Dean's Corner e-Newsletter

Texas College of Osteopathic Medicine
November 26, 2003

I hope all enjoyed the Thanksgiving holiday! For certainly this is truly a time for us to be thankful. I know that most peoples' thoughts this past Thursday were with our troops who are stationed far away, and in harms way, so that we may enjoy the freedom that is America, and that we may help others experience that freedom!

This has been an extremely busy month for many reasons. I attended the Association of American Medical Colleges' annual meeting in Washington, D.C. the early part of November. It is an excellent forum to discuss issues impacting medical education and academic medical centers in this country. They also have an excellent web site, **www.aamc.org**.

The big news in health policy involves the largest overhaul of the federal Medicare program since its inception in 1965. I have included some of the high points for your review.

Highlights of the Medicare Overhaul, by the Date They Would Be Enacted

Changes beginning in 2004

Drug Discount Card

- The bill would provide discount cards for beneficiaries in April 2004. The Department of Health and Human Services (HHS) estimates that the cards would provide savings from 15 percent to 25 percent per prescription until a permanent benefit is established in 2006.
- Low-income beneficiaries would receive an additional $600 in annual assistance in 2004 and 2005.

Hospitals

- For fiscal 2004, the rate of change in payments to hospitals would match the rate of change in the price for a "market Basket: of certain goods used by hospitals.
- For fiscal 2005, 2006, and 2007, hospitals would have to furnish information on quality to the Centers for Medicare and Medicaid Services or face a reduction in payments.
- The bill calls for an 18-month moratorium of the self-referral whole hospital exemption for new specialty hospitals – not including existing hospitals or those under construction.

Payments to Physicians

- The bill would block a 4.5 percent planned cut in 2004 and additional cut in 2005. Instead, doctors would receive at least a 1.5 percent increase in 2004 and 2005.

Durable Equipment (crutches, walkers, etc.)

- Rates would be frozen from fiscal 2004 to 2006.
- Competitive bidding in the 10 largest metropolitan statistical areas would begin in 2007, with a goal of 80 such areas in 2009.

Laboratory Payments

- Payment rates to laboratories would be frozen for five years.

Home Health Care

- The bill would require no co-payment, the same as current law.
- The bill would provide a 5 percent bonus for rural home health care providers for one year, from April 2004 to April 2005.

Cost Containment

- The bill would require a response from Congress or the president if general revenue contributions exceed 45 percent of plan spending.

Rural Package

- Higher payments would be made to rural and small urban hospitals that have a disproportionate share of low-income patients. The bill would adjust payments to hospitals in outlying areas that have a low volume of patients.

Health Savings Accounts

- The new law would establish health savings accounts (HSAs) allowing any taxpayer – not just Medicare recipients – with a high-deductible health insurance plan to save and withdraw money tax-free to pay for medical expenses.
- Individuals could contribute an amount equal to the amount of their deductible. The annual maximum that could be contributed is $2,600 for a self-only policy and $5,150 for a family policy. These amounts would be indexed annually for inflation.
- An employer could contribute to an individual's health savings account and those contributions would not be included in the individual's taxable income. The interest or other investment earnings on the account would not be taxable. Withdrawals also would not be taxable as long as they were used to pay for "qualified medical expenses" incurred by the account holder, spouse or dependents.

Drug Importation

- The bill would allow drugs to be imported from Canada, but only if the HHS Secretary certifies the safety of the drug.
- The bill also calls for a study on drug importation and trade issues.

Changes beginning in 2006

Prescription Drug Benefit

- The benefit would include a $250 annual deductible and an average monthly premium of about $35.
- The government would pay 75 percent of the cost of drugs annually, up to $2,250. Once the beneficiary has paid $3,600 out of pocket, the government would pay 95 percent of the cost of drugs.
- Beneficiaries would be guaranteed access to at least one "prescription drug plan" and one integrated plan in each region. Two "prescription drug plans" would be required if no integrated plan is available.
- If no private plans bid in a region, the government would offer a fall-back plan.

