ARE YOU CONTRACTING AWAY YOUR RIGHT TO BE INSURED BY TMLT?

If you are thinking about becoming employed in an Accountable Care Organization (ACO) or Non-Profit Health Organization (NPHO) aka 5.01(a),

DID YOU KNOW THAT:

1. You may not be able to keep or choose your medical liability insurance carrier. Consequently, you may be required to put your reputation and assets in the hands of the organization’s self-insured entity rather than with the proven insurance professionals at TMLT.

2. You may lose the right to withhold consent to settle if a claim occurs. The captive insurance carrier provided by your employer may be making the decision whether to defend or settle your case.

3. You may have to purchase tail coverage. Unless your new carrier is providing prior acts coverage, you will have to purchase tail coverage. Your new employer may not cover the cost for tail coverage. Additionally, you may lose the free tail coverage that you had earned with your current carrier as well as your accrued claim-free discounts.

4. You may lose access to a physician-focused defense. For instance, if you are insured by a hospital’s captive insurer, its attorneys will have expertise in defending hospitals, but may not have expertise in defending physicians. TMLT claim staff and defense attorneys specialize in defending physicians in lawsuits. Does the hospital’s insurance company have a claims philosophy that focuses on individual physicians’ risk exposures independent of the hospital’s organizational interests? Who will be protecting your career in the event of a claim or lawsuit?

IN ADDITION:

- What if there are conflicts of interest in a lawsuit?
- What if there are disciplinary proceedings?
- Will you have enough coverage?
- What about “moonlighting” coverage?
- What happens if there is a voluntary or involuntary termination?
- Beware of any promises not made in writing.

It is important to clearly understand these questions and their answers if you are looking at signing a contract to become an employed physician. You should also seek advice from an experienced attorney before making a decision. For more information, please visit www.tmlt.org or call John Southrey at 800-580-8658 x5976. The Texas Medical Association web site has additional resources for physicians considering becoming employed by a hospital, ACO, or NPHO at www.texmed.org.

More information is available at www.tmlt.org/employedmd
contact John Southrey, Business Development Coordinator
john-southrey@tmlt.org 800-580-8658 x5976
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Floor of Florence duomo. Photo by Owen Winsett, MD.
THE PRESIDENT’S MESSAGE
Amaryllis in a Box
Brian S. Sayers, MD

PAPER TO ELECTRONIC HEALTH RECORDS
C. Mark Chassay, MD

TCMS/AISD ATHLETIC PHYSICALS
Esther Yaniv, MD

OPEN LETTER FROM AISD PRINCIPALS

TMA PRESIDENT’S INAUGURAL ADDRESS
C. Bruce Malone, MD

PUBLIC HEALTH UPDATE

TOP TEN THINGS TO KNOW ABOUT
RELEASE OF MEDICAL RECORDS
Hugh Barton, JD

TCM ALLIANCE
Vickie Blumhagen

IN THE NEWS

CLASSIFIEDS

TAKE 5: GENERALIZED ANXIETY DISORDER

Texas wildflowers.  Photo by Jeffrey Lava, MD.
Recentl I took part in a presentation about physician burnout. The program was presented by an interfaith spirituality center that, like many other organizations in Austin and around the country, has increasingly realized the unmet need in the medical community regarding physician burnout and the implications that this problem has not only in terms of suffering by affected physicians, but also the safety issues and losses to society that this problem causes.

Physician burnout is an incredibly common problem with anywhere from 25-70% of all physicians affected, most studies putting the incidence somewhere near half. The fact that the incidence is many times more common than most of us would guess speaks volumes as to how well we as physicians hide the problem and, in doing so, delay getting help, letting it fester until our careers and good patient care are threatened. The consequences of burnout are staggering. Health problems, impaired relationships, medical mistakes, suicide, premature departure from direct patient care, depression, and substance abuse are all well-defined consequences of burnout.

The seeds of burnout are planted during our years in medical training. By its nature, medical training is somewhat like being in the military. Old habits are torn away so that we can be molded into something new, to think in a different way. The culture in many training programs is highly competitive, focusing on a competitive demonstration of knowledge and manual skills. It often awards hesitation, mistakes, or lack of immediate answers with humiliation; it inadvertently emphasizes total commitment to medicine at the expense of work-life balance; and it focuses on measurable outcomes more than relationships, on cures rather than healing. And so we enter our careers with a sort of chip implanted. As the years in practice pass, the problem may be compounded by financial pressures – often self-imposed – along with all the other frustrations and challenges of the business of medicine. If not checked as we go through our career, it can turn a once sincere dream into despair and disappointment.

As the seeds of burnout fully bloom, I believe that the first thing we lose is a sense of meaning in our work, and when that is lost we have lost the very soul of medicine. In reading about burnout, experiencing it myself, and getting first and second hand accounts of others’ experiences – doctors have been surprisingly candid with me about their own experiences with burnout – I have come to believe that there are two overlooked faults that rob us of a sense of meaning in our work. They are the resentful relationship that we have with mystery, and the loss of recognition of the miracles that surround us and give meaning to our experiences in this life.

When you think back on your years in training, especially that third year in medical school, you might remember how some days you were figuratively – if not literally – open mouthed in your awe of all the new things that you saw. How you recognized the miracles all around you and, in the forced humility of a student, how you realized the magnitude of mystery that surrounds the human mind and body in spite of all we know and try to control. We humans try to control things, doctors perhaps to an extreme. In doing so we often ignore the great mysteries that, when recognized and appreciated, can give meaning to our work and improve our relationships with patients. Never letting go of control dooms us to a sense of repeated failure and frustration as there are so many things beyond our understanding and beyond the possibility of control.

