DEAN'S CORNER E-NEWSLETTER

Texas College of Osteopathic Medicine

November 30, 2005

November was a busy month as the University of North Texas Health Science Center completes the second month of our contract with the Tarrant County Hospital District to provide clinical and academic services for OB/GYN, Orthopedics, Podiatry, Psychiatry, Community Medicine, and some Medical specialties for John Peter Smith Hospital. As of October 1st, our clinical faculty has nearly doubled with almost 200 physicians, PAs and CRNP faculty. The TCOM administration is preparing for the first faculty meeting since the start of the new clinical faculty.

Last week, I presented a five year review of the Texas College of Osteopathic Medicine to our UNT System Board of Regents. We reviewed the successes in medical education, GME, PA studies, research, and our clinical practice. I will present these successes to the UNTHSC faculty meeting in mid December and to each of the classes throughout the year. However, I have included a link to these slides (http://www.hsc.unt.edu/education/tcom/documents/AcademicpresentationBoR12-05.pdf) for your review.

I would like to wish all of our faculty, staff, and students a very happy holiday season! But more importantly, our thoughts should be with our military who are far from home and in harm's way during the holidays.

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

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Student Affairs:

Thomas Moorman, Ed.D.
Associate Vice President for Student Affairs

Bobbie Ann Adair Recipient of State Award

Bobbie Ann Adair, Student Development Coordinator has been recognized with the Outstanding New Professional Award at the Texas Association of College and University Student Personnel Administrators (TACUSPA) conference on October 10, 2005.

This award is given to a new professional in student affairs who has shown exemplary performance at their individual institutions. Dr. Thomas Moorman, Associate Vice President of Student Affairs wrote that "Bobbie Ann has demonstrated her success as a new professional by engaging students, enduring faculty, and empowering everyone."

During her time here at UNTHSC, Bobbie Ann has made available professional programs, workshops, housing fairs, one on one consultation with students, been involved with the student organizations, been an active member of the EBAC and Alumni Relations Committee. Her sweet personality and happy demeanor is an asset to the UNTHSC campus community. Congratulations Bobbie Ann!

Clinical Affairs / Faculty Practice:

Robert Adams, D.O.
Senior Associate Dean for Clinical Affairs/Chief Medical Officer

We have heard concerns from many of the physicians about the inability to find adequate parking when returning to campus from activities at area hospitals. Now that physicians are practicing at several locations, the ability to find parking is critical to the ability to efficiently manage their time. In an effort to help with this situation, the parking lot across from the PCC now has 10 spaces marked for Physician in and out parking. The time limit is 3 hours. We will monitor the use of these spaces to determine if the number is appropriate. If there are further suggestions about these parking arrangements please let us know.

Educational Programs:

Don Peska, D.O.
Associate Dean for Educational Programs

As everyone begins to sense the oncoming holiday season, graduate medical education finds itself in the midst of recruitment for a new class of intern's and residents. This year, osteopathic training programs are using the ERAS central application service. All sites in the State of Texas are reporting an increased number of applications this year. We are unsure if this is due to the ease of the new service, visibility of our programs or an increasing number of graduates. We suspect that all are contributing to some extent.

Plaza will open its new education center later this month. The facility, located in the adjacent office tower and connected to the main hospital, will house the office of medical education, a dedicated student library, a new resident library, a twelve station computer center linked to the university and offices for the chief residents and Director of Medical Education. Most needed will be three new classrooms, the largest holding sixty-plus people and all equipped to receive teleconferencing. Faculty are invited to come by and visit and should contact Kay Washington, our new house staff coordinator to schedule classroom space as needed.