Low-Income Assistance

- Seniors on Medicare and Medicaid would have access to the Medicare drug benefit.
- Beneficiaries with incomes up to 150 percent of the poverty level (currently $27,600 for a family of four) would get a benefit with no gaps in coverage but would be subject to premiums based on a sliding scale and co-payments.

Company-Provided Retiree Coverage

- Companies would receive $70 billion in subsidies and tax breaks over 10 years to encourage them to continue offering health care for their retirees.
- Qualified retiree plans would be able to have maximum flexibility on plan design, formularies and networks.
- Employers would be able to provide premium subsidies, cost-sharing assistance for retirees who enroll in a Medicare drug plan and integrated plans.

Changes beginning in 2007

Income Relating

- After a five-year phase-in beginning in 2007, Part B Medicare premiums would be subsidized on the following schedule:

Singles Income	Couples Income	Premium Subsidy
Under $80,000	Under $160,000	75%
$80,000 to $100,000	$160,000 to $200,000	65%
$100,000 to $150,000	$200,000 to $300,000	50%
$150,000 to $200,000	$300,000 to $400,000	35%
Over $200,000	Over $400,000	20%

Changes beginning in 2010

Competition

- Private Insurers would be able to begin bidding to serve Medicare beneficiaries in geographic regions beginning in 2006. Payment rates would be based on a blended average of the bids.
- The traditional Medicare system would compete with private plans in up to six metropolitan statistical areas beginning in 2010.

Please supply any pertinent information to my office (deantcom@hsc.unt.edu) by the 3rd Thursday of each month, for inclusion in the next Newsletter.

Student Affairs: (Dr. Mitch Forman)
Associate Vice President for Student Affairs

I want to congratulate all of the TCOM & PA students who participated in the Northside Health Fair several weeks ago. The coordination, cooperation and camaraderie was obvious and if the success was measured by the smiles of those community members who utilized this opportunity to improve their health, y'all hit a home run. I also want to personally thank the medical student who gave me my flu injection.....it was painless; I have not gotten sick and more importantly, I still have that appendage.

There are a many things taking place behind the scenes in Student Affairs. Dr. Moorman continues to negotiate with several book brokers to service our HSC. The latest company is willing to buy back text books from students, provide free shipping or overnight shipping for a reasonable charge, and provide additional financial incentives to students and the HSC. Student Affairs is working to identify as many religious holidays as feasible so that the HSC and faculty have the ability to be sensitive to those students celebrating particular holidays. Mitchell D. Forman, D.O.

Clinical Affairs / Faculty Practice: (Dr. Robert Adams)
Associate Dean for Clinical Affairs/Chief Medical Officer

When President Bush signs the Medicare legislation into law, there will be benefits to the physicians as well as the patients. The 4.5% reduction that was to occur in January 04 will be eliminated and replaced with a 1.5% increase. This will be helpful as we continually try and meet revenue needs. Only time will tell whether the legislation is helpful to our patients in the ways intended.

A brief update on our clinical initiatives.
-The CT scanner that is being funded from a federal grant is getting closer to reality. The make and model of scanner will be selected before the month is out and the scanner should be received during the spring. Planning for where to put the CT is underway and consideration is being given to a variety of options. Whatever the outcome of these discussions, we will have a new service available to our patients and a new research tool on campus.
- JPS discussions are ongoing for the following clinical activities. The cardiology initiative is moving forward with UNT faculty participating in the cardiology clinics at JPS. Additional needs in neurology, critical care, and rheumatology have been identified and discussions about our involvement in these services at JPS are taking place.

We continue to wait for financial data relative to the practice. We have revenue numbers for each of the first three months, but we are unable to complete expense information. This has made it impossible to know what our financial performance is. As you know, this is a result of the ongoing EIS transition. The problems are being worked on for what we hope is a quick solution. Currently, our reports are only one month behind so we hope the data feeds will be corrected in time to catch us up for our November reports.