In my specialty there are almost no diseases with clearly known causes and, when I am honest, I really have very little idea how most of our therapies work. Mystery, those things that are unknowable, instead of being an enemy can give us an appreciation and a sense of wonder in our work. We solve problems for a living, have to find answers and solutions when we can, but when a problem has been solved it is like a book that has been read. It is set aside and its lessons may soon be forgotten. Mystery is a question that lingers, that humbles us, that makes us think. Sometimes saying “I don’t know,” to a patient can produce unexpected rewards. Shared with patients, this sense of mystery reminds them, in humility, that there are limits to medicine, and that good medical care involves a partnership that recognizes and accepts the uncertainty and loss of control that mystery leaves us with. In our most difficult moments in medicine, mystery is always there. Mystery is there when the heart starts to beat after coming off bypass. It is there during a cardiac arrest when some survive and some don’t, when we see some respond to chemo and others don’t, when we see those who pray or meditate or laugh or have

continued on page 8
By Physicians. For Physicians.

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“The staff at MSB do a great job. I feel like I’m always connected, calls are documented, and they take good care of my patients.”

C. Bruce Malone, III, MD Orthopedic Surgeon, Austin
You put it together and water it and it just flat grows. As it happened this year, she put an extra one on our breakfast table. I sit at that table each morning over coffee and wait patiently for my teenage daughter to come downstairs so I can visit with her while she eats a few hurried bites of breakfast. So for several weeks this year, each morning I watched this flower growing. It was really amazing. Some days I felt like it grew a full inch. Then almost overnight this incredible bloom came out. Almost before my eyes as I watched. I realized that I had totally ignored this miracle in all the years before. As I thought about it more driving to work one day, it occurred to me that if we had a whole yard full of them, hundreds of them, after a while I probably wouldn’t even notice such a miracle as I hurry out to my car to leave each morning. It may be much the same as I go through many of my days in a long career, forgetting to leave the house with intent and gratitude of my days in a long career, forgetting to leave the house with intent and gratitude of my days in a long career, forgetting to leave the house with intent and gratitude of my days in a long career, forgetting to leave the house with intent and gratitude of my days in a long career, forgetting to leave the house with intent and gratitude of my days in a long career, forgetting to leave the house with intent and gratitude of my days in a long career, forgetting to leave the house with intent and gratitude.

Over the holidays last year, my wife Maryann bought family and friends an amaryllis in a box. You might have seen these. They come in a little box packed with a bulb, a cup, and some special soil.
Same day consultation and treatment.

In office Fluoroscopy and Ultrasound interventional suite.

Close communication with providers.

Helping patients live life to the fullest.
The shift from paper records to an electronic health record (EHR) system can have a profound impact on your practice. You might already recognize the potential benefits an EHR can have with meeting quality clinical standards, getting lab results and other patient information more quickly, and working more efficiently. Eventually this will lead to your being part of a broad network of electronic information exchange. The goal is better health care, but you also can improve your earnings by using an EHR (also called an electronic medical records, or EMR) — starting today, and with help from the federal government.

The American Recovery and Reinvestment Act of 2009 (ARRA) offers financial incentives to physicians who use an EHR, and subsidizes on-site technical consulting to help physicians select and implement an EHR system. Travis County physicians are in the service area of the CentrEast Regional Extension Center (CentrEast REC), one of four centers that serves Texas.

“EHRs are valuable in disputing inaccurate rankings by insurers, as well,” said Sidney Ontai, MD, MBA, Texas Medical Association Council on Practice Management Services chair and member of the Ad Hoc Committee on Health Information Technology (HIT). Insurers issue physician rankings based on filing data that — insurance companies claim — constitute evidence-based measures. “EHRs are capable of sophisticated data mining, which will help physicians not only improve performance, but also contest erroneous insurance company rankings,” Dr. Ontai said.

Schedules of Physician Incentives and Penalties
ARRA provides $17 billion of incentive payments to physicians and hospitals who demonstrate “meaningful use” of EHRs. Physicians can qualify for up to $44,000 in Medicare incentive payments from 2011 to 2016 and up to $63,750 in Medicaid incentive payments from 2011 to 2021 (see table). Physicians may participate in either the Medicare or the Medicaid incentive program but not both. In January, the Centers for Medicare & Medicaid Services (CMS) announced registration for the EHR incentive programs has opened.

Details are available at www.cms.gov/EHRIncentivePrograms/.

Incentive program eligibility is determined by federal law. Hospital-based physicians are not eligible for federal incentives if 90 percent or more of their services are furnished in a hospital. Physicians eligible for both the Medicare and the Medicaid EHR incentive programs must choose which incentive program they wish to participate in when they register. Before 2015, physicians may switch programs only once after the first incentive payment is initiated.

To avoid 2012 penalties (1 percent of Medicare Part B claims), Medicare physicians must report E-prescribing via claims on at least 10 unique Medicare encounters by June 30, 2011. In 2013 and 2014, the Medicare penalty for not e-prescribing increases to 1.5% and 2.0% respectively. Beginning in 2015, physicians that are not meaningful users of certified EHR systems will see a 1 percent reduction of Medicare Part B claims, 2 percent in 2016, and 3 percent in 2017. Medicaid does not currently have punitive penalties for physicians who are

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With the new toll road, Mopac Expressway is the preferred north/south highway for the Austin metro area.

Adjacent to St. David's North Austin Medical Center ranked as one of the top 20 hospital systems in the nation, with the largest women's health care facility in the region.

One exit north of the world-class Domain master planned development, dubbed the second downtown of Austin.

Call now to reserve your new north Austin office in the beautiful new Plaza North Office Building!