Academic Affairs:

Bruce Dubin, D.O., J.D.
Associate Dean for Academic Affairs
Medical Education

Update on "Eye on Detail"

Part of being a physician is the ability to quickly observe a patient and draw important inferences that will lead a clinician to a rapid and correct diagnosis. These are not skills that are easily attainable. They must be learned and practiced. For the second year in a row, all first year TCOM students are participants in the "Eye on Detail" program that uniquely trains them in the art of observation. A joint project between TCOM and the Amon Carter Museum of Western Art, this unique program rapidly and quickly trains students to skillfully observe using "great works of art." Students begin this three hour session by observing important and subtle features in oil paintings, and then progress to the world famous "Avedon Collection" of western photographs. The transition is remarkable as first year students rapidly progress to competency in the art of observation. Students feel this is a real asset to their physical diagnosis training. Any faculty wishing to sit in on one of these programs should contact the office of medical education to arrange for an opportunity to participate. They can be reached at extension 2221.

Clinical Research:

Michael Clearfield, D.O.
Associate Dean for Clinical Research

[No article this month]

Admissions:

Russell Gamber, D.O.
Assistant Dean of Admissions and Outreach

For the past four years, UNTHSC has been a participant in a statewide program called the Joint Admission Medical Program (JAMP). JAMP was created by the 77th Texas State Legislature to provide support and encouragement to economically disadvantaged students who want to pursue a medical education. Every year, 69 undergraduate students are selected statewide and participate in summer internships at all eight Texas medical schools. In the past three summers, UNTHSC has had 36 JAMPers on our campus during which time many of the UNTHSC faculty and staff have taught, preceptored, and otherwise helped these students prepare for success in medicine. Dr. Alan Podawiltz, Chairman of Psychiatry, serves as the JAMP Council member for TCOM, and Leila Torres, TCOM Admissions and Outreach, serves as the JAMP Coordinator.

This interview season, 44 JAMP students were interviewed at all eight Texas medical schools. On November 2, 2005, the JAMP Council met in Houston to determine how many JAMP students from the 2003 accepted JAMP class would continue on to the JAMP Match to take place on December 15, 2005. At that meeting, 10 students were dismissed from JAMP because they did not meet the GPA and/or MCAT requirement set by the Council; therefore, 34 students will be participating in the JAMP Match. Each medical school will match with a percentage of these students based on their class size. TCOM will be matched with 4 students to matriculate into the Entering Class of 2006.

In the general TCOM applicant pool, we have received applications from 1838 applicants (1633 Texans, 205 nonresidents) as of November 9, 2005. This number is up 16.5% over last year's applications at the same time in the admissions cycle (1578 on November 10, 2004). We have interviewed 378 applicants (357 Texans, 21 nonresidents).

TCOM Admissions expects to schedule interviews for approximately 550 students this season. We appreciate the efforts of our faculty interviewers and scheduling staff to the present time and count on their continued assistance through the remainder of the regular interviewing season, which ends on December 16.

PA Studies:

Hank Lemke, P.A.
Vice Chair for PA Studies

[No article this month]

Science and Health News:

Health Economics 101
[November 14, 2005]
By PAUL KRUGMAN

Several readers have asked me a good question: we rely on free markets to deliver most goods and services, so why shouldn't we do the same thing for health care? Some correspondents were belligerent, others honestly curious. Either way, they deserve an answer.

It comes down to three things: risk, selection and social justice.

First, about risk: in any given year, a small fraction of the population accounts for the bulk of medical expenses. In 2002 a mere 5 percent of Americans incurred almost half of U.S. medical costs. If you find yourself one of the unlucky 5 percent, your medical expenses will be crushing, unless you're very wealthy - or you have good insurance.

But good insurance is hard to come by, because private markets for health insurance suffer from a severe case of the economic problem known as "adverse selection," in which bad risks drive out good.

To understand adverse selection, imagine what would happen if there were only one health insurance company, and everyone was required to buy the same insurance policy. In that case, the insurance company could charge a price reflecting the medical costs of the average American, plus a small extra charge for administrative expenses.

But in the real insurance market, a company that offered such a policy to anyone who wanted it would lose money hand over fist. Healthy people, who don't expect to face high medical bills, would go elsewhere, or go without insurance. Meanwhile, those who bought the policy would be a self-selected group of people likely to have high medical costs. And if the company responded to this selection bias by charging a higher price for insurance, it would drive away even more healthy people.

