TCMS Members Stand Up for Medicine During 85th Texas Legislature
rate-a-doc

Dr Williams

I really loved this doctor’s ability to quickly type my personal data in the EHR. I would guess she can do 90 words per minute? Impressive! Dr Williams was able to look at me and the computer all at the same time. MD? More like PHD in speed-typing! Her computer skills by far exceed any doctor I have ever visited.

Dr Williams

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TCMS Journal

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One major focus of TCMS leadership for the past year has been interfacing with the new Dell Medical School. This is an update on what we've been doing.

For historical perspective, in the early 1970's the Medical Society had the foresight, the grit and the sophistication to start the residency program at Brackenridge (not an easy task for a bunch of doctors without the support of an academic medical center). I'm sure that back then there was a need, and there were physicians willing to (volunteer) invest their time and expertise into making it happen. Fast forward to 2013, and again physicians were intimately involved with voting the new medical school into existence for the same reason, there was a need.

It goes without saying that Travis County physicians care deeply about finding care of the people of our community (those who can afford their medical care and those who cannot), and making sure that our physician community continues to practice excellent medicine. There is also a need to 'reproduce' as I call it—to get the next generation of physicians trained so that there are doctors available to cover the growing population of Central Texas, and to take over when we retire.

A new medical school obviously brings more physicians into the community, and it also brings the potential for changing the way we've practiced medicine. Understandably, there are lots of questions and concerns about these potential changes. I think the biggest concern that I've heard from our membership is that there will be a 'town vs. gown' problem—which in a nutshell is worry that the medical school will get so big and hire so many physicians that it pushes out the community doctors. Another concern is that Travis County taxpayers voted the medical school into existence with the understanding that they would help care for the underserved. How much of that have they done so far, and what is the plan for the future? There is also the question of payment for community docs for teaching residents. And how do the hospital systems (Seton, St. David’s and Baylor Scott and White) come into play? These are questions that impact us all that need to be considered.

Believe me, your board members have been listening to and hearing these questions, and have been working to get them addressed. And in doing so, we’ve been happy to find that as much as we have wanted to engage with Dell Medical School, they have wanted to engage with us. For several months now, TCMS and DMS leadership have been meeting under the umbrella of the Medical Society. This joint leadership group consists of me, Rob Cowan, Jeff Apple and Tony Aventa along with DMS Vice-Dean for Clinical Affairs, Rich Freeman and Executive Vice-Dean for Academics and Chair of Medical Education, Sue Cox.

I titled this article ‘perception vs. reality’. It was the first item on the agenda of our first meeting, and it’s come to be an accurate one-liner for many of these questions. We are working to get these perceptions addressed, and to provide venues where those who are interested can get a clearer understanding of the ‘reality’, or the whole picture. This involves opening up communication between the community physicians and the medical school and vice versa. Figuring out exactly how to do that most effectively is a challenge, and we know that it will need to be an ongoing process.

Our plan in the coming months is to have some events that are jointly sponsored between us, and we hope to give those of you who are curious or concerned a chance to attend and get more information. Even more than just addressing questions, we really want to start a partnership between the community and the medical school involving CME, the TCMS Journal and other activities.

Dr. Cox and Dr. Freeman contributed an excellent article for this issue of the TCMS Journal (pg 8) from the perspective of the medical school and I encourage you to read it.

In addition to our leadership meetings, it’s helped tremendously to have Assistant Dean and Designated Institutional Official for Graduate Medical Education, Jonathan MacClements on the TCMS Executive Board. This is especially fitting because teaching residents, and the funding for teaching programs continue to be things that many of us care deeply about.

As you all know, the basic mission for an academic medical center is threefold—research, patient care and teaching. UT Dell Medical School is just getting started, but I think DMS would agree that they have the distinct advantage of being in Travis County, with a vibrant physician community that is, and was already doing most of these things. The goal is to tap into this to grow a partnership that will be strong and productive for all of us in the years to come.
TCMS Welcomes Dell Med’s NEXT Class

TCMS members officially welcomed Dell Medical students with a taste of Austin at the famous Hula Hut restaurant. Under a thatched palapa overlooking Lake Austin, physicians and students discussed everything from medical school jitters to the realities of private practice. TCMS president Sara Austin, MD, wished the students luck with their first year and touted the benefits of organized medicine.
Over the last few months, Travis County Medical Society and Dell Medical School leadership has been meeting to better define how each organization might help the other. Our desire was to establish and nurture open communication and a mutually supportive relationship between the society and medical school; between academic and community physicians. After several meetings, the TCMS/DMS leadership group adopted a mission statement to guide its activities and projects.

**Mission Statement for Travis County Medical Society and Dell Medical School Collaboration**

To improve the health of our community, Travis County Medical Society and Dell Medical School will foster a strong partnership to facilitate the professional development of all physicians in We do this through vigorous exchange of ideas, continued improvement of care for the underserved, collaboration on projects that enhance patient care, promotion of the science of medicine, and training the next generation of physicians.

