Search 800/444-TOMA

TEXAS STATE AGENCIES

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

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

FEDERAL AGENCIES

Drug Enforcement Administration
For state narcotics number. . . . . 512/424-2000 ext. 2150
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