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Continuing a tradition of more than thirteen years, the TCMS Public Relations Committee sponsored a service project with the AISD Student Health Services to provide free athletic physicals to AISD students who are uninsured or do not have affordable access to health care. For many students this is the only time they see a physician for a well visit.

With the assistance of 83 TCMS physician volunteers – many who volunteered for more than one shift and/or day, more than 640 middle school and high school students were screened over the course of four nights in April and May. Thanks go out to specialists from orthopedics, pediatric cardiology, otolaryngology, general surgery, pediatric surgery, pain management, and emergency medicine who joined their pediatrician, internist, and family medicine colleagues at Burger Activity Center and Delco Activity Center.

The physician volunteers were assisted by volunteer nurses, student nurses, and health educators from AISD, UT School of Nursing, and Dell Children’s Medical Center. Numerous volunteers from the Blood and Tissue Center of Central Texas’ Lend a Hand program helped with crowd control, snacks, and chaperoning duties.

In 2010, TCMS and the Travis County Medical Alliance Be Wise – Immunize volunteers, along with AISD, piloted an immunization clinic during one night of the middle school physical exams. Due to the success of the clinic, an additional night was added in 2011 for middle school students. Over 100 vaccines were given to 38 middle school students. The clinics continue to assist in bringing down the vaccine delinquency rate for the school district. Often, the same students in need of the free physicals are the ones who need to be brought current on their immunizations. Our thanks go to the Alliance as well as to Austin Radiological Association and University Federal Credit Union (members of the TCMS Friends of the Society Program) who made financial and in-kind donations to provide healthy snacks and water for the students.

The Society could not continue to offer this program without the generosity of all those who volunteered their services and support.
Outstanding performance is something worth repeating. So we did.

St. David’s Medical Center, a Top 100 Hospital in the nation for two years in a row.

Named 1 of the 20 best large community hospitals in the country.

And, The only hospital in Central Texas to receive this prestigious honor in 2011.
Open Letter From AISD Principals

... we know that the single most important predictor of success in high school is attendance.

March 23, 2011

Brian S. Sayers, MD
President, Travis County Medical Society
P.O. Box 4679
Austin, Texas 78765

Dear Dr. Sayers:

As the principals of AISD’s high schools, we would like to alert you to a challenge we currently face regarding student attendance. We respectfully request the support of the Travis County medical community to assist us in improving the attendance of our students and to improve their academic success.

We know that the single most important predictor of success in high school is attendance. Those students with few absences tend to do very well in school. They are present for instruction, available for targeted and focused intervention through tutorials and advisory, and on track to complete and deliver homework and projects. The school district, as a whole, recaptures $1,000,000 every time we improve attendance in our schools by 1%. That supports the progress of all students by helping to ensure adequate funding for the instruction of our students.

Our challenge lies with students who are missing school due to an excessive amount of medically “excused” absences. We have students who miss a large number of school days and return with excused absence slips from their physicians. As an example, one student missed thirty-seven days this year, each one excused by the physician. The illnesses were marked as sore throat, stomachache, headache, cold, etc. If this were an isolated incident, we would not be concerned. However, it is not and we are seeing more and more of these doctors’ notes that seem quite casually written. A common occurrence is a student who asks for a list of the days in which she/he had absences and then returns with a note from the physician basically stating, “reason all reported absences for this student from October 12th – February 17th.” No reason given. As you can see, this does no favors for the student or the school.

We are not in a position to question the medical diagnosis of physicians, nor would we ever attempt to do this. However, we know that we are putting many children in jeopardy with their educational advancement when we allow them to stay home from school when they could be in the classroom. Our request of the Travis County medical community would be that excused absence slips be given judiciously and only when it is inadvisable for the student to be at school. You, as the Travis County Medical Society, could assist us in our efforts to improve outcomes for our students by helping to ensure that students are in school and miss only when it is absolutely necessary. We thank you for your partnership in helping our students achieve at their highest level by being in attendance for instruction during the school year.

Respectfully,

[Signatures]
Congratulations!
TMA LEADERSHIP COLLEGE CLASS OF 2011

Standing, left to right: Bradford Holland, MD; Brian M. Bruel, MD; Rick Ngo, MD; Sandra Parker, MD; Gregory Johnson, MD; Michelle Markley, MD; Piyush Mittal, MD; Jeffrey Apple, MD; Chelsea Clinton, MD; Darrell Alley, MD; Susan Pike, MD; Carla Davis, MD; Talmadge Trammell, MD; Osvaldo “Steve” Gigliotti, MD.

Seated, left to right: Lenore DePagter, DO; Ray Callas, MD; Erica Hughes, MD; Angela Hilger, MD; Bindu Raju, MD; Radha Iyengar, MD; Theodore Spinks, MD; Wendy Chung, MD.

Texas Medical Association Leadership College is an intensive leadership program designed to identify, orient, and train young TMA members for future leadership positions at the county and state levels. Our mission is to ensure strong and sustainable leadership and promote the role of physicians as trusted leaders in their local communities. The program combines the elements of organizational education, skills training, mentoring, and guided experiences that cover the three “Ps” of leadership: philosophy, principles, and practice.
In this time of disruptive change, we cannot just say "No."

C. Bruce Malone, MD
President, TMA

We have to help create a reorganized medical marketplace that creates value for the consumer and gives us a right to practice in the “public” system while having the option to private contract with patients who want more.

Thanks for allowing me to serve. This is a roomful of servant leaders. We all share a love of the profession and respect for our colleagues. I am counting on all of you to help us make a change for the better as health reform evolves.

Where Are We Now?

We are working in a system that costs too much. Business is worried that medical costs are going to make US goods non-competitive. We have employer-based health insurance versus personal taxes in other countries and per-capita spending for medical care that is at least two . . . and sometimes three times (that of) other developed countries. We have amazing technology and skills, but overall, US health is not outstanding because of obesity, diabetes, heart disease, and violence . . . and the uninsured.

