Dean's Corner e-Newsletter

Texas College of Osteopathic Medicine

August 31, 2006

First of all, I would like to welcome all of our new students to campus, and wish you all the best as you begin your studies in your chosen field! The DO class of 2010 and the PA class of 2009 are the largest, brightest and most diverse students to date to matriculate at TCOM. The DO program has 162 and the PASP 32 students. This year we also begin the new Rural Track Curriculum in the medical school. The program offers a unique curriculum for the 13 students enrolled and it represents TCOM's continued commitment to excellence in Primary Care for the State of Texas, and the nation.

Speaking about welcomes, please also join me in welcoming our new President, Scott Ransom, DO, MBA, MPH as the 5th president of the University of North Texas Health Science Center. He joins us from the University of Michigan-Ann Arbor, where he has served as executive director of the program for healthcare improvement and leadership development and as professor of obstetrics, gynecology, health management and policy. In Michigan, he also has served as the director of women's health and gynecology at the Ann Arbor VA Medical Center. Dr. Ransom's research and consulting include areas related to improving the health care delivery system, women's health, leadership development, health disparities and performance improvement.

Prior to joining the University of Michigan, Dr. Ransom was vice president for medical affairs and then senior vice president at the Detroit Medical Center, a $1.8 billion, seven-hospital health care system. He is past president of the American College of Physician Executives, which includes a national membership of more than 11,000 physician leaders.

Dr. Ransom received a doctorate in osteopathic medicine from the University of Health Sciences in Kansas City, a master of business administration from the University of Michigan-Ann Arbor and a master of public health from Harvard University. He completed his residency in obstetrics and gynecology at Oakwood Hospital in Dearborn, Mich. Dr. Ransom also is a graduate of the U.S. Marine Corps Officer Candidate School.

I have just returned from Thailand where I served as one of six foreign faculty at the International Meeting on "Medical Education in the Changing Health Systems" held at Naresuan University Hospital, in Phitsanulok, Thailand. I was joined by faculty from the New England University in Australia, Dresden University in Germany and Harvard University. I lectured to the group of more than 400 on the US Health Care System, Medical Education in the 21st Century (including information on the growth of the Osteopathic Profession), and the TCOM Rural Track program. The talks were well received and I anticipate that we will be expanding our international affiliations to perhaps Thailand, Viet Nam and Australia.

September 8th is the date for our White Coat Ceremony and Convocation. This special ceremonial event welcomes freshman students at the Health Science Center into the healing arts with the donning of the traditional white coat. There will be a reception for students and their family immediately following the event in the Atrium at the University of North Texas Health Science Center.

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

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Student Affairs:

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

A Celebration of the New Academic Year

The University of North Texas Health Science Center's Annual Convocation/White Coat Ceremony will be held on Friday, September 8, 2006, at 2:00 p.m. The ceremony will be held at the Will Rogers Memorial Auditorium, 3401 W. Lancaster, Fort Worth, Texas. The White Coat Ceremony is a tradition in which the institution welcomes all new entering students. In the presence of family members, friends, and school faculty, students are cloaked in their white coats by faculty mentors and take a pledge of commitment, integrity, and ethics to their new profession.

Support for Your Academic Success

The Office of Academic Support (OASIS) in the Division of Student Affairs, offers a number of services designed to enhance the academic success of ALL UNTHSC students. These services include:

1. One-to-one and group learning strategies sessions designed to support students in meeting the challenges of professional school curriculums. Areas most often addressed in these sessions are time management, study strategies, and test-taking skills.

2. OASIS also provides several peer tutoring options tailored to fit the needs of each curriculum. Not only do these peer tutors assist with content clarification, they also model "best practices" study strategies for those they tutor. There are several types of tutoring, and requirements to access services vary according to type:

    A. Large Group Tutorials are content-oriented two-hour review sessions taught by upperclassmen. Scheduled at strategic times and open to all medical students in a given course, their purpose is to help students develop effective exam preparation strategies.

    B. Drop-in gross anatomy lab tutoring sessions are also scheduled at strategic times and open to all PA and medical students in gross anatomy courses.

    C. However, the most effective type of tutoring offered by OASIS, because it fosters active learning and individual responsibility, is Referral Tutoring. This involves a peer tutor working with two to six students, and is available in selected courses to students in all programs. To access this service, a student must schedule a conference with either Peg Dansereau, Director of Academic Support, or Eryn Loney Coordinator for Academic Support. At this initial conference, learning strategies, as well as eligibility for referral tutoring will be assessed. If a student qualifies, and if tutoring resources are available, a referral to a specific OASIS tutor is emailed to the student. To keep their referral tutor, a tutee must periodically meet with OASIS staff. Although the requirements are more stringent, for a student who is struggling in a course, referral tutoring is by far the best option.

For more information regarding the tutoring program and other OASIS resources, please contact Peg Dansereau, Director of Academic Support at pdansere@hsc.unt.edu, Eryn Loney, Coordinator for Academic Support at eloney@hsc.unt.edu or the OASIS website at http://www.hsc.unt.edu/departments/Oasis/Links.htm.