Academic Affairs/Graduate Medical Education: (Dr. Don Peska)
Associate Dean for Academic Affairs

Program Closure……We learned last week that Dallas Southwest Medical Center ceased operations as an acute care facility. With that closure came the loss of nine osteopathic postgraduate training positions including traditional internships and family practice residencies. Sources at DSWMC, formerly Dallas Family Hospital and Stevens Park Hospital, indicate that they have been providing osteopathic graduate medical education for over fifty years with records on file dating back to 1952. DSWMC was a member of the Texas OPTI and a long-time teaching affiliate of TCOM hosting student rotations right up to the time of closure. The office of Clinical Education has worked quickly to move students to new rotation sites in an effort to avoid any interruption in the educational process. The cooperation of the clinical departments involved is very much appreciated. Through its network of affiliated training programs, the Texas OPTI has secured relocation sites for qualified residents that were displaced by this unfortunate occurrence. All those resettled are expected to complete their training on schedule.

The OPTI concept (Osteopathic Postdoctoral Training Institute) was developed by the American Osteopathic Association to strengthen accredited postgraduate training sites through a formal linkage to an osteopathic medical school. Inherent in the structure are the benefits of consortium education. When many of our smaller programs become unable to marshal adequate resources to be self-sustaining, the OPTI is able to provide the necessary support or, at times, facilitate the relocation activities that occurred in this instance.

Medical Education: (Bruce Dubin, D.O.)
Associate Dean for Medical Education

The phase director group, curriculum committee and student focus groups have been working hard to continuously improve our TCOM medical curriculum. Some of the fruits of their labor will be seen the November and December.

The mannequin simulation lab will be put to good use during weeks II and III of the Respiratory System II course. During this period, students will explore the diagnosis and treatment of respiratory problems as well as develop important clinical skills. Were excited about the opportunity to incorporate this into our educational efforts. The use of these simulation exercises will increase throughout all 4 years here at TCOM as an exciting part of our curriculum.

Newer materials covering microbiology, infections disease, and clinical medicine will enhance respiratory II as well. Basic and advanced topics that have been enhanced include microbiology,

infections disease, immunology, pharmacology, and HIV/AIDS. A new topic for second year students will review the "presurgical evaluation of a surgery patient with preexisting pulmonary disease". This material will be presented from the perspective of the anesthesiologist.

The Department of Medical Education has started focus groups for year III students. During these year III meetings, the opportunity for input between students and faculty exists. Were excited about the progress that took place during our mid November meeting and look forward to enhancing this ongoing dialogue.

Clinical Research: (Dr. Michael Clearfield)
Associate Dean for Clinical Research

I will keep this installment of the monthly report short. However, I want to again congratulate all of those participated in research over the past year for exceeding all expectations. Now that the bar has been raised we have a greater task ahead of us for this year. The new forms to be used for clinical trials are now available through the clinical trials office. This form needs to be completed before any industry-sponsored trial will be approved.

PA Studies: (PA Hank Lemke)
New PA Curriculum

Progress continues on the "new" second year PA curriculum, which began this fall for the Class of 2005. So far, the PA students have received new or revised didactic instruction delivered by physician and PA faculty, as well as guest faculty affiliated with the institution. Clinically related topics conducted so far include clinical therapeutics, psychiatry, dermatology, and EENT, musculoskeletal, cardiovascular, and pulmonary disease and disorders. Feedback from the students has been very positive and favorable for the new curriculum. Several PA students have expressed appreciation for the opportunity to receive instruction focused on their needs as future practitioners of medicine from several of the medical school's clinical faculty. The PA program would like to extend special appreciation to all of the clinical and science faculty who are putting forth extra effort to make this semester and next a success!