We cannot just pretend these facts away. In this time of disruptive change, we cannot just say “No, we want things to stay as they always were” because change is happening all around us. If we think we don’t like radical change, we are really not going to like being irrelevant.

Where Are We Going?

The new Affordable Care Act has doctors and patients confused. Factions challenge the mandate for insurance. (We cannot have universal coverage without some sort of mandate; our AMA policy is that we have individual ownership that is portable.) No commercial market can survive without the mandate if the popular guaranteed issue is part of reform. We may litigate our way into a single-payer system as probably the only viable option. The US government pays for 40 percent of all care now.

TMA has said all along that we want to keep what is good . . . get rid of what is bad . . . and add what is needed to the Affordable Care Act. And we have written it down. In this time of disruptive change, we cannot just say “No.” We have to help reorganize the medical marketplace so that it creates more value for those who pay for it. We have to help reorganize the medical marketplace so it gives us the right to practice in the ever-expanding public system with the option to contract privately with patients who want more.

The good news is we spend such a large amount of money on health care that if the doctors who know how to treat are allowed to organize, we can cover everyone for basic services . . . and we can cover advanced care for those who want it. US Rep. Tom Price’s bill on private contracting is the start of a terribly important legislative battle for American medicine.

Another new trend is doctor employment. TMA wants to be relevant to all

Drs. Linda and James Prentice and TCMS COO Belinda Clare congratulate Dr. Bruce Malone on becoming 146th President of the Texas Medical Association.
doctors in Texas no matter how they are paid. We know that doctors need to be protected from some corporate methods, but like any innovation in medicine, organization of new care systems is crucial. So we introduced novel legislation to protect employed physicians’ clinical autonomy.

To satisfy the value proposition: We have to reorganize the medical marketplace so it delivers the right care … at the right place … at the right time … and at the best price. Good medical care will never be cheap. Prevention can be.

Focus on the Future

Looking ahead, there will be more regulation through the Independent Payment Advisory Board. There will be major changes to Medicare and Medicaid: President Obama’s devastating cuts versus Congressman Ryan’s vouchers that shift costs to individuals. There will be limited panels on commercial insurance based on cost efficiency, an urgent matter.

We cannot just say “No” to these changes. We have to offer a better way to our patients … to the government … to the private insurers and the employers. We have to reorganize the medical marketplace. We need private contracting to give us the ability to work within the public system no matter how misdirected. We need more patient choice.

We are often not very focused in our legislative agenda. We have opinions about everything and get real results on very few. The best result we have achieved in my memory was the 2003 tort reforms … because we were focused. We have to keep our eye on the real prize in this reform. We cannot just say “No.” As physicians, we must defend our autonomy or risk being dumbed down. We must create new forms of practice while making care safer.

Finally, if we work with our patients in mind, they will support private contracting because they will have more choices, and we will have more autonomy and the ability to continue to innovate and advance technology in practice.

We are so fortunate to have our life’s work be meaningful and valuable, combining increased population productivity with the privilege of being part of our patients’ lives. So let’s roll up our sleeves and meet the challenges. Let’s stop saying “No” to the change all around us … some of it is very necessary. Let’s be leaders in reorganizing the medical marketplace.

When we meet these challenges just as our predecessors have done … with science and innovation … we will be helping to create a unique American system of care that works for us … and that works for our patients.

I hope you all will help.

Dr. Malone became TMA’s 146th president in an installation ceremony during TexMed 2011 in Houston.

TMA House of Delegates
Michelle Berger, MD
Chair, Travis County Delegation

In its annual elections at TexMed 2011, the TMA House of Delegates re-elected the following Travis County physicians for an additional term of service: Clifford Moy as Vice-Speaker; William Caldwell as Vice-Councilor; Bruce Malone and Clifford Moy as Delegates to the AMA House; and Charlotte Smith and Michelle Berger as Alternate Delegates to the AMA House.

The TMA House of Delegates adopted new policy on a slew of important issues. The house agreed to support legislation to allow physicians to dispense and charge for pharmaceuticals, other than schedule I-V controlled substances. A bill allowing physician dispensing has passed the Texas Senate and is scheduled for a House committee hearing this week. In other action, delegates:

- Voted to require these safeguards in any accountable care organization: voluntary physician and patient participation, physician leadership on the governing board, and physician supervision of economic and quality measures;
- “Took a firm stand against the epidemic use” of cell phones and texting while driving because they often cause accidents;
- Adopted policy requiring insurers to compensate physicians for the cost of seeking preauthorization for medications, studies, or procedures; and
- Asked the legislature to encourage natural gas production but protect Texas water from the risk of hydrofracking by requiring disclosure of fracking fluid components.

For a complete list of actions taken by the House of Delegates contact the Travis County Medical Society or visit www.texmed.org.
Public Health Update
Tobacco Statistics in Travis County

Phil Huang, MD, MPH
Medical Director/Health Authority
Austin/Travis County Health and Human Services

In Travis County, tobacco use kills more than aids, crack, heroin, cocaine, alcohol, car accidents, fire, murder, and suicide - COMBINED.

This is a message that the Austin/Travis County Health & Human Services Department (A/TCHHS) is disseminating through TV and radio ads, because A/TCHHS has come to realize that most people don’t know, or even believe this fact. In this article Phil Huang, MD, MPH, A/TCHHS medical director/health authority will review some of the numbers behind the statistic.

Data Sources and Methods
Mortality data for Travis County in 2008 were obtained from the Texas Department of State Health Services. The underlying causes of death (using ICD-10 codes) were tabulated to directly count deaths due to preventable causes, including AIDS, crack, heroin, cocaine, car accidents, fire, murder, and suicide, and to input into calculations to estimate the number of deaths attributable to tobacco use and alcohol use.