That's why insurance companies don't offer a standard health insurance policy, available to anyone willing to buy it. Instead, they devote a lot of effort and money to screening applicants, selling insurance only to those considered unlikely to have high costs, while rejecting those with pre-existing conditions or other indicators of high future expenses.

This screening process is the main reason private health insurers spend a much higher share of their revenue on administrative costs than do government insurance programs like Medicare,

which doesn't try to screen anyone out. That is, private insurance companies spend large sums not on providing medical care, but on denying insurance to those who need it most.

What happens to those denied coverage? Citizens of advanced countries - the United States included - don't believe that their fellow citizens should be denied essential health care because they can't afford it. And this belief in social justice gets translated into action, however imperfectly. Some of those unable to get private health insurance are covered by Medicaid. Others receive "uncompensated" treatment, which ends up being paid for either by the government or by higher medical bills for the insured. So we have a huge private health care bureaucracy whose main purpose is, in effect, to pass the buck to taxpayers.

At this point some readers may object that I'm painting too dark a picture. After all, most Americans too young to receive Medicare do have private health insurance. So does the free market work better than I've suggested? No: to the extent that we do have a working system of private health insurance, it's the result of huge though hidden subsidies.

Private health insurance in America comes almost entirely in the form of employment-based coverage: insurance provided by corporations as part of their pay packages. The key to this coverage is the fact that compensation in the form of health benefits, as opposed to wages, isn't taxed. One recent study suggests that this tax subsidy may be as large as $190 billion per year. And even with this subsidy, employment-based coverage is in rapid decline.

I'm not an opponent of markets. On the contrary, I've spent a lot of my career defending their virtues. But the fact is that the free market doesn't work for health insurance, and never did. All we ever had was a patchwork, semiprivate system supported by large government subsidies.

That system is now failing. And a rigid belief that markets are always superior to government programs - a belief that ignores basic economics as well as experience - stands in the way of rational thinking about what should replace it.

Bob Herbert is on vacation.

Toward a Digital Health-Care Ecosystem

[October 25, 2005; page B2]
By CAROL KOVAC

The problems bedeviling health care in America are well understood: rapidly rising costs, with no commensurate improvement in national health to show for the trillions we are spending. This has become -- quite literally -- a matter of life and death. Every year, nearly 100,000 deaths in the U.S. are attributed to medical errors like mistakes in drug dosages or dangerous interactions between medications.

Even more puzzling, while there is much disagreement about what is ultimately to be done, we have reached a consensus on at least one solution: We need to wire our entire health-care infrastructure into an intelligent national network. Doing so will transform the quality of care, while streamlining and automating the economics of health care to produce dramatic cost savings -- billions annually, according to a recent RAND report. This vision of a coherent, computerized system for health care is shared by Senators Bill Frist and Hillary Clinton, who proposed legislation along these lines, underscoring the bipartisan support for change across American society.

And Nevada Rep. Jon Porter recently said he plans to introduce legislation to mandate the creation of an electronic health record (EHR) for every person covered by the Federal Employees Health Benefits Program.

So in the face of health care's challenges, what is holding us back? The remedy requires two elusive ingredients: more courageous leadership, and a measure of societal collaboration that transcends politics and preconceptions.

To lead (and collaborate) by example, the Information Technology industry announced this month it would do its part to accelerate the arrival of interconnected, electronic health care by making personal, private electronic health records available to each of our 800,000 U.S. employees as soon as possible. IBM, for its part, will introduce a personal health records service for its U.S. workforce early next year, one initial step in accelerating the evolution of healthcare.

Of course, personal health records are only one piece of the puzzle for a true health-care system -- something we do not have today. Doctors, hospitals and insurers will have to plug into the same network to achieve the kind of sweeping change President Bush called for in 2004, asking America to begin building a National Health Information Network. All the experts agree that this will be a major integration challenge -- including the need to ensure the privacy and security of such deeply personal information.

We know there's a long road ahead. By committing to personal health records for our employees now, the IT industry is aiming to build momentum for a more rapid rollout of the kind of system we so desperately need.