**Dell Medical School’s Perspective**

From our point of view, Dell Medical School can only achieve its goals by collaborating with community physicians every step of the way. Partnering with Travis County Medical Society and building on its long involvement with medical education is a perfect avenue to further the goals of both organizations.

Dell Med sees its role as supporting the medical community to enhance their professional development and advance the science and art of medicine.

Dell Med’s success depends on physicians in our community actively participating in and providing feedback about our UME, GME and CME programs.

Dell Medical School recognizes and will continue to support the ongoing commitment by community physicians in delivering care for the underserved.

**The Bottom Line for Us**

We’re in this together. Whether academic physicians employed by Dell Medical School or community physicians in private practice; whether primary care providers or specialists; we are physicians first. We feel that it’s in the best interest of our profession, our community, and our shared heritage in the Travis County Medical Society for all of us to be working together.

**Ways that TCMS members can have input into, engage with, and participate in Dell Medical School activities include:**

- Attend CME and Departmental educational events or help to develop educational events of interest to you.
  
  Visit dellmed.utexas.edu/events or contact individual departments for their events and functions
- Serve as teacher or mentor for Dell Medical Students or residents.
  
  Contact individual departments for more information.

**Department Contacts**

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- Contribute to, or develop your own research project.
  
  Visit dellmed.utexas.edu/research or contact individual departments for more specific information.
- Apply to join the Dell Medical School’s Faculty.
  
  Visit dellmed.utexas.edu/faculty-affairs or contact individual departments for more specific information.

TCMS and Dell Medical School

Sue Cox, MD
Richard Freeman, MD
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in the News

Steven E. Zimmet, MD receives Distinguished Fellowship

The American Venous Forum (AVF) recently named Steven E. Zimmet, MD RPVI RVT FACPh as a Distinguished Fellow. The AVF is recognized internationally as thought leaders, expert investigators and clinicians in venous and lymphatic disease. In addition, the American College of Phlebology (ACP) named Zimmet an Honorary Member. The ACP is the largest membership society in the world solely devoted to venous disease.

TCMS Marketing Materials Win Creative Award

The new print campaign promoting TCMS membership, benefits and programs was recently awarded the 2017 Hermes Gold Award for excellence in communications/marketing. Hermes Creative Awards is an international competition for creative professionals involved in the concept, writing and design of traditional materials/programs and emerging technologies. “A New Look for the Travis County Medical Society” was created by Leanne DuPay, TCMS director of Marketing & Communications.

Most HIV positive persons had previous visits to a medical facility where they were not tested for HIV.

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For a long time health care has been an industry somewhat immune from having to think competitively about customer service. After all, if we treat the patient and they have a positive outcome, they should be happy, right? Not necessarily.

It’s no surprise that more and more practices are being forced to focus on their patients’ customer service experience, public relations and their online reputation. Social media sites like Yelp and Twitter can quickly become a practice’s public relations nightmare. It only takes a few bad reviews for patients to select the competition over your practice. So how do you provide a customer service experience that exceeds the patient’s expectations and results in positive reviews and referrals?

Here are some key elements that will provide an exceptional customer service experience as a patient progresses through your scheduling, check-in, treatment, check-out and follow-up process.

First Impressions
Scheduling is typically the first interaction a patient has with a practice. This experience will create a mindset for their entire visit prior to meeting the physician. What is their perception if the phone rings too long, if they get a voicemail or if they are accidentally disconnected? The voice, attitude and helpfulness of the person who answers the phone and schedules the appointment will set the tone for their expectations.

Key Recommendations:
1. Have enough staff to answer every scheduling call. Assign back up staff to answer overflow calls.
2. Return scheduling calls within an hour. Waiting longer erodes trust and confidence that you will be responsive once they are a patient. If you can’t accommodate this, it is a sign you need more staff or need to better train current staff.
3. Ensure staff have proper training on phone systems, how to answer the phone with an upbeat, friendly voice and to be personable. Adopt a standard greeting that includes, “Thank you for calling,” the practice name and their name.
4. Avoid having your check-in or check-out staff perform scheduling duties. A dedicated scheduler who assists with administrative tasks that can easily be stopped and started is ideal. Expecting an employee to interrupt patient interactions at check-in or check-out will result in more errors, increased employee stress and frustration and a lowered customer service experience for both the caller and the patient at the window.

Greetings
A bad experience at the front desk can put a patient in a bad mood and change the lens through which they view their appointment. This can cause them to focus on the negative aspects of their interaction instead of the positives.

Key Recommendations:
1. Train employees at the front desk to acknowledge every patient with a smile as they enter. If they are on the phone or engaged with another staff member, priority should be given to acknowledging the patient’s presence.
2. If the staff member is on the phone, they should look at the patient, and mouth the words, “I will be right with you.” The phone conversation can continue if it is with another patient or provider, but should end immediately or be put on hold if it is personal or with another staff member, including an internal physician.
3. Ensure patient sign-in information is private. Many patients are aware by now that their name should not be seen by other patients. If your practice is still using lists and scratching out the patient’s name, that can earn distrust. Taking shortcuts around HIPAA could give the impression that you take shortcuts elsewhere.
4. Front office employee body language and interactions with each other show patients their level of job satisfaction which ultimately reflects on the practice and the providers. Make sure staff is aware of how they behave, how they present themselves and how they communicate—a sideways glance, rolled eyes or a sigh can convey negativity.