PA Utilization discussed in Family Practice News
The following brief article on PA utilization was taken from the November issue of Family Practice News. The article includes a quote from Dr John Fling. Dr Fling supervises PAs in the Department of Pediatrics and he is physician member of TCOM's PA Student Performance Committee.

Family Practice News
November, 15, 2003, Volume 33, Number 22

Team approach
More PAs Heading Into Physicians' Office Practices
Mary Ellen Schneider
Senior Writer

More physician assistants are working in solo and group medical practices, continuing a trend toward greater collaboration with physicians in the office setting.

Nearly 43% of physician assistants (PAs) work in a physician's office, up from about 40% in 2002, according to the 2003 annual census of PAs conducted by the American Academy of Physician Assistants (AAPA).

More than 30% of PAs reported working in a group practice setting, and 13% work with a solo practice physician, according to the survey. More than 20,000 PAs-about 45% of all PAs in clinical practice-completed the survey.

"These data indicate that we will see increasing roles for the profession of physician assistants in the years ahead, not only in hospitals, but increasingly in specialized and general-practice medical offices," said Steve Crane, Ph.D., executive vice president and CEO of the American Academy of Physician Assistants.

About 44% of PAs work in primary care, with 31% working in family or general practice, 8% in general internal medicine, 3% in ob.gyn., and 3% in pediatrics. This is a slight decrease from the 2002 figure for total percentage of PAs working in primary care settings.

Approximately 10% of PAs reported working in subspecialties of internal medicine, which could represent a trend toward more specialty care being provided by PAs, according to the AAPA.

These figures don't come as a surprise to Dr. David Edmonds, a family physician in group practice in Salem, Ore. PAs are able to help handle a large volume of patients, they are cost effective, and they provide quality care, Dr. Edmonds said.

He and his colleagues hired their first PA almost 8 years ago, and they now have one full-time PA and one part-time PA working in their practice. The PAs in Dr. Edmonds' practice see many acute patients who request same-day visits. This allows the physicians in the practice to see more complex patients.

Initially, not everyone in the practice was in favor of hiring a PA because of concerns about quality of care, but now they aren't sure what they would do without the help of PAs, Dr. Edmonds said.

"Physicians are continuing to try to find ways to deliver more efficient care," said Dr. Munsey S. Wheby, president of the American College of Physicians (ACP).

Utilizing PAs is one way to help improve the patient flow through the office and decrease waiting times, Dr. Wheby said. The presence of the PA also allows the physicians to focus on patients who are sicker and require more care, while the PAs focus on the management of chronic conditions, follow-up care, patient education, and medication checks.

PAs are also part of the move toward creating a medical team to provide care. "I see the physician assistant as part of my team," said Dr. Michael Fleming, president of the American Academy of Family Physicians.

Dr. Fleming uses PAs as the primary contact with patients for education, to triage acute cases, and even to do paperwork for the physician, he said.

PAs can also add to a patient's continuity of care, said Dr. Penelope K. Tippy, professor of family and community medicine at Southern Illinois University, Carbondale, because patients can see either the physician or the PA and know that the care is integrated.

And the presence of the PA can sometimes offer patients more options. For example, Dr. Tippy works with a male PA and she said that allows patients to see either a male or female provider based on what makes them more comfortable.

PAs are also cost effective, Dr. Crane said. The average starting salary for a PA is $64,565, according to the AAPA census, and for that price, a PA can substantially increase the quality and quantity of care provided, he said.

Practices are being forced to make changes because of decreasing reimbursement and the need to cut costs, said Dr. John A. Fling of the University of North Texas Health Science Center in Fort Worth.

Practices need to see more patients to cover costs, so some are turning to mid-level providers to fill that gap, he said. PAs increase productivity by allowing the practice to offer more appointments.

But careful supervision of PAs is also important. The level of oversight depends on the clinical experience of the PA, Dr. Wheby said.