The primary method for estimating the number of deaths attributable to smoking among adults 35 years and older was through use of the Smoking-Attributable Morbidity, Mortality and Economic Cost (SAMMEC) application developed by the Centers for Disease Control and Prevention (CDC). The SAMMEC program estimates smoking-attributable mortality from 19 diseases caused by cigarette smoking, including malignant neoplasms (cancer), cardiovascular diseases, and respiratory conditions, using attributable-fraction methodology.1 The smoking-attributable fractions of deaths are calculated using sex- and age-specific smoking prevalence and estimates of relative risk of death for current and former smokers. Travis County-specific smoking prevalence estimates by sex and age were obtained using the state Behavioral Risk Factor Surveillance Survey (BRFSS) data from 2007-2009. County-level population estimates for 2008 were provided by the Texas State Data Center. The CDC SAMMEC methodology has been reviewed by the United States General Accounting Office and certified as reasonable estimates that use the best data sources available.2

Additional information regarding tobacco-related mortality was obtained directly from death certificates as a secondary method for estimating tobacco-related deaths. Since 1994, the Texas death certificate has included the question: “Did Tobacco Use Contribute to Death?” We examined Travis County deaths for 2008 and considered the death to be tobacco related if the certifier of death checked “Yes” or “Probably.”

The estimated number of deaths due to alcohol consumption was calculated using the Alcohol-Related Disease Impact (ARDI) software developed by CDC.3 The methodology applies alcohol-attributable fractions to the number of deaths for specific conditions to obtain the number of alcohol-attributable deaths. Data inputs included Travis County-specific alcohol consumption prevalence estimates by age and sex from 2007-2009 BRFSS and Travis County mortality data from 2008.

<table>
<thead>
<tr>
<th>Cause</th>
<th>Number of deaths</th>
<th>Cause</th>
<th>Number of deaths</th>
</tr>
</thead>
<tbody>
<tr>
<td>Tobacco use (SAMMEC estimate)</td>
<td>570</td>
<td>AIDS (ICD-10: B20-B24)</td>
<td>31</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Crack, heroin, cocaine (ICD-10: F11, F14, F19, X42, Y12)</td>
<td>44</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Alcohol (ARDI estimate)</td>
<td>227</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Car accidents (ICD-10: V02-V89)</td>
<td>119</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Fire (ICD-10: X00-X09)</td>
<td>2</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Suicide (ICD-10: X60-X84, Y87.0)</td>
<td>108</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Murder (ICD-10: X85-Y09, Y87.1)</td>
<td>27</td>
</tr>
<tr>
<td>TOTAL</td>
<td>570</td>
<td>TOTAL</td>
<td>558</td>
</tr>
</tbody>
</table>
Results
Based on SAMMEC calculations, the estimated number of deaths attributable to smoking in 2008 was 570 (see Table on page 18). The combined number of deaths due to AIDS, crack, heroin, cocaine, alcohol, car accidents, fire, murder, and suicide was 558.

As supplemental verification, in 2008, 586 of 4519 death certificates (13.0%) in Travis County were certified that tobacco use definitely or probably contributed to the death.

Conclusions
Based on CDC SAMMEC calculations, we estimate that approximately 570 smoking-attributable deaths occurred in Travis County in 2008. This figure is also supported by direct check box information from 2008 death certificates for Travis County, in which the certifiers of death identified 586 deaths with tobacco use having contributed to the death. In 2008, tobacco killed more Travis County residents than AIDS, crack, heroin, cocaine, alcohol, car accidents, fire, murder, and suicide – Combined!

Q: When A Patient Wants Copies of Medical Records What Rules Do I Have To Follow?
A: Under the Texas Medical Practice Act, patients may consent to the release of their medical records by signing a “consent for release of confidential information” that meets five legal requirements:

1. Written: Consent for release of confidential information must be in writing.
2. Signed: It must be signed by the patient. If the patient is a minor, it must be signed by their parent or legal guardian. If the patient is adjudicated to be incompetent, it must be signed by a legal guardian.
3. Reasons: The reasons or purposes of the release must be specified.
4. Identify Records: The consent must identify the information or medical records to be released. Tex. Occ. Code §159.005(b). An Attorney General Opinion says the records subject to the release must be merely “identifiable.” Thus, it is not a valid objection, in the Attorney General’s view, that the patient has not described the records he wants with “sufficient specificity” to the physician’s satisfaction.
5. To Whom Released: The consent must specify the persons to whom the information or medical records are to be released. Id. Thus, a patient is free to designate anyone as the recipient of their medical records, and has the right to have copies of medical records released to himself under this provision.

Note: The HIPAA Privacy Rule requires a more extensive 12-element release form that includes, in addition to these elements, statements of patient’s rights and an expiration date.

Q: If A Patient Is Deceased, Can I Release Records To Next Of Kin?
A: No. The Medical Practice Act states that, when a patient is deceased, the consent for release of information form must be signed by a “personal representative,” and under the Probate Code, the term “personal representative” means executors, independent executors, administrators, independent administrators and temporary administrators, but does not include “next of kin.” Tex. Prob. Code §3. Thus, “next of kin” need to start a probate proceeding in order to get records.