Beauty is in the Eye of the Beholder
An element of customer service that often gets overlooked is the appearance of the practice. What impression does your reception area and waiting room convey? Does it say, “We care about your comfort, we have good hygiene, we will take good care of you?” Or does it say,
“Your comfort doesn’t matter to us, we don’t value cleanliness, we don’t take good care of our own office so we won’t take good care of you.”

Key Recommendations:
1. Keep office decor updated.
2. Ensure seats are comfortable, wide enough and sturdy enough for larger patients. Create spaces between groups of seats so that patients don’t feel they are sitting too close to each other.
3. Keep the temperature comfortable.
4. Keep relevant and updated reading material.
5. Keep TV volumes comfortable and provide relevant programs that are also appropriate for children.
6. Waiting area and check-in desk should be clean and tidy.
7. Bathrooms should be very clean and checked frequently for soap and tissue supplies.

Wait on Me
There are life situations where we cannot be late, but can predict we will likely have to wait. It is hard for a patient to understand why they must sit in a practice’s waiting room for 45 minutes and then spend another 20 minutes waiting in the exam room—especially after scheduling an appointment far in advance. Very few patients are going to return or refer a friend or family member to a practice where they have to wait extended periods of time. Running late to an appointment or meeting conveys to the other party that you do not value their time. It sends a powerful statement of, “I am more important than you, and you must wait on me.” It’s even more insulting when a practice that has long wait times will cancel a patient’s appointment if they are running late.

Key Recommendations:
1. Ensure you have a workable schedule for the physician and have processes in place to make sure the clinic runs smoothly. The best customer service experience is when patients are seen by the physician within 15 minutes of their appointment time.
2. Hiccups do happen but they should be the exception instead of the rule. When a patient has to wait, the staff should be trained to check in with the patient and update them after 15 minutes. Give a realistic expectation of how much longer their wait time will be. The patient should also be given the option to reschedule.
3. Be mindful of the wait in the exam room. Update the patient if they have to wait longer than 5-10 minutes. Be sure to provide reading material in your exam rooms.

The Main Course
All of the preparation and customer service up to this point has little value if the actual clinical experience doesn’t keep the patient experience in mind. There are many articles on bedside manner. Focus should also be given to other aspects of the clinical experience.

Key Recommendations:
1. The bedside manner of other health care providers and support staff is just as important as the physician’s. Warmth, friendliness and compassion are key. The patient should feel that they matter. Treat patients with dignity and respect.
2. Listen carefully to patients. Allowing a little personal conversation from the patient can be important for them to feel cared for.
3. Make sure that the physician and the support staff are on the same page regarding patient treatment plans. Patients will get frustrated when the physician and other non-physician health care providers suggest different options and will lose trust in your practice.
4. Provide written instructions to the patient. Many you provide care for will be ill or dealing with stressful health situations. Expecting patients to remember all instructions is a recipe for time consuming call backs, decreased patient compliance and negative outcomes. Send your patients home with a list of recommendations as well as medication instructions.
5. ASK the patient if they have any questions before you end the appointment. Verify that they understand everything you have discussed.
6. Too many times patients are left sitting in the exam room after the appointment is over and they don’t know what to do next. Communicate clearly when the appointment has ended and show them where to find the check-out desk.

The End
The check-out and follow-up experience can have just as much impact on the patient as their time with the physician.

Key Recommendations:
1. Keep wait times and lines at check-out to a minimum. It is ideal to have a private area where patients can discuss follow-up appointments and referrals—especially with more private health issues.
2. Just as check-in staff needs to acknowledge patients as they approach their work area, check-out staff should be held to the same standard. Making eye contact rather than simply taking the patient encounter sheet without acknowledging the patient is not friendly. Ask patients if they have questions before they leave to help avoid confusion.
3. Ensure that staff has a system to follow-up with patients when promised. The best customer service is proactive, including giving patient lab and test results versus reactively responding to patient calls.
4. If you want to meet the minimum expectation, return patient phone calls within 24 hours and ensure that your message sets the expectation appropriately. If you want to exceed expectations and create a more positive patient experience, return calls to all patients by the end of the day. The longer the patient waits, the worse their opinion of your practice becomes.

There are many areas throughout the entire patient encounter that are critical to the patient’s overall customer service experience and perception of the practice. It can be overwhelming for the physician or manager to address all of these points. Often, staff is already aware of the areas where your practice falls short and likely have great ideas to share. Empower your staff by having a customer service team for each of the areas listed above. Give them the opportunity to come up with ideas, propose solutions and implement your new customer service initiatives. In the end, staff will have much more buy in to what they have created and will take more pride in the practice’s reviews and customer service delivery.
Stephanie Triggs

May 2, 2017, was the last First Tuesday lobby day of the 85th Texas Legislative Session. TCMS members, including residents and medical students were joined by Alliance members to lobby state senators and representatives—"asks" were made of them and their legislative aides to vote for good bills or against bad bills affecting patients and physicians.