And if we required more proof of that urgency, Hurricane Katrina tragically provided it. More than a million pages of medical records were lost to floods and destruction. Significantly, the only patient records saved were those that had been digitalized by the U.S. Department of Veterans Affairs, which deployed an electronic record system in 2004. In fact, on Veterans Day, the VA is rolling out an on-line system for personal health records called My HealtheVet.

Ultimately, to undertake a challenge on the scale of transforming the nation's system requires unprecedented collaboration among every player in the American health care environment -- including federal and state government, all industries and all healthcare providers.

Earlier this month, the Tech CEO Council, an umbrella advocacy group comprised of nine leading technology firms including Applied Materials, Dell, EMC, HP, Intel, Motorola, NCR, Unisys and IBM, put forward a seven-point plan as a roadmap for such leadership.

It notes, for instance, that as America's largest health-care provider, the U.S. federal government has a decisive role to play in catalyzing the complex shift toward electronic health. Government agencies can spur the adoption of open technology standards that will be critical to progress.

We can also look to successful implementation of digital health care in places like Denmark, New Zealand and Singapore, which have improved the health of both individuals and national economies. Great Britain is also investing several billion dollars to empower its National Health Service with electronic health records.

With employer health-care costs growing faster than revenues, and more people dying in the U.S. of medical errors than AIDS, homicides and automobile crashes combined, we believe that transforming healthcare with technology and innovation has become a matter of national security in both human and economic terms.

A robust electronic ecosystem for health would also serve as a platform for entirely new capabilities, such as providing early warning of infectious diseases, food-borne illness or bioterror. Imagine a real-time "weather map" that would help us manage our national health with more rapid and informed responses to various threats.

Personal health records are a first step toward achieving this compelling future, and the IT industry is moving forward with them and related recommendations today, with the aim of pointing the way forward. We welcome others to join us -- to work together to weave the kind of 21st-century health-care ecosystem we agree that we need (and deserve) for the billions of dollars we're investing in health care.

Ms. Kovac is the general manager of health care and life sciences for IBM.

Health Policy News:

House Defeats HHS Spending Bill

The House of Representatives Nov. 17 voted 224-209 to reject the conference agreement of the FY 2006 Labor, Health and Human Services, and Education appropriations bill (H.R. 3010, H.Rpt.109-300), sending it back to the conference committee for further consideration. AAMC President Jordan J. Cohen, M.D., Nov. 17 sent a letter to the House and Senate opposing the conference agreement, stating that the severe cuts to Title VII health professions programs and the minimal increase for the National Institutes of Health (NIH) "do not serve the best interests of the health and well-being of the American people."

Congress Approves Funding Extension

The Senate Nov. 18 cleared for the White House a second stopgap funding measure (H.J.Res. 72) to continue funding for federal programs through Dec. 17. The House of Representatives Nov. 17 voted 413-16 to approve the measure. The bill, known as a continuing resolution or CR, provides funds for those programs supported by appropriations bills not yet enacted, including the Labor-HHS-Education bill (H.R. 3010).

House Approves Budget Reconciliation Bill

The House approved Nov. 17 budget reconciliation legislation (H.R. 4241) by a 217-215 vote after House Republican leaders revised the bill a second time to appease House Republican moderates. The new revisions include a softening of cuts to the Medicaid program. The bill still includes a provision of concern to the AAMC that would limit hospital payments for emergency services provided to "out-of-network" Medicaid managed care beneficiaries.

AAMC Comments on Accreditation Provisions of HEA Reauthorization

The AAMC, in coordination with the Liaison Committee on Medical Education (LCME) and in consultation with the American Medical Association, sent a comment letter Nov. 15 to the House Committee on Education and the Workforce and the Senate Committee on Health, Education, Labor, and Pensions. The letter expresses concerns regarding the accreditation provisions of the Higher Education Act (HEA) reauthorization bills (H.R. 609, S. 1614).

Members of Congress Send Letter to CMS on Residency Training in Non-Hospital Sites

Reps. Kenny Hulshof (R-Mo.), John Tanner (D-Tenn.) and 65 other Members of Congress sent a letter Nov. 9 to Centers for Medicare and Medicaid Services (CMS) Administrator Mark McClellan, M.D., Ph.D., urging CMS to extend the moratorium on payment denials related to family medicine residents training in non-hospital settings established in the Medical Modernization Act.