The Office of Academic Support Services (OASIS) has been very busy this summer! The office recently made numerous tutor referrals for TCOM students; They are participating in the GSBS Core Forum in late August to present test taking strategies to new students. They are reviewing and editing personal statements and curriculum vitaes for all UNTHSC students. In addition, They are part of a core team for Careers in Medicine, an exciting new program that educates students regarding medical career choices, issues, and opportunities.

OASIS has become synonymous with relief to UNTHSC students who meet with Peg Dansereau and Eryn Loney to discuss time management issues, academic challenges, test taking strategies, and learning styles. Students are comfortable discussing a variety of issues, and enjoy the close

relationships created with repeat visits. They love what they do. When students are happy, they are happy.

Scholarship Information

The Scholarship website at http://www.hsc.unt.edu/departments/financialaid/scholarships.cfm now includes new and updated information. A new section including links to military scholarship information is now accessible. Also, students may complete their own external scholarship searches by clicking on the external scholarships website links. In addition, applications, deadlines, criteria, and eligibility requirements for internal and external scholarships are listed and updated monthly. Please contact Lori Fielding with the Financial Aid Office at lfieldin@hsc.unt.edu for questions or additional information.

Clinical Affairs / Faculty Practice:

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

Hopefully, you have had the opportunity to hear Dr. Ransom talk of his vision for the Health Science Center. As he discusses his plans for how we will become a top 10 health science center, it is apparent that there will need to be an enhanced level of collaboration in effort and responsibility. Also, it is apparent that we will all be involved in the measure of our accomplishments through defined metrics as indicators of our success during the journey.

The clinical area has used metrics to monitor and measure achievement for a long time. What we haven't done is consolidate the varied metrics together into a scorecard that provides a bigger picture of who we are. Starting in September 2006, we will begin an effort to create a picture of our practice on a monthly basis, and focus on whether we are achieving our goals or not. These results will be shared openly within the institution so we may celebrate our successes and identify our challenges.

The vision for the clinical practice is "to become the preeminent multi-specialty medical practice in Tarrant County and the health care partner of choice." To achieve this vision we will have to be successful in three areas; 1. Financial, 2. Patient satisfaction, and 3. Employee satisfaction. These three areas have an interrelationship that makes success in one dependant on the success of the other two. We will focus on tracking metrics that allow us to measure our level of achievement in each of these areas.

Please commit to the achievement of our vision and help us identify how we can be successful in all that we do.

Educational Programs:

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

Compact Between Residents and Teachers

The American Osteopathic Association recently endorsed a document prepared by the Association of American Medical Colleges that articulates the purpose of Graduate Medical Education. In that document are listed certain commitments that faculty must make as educators of medical graduates. The following is taken from that *Compact.*

1. As role models for our residents, we will maintain the highest standards of care, respect the needs and expectations of patients, and embrace the contributions of all members of the healthcare team.

2. We pledge our utmost effort to ensure that all components of the educational program for resident physicians are of high quality, including our own contributions as teachers.

3. In fulfilling our responsibility to nurture both the intellectual and the personal development of residents, we commit to fostering academic excellence, exemplary professionalism, cultural sensitivity, and a commitment to maintaining competence through life-long learning.

4. We will demonstrate respect for all residents as individuals, without regard to gender, race, national origin, religion, disability or sexual orientation; and we will cultivate a culture of tolerance among the entire staff.

5. We will do our utmost to ensure that resident physicians have opportunities to participate in patient care activities of sufficient variety and with sufficient frequency to achieve the competencies required by their chosen discipline. We also will do our utmost to ensure that residents are not assigned excessive clinical responsibilities and are not overburdened with services of little or no educational value.

6. We will provide resident physicians with opportunities to exercise graded, progressive responsibility for the care of patients, so that they can learn how to practice their specialty and recognize when, and under what circumstances, they should seek assistance from colleagues. We will do our utmost to prepare the residents to function effectively as members of healthcare teams.

7. In fulfilling the essential responsibility we have to our patients, we will ensure that residents receive appropriate supervision for all of the care they provide during their training.

8. We will evaluate each resident’s performance on a regular basis, provide appropriate verbal and written feedback, and document achievement of the competencies required to meet all educational objectives.

9. We will ensure that resident physicians have opportunities to partake in required conferences, seminars and other non-patient care learning experiences and that they have sufficient time to pursue the independent, self-directed learning essential for acquiring the knowledge, skills, attitudes, and behaviors required for practice.

10. We will nurture and support residents in their role as teachers of other residents and of medical students.

Academic Affairs:

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

[No article this month.]

Clinical Research:

Peggy Smith-Barbaro, Ph.D.
Director Division of Health Related Programs

The future of research is alive and well at TCOM. This past academic year proved to be one of unprecedented growth with close to seven million dollars in grants and contracts awarded to TCOM. This is a 30% increase over last year's award levels. Of particular note were funding awards to the DNA laboratory, ORC, internal medicine, family medicine and surgery. In addition, thirty-five clinical trials were conducted at TCOM this past academic year.

Students also played a significant role in TCOM's research success. Twenty-one student posters were presented at Research Appreciation Day. TCOM students made their research presence known at several national meetings including the annual AOA research meeting where they presented their study results.

We are up to the challenge of continuing this important trend of expanding academic involvement in research. If you would like more information on how you can become involved in research at TCOM please contact me.