The session ended after 140 days on May 29. As usual, there were good, bad and ugly bills relating to health care in the State of Texas.

A bill of particular interest was one to reauthorize the Texas Medical Board (TMB) and the Medical Practice Act beyond their scheduled demise of August 29, 2017. Due to a long-brewing feud between the House and Senate over unrelated issues, the bill did not pass. Governor Greg Abbott has called a special session to begin on July 18. Among the 20 items the governor set to be debated in the special session is the reauthorization of the TMB and the Medical Practice Act—the governor clearly stated that lawmakers must reauthorize the TMB before moving on to the other 19 items.

Budget

The final budget for the 2018-2019 biennium totals $216.7 billion in all funds which includes $106.8 billion in state general revenue dollars. The budget also draws $1 billion from the Rainy Day Fund. Among items included in the budget related to medicine:

- Medicaid: approved $427 million in general revenue in Medicaid cost-containment (technically the rider applies to all HHSC agencies, but most of the savings would come from Medicaid).
- Graduate Medical Education: added $44 million for GME expansion grants and increased the GME formula funding by $4.3 million. The Family Medicine Residency Program was cut by $6 million, and the Physician Education Loan Repayment Program was cut by $8.4 million.
- Department of State Health Services: roughly $30 million was cut in public health preparedness and reduces funding for immunizations, HIV/AIDS, infectious diseases, chronic disease prevention and the Children with Special Health Care Needs program.

Medicine’s Bills Signed by the Governor

- Senate Bill 507 which expands the billing mediation process to all physicians and others providing out-of-network services at certain in-network facilities and expands mediation to out-of-network emergency care situations. Keeps in place the $500 threshold for mediation.
- Senate Bill 680 empowers physicians to override health plans’ step therapy protocols, allowing them to continue prescribing an effective medication even if the insurer’s step therapy plan calls for a change in medication.
- Senate Bill 1107 establishes a statutory definition for telemedicine and clarifies that the standard of care for traditional in-person medical settings also applies to telemedicine services. The bill makes it clearer that telemedicine is not a distinct service, but a tool physicians can use. It also prohibits health plans from excluding telemedicine from coverage just because the care isn’t provided in person.
- House Bill 62 bans texting while driving statewide.
- House Bill 2561 relates to the Physician Drug Monitoring Program (PDMP). It includes initiatives to identify potentially harmful prescribing or dispensing patterns or practices that might suggest drug diversion or “doctor shopping.” Calls for physicians and all other prescribers and dispensers to check the PDMP before prescribing any of the listed classes of medications after September 1, 2019.
- Senate Bill 922 by TCMS member and Texas State Senator Dawn Buckingham, MD allows Medicaid to reimburse school districts and open-enrollment charter schools for telehealth services provided to students.
- Senate Bill 1148, another bill from Dr. Buckingham, prohibits the state from using maintenance of certification (MOC) as a requirement for state licensure or renewal or insurance participation. It permits health facilities to use MOC if hospital medical staff votes it appropriate for their own hospital.
- House Bill 435 allows DSHS to post signs prohibiting handguns at Texas’ 10 state mental health hospitals.

TMA/TCMS Supported Bills that Did Not Pass

- Senate Bill 1929 that would have continued the Maternal Mortality and Morbidity Task Force at DSHS, which is helping the state identify the causes of Texas’ high and growing rates of maternal mortality and morbidity.
- House Bill 477 would have required health coverage providers to educate consumers purchasing individual health benefit coverage.
- House Bill 1908 would have raised the age to purchase tobacco products from 18 to 21. A compromise in the budget requires HHSC and the comptroller to study how increasing the legal age for purchasing and using tobacco could result in Medicaid savings due to fewer pre-term and low-birth weight births.
- House Bill 2249 AKA the “Parents’ Right to Know” bill, would have required the state to report vaccination exemption-rate data at the more precise school level rather than at the school district level.
- House Bill 2760 would have required updates of health plans’ network directories.
- House Bill 3124 would have allowed physicians in physician-led
The 2017 annual conference of the Texas Medical Association, TexMed, took place in Houston May 5-6. The conference consisted of council and committee meetings, CME presentations and the work of the TMA House of Delegates (HOD)—the policymaking body representing individual delegates, county medical societies and boards, councils, committees and sections.

During the HOD, Carlos Cardenas, MD (Edinburg) was installed as TMA president and Doug Curran, MD (Athens) was elected TMA president-elect. In addition, TCMS members Michelle Berger, MD was re-elected TMA secretary/treasurer and Robert Emmick, MD was elected alternate delegate to the TMA Delegation to the American Medical Association.

Among the measures delegates adopted were directives to TMA to:
- strongly advocate for maintaining mandated minimum services, benefits and cost-sharing requirements for pregnant women and children;
- advocate for exceptions to deadlines to set Medicare Graduate Medical Education (GME) funding caps for medical schools and teaching hospitals in medically underserved and economically depressed areas;
- work to build the state’s physician workforce to meet the state’s health care needs;
- support a long-range study to bring funding for medical education, GME and other education and training programs in line with the state’s workforce needs;
- monitor maintenance of certification (MOC) reforms;
- adopt Disaster Preparedness Planning and Response policy and call for the Texas Department of State Health Services (DSHS) to work with physicians and develop a statewide framework for crisis standards of care and
- make recommendations to guide TMA activities on gender equality and sexual diversity measures and adopt policy on fighting discrimination, studying best practices for care and reducing suicide rates.