For example, ACP advises physicians that from the outset, there should be a clear understanding of the responsibilities being delegated to the PA. The physician and PA should sit down and develop these parameters, even if they are revised later, Dr. Wheby said.

In addition, the physician should review the activities of the PA and be available for consultations on patients, Dr. Wheby said. And PAs should

understand that there are limits to what they can do without the physician, he said.

Physicians who hire PAs should also know local laws and regulations about using midlevel providers, Dr. Fling said.

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Science and Health News:

New York Times

November 27, 2003

H.I.V. Infections Continue Rise, Study Says
By ANAHAD O'CONNOR

The number of new H.I.V. cases diagnosed in the United States is continuing to climb, and the most significant rise has been among Hispanics and gay and bisexual men, according to the Centers for Disease Control and Prevention.

The study by the centers, which appeared in its Morbidity and Mortality Weekly Report, looked at data from 29 states that included a confidential system that was started in 1999. The picture of H.I.V., the virus that causes AIDS, might even be much worse than the data indicate because states with the highest populations and possibly the highest rates of infection, like New York and California, were not included in the four-year study.

From 1999 through 2002, the number of new H.I.V. cases soared by 26 percent among Hispanics and by 17 percent among men who have sex with men, while the increase in new cases over all for that period was 5.1 percent, according to the study.

"Because more effective treatments are available, there seems to be a perception particularly in the gay community that H.I.V. is a manageable disease," said Dr. Robert Janssen, director of the division of H.I.V. and AIDS prevention at the centers. "Most of the increase in the Latino community is due to men having sex with men. I think the disease just doesn't have the fear that it once carried."

Several other groups also showed increases in the rate of diagnosis. African-Americans still make up the largest portion of new cases, at 55 percent, while whites accounted for 8 percent of the new cases, the study found. The numbers for men in general went up 7 percent.

Whether the study's findings reflect higher rates of H.I.V. infection is difficult to say because some cases are not diagnosed immediately.

But if that was a factor, Dr. Janssen said, the study would have detected more cases that had progressed to AIDS. Instead, he said, rates of testing have stayed about the same and many of the recently detected H.I.V. infections were caught in the earlier stages.

"We're seeing an increase in people with H.I.V. but not necessarily an increase in simultaneous diagnoses of H.I.V. and AIDS," he said.

The new findings reinforce the notion that there is a growing sense of complacency among groups at the highest risk for contracting the disease. Advances in AIDS treatments in recent years, some experts are saying, could be undermining efforts to promote safe sex. The latest figures, in that case, might reflect a more widespread willingness to engage in risky behaviors.

Earlier this week, for example, the centers released figures showing that rates of syphilis infections had risen sharply in 2002 for the second consecutive year. Gay and bisexual men accounted for a disproportionate number of those cases, Dr. Janssen said, and in most cities more than half the men involved in the outbreak also had H.I.V.

Dr. Jeffrey Laurence, program consultant for the American Foundation for AIDS Research in New York, said: "Even among populations targeted for outreach, it's as if people think they can become infected because there's a pill to take care of them. There needs to be a stronger message that it's not a picnic to be on these drugs and that even when you're being treated you can still transmit this disease."

Efforts to promote AIDS prevention and convey the gravity of the disease have not reached Hispanics and other minorities, experts say. Too often, Dr. Laurence said, AIDS education programs rely on blanket messages that are too weak to combat the widespread images of healthy, resilient AIDS patients in drug advertisements.

"There's such a striking disparity among Hispanics and blacks that we're obviously not doing a good enough job of targeting them and conveying the right idea," he said. "Here's a population that is not responding to the messages we're sending. Perhaps it is because that message is getting stale."

More than 850,000 Americans are infected with H.I.V., the greatest number since the AIDS epidemic started in the early 1980's. According to the centers, about 40,000 people in the United States are infected with H.I.V. every year.