Admissions:

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

Physician Ambassador Program

On June 15, 2006, Dr. Russell Gamber, Assistant Dean for TCOM Admissions, and Joel Daboub, MBA, Director of TCOM Admissions and Outreach, conducted a workshop for Physician Ambassadors at the Hotel Intercontinental in Addison, Texas, during 107th Annual TOMA Convention and Scientific Seminar. Mr. Daboub presented an overview of the TCOM admissions process, and Dr. Gamber discussed the revised TCOM curriculum. The Physician Ambassadors, most having served as TCOM Student Ambassadors during their sophomore year at TCOM, have agreed to serve as regional resources to potential TCOM applicants. The names and contact information for the Physician Ambassadors will soon be posted on the TCOM Admissions web site for easy access to interested potential applicants.

JAMP summer students and TCOM's newly matriculated JAMP students

For six weeks during the summer of 2006, seventeen Joint Admissions Medical Program (JAMP) students were on the UNTHSC campus for a Summer II Internship program. JAMPers took courses in physiology, medical ethics, medical terminology, and MCAT preparation as well as shadow physicians. These students have returned to their home universities across Texas to begin their junior years.

In July, four JAMPers matriculated into the TCOM class of 2010. Those students are Christina Doan - University of Houston, Julian Garcia – Texas A&M International University, Tho Luong – University of Texas at Arlington, and Audrey Sato – Angelo State University. These four were part of the first JAMP class to matriculate into Texas medical schools.

New TCOM class starts and interviews for next year begin

On July 24th 155 new medical students began their medical training at the Texas College of Osteopathic Medicine. These students come from a diverse background and are the most academically competitive class entering an osteopathic medical school this year. Below are some basic statistics:

1) GENDER – 51% MALE / 49% FEMALE
2) 13% UNDERREPRESENTED MINORITIES
3) 3.56 OVERALL GPA
4) 27 MEAN MCAT
5) TOP 5 FEEDER INSTITUTIONS
- UNIVERSITY OF TEXAS
- TEXAS A&M UNIVERSITY
- BAYLOR UNIVERSITY
- UNIVERSITY OF HOUSTON
- UNIVERSITY OF NORTH TEXAS

PA Studies:

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

Program Admits Class of 2009

From well over 550 applications received last year, 32 new PA students were selected for admission to the PA Class of 2009, which began classes in August. The average GPA for the entering class is 3.56. The average science GPA is 3.48. Seven students in the new class are male, leaving 78% as female. 22% of the new class represents ethnic minority groups. Two are non-residents of Texas; hailing from Nebraska and Colorado. Eighty-seven percent of students hold bachelors or higher degree; 2 have a master's degree. Texas A&M University was top feeder school for the fourth year in a row. The most popular fields of undergraduate study were Biology, Psychology and Biomedical/Health Sciences.

Content Advisors Needed

We are looking for PA, physician and scientist faculty members who are interested in helping PA students as Content Advisors on their master's projects. All students in the PA program are required to complete research projects during their first two years of study. Doing so encourages them to develop solid research habits and their appreciation for research in healthcare. In the past, students' projects have ranged from literature reviews on clinically-related questions to small data collection projects. Our goal is to link each student with a Content Advisor that shares a similar research interest. Perhaps you have an ongoing research project that could be tied to one of our student's interests and project goals. If you are interested, please call Dr. Olive Chen in the PA Program. (Ext. 817-735-0203)

PA Curriculum News

The PA Program convened its annual planning retreat last July. This annual activity is part of the ongoing self-study and strategic planning processes for PA Studies and for achieving short and long-term curriculum enhancements. Among changes planned for the MPAS curriculum, the faculty approved adding coursework in the Summer Semester between the first and second years of the program and moving certain classroom activities to earlier in the program to permit increasing clinical rotations by 4 weeks. These changes in the academic calendar were prompted by the faculty and by suggestions from students who wanted more clinical experiences. The change will also allow students needed access to financial aid over the summer months.

Congratulations are extended to **PA Pagels** who was elected in May as Director-at-Large on the Board of Directors of the American Academy of Physician Assistants (AAPA). The AAPA is the only nationwide professional organization representing all PAs. Last June **PA Lemke** and **PA Clark** served as Delegates in the AAPA House of Delegates in San Francisco.

Science and Health News:

MD Consult
[August 30, 2006]
By DOUG KAUFMAN

ST LOUIS - With an aging population, planning is crucial to handle the increased demand on critical care units, according to a trauma expert.

"Critical care has saved and extended the lives of a very large number of people," said Dr Timothy Buchman, chief of burn, trauma, and surgical critical care at Washington University School of Medicine in St. Louis. "As our populations nationally and internationally age, and as [these] populations become progressively more ill, the demand on critical care services is going to continue to rise. It will probably rise faster than we can build additional ICUs [intensive care units] or train additional personnel."

Dr Buchman, who also serves as medical director of the trauma center at Barnes-Jewish Hospital in St. Louis, said a proactive approach is necessary.

"It is going to be incumbent on all of us, as health care professionals, to deploy and use critical care resources as wisely as we can," he said.