Now is the time to gear up for the 2018 elections and fundraising activities. Check out www.texpac.org to see how you can help elect medicine-friendly candidates.

Stay tuned for more information regarding the special legislative session and the reauthorization of the Texas Medical Board and Medical Practice Act.

For additional information on the 85th Legislature contact Stephanie Triggs, TCMS senior director of physician services and community relations, at striggs@tcms.com or 512-206-1124.

TCMS Journal  July • August 15

TexMed 2017
TMA House of Delegates

Drs. Tony Aventa and Michelle Berger speak with Colby Evans, MD, a TCMS alternate delegate.

Bills TMA/TCMS Opposed that Died
- House Bill 1415 would have granted advanced practice registered nurses full, independent practice and prescribing authority without physician supervision.
- Senate Bill 728 would have allowed patients 30 days of direct access to treatment by physical therapists without first being seen by a physician.
- House Bill 719 would have indexed the caps established by the 2003 tort reform law according to changes in the Consumer Price Index.
- House Bill 593 would have allowed psychologists prescribing authority, a practice reserved for medical school-trained physicians.
- Senate Bill 2127 would have prohibited credit report agencies from including a collection amount for certain health care services provided by out-of-network physicians on a credit report.
- House Bill 1675 would have allowed health plans to require physicians to accept virtual credit cards for payment of services rendered.
- House Bill 1070 would have prohibited physicians from refusing to care for a patient based on his or her immunization status.
- House Bill 1124 would have made it easier for parents to opt-out of vaccinating their children.
- House Bill 3476 would have required pre-participation electrocardiograms for all school student athletes, a test that not every student athlete needs and one that could result in false positives, which could ultimately harm students and their parents.

For more information regarding the TMA House of Delegates, visit www.texmed.org/hod.
Is it OK to put plastic containers in the microwave? What are some ways to minimize exposure to pesticides in the home? Is nail polish safe for young children?

These are just some of the many questions that Toxic-Free Child, a new program developed by Texas Physicians for Social Responsibility (PSR), seeks to address in a novel, evidence-based curriculum created and presented in Central Texas over the last year. After completion of a successful pilot year, Texas PSR is ready to share its materials and curriculum (available online and free of charge) with interested physicians and clinics.

A growing body of research shows that toxics such as lead, caustic household cleaners, mercury in fish, bisphenol A (BPA) and pesticides can adversely affect health. Infants and young children, including developing fetuses, are especially vulnerable because chemicals can interfere with their neurologic, endocrine and immune system development. Yet many physicians lack the training and tools to educate families about strategies to reduce risks from environmental toxics. The Toxic-Free Child program seeks to fill this information gap by offering pregnant women and young families positive, practical tips to minimize exposure to toxic substances. The interactive content delivery is about 50 minutes, organized into segments on common toxic substances in the home, kitchen, beauty products and outside air.

Funded by the Episcopal Health Foundation and launched by Program Manager Trish O’Day, MSN, RN, CNS-Community Health and Yaira Robinson, MTS, of 2016, the Toxic-Free Child prenatal and parenting classes go far beyond traditional patient education on avoiding cigarette smoke and mercury in fish. Local Ob/Gyn and pediatric physicians reviewed and helped to refine the curriculum. Focus groups conducted at People’s Community Clinic also provided helpful insights and guidance.

In a relaxed, interactive format, the curriculum covers threats from lead, flame retardants, pesticides, paint, smoking, cleaning products, BPA, mercury, triclosan, nail polish and Ozone Action Days. In each case, simple strategies are suggested for threat reduction. For example, flame retardant chemicals in sofa cushions can affect brain development. To reduce potential harm from exposure, the curriculum recommends that tears in fabric be immediately sewn. In addition floors should be wet-mopped rather than swept with a broom. Other advice includes using glass instead of plastic in the microwave, removing shoes when coming home to avoid tracking in chemicals and reviewing the ingredients of beauty products to identify potential threats. These simple, effective strategies empower families to make proactive choices to safeguard the health of their youngest members.

Classes include an interactive demonstration of how to make simple, inexpensive cleaning products using basic ingredients such as vinegar and baking soda. Participants receive colorful magnets with three different recipes—glass cleaner, all-purpose cleaner and baking soda scrub—in Spanish and English. And each class participant receives an informative brochure in Spanish or English, “Healthy Kids: Protecting Your Child from Toxic Exposures.” The Toxic-Free Child curriculum provides information that is helpful for families of all socio-economic levels, but in the pilot year, Texas PSR targeted our most vulnerable community members. According to the Texas Medical Association, about 19 percent of Travis County residents are uninsured. Low-income Spanish-speaking families, especially recent arrivals to Central Texas, often live in neighborhoods with sub-standard housing and fewer community services. Undocumented persons have difficulty
obtaining health care and experience other barriers with literacy, language and transportation.