Four Children Die of Flu in Colorado
By THE ASSOCIATED PRESS

ATLANTA, Nov. 26 — Four children have died of the flu in Colorado since last week in what officials at the federal Centers for Disease Control and Prevention said could foretell a severe flu season for the country.

The deaths surprised some health officials because they happened so close together and so early in the flu season. Last year, Colorado had four child deaths during the season, which normally peaks in January and February and runs through April.

Even before the deaths, there were signs that this could be an especially bad flu season. Some parts of the country, particularly Colorado, Texas and Nevada, have been hit hard a month earlier than usual.

Also, the flu strain that doctors are seeing is the H3N2 Fujian, part of a class of flu viruses that caused severe outbreaks in the United States in the 1990's.

Health Policy News:

Conferees Struggle to Finish Labor-HHS Spending Bill

House and Senate negotiators continue to struggle to finish an omnibus spending package that includes the FY 2004 Labor-HHS-Education appropriations bill (H.R. 2660) amid increasing pressure from the White House and the House GOP leadership.

Senate Approves Veterans Health Legislation

The Senate Nov. 19 approved by voice vote legislation (S. 1156) encompassing several veterans' health care-related provisions that Senators have been "pre-conferenced" with their House counterparts.

Conferees Complete Omnibus Spending Bill

House and Senate negotiators have reached agreement on an omnibus spending bill that provides a $1 billion increase for the NIH, restores much of the funding for the health professions education programs and provides a significant increase for veterans medical care. However, final passage of the measure, which includes seven FY 2004 appropriations bills, may not occur until January.

CY 2004 Outpatient PPS Payments To Increase 4.5 Percent Under Final Rule

Under the final rule published in the Nov. 7 Federal Register, Medicare outpatient prospective payment system (OPPS) payments for services provided on or after Jan. 1, 2004 will increase by an average of 4.5 percent. This increase reflects an inflationary increase to the base payment rate (the "conversion factor") equal to the full hospital market increase of 3.4 percent plus additional upward adjustments. The Centers for Medicare and Medicaid Services (CMS) expects to pay hospitals about $22.8 billion in 2004 through the OPPS.

House Committee Examines Commissioned Corps Reform Plan

The House Government Reform Committee Oct. 30 held a hearing to examine the proposed plan to transform the Public Health Service Commissioned Corps that was announced by the Department of Health and Human Services (HHS) in July. The proposed plan would expand the Corps by recruiting 1,000 nurses and 100 physicians each year to practice in underserved areas and better prepare the Corps for public health emergencies by making it deployable by 2005.

Research and Funding Opportunities:

Agency for Healthcare Research and Quality (AHRQ) Issues Three New RFAs to Support Health Information Technology to Improve Patient Safety and Quality of Care

AHRQ announced three new Requests for Applications (RFAs) for approximately 100 grants to plan, implement, and demonstrate the value of health information technology to improve patient safety and quality of care. The $41 million grant program, "Transforming Healthcare Through Information Technology," will be part of a $50 million portfolio of grants, contracts, and other activities to demonstrate the role of health information technology to improve patient safety and the quality of care. The RFAs emphasize the importance of partnerships with rural communities and with small and rural hospitals. Select these links to access the press release or to read the RFAs.

Quotes

The real differences around the world today are not between Jews and Arabs; Protestants and Catholics; Muslims, Croats, and Serbs. The real differences are between those who embrace peace and those who would destroy it; between those who look to the future and those who cling to the past; between those who open their arms and those who are determined to clench their fists.
William J. Clinton

Peace and justice are two sides of the same coin.
Dwight D. Eisenhower

An eye for eye only ends up making the whole world blind.
Mohandas Gandhi

Marc

Marc B. Hahn, DO
Dean
Texas College of Osteopathic Medicine
University of North Texas-Health Science Center
3500 Camp Bowie Boulevard
Fort Worth, Texas 76107-2699
817-735-2416 or 2244
facsimile 817-735-2486