Q: Can I Refuse to Release Records For Any Reason I Decide Is Valid?
A: No. The Medical Practice Act contains only one explicit circumstance in which a physician may refuse to comply with a patient’s valid written request for disclosure: when the physician determines that access to the information would be “harmful to the patient’s physical, mental, or emotional health.” Tex. Occ. Code §159.006. Texas Medical Board (TMB) rules require that, if a physician denies the request for copies of medical records in whole or in part, the physician shall furnish the patient a written statement, signed and dated, within 15 business days of receipt of the request stating the reason for the denial and how the patient can file a compliant with the Federal Department of Health and Human Services (if the physician is subject to HIPAA) and the TMB. A copy of that denial must also be placed in the patient’s medical and/or billing records as appropriate. 22 TAC §165.2. Thus, a physician should be careful about the reason given to deny release, as the next time he sees that letter it may be part of a complaint to the TMB.

Q: Are Patients Allowed To Obtain Copies Of Diagnostic Imaging Studies?
A: Yes. If a physician received a written request for release of information that complies with the above mentioned requirements, the physician “shall allow access” to imaging studies in his possession by: (1) providing copies of the imaging studies to the patient; or (2) releasing the original imaging studies to the patient. Evidence of the transfer of original studies may be done by a signed and dated receipt, acknowledging receipt of, and responsibility for, the original imaging studies.

Q: How Long Do I Have To Release Records?
A: From 1981 to 1994, a physician had a “reasonable time” to respond. That changed to 30 calendar days in 1995, and to 15 business days in 1999. Thus, when a physician receives a proper written request for release of records, he has 15 business days to respond, or as outlined above, provide a written reason why not. Tex. Occ. Code §159.006(a). Note: the rules are not consistent across the board – hospitals have 15 business days to respond.

Q: Do I Release Records Received From Other Sources?
A: Yes. The Medical Practice Act provides that “[a] physician shall furnish copies of medical records requested, or a summary or narrative of the records, including records received from another physician or health care provider involved in the care or treatment of the patient, pursuant to a written consent for release of the information...” Tex. Occ. Code §159.006(a) (emphasis added). TMB Rules mirror this provision. 22 TAC §165.2. This has been the law since approximately 1995.
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The Alliance at Work . . .

This year’s MadMed Gala held on February 26 was very successful. Proceeds will fund the following community service grants for local health related non-profit organizations:

- Austin State Hospital $3,800
- BookSpring $3,800
- Family Eldercare $3,800
- Hospice of Austin $1,720
- LifeWorks $3,800
- People’s Community Clinic $3,800
- Saint Louise House $3,800
- Volunteer Healthcare Clinic $3,800

The Volunteer Healthcare Clinic Committee will help with a Backpack’s for School event and plan to gather and distribute 30-35 backpacks filled with school essentials.

The Keep Austin Healthy Committee helped TCMS and AISD with their annual free athletic physicals on April 12 and 14. Along with the physical exams for uninsured/underinsured students, those in need were also brought up-to-date on their immunizations.

The Ronald McDonald House Committee continues to provide home cooked meals once a week for families staying at the Ronald McDonald House while their child is hospitalized.

The Literacy Outreach Committee continues to deliver gently used books to the waiting rooms of numerous clinics for low income patients.

Did You Know?

The Alliance is much more than a social organization:

- There are over 320 members of the Alliance – many are physicians.
- Several male spouses are members and have formed a men’s group.
- Tens of thousands of dollars are raised each year for local non-profit health care related organizations.
- Each year, members volunteer hundreds of hours for several philanthropic projects.
- The Alliance is very politically involved to promote health care issues.
- Two nursing school scholarships are awarded each year – one to a student at the UT School of Nursing and one to a student at the ACC School of Nursing.
- The Alliance is committed to supporting their members in need, such as when an illness or death in a family arises.
- The Alliance has a long history of financial support for numerous public schools’ project graduation which helps to provide a drug-free, alcohol-free, lock-in event for graduating seniors.
- Each year, the Alliance is a sponsor of the Austin Energy Regional Science Festival.
- The Alliance has eleven Quality of Life/special interest groups.

Alliance Member Spotlight – John Dapper

John joined TCMA in 2010 and is chair of the nascent Men’s Group. His plans for the group include getting together for breakfast, happy hours, and to attend the occasional sporting event. John and his wife, Jessica, an emergency medicine physician with Capitol Emergency Associates at North Austin Medical Center, are both from Austin (he went to Reagan, she went to Westwood). They met while students at Southwestern University in Georgetown and lived there while Jessica was completing her residency at Scott & White before moving back to Austin in 2000.

A self-described “recovering” attorney after 10 years in private practice and as in-house corporate counsel, John is now building a practice as a financial advisor at the Austin office of Memphis-based Morgan Keegan & Co. He says he doesn’t miss keeping track of his billable hours one single bit.

An Eagle Scout, John is a past chair of the Friends of Scouting luncheon, was a member and officer in the Austin Young Men’s Business League benefiting the Austin Sunshine Camps, and has been active in his fraternity’s alumni board. He is a past member of Westlake Rotary Club and recently joined the Finance Committee for Wonders & Worries, which offers support for children when a member of the family is struggling with chronic illness. When he is not barbecuing or rooting for the Longhorns (or both), John spends as much as time as he can with his two daughters, Ava and Lorelei.
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Diabetes is the seventh leading cause of death in the United States. Join us for this crucial look at ways to prevent, manage and treat diabetes and its complications.
I had a pretty young woman for a GI series who was the daughter of an ob-gyn and wife of a doctor. I asked her if her dad ever told her about almost being arrested for bank robbery by the FBI? She said, “No.”

He had parked in the doctor’s lot at the old Seton and went in to deliver his patient’s baby. A man took his car, drove a few blocks to a bank and robbed it. He got back in the car and returned it to the Seton parking slot and escaped on foot. A witness had seen the car. When the doctor finished his patient care and returned to his car, he was accosted by FBI agents for the bank robbery. Fortunately, in spite of the OR mask, the assistants in the delivery room knew he was there.