During the pilot year, Texas PSR partnered with local agencies and clinics—including Any Baby Can, El Buen Samaritano and AVANCE—in both rural and urban settings, to reach low-income and Spanish-speaking populations in the Austin area. In the pilot year, 112 pregnant women or parents of very young children participated in a class session. Classes were taught by experienced, well-trained nurses and were offered in Spanish and English.

The pilot year of the Toxic-Free Child program validated Texas PSR’s concern that low-income women and young families in Travis County are poorly informed about common environmental threats in the home. Class attendees were attentive and inquisitive about how to modify cooking, cleaning and home maintenance practices.

Classes at all agencies were very well-received. Participants were engaged and asked many questions, such as, “How do I know if I have lead in my home?” and “I work at a hotel, cleaning, and I am worried about my pregnancy using those cleaning products.”

Texas PSR conducted an evaluation of the program, analyzing pre-and post-test results for pilot year class attendees. In terms of basic knowledge, 63 percent of questions on the pre-test were answered correctly, while 92 percent of questions on the post-test were answered correctly (a 46 percent improvement). Of those completing the post-test, 100 percent answered “Yes” to both “1. This session provided useful information,” and “2. I am likely to change in some ways to reduce exposures to toxic substances in my home.”

Texas PSR is confident in the quality, value and effectiveness of this program and now wants to make it widely available. With a new suggested class script available in both Spanish and English and an instructor guide, the Toxic-Free Child Program is accessible for providers throughout Travis County and beyond. On the Texas PSR website (http://texaspsr.org/toxic-free-child/), you can download the instructor guide and suggested script, along with printable cleaning product recipe cards and the Healthy Kids brochure.

Texas PSR is also seeking other partners and funds to further develop and disseminate the program. Please contact Executive Director Yaira Robinson at (TXPSRdirector@gmail.com) for more information about the program or other Texas PSR activities.

Texas Physicians for Social Responsibility is the Texas chapter of Physicians for Social Responsibility. We are physicians, nurses and concerned citizens committed to a safe environment and healthier Texas. Guided by medical and public health expertise, Texas PSR works in partnership with national PSR and other PSR chapters to protect human life from the gravest threats to health and survival through outreach, education and advocacy.
IN MEMORIAM

The Medical Society extends deepest sympathy to the family and friends of the following physician.

Steven Clifford Bauserman, MD, 80, passed away on May 3. A native of Iowa City, Dr. Bauserman graduated from Grinnell College where he studied French and was team captain and quarterback of the football team. Attracted to medicine by a physician he admired, he attended the University of Iowa School of Medicine followed by an internship in Montreal. He practiced family medicine in Agency, Iowa as the town’s only physician for four years before returning to the University of Iowa Hospitals for a residency in pathology. He served in the Army in the 70’s during which time he acquired subspecialty expertise as a neuropathologist, with assignments in Hawaii and Walter Reed’s prestigious Armed Forces Institute of Pathology. After completing his military service, he practiced pathology at hospitals in Michigan and in Temple, TX before joining Austin Pathology Associates in 1997.

Dr. Bauserman was a nationally recognized expert in neuropathology, and was well known as a speaker, teacher and mentor to his colleagues. Longtime friend and partner Dr. Phillip Collins recalls that Dr. Bauserman contributed greatly to Austin medicine by bringing his cutting edge skills in neuropathology and electron microscopy to a young medical community that lacked those advanced skills at that time. “He knew how to be a good partner, he was enthusiastic, insightful and fun to work with.” With a love of animals extending back to his youth, he surrounded himself with his beloved pets and horses throughout his life. He was an accomplished trumpet player, playing in bands, jam sessions at Don’s Depot, weddings, church services and for the entertainment of family and friends. He is survived by his companion Martha McBride, and was devoted to his extended family, including the all-important grandchild count that was up to eighteen by the end of his life.
CDC recommendation:
Test everyone born from 1945-1965 for Hepatitis C

People born from 1945-1965 account for 3 out of every 4 people with Hepatitis C, and more are unaware of their infection.

- Testing only patients with elevated ALT’s may miss 50% of infection
- Hepatitis C is a leading cause of liver cancer and liver transplants
- Care and treatment can help prevent Hepatitis C-related disease and deaths

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Member Spotlight: Sahar Askew

Sahar Askew was born and raised in Houston and is a graduate of UT Austin. She earned her BS in Education but pursued a career in sales. Sahar started her career in pharmaceutical sales with Eli Lilly and Company after college. After three fun and successful years, she joined medical device company Covidien, now Medtronic’s Minimally Invasive Therapies, and spent the next several years in the operating rooms of hospitals and surgery centers partnering with individuals on endomechanical products. Sahar has always had a passion for making a positive impact on others both professionally and personally.