Dr Buchman's recommendations include the following:

* "First, it means that the right patients get to the ICU," he said. "That means patients who truly do have an illness that will benefit from critical care. In general, that means a patient with an acute and potentially reversible problem. It generally means that we should consider how we use critical care resources on behalf of patients who stand to benefit less.

"Either those patients who simply need high-intensity monitoring, or alternatively, those patients whose illness is so far advanced that critical care cannot return them to a state of health."

* "The second thing I think is important for health care professionals to grasp is the importance of providing critical care as effectively and efficiently as we can. For patients to benefit from critical care, it's important that we identify the life-threatening processes, stabilize them as quickly as possible, and prevent further complications that can occur in the critical care environment-such as catheter-related infections, ventilator-associated pneumonias, pulmonary emboli.

"The point being that we in the critical care environment have just as strong a stake in patient safety as any other realm in healthcare, perhaps more so, because of the highly technical and highly invasive nature of critical care."

Critical care is crucial to a hospital's success in dealing with an aging population, Dr. Buchman said.

"It increasingly is going to become the core of what the hospital does as the nation ages and accumulates more and more illnesses," he said.

Dr. Buchman compared the need for an efficient critical care unit with a healthy person who lifts weights to build up the arms, legs, and chest while neglecting the core.

"If the muscles of the core and trunk can't support the rest of the activity, none of that focused muscle development does any good," he said. "Similarly, as we transition from hospitals being more or less acute care of otherwise healthy people to seeing increasing numbers of older and sicker patients, the critical care activities are going to move more and more to center stage as the core of the hospital activity. We will need ICUs to help manage trauma care in an increasingly older population that is more frail.

"We are going to need critical care to help support advanced operations and advanced non-operative but highly technical care such as chemotherapy for cancer. We are going to need critical care to continue to care for patients who must remain in the hospital, while a lot of traditional hospital care gets migrated out to either skilled nursing facilities, or even into the home," he said. "... One solution to managing the aging population is to ask families to become more and more involved in the care of their loved ones."

Older patients can be cared for at home, in an environment they find most comfortable, he said.

"The consequence of taking those relatively simpler problems out of the hospital is that you concentrate more complicated and acute problems inside the hospital," Dr. Buchman said. "That requires, de facto, the hospital to have more critical care as its core activity."

Intensivists-specialists in critical care medicine-are playing a bigger role in seeing the whole picture.

The goal of critical care is to "deliver the right care, right now," Dr. Buchman said. "Generally we're talking about really sick folks with not one, but a whole series of problems. All of which have to be managed in parallel, understanding that each of the treatments probably affects more than one body system."

Each of the treatments also involves a trade-off, he said.

"There is no such thing as a treatment that is only good, and is good generally, for the entire patient and every body system. Every time we do something that tries to help a patient heal, there is at least the potential for adverse effects," Dr. Buchman said. "It's important that there be someone who is the patient's advocate, who is looking at the entire patient as a whole, as these multiple parallel problems and multiple parallel treatments are being applied and managed.

"The persons who are in the best position to manage these multiple parallel processes are the intensive care physician and the intensive care nurse," he said. "Each of these individuals has received basic training in medical and nursing skills. Each of them has received additional training and certification in the management of this complex physiologic process and intervention that we call critical care."

In the past, the traditional model involved a nurse assigned to the ICU and a doctor who came in for short periods each day to check on ICU patients.

"The aging and complexity of the population now demands that we have people who are really focused on managing the collection of problems as a whole," Dr. Buchman said.

This means, he continued, "that the right care-meaning the care that will do the greatest good for the greatest number of systems-can be delivered right now when it's needed, rather than 6 hours, or 2 days from now, when the patient has further deteriorated. So the core idea is that we have a geographically dedicated team ... who are focused on the patient as a whole."

None of which actually cures the patient, he said.

"What we do in the intensive care unit is to set the stage for healing," he said. "To try to give the patient protected space-for example, unloading the lungs by means of a mechanical ventilator. And adequate time to emerge from their current illness-which typically requires a lot of life and systems support-to a point where they can get along on their own."

Nationwide, there is a growing awareness of the need to offer top-notch critical care.

"Hospital communities are truly aware of the importance of high-quality critical care as a key component of any acute care hospital," Dr. Buchman said. "They are trying to find different solutions that are best suited to local needs. In a large teaching hospital such as Barnes-Jewish Hospital, there has been a turn toward full-time intensive care physicians.

"In some smaller, more rural hospitals, great advances are being made with remote critical care using electronic ICUs that allows local providers the support of expert intensive care physicians and intensive care nurses who can monitor the patient's ... physiologic systems and medical conditions and provide 24-by-7 advice and support."

The support system appears to be solid, with good growth potential.

"We are seeing a proliferation of advance practice nurses who are receiving additional training in acute and critical care to try to support the population of physicians and critical care nurses that presently exists," he said. "So I think it's fair to say that all of our partners in health-the administrators of the nation's hospitals-recognize the need to provide round-the-clock high-quality critical care services. They are all trying to meet the challenge, in the context of local needs, with a wide variety of resources and solutions."

Still, Dr. Buchman and other experts foresee a "significant shortfall" of physicians to staff critical care facilities. A joint effort will be necessary among health care providers to ensure the availability of critical care services.