NRC Urges Reforms on Patent Policies in Genomic and Proteomic Research

The National Academies' National Research Council (NRC) released Nov. 17 its recommendations for U.S. patent policies affecting biomedical research, particularly in genomic and proteomic research. Roderick R. McKelvie, a former judge and partner in the firm Covington and Burling, co-chaired the 18-member committee with Shirley Tilghman, Ph.D., president of Princeton University. David Korn, M.D., AAMC Senior Vice President for Biomedical and Health Sciences Research, was also a member of the committee.

IRS Issues Exempt Organizations Implementing Guidelines

The Internal Revenue Service (IRS) Tax Exempt and Government Entities Division released Oct. 25 its "FY 2006 Exempt Organizations (EO) Implementing Guidelines." A letter from the director of the division accompanying the guidelines states that the IRS is "considering a compliance project to determine how hospitals determine and pay executive compensation as well as how they meet the community benefit standards for purposes of section 501(c)(3)."

MedPAC Focuses on Physician Issues

At its Nov.15-16 meeting, the Medicare Payment Advisory Commission (MedPAC) covered a variety of physician issues including: valuing physician payments, reviewing beneficiary access and physician supply, and updates on special projects regarding resource use and coordination of care. The commissioners highlighted the importance of determining accurate payments for physician services, citing concern that overvalued services are not routinely identified or updated. MedPAC staff presented preliminary findings regarding beneficiary access and physician supply.

Research and Funding Opportunities:

National Institutes of Health (NIH)
High-Risk Research in Anthropology (HRRA)
Anthropological research may be conducted under unusual circumstances, often in distant locations. As a result the ability to conduct potentially important research may hinge on factors that are impossible to assess from a distance and some projects with potentially great payoffs may face difficulties in securing funding. This program gives small awards that provide investigators with the opportunity to assess the feasibility of an anthropological research project. The information gathered may then be used as the basis for preparing a more fully developed research program. Projects which face severe time constraints because of transient phenomena or access to materials may also be considered.

TITLE: THE RELATIONSHIP BETWEEN HYPERTENSION AND INFLAMMATION
National Heart, Lung, and Blood Institute (NHLBI), (http://www.nhlbi.nih.gov/)
Announcement Type - New
Looking Ahead: As part of the Department of Health and Human Services' implementation of e-Government, during FY 2006 the NIH will gradually transition each research grant mechanism to electronic submission through Grants.gov and the use of the SF 424 Research and Related (R&R) forms. Therefore, once the transition is made for a specific grant mechanism, investigators and institutions will be required to submit applications electronically using Grants.gov. For more information and an initial timeline, see http://grants.nih.gov/grants/guide/notice-files/NOT-OD-05-067.html. NIH will announce each grant mechanism change in the NIH Guide to Grants and Contracts (http://grants.nih.gov/grants/guide/index.html). Specific funding opportunity announcements will

also clearly indicate if Grants.gov submission and the use of the SF424 (R&R) is required. Investigators should consult the NIH Forms and Applications Web site (http://grants.nih.gov/grants/forms.htm) for the most current information when preparing a grant application.
Program Announcement (PA) Number: PA-06-035
Catalog of Federal Domestic Assistance Number(s)
93.837
Key Dates
Release Date: October 21, 2005
Letters of Intent Receipt Date(s): Not applicable
Application Submission Dates(s): Standard dates apply, please see http://grants.nih.gov/grants/funding/submissionschedule.htm#reviewandaward for details
Peer Review Date(s): Standard dates apply, please see http://grants.nih.gov/grants/funding/submissionschedule.htm#reviewandaward for details
Council Review Date(s): Standard dates apply, please see http://grants.nih.gov/grants/funding/submissionschedule.htm#reviewandaward for details
Earliest Anticipated Start Date: Standard dates apply, please see http://grants.nih.gov/grants/funding/submissionschedule.htm#reviewandaward for details
Additional Information To Be Available Date (Url Activation Date): Not applicable
Expiration Date: November 2, 2008