Sahar is married to William Askew, an anesthesiologist, with Capitol Anesthesiology of Austin. Helia (8) and Stone (6) are their children along with their two doggy babies, Malley and Reef. Although caring for her family is her main focus, she enjoys reading, traveling, tennis, exercising, spin class and volunteering. As a family, the Askews enjoy traveling, dancing, playing board games and tennis. Sahar has been an active member with the Travis County Medical Alliance since 2007 and has enjoyed the friendship and purpose behind TCMA throughout the years.
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Public Health

Human Papilloma Virus and Immunization in Travis County

Philip Huang, MD, MPH, Medical Director, Austin Public Health
Sarah Seidel, DrPH, Austin Public Health
Anna Kiloueva, MPH, Austin Public Health

Summary of Part 1
(published in the May/June issue of the TCMS Journal)

- An estimated 280,000 Travis County residents are currently infected with mucosal Human Papilloma Virus (HPV).
- In Travis County, an estimated 102 cancer cases per year are caused by HPV; approximately 60 of these cancer cases are diagnosed in women, with the remaining 42 in men.
- Though cervical cancer incidence rates and mortality rates have decreased significantly due to the effectiveness of Pap test screening, disparities in Travis County among racial/ethnic groups remain. The highest incidence rates (2004-2014) of cervical cancer in Travis County are found in Hispanic women, followed by non-Hispanic black women, non-Hispanic Asians/Pacific Islander women, and non-Hispanic white women.

Table 2 (Corrected from Part 1)

<table>
<thead>
<tr>
<th>Cost component</th>
<th>Number of Cases</th>
<th>Cost per Case</th>
<th>Annual cost (millions, U.S. dollars)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervical screening: routine</td>
<td>168,170</td>
<td>$103</td>
<td>$17.32</td>
</tr>
<tr>
<td>Cervical screening: follow-up</td>
<td>n/a</td>
<td>n/a</td>
<td>$3.96</td>
</tr>
<tr>
<td>Cervical cancer</td>
<td>33</td>
<td>$38,000</td>
<td>$1.25</td>
</tr>
<tr>
<td>Oropharyngeal cancer</td>
<td>39</td>
<td>$43,200</td>
<td>$1.68</td>
</tr>
<tr>
<td>Anal cancer</td>
<td>15</td>
<td>$36,200</td>
<td>$0.54</td>
</tr>
<tr>
<td>Vulvar cancer</td>
<td>8</td>
<td>$23,600</td>
<td>$0.19</td>
</tr>
<tr>
<td>Vaginal cancer</td>
<td>2</td>
<td>$27,100</td>
<td>$0.05</td>
</tr>
<tr>
<td>Penile cancer</td>
<td>2</td>
<td>$19,800</td>
<td>$0.04</td>
</tr>
<tr>
<td>Genital warts</td>
<td>1,327</td>
<td>$810</td>
<td>$1.07</td>
</tr>
<tr>
<td>RRP</td>
<td>n/a</td>
<td>n/a</td>
<td>$0.64</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td><strong>$26.74</strong></td>
</tr>
</tbody>
</table>

Source: Adapted from Chesson et al., 2012

Part 2
HPV Vaccination rates in Texas

Because there is no screening for oropharyngeal cancer and other HPV-associated non-cervical cancers such as anal, vulvar and penile cancers, HPV vaccination is the best and only prevention strategy.

Accurate data on vaccination rates in Travis County are not currently available. In Texas and the US, rates of HPV vaccination among adolescents lag behind those of other vaccines given at the same age, such as pertussis, meningococcal and varicella (Table 1). As of 2015 in Texas, approximately 60 percent of adolescent females ages 13–17, and 41 percent of adolescent males 13–17 initiated the HPV vaccine series (i.e., received at least one HPV vaccine dose). Additionally, only 41 percent of adolescent females and 24 percent of adolescent males completed the 3-dose vaccine series. By contrast, 85 percent of adolescents had received the tetanus, diptheria and pertussis vaccine and 90 percent had received the meningitis vaccine. Though progress with HPV vaccination coverage is occurring, there is still significant room for improvement.

Vaccination Recommendations and Dosing Schedule

The HPV vaccine is recommended for all adolescents 11 to 12 years of age (vaccination may begin at nine years of age and older) and for females ages 13 to 26 and males ages 13 to 21 who did not
receive adequate vaccinations when they were younger. Additionally, young adults aged 22 to 26 with immunocompromising conditions or who engage in high risk sexual practices and were not adequately vaccinated at a younger age are also recommended to receive the vaccination series.8 Though individuals should receive the vaccine prior to HPV exposure, someone who has already been infected with HPV can still gain protection to the other types of HPV in the vaccine.8 As of 2017, only the 9-valent HPV vaccine (Gardasil 9, Merck & Co.) will be distributed for use in the US.