"To be direct, [patients] lives may depend on it," he said.

Health Policy News:

CMS Changes DRG Methodology in Inpatient Final Rule

The Centers for Medicare and Medicaid Services (CMS) will move from a charge-based to a cost-based methodology for determining per case payment weights according to the fiscal year (FY) 2007 Medicare hospital inpatient prospective payment system (IPPS) final rule, published Aug. 1 on the CMS Web site. However, the methodology contains significant changes from what was originally proposed and will be phased-in over 3 years. In addition, CMS will not implement a new consolidated severity adjusted diagnosis-related group (CS-DRGs) system, but will add 20 new DRGs to the current system. The changes will go into effect Oct. 1.

While CMS did not implement a one-year delay in the changes, as urged by the hospital community and others, CMS was responsive in making a number of significant technical corrections that had been identified by hospitals. CMS also decided to retain the current method of "standardizing" costs across hospitals, rather than implementing a new hospital-specific relative value (HSRV) standardization process. However, the agency said it will continue to analyze the HSRV option and may implement it in the future.

In terms of refining the DRG classification system to better reflect patient severity, CMS stated that while it decided not to implement the CS-DRGs this year, the Agency will conduct an evaluation "with public input" of alternative systems to make more comprehensive changes in FY 2008.

In other areas, the final rule:

* sets the outlier threshold at $24,475 in FY 2007, which is $875 more than the current year, but $1,055 less than what was proposed; and

* postpones publication of wage index values to collect occupational mix data (to comply with the court-ordered move to a 100 percent occupational mix adjustment in FY 2007). CMS states in the final rule that these values will be published in a separate notice before Oct. 1.

The rule will be published in the Aug. 18 Federal Register.

CMS Modifies Position on "Didactic Activities" in Inpatient Final Rule

In the FY 2007 Medicare inpatient prospective payment system (IPPS) final rule, published on the CMS Web site Aug. 1, CMS modified its position regarding when hospitals may count the time residents spent in didactic activities, such as conferences and educational lectures, for purposes of calculating direct graduate medical education (DGME) and indirect medical education (IME) payments. In the proposed rule, CMS stated that didactic time must be excluded in all IME calculations, and for DGME calculations in nonhospital sites, because the activities are not "related to patient care." Over 1,200 commenters urged CMS to rescind this position and recognize the integral relationship between didactic activities and patient care delivery.

While CMS staunchly defends its position in the final rule that didactic time is not related to patient care, because of the documentation burdens associated with identifying all didactic activities, CMS has decided, effective Oct. 1, 2006, to institute a "one workday" threshold for documentation purposes. CMS states, "as long as an entire workday is not scheduled for didactic activities, then for documentation purposes, that day may be recorded as spent in patient care activities" (page 851).

Rehab Facilities Receive a 3.3 Percent Update in FY 2007 IRF Final Rule

CMS Aug. 1 issued its Medicare inpatient rehabilitation facility (IRF) final rule for FY 2007 on its Web site. The final rule provides for an update to IRF payment rates, equal to the rehabilitation, psychiatric, and long-term care hospital (RPL) market basket increase of 3.3 percent.

Overall, however, the estimated payments per discharge for IRFs in FY 2007 are projected to increase by only 0.8 percent. This is largely due to a 2.6 percent cut in the standard payment amount to adjust for coding changes that CMS believes do not reflect changes in patient severity. This cut is slightly lower than the 2.9 percent reduction included in the proposed rule. CMS reduced the payment cut in response to comments expressing concern that the proposed reduction to the standard payment amount did not take into account patient severity changes resulting from the transition to the 75 percent threshold.

CMS also implements a one-year extension of the 75 percent compliance threshold (75 percent rule) phase-in period to conform with the statutory language in section 5005 of the Deficit Reduction Act of 2005 (P.L. 109-171). The 75 percent rule, when fully phased-in, will require at least 75 percent of an IRF's patient population to have 1 of 13 designated medical conditions for which intensive inpatient rehabilitation services are medically necessary. For providers with cost reporting periods that start on or after July 1, 2006, and before July 1, 2007, the compliance threshold will be 60 percent; for providers with cost reporting periods starting on or after July 1, 2007, and before July 1, 2008, the compliance threshold will be 65 percent. The 75 percent threshold will be imposed for providers with cost reporting periods beginning on or after July 1, 2008. Until the 75 percent rule is fully implemented, the final rule also extends the use of co-morbidities meeting the criteria outlined in the regulations to determine compliance with the 75 percent rule.

In other areas, the final rule:

* Increases the outlier threshold from $5,129 to $5,534, which is less than the $5,609 in the proposed rule;

* Establishes requirements for suppliers of durable medical equipment, prosthetics, and supplies (DMEPOS) to be accredited by CMS-approved independent accrediting organizations to ensure compliance with future quality standards; and

* Implements a provision of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (P.L. 108-173) that gives CMS the authority to use contractors to assist in the implementation of the DMEPOS Competitive Bidding Program.

The final rule will be published in the Aug. 18 Federal Register. The policies will become effective Oct. 1.