That same doctor had delivered our daughter on a different day without charge. I didn’t charge his daughter for her GI Series. For you new doctors, it was called professional courtesy.

Dr. Bob

Retired Membership is granted to those physicians who have retired from the active practice of medicine. Upon nomination from the Board of Ethics, the TCMS Executive Board elected the following to Retired Membership:

Nancy L. Childs, MD

Life Membership is granted to those physicians who have been a dues paying member of organized medicine for 35 years, of which 25 years must have been dues paying years in the TMA and who have reached a point of comparative inactivity in the practice of medicine, as determined by the Society. Upon nomination from the Board of Ethics, the TCMS Executive Board elected the following to Life Membership:

James D. McNabb, MD

The Texas Medical Association has elected Charles B. Mullins, MD, president of its 50-Year Club, a group of physicians who graduated from medical school at least 50 years ago but whose commitment to the advancement of medicine remains strong.

Gov. Rick Perry recently appointed Stanley Wang, MD to the Texas Medical Board.

George Willeford III, MD, was reappointed for another term.

Other TCMS members who serve on the TMB are Patrick Crocker, DO, Melinda McMichael, MD, and Charles E. Oswalt, MD.

Life Membership

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

Ross Pershing Chiles, MD, died on March 23, 2011, at the age of 71. He graduated from Aberdeen Central High School in 1957. He attended South Dakota State University and the University of South Dakota. He received his medical degree from the University of Michigan in 1964. He did his internship and residency in Internal Medicine and a fellowship in Endocrinology at Ohio State University.

Dr. Chiles served in the Air Force and was stationed at Keesler Air Force Base in Biloxi, Mississippi.

In 1972, Dr. Chiles joined the Austin Diagnostic Clinic where he worked for 35 years. He sang in the church choir, and played the hand bells. He loved music and sang with the Texas Choral Consort from its beginning.

Albert A. LaLonde, MD, age 93, passed away peacefully at home on 18 April, 2011. He received his undergraduate degree from the University of Texas at Austin in 1938 and received his medical degree at the University of Texas Medical Branch at Galveston in 1942.

In 1949, he returned to Austin as its first board-certified Neurosurgeon. For several years he was the only Neurosurgeon between Dallas and San Antonio, and on-call at all times. Dr. LaLonde was honored by his colleagues in 1996 when he was selected TCMS Physician of the Year. He retired from surgery in 2005 at the age of 88, but continued working for the Texas Medical Board reviewing insurance claims with fellow semi-retired physicians until 2007, when he finally decided to retire and relax.
TMB Rule §165.2(h). The AMA also considers this practice unethical.

Q: What Are The Penalties For Violating TMB Release Rules?
A: Failure to timely provide copies of medical or billing records on written request carries the following penalties under TMB rules: furnish the records requested, restitution, and a penalty of $1,000 per violation.

Q: Didn’t HIPAA Change All This?
A: Not really. A “covered entity” − which includes virtually every physician and health facility in the US − is “permitted” to disclose “protected health information” (which basically encompasses all information in medical records) to “the individual” who is the subject of the information and is “required” to disclose that information when they submit a written release form, or invokes their HIPAA-based “right of access to inspect” their records. 45 CFR sections 164.502 & 164.524. HIPAA basically uses different terminology to reach the same end.

One point where HIPAA conflicts with Texas law is that a patient has no right to inspect or copy their “psychotherapy notes” under HIPAA, whereas Texas law contains no such limitation. Another conflict is that HIPAA allows a physician to deny access if they think that it is “reasonably likely to endanger the life or physical safety of the individual or another person.” As seen above, the test in Texas is merely that it be “harmful” to the patient − a much lower standard. The rules for resolving conflicts between HIPAA and state law suggest to the author that the Texas rules should apply over HIPAA in these instances, though there is some room for argument.

Hugh M. Barton is a health lawyer in Austin, Texas. He concentrates on business and regulatory issues affecting licensed health professionals. Mr. Barton has been practicing health law for 27 years and is Board Certified in Health Law by the Texas Board of Legal Specialization. He can be reached at (512) 499-0793 or at bartonlaw@yahoo.com.
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**Office Space:** Cedar Park - 1935 sf - Medical office complex w/dedicated monument and great exposure to Cypress Creek. $15/sf. Contact Steven at (512) 335-8121.

**For Lease:** Northfield Professional Building, 101 W Koenig. 4000 or 8500 sq/ft of shell space. Free parking. Contact Joel Haro, joelharo@pmgmt.com for rates and terms.

**Sublease Available:** Lakeway, beautiful new construction medical office on RR 620. 4 exam rooms. Fully furnished. Receptionist available. Near future Lakeway Regional Medical Center. $250/half day. Contact Mike Barrett at (512) 485-0146 or drmichael.barrett@tpgst.com.

**Bee Caves Road Medical:** 1827 sq/ft of finished out medical office next door to an ENT Doctor. First building/ground floor drive up parking plus 2 covered parking space. 22.00 sq/ft plus nnn. Finish out available or some free rent. E-mail for floor plan: theaton2@austin.rr.com. Call Tom Heaton, Broker, (512) 219-7732.

Meaningful Use and Certification

Now that CMS has released final rules on meaningful use, physicians can realize the benefits of an EHR and the incentive payments. ARRA specifies three main components of meaningful use:

1. The use of a certified EHR in a meaningful manner, such as e-prescribing;
2. The use of certified EHR technology for electronic exchange of health information to improve quality of health care; and
3. The use of certified EHR technology to submit clinical quality and other measures.

Simply put, “meaningful use” means physicians need to show they are using certified EHR technology in ways that can be measured in quality and in quantity. The criteria for meaningful use will be phased in via three stages starting this year.