Due Dates for E.O. 12372
Not Applicable

Additional Overview Content

Executive Summary
This initiative will encourage the study of the sequence of events in which the vascular inflammatory state contributes to the development and maintenance of hypertension. Ample evidence suggests that inflammation may play a role in the pathogenesis of hypertension or that it may characterize a functional state of the vessel wall as a consequence of high blood pressure. Angiotensin II (Ang II), a widely recognized vasoconstrictor and anti-natriuretic involved in blood pressure regulation, also acts as a pro-inflammatory factor in the cardiovascular system. Ang II stimulates the expression of several inflammatory cytokines, which in turn affect blood pressure. A potential linkage between Ang II and immuno-cytokines is their shared ability to induce the level of reactive oxygen species (ROS), which serve as second messengers for many intracellular signaling pathways. The production of ROS not only decreases bioavailability of nitric oxide (NO), a vasodilator, but also initiates the functional and morphological alterations, such as remodeling, in the vascular wall that accompany the hypertensive state over time. This initiative would provide an opportunity to bring focus on the potential causal relationship between hypertension and inflammation in a cohesive, integrated manner. A new understanding of hypertension and inflammation would provide novel opportunities to prevent and treat the disease.
• This funding opportunity will use the R01 award mechanism. Because the nature and scope of the proposed research will vary from application to application, it is anticipated that the

size and duration of each award will also vary. The total amount awarded and the number of awards will depend upon the numbers, quality, duration, and costs of the applications received.
- Eligible domestic and foreign institutions/organizations include for-profit or non-profit, public or private, and faith-based or community-based organizations, units of State Tribal government, units of Local Tribal government, units of State and Local governments, and eligible agencies of the Federal government.
- Eligible principal investigators include any individual with the skills, knowledge, and resources necessary to carry out the proposed research.
- Applicants may submit more than one application, provided they are scientifically distinct.
- See Section IV for application materials.
- Telecommunications for the hearing impaired is available at: TTY 301-451-0088

National Institutes of Health
Research on Ethical Issues in Human Studies

The National Institutes of Health (NIH) invite research grant applications (R01) to investigate ethical issues in human subjects research. The Code of Federal Regulations - Protection of Human Subjects (45 CFR, Part 46) provides a regulatory framework that all NIH-supported researchers must follow. Recent developments in biomedical and behavioral research, however, including the rapid growth of new interventions and technologies (e.g., stem cells, genetics research), increasing involvement of foreign populations in clinical research, and concerns about financial conflicts of interest among researchers, challenge investigators' abilities to interpret and apply the regulations. Other situations (e.g., research with vulnerable populations, the use of data banks or archives, research on stigmatizing diseases or conditions) may present difficulties for identifying strategies, procedures, and/or techniques that will enhance/ensure the ethical involvement of human participants in research. The purpose of this program announcement is to solicit research addressing the ethical challenges of involving human participants in research in order to inform and optimize protections for human participation in research.
Research on Ethical Issues in Human Studies

Funding Agencies:
- National Institutes of Health (NIH)

FEDERAL AGENCIES:

Fulbright Scholar Program (CIES):
www.cies.org/cies/us_scholars/

Institute of Museum and Library Services:
www.imls.gov/

National Academy of Sciences:
www.nas.edu

National Institutes of Health:
www.nih.gov

National Research Council:
www.nas.edu

National Science Foundation:
www.nsf.gov/

Office of Naval Research:
www.onr.navy.mil/

U.S. Air Force Office of Scientific Research:
www.afosr.af.mil/

U.S. Army:
www.army.mil/

U.S. Department of Education:
www.ed.gov/legislation/FedRegister/announcements/index.html

U.S. Environmental Protection Agency:
www.epa.gov/

Quotes:

It is the mark of an educated mind to be able to entertain a thought without accepting it.
Aristotle

When a subject becomes totally obsolete we make it a required course.
Peter F. Drucker

There is nothing so stupid as the educated man if you get him off the thing he was educated in.
Will Rogers

Marc

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