OIG and CMS Issue Final EHR Rules

The HHS Office of Inspector General and the Centers for Medicare and Medicaid Services (CMS) Aug. 1 released final rules that provide for an exception to the physician self-referral ("Stark") law and a safe harbor to the anti-kickback law for the donation of electronic health records (HER) information and related technology. They will be published in the Federal Register on Aug 8. The exception and safe harbor will be effective 60 days after publication. Both rules differ significantly from the proposed rules that were published in 2005.

The "Stark" exception protects donations of software or information technology (including connectivity and maintenance services) and training services (including help desk and similar support) necessary and used predominantly to create, maintain, transmit, or receive electronic health records. The donation of hardware is excluded from the exception. Among the conditions of the exception is that physicians must pay 15 percent of the cost of the donated items and services. The anti-kickback safe harbor is similar, though due to underlying statutory differences, it covers a broad array of providers, suppliers, practitioners and health plans. Consistent with the President's goal of adoption of electronic health records technology by 2014, the exception and safe harbor will sunset on Dec. 31, 2013.

House Passes Health IT Bill

The House July 27 passed (270-148) the "Health Information Technology (HIT) Promotion Act of 2006" (H.R. 4157). Of interest to teaching hospitals and medical schools, the bill:

* Amends the self-referral ("Stark") and anti-kickback laws to provide exceptions/safe harbors for the provision of HIT and training services. The exceptions/safe harbors apply to hospitals, group practices, prescription drug plan sponsors, Medicare advantage organizations, or any other such entity specified by the Secretary. Within 3 years, the Secretary must complete a study

determining the impact of such changes on rate of HIT adoption, types of resources offered to providers, changes in provider relationships, and healthcare quality;

* Provides similar exceptions/safe harbors for consortia of healthcare providers, payers, employers and others to either collectively purchase and donate health information technology or offer a choice of technologies that take into account the varying needs of such providers;

* Directs the President to promote the advancement of healthcare quality and health research by allowing access to "useful categories" of non-identifiable electronic health information;

* Provides $15 million in matching grants in both FY 2007 and FY 2008 to help integrated health systems use HIT to better coordinate the provision of care;

* Directs the HHS Secretary to implement ICD-10 codes by Oct. 1, 2010. However, the Secretary can not demand a "level of specificity" that requires documentation of "non-medical information;" and

* Directs the HHS Secretary to study whether there is a need for "greater commonality" in state privacy laws and regulations.

The bill, which contains several other related provisions, must now be reconciled with the Senate's HIT bill (S. 1418). The Senate bill does not include the AAMC-supported Stark and anti-kickback provisions. It also provides a higher level of funds for purchasing HIT.

Committee Leadership Urges Extension of Specialty Hospital Moratorium

Senate Finance Committee Chair Charles Grassley (R-Iowa) and Ranking Member Max Baucus (D-Mont.) sent a July 28 letter to CMS Administrator Mark McClellan after learning of "significant shortcomings" in the agency's survey of how specialty hospitals affect community hospitals. As required under the Deficit Reduction Act of 2005 (P.L. 109-171), HHS will use CMS' findings to develop a strategic and implementing plan that addresses physician investment in specialty hospitals. The plan is due Aug. 8.

Sens. Grassley and Baucus have "received numerous reports" that "inappropriate hospitals are being surveyed, while appropriate hospitals are not being surveyed." Because the Senators have "serious questions as to whether CMS will obtain accurate information," they ask the agency to "reexamine the information...and determine whether or not additional information or time is needed." Since the Deficit Reduction Act permits a limited extension of the specialty hospital moratorium, the Senators "strongly recommend" that CMS use the additional time "to ensure that the strategic and implementing plan is based on adequate and accurate information."

The letter also criticizes Administrator McClellan for failing to submit responses to questions raised about the opening of 43 new specialty hospitals following the 2003 moratorium. Sen. Grassley also re-iterates his request for a "detailed response" regarding the selection of surveyed hospitals.

Reps. Johnson, Cardin Circulate Letter Urging Physician Payment Relief

Reps. Nancy Johnson (R-Conn.) and Ben Cardin (D-Md.) are seeking signatures for a bipartisan letter to Speaker Dennis Hastert (R-Ill.) and Minority Leader Nancy Pelosi (D-Calif.), urging House action to address the 2007 Medicare physician payment reductions before adjournment in October.

The letter, which is similar to a July 17 bipartisan Senate letter that was signed by 80 Senators [see Washington Highlights, July 28], states that "at a minimum, we must provide...a modest increase for physicians as they received a zero increase this year." Calling physicians the "foundation of our nation's health care system," the letter advises that a "stable and predictable payment law...is critical to preserving a patient centered care system."

Webcasts now available on Kaisernetwork.org

Committed to Action: 15 Years of the Ryan White CARE Act -- 9th Annual Clinical Update Ryan White CARE Act Grantee Meeting
http://www.kaisernetwork.org/healthcast/rwca/28aug06
This meeting focused on identifying strategies to improve systems of care for people living with HIV/AIDS. Other goals for the meeting focused on grantees and included increasing knowledge of requirements, sharing models of care and encouraging collaboration and networking.