The CDC and Advisory Committee on Immunization Practices (ACIP) updated recommendations for dosing schedules following a review of clinical trial data showing two doses of HPV vaccine in younger adolescents (aged 9-14 years) produced an immune response similar or higher than the response in young adults (aged 16-26 years) who received three doses. Based on the available evidence in October 2016, CDC and ACIP now recommend a 2-dose schedule for adolescents who begin the HPV vaccination series (0 and 6-12 month schedule) before their 15th birthday. The schedule remains three shots (0, 1-2, 6 month schedule) for persons between the age of 15 and 26 and for persons with immunocompromising conditions.9

Factors Regarding HPV Vaccine Uptake

Systematic review of the literature on barriers to HPV vaccination among US adolescents found that a health care professional’s recommendation was one of the most important factors in their decision to obtain HPV vaccination for their children.10 Additionally, systematic review of interventions to increase HPV vaccine uptake found that providers pose a more significant barrier to vaccine series initiation while patients or families pose a barrier to series completion. Thus, interventions targeting patients and providers have the greatest potential for success.11

Table 1

<table>
<thead>
<tr>
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<tbody>
<tr>
<td>HPV vaccine, ≥1 dose, Females</td>
<td>50.7%</td>
<td>60.1%</td>
<td>+9.4%</td>
<td>62.8%</td>
</tr>
<tr>
<td>HPV vaccine, ≥1 dose, Males</td>
<td>36.6%</td>
<td>41.4%</td>
<td>+4.8%</td>
<td>49.8%</td>
</tr>
<tr>
<td>HPV vaccine, ≥3 dose, Females</td>
<td>33.9%</td>
<td>40.9%</td>
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<tr>
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<td>17.7%</td>
<td>24.0%</td>
<td>+6.3%</td>
<td>28.1%</td>
</tr>
<tr>
<td>MenACWY, ≥1 dose</td>
<td>88.6%</td>
<td>89.6%</td>
<td>+1.0%</td>
<td>81.3%</td>
</tr>
<tr>
<td>Tdap, ≥1 dose</td>
<td>88.2%</td>
<td>85.1%</td>
<td>−3.1%</td>
<td>86.4%</td>
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1 National Center for Health Statistics (2017). Prevalence of HPV in Adults Aged 18-69: United States, 2011-2014. Note: Because HPV infection is not a reportable condition to the state health department in Texas, Travis County estimates are extrapolated from U.S. estimates of genital HPV infection in adults 18-59 from NHANES 2011-2014 (42.5% of the population aged 18-59 using US Census 2010).
2 Ibid, CDC (2016a). Note: Cancer statistics from the state health department in Texas do not specify HPV association. Thus, Travis County estimates are extrapolated from U.S. estimates (30,700 HPV-associated cancers; 19,200 in women; 11,600 in men) of HPV-associated cancers in the U.S. using US Census 2010).
3 Department of State Health Services, Texas Cancer Registry, 2000-2014. Note: 10-year incidence rates were required in order to establish comparable rates among all four racial/ethnic groups.
4 Department of State Health Services, Texas Cancer Registry, 1999-2013.
7 Department of State Health Services, Texas Cancer Registry, 2010-2014. Note: 10-year incidence rates were required in order to establish comparable rates among all four racial/ethnic groups.
Talking to Parents about HPV Vaccine

Recommend HPV vaccination in the same way and on the same day as all adolescent vaccines. You can say, "Now that your son is 11, he is due for vaccinations today to help protect him from meningitis, HPV cancers, and pertussis." Remind parents of the follow-up shots their child will need and ask them to make appointments before they leave.

Why does my child need HPV vaccine?
HPV vaccine is important because it prevents infections that can cause cancer. That's why we need to start the shot series today.

What diseases are caused by HPV?
Some HPV infections can cause cancer—like cancer of the cervix or in the back of the throat—but we can protect your child from these cancers in the future by getting the first HPV shot today.

Is my child really at risk for HPV?
HPV is a very common infection in women and men that can cause cancer. Starting the vaccine series today will help protect your child from the cancers and diseases caused by HPV.

How do you know the vaccine works?
Studies continue to prove HPV vaccination works extremely well, decreasing the number of infections and HPV precancers in young people since it has been available.

Why do they need HPV vaccine at such a young age?
Like all vaccines, we want to give HPV vaccine earlier rather than later. If you wait, your child may need three shots instead of two.

I'm worried my child will think that getting this vaccine makes it OK to have sex.
Studies tell us that getting HPV vaccine doesn't make kids more likely to start having sex. I recommend we give your child her first HPV shot today.

I'm worried about the safety of HPV vaccine. Do you think it's safe?
Yes, HPV vaccination is very safe. Like any medication, vaccines can cause side effects, including pain, swelling, or redness where the shot was given. That's normal for HPV vaccine too and should go away in a day or two.

Can HPV vaccine cause infertility in my child?
Sometimes kids faint after they get shots and they could be injured if they fall from fainting. We'll protect your child by having them stay seated after the shot.

There is no known link between HPV vaccination and the inability to have children in the future. However, women who develop an HPV precancer or cancer could require treatment that would limit their ability to have children.

Would you get HPV vaccine for your kids?
Yes, I gave HPV vaccine to my child (or grandchild, etc.) when he was 11, because it's important for preventing cancer.

What vaccines are actually required?
I strongly recommend each of these vaccines and so do experts at the CDC and major medical organizations. School entry requirements are developed for public health and safety, but don't always reflect the most current medical recommendations for your child's health.

Would you get HPV vaccine for your kids?
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