- **Stage 1** criteria consist of 25 measures, of which 15 are considered “core” and 10 are “menu.” Physicians must demonstrate all 15 core measures and select five of 10 menu measures. Criteria include capturing health information, tracking key clinical conditions, communicating information for care coordination purposes, implementing clinical decision-support tools, engaging patients and families, and reporting clinical quality measures and public health information.

- **Stage 2** is proposed to take effect in 2013. It focuses on continuous quality improvement at the point of care and information exchange in the most structured format possible, including computerized provider order entry (CPOE) and the electronic transmission of diagnostic test results.

- **Stage 3** is proposed to take effect in 2015. It promotes improvements in quality, safety, and efficiency leading to improved health outcomes, decision support for national high-priority conditions, patient access to self-management tools, access to comprehensive patient data through patient-centered health information exchange, and improvement in population health.

Each stage requires increasing activities to fulfill the criteria for incentive payments. Under Medicare, physicians must meet the Stage 1 meaningful-use criteria for 90 days in the first year of enrollment in the incentive program. Under Medicaid, physicians must demonstrate they are live with the EHR in year one to be eligible for the first incentive payment. For Medicaid year two, physicians must demonstrate meaningful use for 90 days. The incentive program also requires the use of a certified EHR technology. Even if you are already using EHR technology, it must be tested and certified specifically for the Medicare and Medicaid EHR incentive programs. (See a current list of certified products at http://onc-chpl.force.com/ehrcert.)

**HIT Regional Extension Centers**

Reaching meaningful use presents both a financial and a technical challenge. ARRA recognized the technical aspect by setting aside funds to create the RECs. All four Texas RECs charge primary care physicians an annual subscription fee of $300 per provider for technical consulting services valued at more than $5,000.

TMA has ensured each REC remains physician-centric by asking that half of each REC governing board be comprised of physicians nominated by TMA and a county medical society. Physicians on the CentrEast advisory board are Drs. Mark Chassay (Austin), Lenore DePagter (San Marcos), George Hugman III (Nacogdoches), Timothy Barker (Waco), and Robert Morrow (Houston).

The centers can help physicians choose and implement the right EHR system, analyze their workflow before EHR implementation, evaluate the EHR implementation plan, answer questions and concerns during implementation, provide technical assistance, and assess the EHR’s functionality and how a practice uses the technology to achieve meaningful use.

RECs are going to be crucial in helping physicians select and implement EHRs and achieve meaningful use,” Dr. Murray said. To date, over 50,000 physicians and other providers have enrolled for REC services.

**How Can I Learn More About the CentrEast REC?**

Call the CentrEast REC directly to enroll for technical consulting services at (979) 862-5001 or by visiting www.centreastrec.org. The REC will make efficient use of your time and help you meet the needs of your practice to reach meaningful use. The federal incentives for consulting and EHR use are unprecedented and will not last long. TMA has also set-up a health information technology helpline at (800) 880-5720 to answer physician questions about these topics.
Managing money is a necessary skill for people to remain living on their own or independently. When individuals have cognitive impairment (difficulty thinking and processing information) from medical problems or mental illness, or as a consequence of dementia or Alzheimer disease, money management and other activities of daily living may become confusing or difficult. Cognitive impairment may appear slowly over time, but one of the first signs of dementia may be inability to manage finances. Problems with daily life may be hard to spot, even for regular caregivers of the person with cognitive impairment. Sometimes a major event, such as repossession of a car or foreclosure of a mortgage, happens before problems with money management are discovered.

Financial capacity is the ability to manage financial affairs on one’s own, consistent with a person’s own best interest. When financial capacity is diminished (less than what is usual), a trusted family member, friend, or representative can assist in financial decision making. It is important for people to consider their choice of agent (the person who is appointed to assist or take over financial decision making) very carefully to avoid misuse, deception, fraud, or theft. Major decisions, like selecting an agent, are best made in advance, while a person is of sound mind.

**Signs Of Problems With Money Management**

- Inability to count money
- Trouble paying bills and balancing a checkbook
- Concerns about stolen money or missing money
- Calls from banks and other financial institutions about problems with accounts
- Financial abuse, such as from scams, unscrupulous merchants or telemarketers, or con artists

**Helping To Manage Money**

Advance financial planning is the best way to prevent problems when cognitive impairment occurs. Putting an adult next of kin or trusted friend or family member as a signer on checking and savings accounts makes transitions easier when cognitive impairment or dementia develops. Creating a durable power of attorney for financial matters, a document that spells out who will be responsible for financial decision making, is a way for individuals to direct how their affairs will be handled if they become cognitively impaired. This is different from a health care power of attorney, which is specific to health care decisions only. Sometimes the court system needs to be involved, with a conservatorship (appointing a guardian for financial and business matters) created for the impaired individual.

**Resources For Families Of Individuals With Cognitive Impairment**

- Adult protective services should be notified in suspected cases of elder financial abuse.
- Mental health professionals may be involved to evaluate the person with cognitive impairment. They can suggest treatment options, including recommendations for improving skills of daily living.
- Attorneys can create durable powers of attorney for financial matters and for health care, wills, and trusts. These forms can sometimes be found on the Internet.
- Social workers help patients and families find community and government resources best suited for their specific situation.

**For More Information**

- Alzheimer’s Association  [www.alz.org](http://www.alz.org)
- ElderCare Locator Department of Health and Human Services, Administration on Aging  [www.eldercare.gov](http://www.eldercare.gov)
- National Council on Aging  [www.benefitscheckup.org](http://www.benefitscheckup.org)
- American Bar Association Commission on Law and Aging  [www.americanbar.org/groups/law_aging.html](http://www.americanbar.org/groups/law_aging.html)

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