From the States: An Update with Beth Scalco, Louisiana AIDS Director Kaiser Network
http://www.kaisernetwork.org/closerlook/28aug06
Jackie Judd, a vice president of the Kaiser Family Foundation, talked with Beth Scalco, LCSW, administrative director of the Louisiana HIV/AIDS Program. Scalco was first interviewed immediately after Hurricane Katrina struck the Gulf Region. In this follow-up discussion she described hat progress and setbacks have occurred in re-building the HIV/AIDS program during the past year. A podcast is also available.

Access to HIV Care: Do We Need a New Model?
NAPWA, The AIDS Institute, Title II Community AIDS National Network, Inc.
http://www.kaisernetwork.org/healthcast/titleII/30aug06
A panel of speakers will discuss access to HIV care and the National Access to HIV Care Campaign. This program will be held during the 15th Anniversary of the Ryan White CARE Act Grantee Conference and 9th Annual Clinical Conference Update. This webcast will be available later today.

NIH Reissues CTSA Request for Applications

NIH Aug. 22 issued a second request for applications (RFA) for the Clinical and Translational Science Awards (CTSAs) that are intended to provide academic "homes" for clinical and

translational science. The language and requirements of the RFA are essentially unchanged, although a greater amount of money is allocated to the program in FY 2007.

VA Suspends Project HERO

The VA Aug. 29 suspended the Healthcare Effectiveness through Resource Optimization (HERO) pilot program. Project HERO is a demonstration program to be piloted in selected Veterans Integrated Service Networks (VISNs 8, 16, 20, and 23) to allow the VA to manage contracted health care more effectively. The initial Request for Proposals (RFP), issued Aug. 1, prompted approximately 600 requests for clarification. The VA subsequently cancelled the RFP to refine the proposal requirements.

CMS Updates PPAC on Physician Payment Changes

CMS staff summarized proposed changes to the 2007 physician fee schedule at the Aug. 28 quarterly meeting of Practicing Physicians Advisory Council (PPAC). CMS issued two proposed rules for physician payment this summer. The first rule, published in the June 29 Federal Register, focused on changes to physician work and practice expense relative value unit (RVU) weights, two main components in the formula to determine physician payment rates. The second rule, published in the Federal Register on Aug. 22, addressed all other payment issues including implementing the provisions of the Deficit Reduction Act and providing the update to the physician conversion factor.

President Bush Names NCI Director

President Bush Aug. 16 announced his intention to appoint John E. Niederhuber, M.D. as director of the National Cancer Institute (NCI). Secretary of Health and Human Services Michael Leavitt designated Dr. Niederhuber as the Institute's acting director in June, when former NCI director Andrew von Eschenbach, M.D., left to head the Food and Drug Administration.

Research and Funding Opportunities:

Notices

Clarification Of Eligibility For Mid-Career Investigator Award In Patient-Oriented Research (K24)
(NOT-OD-06-095)
National Institutes of Health
http://grants.nih.gov/grants/guide/notice-files/NOT-OD-06-095.html

NIH Announces Requirement for Detailed (Non-Modular) Budget Submissions for All Competing Grant Applications from Foreign (Non-U.S.) Institutions
(NOT-OD-06-096)
National Institutes of Health
http://grants.nih.gov/grants/guide/notice-files/NOT-OD-06-096.html

NIBIB Participation in Mentored Clinical Scientist Development Award (K08) Initiative PA-06-512
(NOT-EB-06-007)
National Institute of Biomedical Imaging and Engineering
http://grants.nih.gov/grants/guide/notice-files/NOT-EB-06-007.html

Additional Receipt Date for NIBIB Research Supplements to Promote Clinical Resident Research Experiences (PAR-06-531)
(NOT-EB-06-008)
National Institute of Biomedical Imaging and Engineering
http://grants.nih.gov/grants/guide/notice-files/NOT-EB-06-008.html

Clarification of Review Criteria for RFA-HD-06-018, International Extramural Associates Research Development Award (IEARDA) (G11)
(NOT-HD-06-011)
National Institute of Child Health and Human Development
http://grants.nih.gov/grants/guide/notice-files/NOT-HD-06-011.html

NINDS Guidelines for K25 Mentored Quantitative Research Career Development Award
(NOT-NS-06-011)
National Institute of Neurological Disorders and Stroke
http://grants.nih.gov/grants/guide/notice-files/NOT-NS-06-011.html

Changed and Additional Instructions for PAR-06-436 and PAR-06-437, Introduction and Budget sections
(NOT-TW-06-008)
John E. Fogarty International Center
http://grants.nih.gov/grants/guide/notice-files/NOT-TW-06-008.html
Requests for Applications

Technology Development of Image-Guided Interventions: Phase I (R21)
(RFA-EB-06-003)
National Institute of Biomedical Imaging and Engineering
National Cancer Institute
Application Receipt Date(s): October 23, 2006
http://grants.nih.gov/grants/guide/rfa-files/RFA-EB-06-003.html

Bioengineering Approaches to Energy Balance and Obesity (R21)
(RFA-HL-07-007)
National Heart, Lung, and Blood Institute

National Cancer Institute
National Institute on Aging
National Institute of Biomedical Imaging and Engineering
National Institute of Diabetes and Digestive and Kidney Diseases
Application Receipt Date(s): December 22, 2006
http://grants.nih.gov/grants/guide/rfa-files/RFA-HL-07-007.html

Institutional Clinical and Translational Science Award (U54)
(RFA-RM-07-002)
National Institutes of Health
Application Receipt Date(s): January 17, 2007
http://grants.nih.gov/grants/guide/rfa-files/RFA-RM-07-002.html
Program Announcements

Preclinical Therapeutics Development for NeuroAIDS (R21)
(PA-06-528)
National Institute of Mental Health
National Institute on Drug Abuse
National Institute of Neurological Disorders and Stroke
Application Receipt/Submission Date(s): Multiple Dates, See Announcement.
http://grants.nih.gov/grants/guide/pa-files/PA-06-528.html

Preclinical Therapeutics Development for NeuroAIDS (R03)
(PA-06-529)
National Institute of Mental Health
National Institute on Drug Abuse
National Institute of Neurological Disorders and Stroke
Application Receipt/Submission Date(s): Multiple dates, see announcement.
http://grants.nih.gov/grants/guide/pa-files/PA-06-529.html

Parenting Capacities and Health Outcomes in Youths and Adolescents (R21)
(PA-06-530)
National Institute of Nursing Research
National Heart, Lung, and Blood Institute
National Institute on Alcohol Abuse and Alcoholism
National Institute of Child Health and Human Development
National Institute on Drug Abuse
Application Receipt/Submission Date(s): Multiple dates, see announcement.
http://grants.nih.gov/grants/guide/pa-files/PA-06-530.html

Functional Links between the Immune System, Brain Function and Behavior (R21)
(PA-06-533)
National Institute of Mental Health
National Cancer Institute
National Institute on Aging
National Institute of Arthritis and Musculoskeletal and Skin Diseases

National Institute of Biomedical Imaging and Engineering
National Institute on Drug Abuse
National Institute of Neurological Disorders and Stroke
Application Receipt/Submission Date(s): Multiple dates, see announcement.
http://grants.nih.gov/grants/guide/pa-files/PA-06-533.html

NIBIB Research Supplements to Promote Clinical Resident Research Experiences (R01, R37, P01, P41, P50, U01, U54)
(PAR-06-531)
National Institute of Biomedical Imaging and Engineering
Application Receipt/Submission Date(s): October 24, 2006
http://grants.nih.gov/grants/guide/pa-files/PAR-06-531.html

Translational Research for the Prevention and Control of Diabetes and Obesity (R18)
(PAR-06-532)
National Institute of Diabetes and Digestive and Kidney Diseases
National Institute of Nursing Research
Office of Behavioral and Social Science Research
Application Receipt/Submission Date(s): Multiple dates, see announcement.
http://grants.nih.gov/grants/guide/pa-files/PAR-06-532.html

Innovations in Biomedical Computational Science and Technology Initiative (STTR [R41/R42])
(PAR-06-534)
National Institute of General Medical Sciences
National Cancer Institute
National Center for Research Resources
National Human Genome Research Institute
National Heart, Lung, and Blood Institute
National Institute on Aging
National Institute on Alcohol Abuse and Alcoholism
National Institute of Allergy and Infectious Diseases
National Institute of Biomedical Imaging and Engineering
National Institute on Drug Abuse
National Institute on Deafness and Other Communication Disorders
National Institute of Environmental Health Sciences
National Institute of Mental Health
National Institute of Neurological Disorders and Stroke
National Library of Medicine
Application Receipt/Submission Date(s): September 24, 2006
http://grants.nih.gov/grants/guide/pa-files/PAR-06-534.html

Innovations in Biomedical Computational Science and Technology Initiative (SBIR [R43/R44])
(PAR-06-535)
National Institute of General Medical Sciences
National Cancer Institute
National Center for Research Resources

National Human Genome Research Institute
National Heart, Lung, and Blood Institute
National Institute on Aging
National Institute on Alcohol Abuse and Alcoholism
National Institute of Allergy and Infectious Diseases
National Institute of Biomedical Imaging and Engineering
National Institute of Child Health and Human Development
National Institute of Child Health and Human Development
National Institute on Drug Abuse
National Institute of Environmental Health Sciences
National Institute of Mental Health
National Institute of Neurological Disorders and Stroke
National Library of Medicine
Application Receipt/Submission Date(s): September 24, 2006
http://grants.nih.gov/grants/guide/pa-files/PAR-06-535.html

National Research Service Award Postdoctoral Fellowships In Epidemiology, Clinical Trials, And Outcomes Research In Skin Diseases(F32)
(PAR-06-536)
National Institute of Arthritis and Musculoskeletal and Skin Diseases
Application Receipt/Submission Date(s): Application Receipt Date(s): Oct. 23, 2006; Feb. 23, June 23, Oct. 23, 2007; and Feb. 23, June 23, 2008
http://grants.nih.gov/grants/guide/pa-files/PAR-06-536.html

Quotes:

You must be the change you wish to see in the world.
Mohandas Gandhi

Without change, something sleeps inside us, and seldom awakens. The sleeper must awaken.
Frank Herbert

If there is anything we wish to change in the child, we should first examine it and see whether it is not something that could better be changed in ourselves.
Carl Jung

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