1.2 TESLA OPEN MRI
Need Insurance? We Can Help.

Request a quote.

Call: (800) 880-8181 • Visit: www.tmailt.org

TMA INSURANCE TRUST
Exclusively endorsed by the Texas Medical Association
Table of Contents

Volume 38 • Number 2
June 2015

2 President’s Comment - Syed A. Yusoof, MD
5 Editorial Comment - Alison L. Days, MD

LETTER TO THE EDITOR

6 Baptist Clinic

SCIENTIFIC REVIEW

7 The Need for Renal Risk Stratification When Using The New Oral Anticoagulants
Patricio Pazmiño, PhD, MD, FACP, FASN

CASE REPORT

10 A 45 Year Old with Idiopathic Pancreatitis
Kanika Monga, MSIV, Mark Hall, MSIV and Diego De La Mora, MD

12 Colon Tumor Malignancy vs. Retroperitoneal Fibrosis
Arleen M. Ortiz, MD, Brian Davis, MD, Osvaldo Padilla, MD and Richard W. McCallum, MD, FACP, FRACP (Aust) FACP, AGAF

ACADEMIC ABSTRACTS

15 HIV-1 Evolution under Low CCR5 Selection Pressure
15 Protocol for Early Detection and Treatment of Schizophrenia in Children and Adolescents
16 Pulmonary Thromboembolism as a Complication of Systemic Lupus Erythematosus and Antiphospholipid Syndrome
16 Effect of Moderate Exercise in Diabetic Neuropathy
16 The Psychiatric and Neurocognitive Manifestations of Sheehan’s Syndrome: A Case Report
17 A CRISPR-Cas9-based Screen for Human Genes Essential for West Nile Virus-Induced Cell Death
17 Suicide Prevention: A Culturally Sensitive Approach to Determine Best Prevention Program for the El Paso Area
17 Inhibition of Breast Cancer Cell Growth and Sensitization to Chemotherapeutic Agents by the Carotenoid Lutein
18 A Boy with Facial Edema and Hypertension
18 Characterization of Geriatric ED Patients by Sex

PHARMACY CORNER

19 Diabetes Guidelines: Updates, Similarities, and Disparities
Joanne Savage, Pharm.D. Candidate 2016, Michael B. Lugo, Pharm.D. Candidate 2016, and Celeste M. Vinluan, Pharm.D., B.S., Clinical Assistant Professor

MEDICAL STUDENTS

26 News

PUBLIC HEALTH

29 Emerging Threat of Chikungunya Disease to El Paso - Juarez Community
Doug Waits, Ph.D., Fernando Gonzalez, MD, Miguel Escobedo, MD, Cindy Crews, MS, and Carla L. DeSisto, MPH

LEGISLATIVE

30 Report from the AMA Alterante Delegate
Roxannce Tyroch, MD, FACP
31 TMA Legislative News

PRACTICE MANAGEMENT

34 The Role of Regional Extension Centers in Practice Transformation
Bruce C. Edmunds, M.Ed., PMP, CHTS-IM, IS, PW

MONTHLY FEATURES

35 NEWS
45 CME
My dear fellow members of El Paso County Medical Society, it gives me great pleasure to announce that sustainable growth rate (SGR) is finally dead. It was the endless work of Dr. Michael Burgess, Texas Medical Association, County Medical Societies, and the AMA. We thank all for their tireless efforts. It has taken 18 years for this to occur.

Currently we are fighting to get bipartisan support in house bill HR #2126, regarding ICD 10. As you all know the ICD 10 is due to start in October 2015, but with this huge change, Physicians are overwhelmed with the prospect of the tremendous administrative and financial burdens of transitioning to ICD-10. ICD -10 consist of 68,000 codes fivefold increase from current ICD-9. Implementation of ICD-10 will affect physician claims submission and most business processes within a physician’s practice, the entire cost of transition will rest on the practice. Furthermore, physicians face the prospect of disruption in claims processing and payments during the transition to ICD-10 possibly up to 2-3 months and some practices might not be able to sustain. Any physician who is unable to transition to ICD-10 by the implementation date simply will not get paid.

On behalf of our organizations and more than 48,000 physicians and medical students, these are medicine’s recommendations for crafting a healthier State of Texas 2016-17 that became successes this Legislative session:

- Expansion of Graduate Medical Education - $53 Million
- Women’s Health - $50 million
- Mental Health and Substance abuse funding - $80 Million
- Infectious Disease surveillance - $20 Million

These are issues near and dear to El Paso as we want to see the PLF-SOM/TT campus thrice and we want to see more residents committing to staying in the El Paso area.

Thanks to all that lobbied on behalf of medicine throughout this Legislative session, especially the Advocacy team at TMA lead by Mr. Darren Whitehurst. Without a lot of sleepless nights and efforts much of this would not have occurred on our behalf.

Some wins for Medicine are:
- Fairer rules governing Medicaid fraud investigations, red-tape reductions, including the elimination of the DPS controlled substances regulation permit, greater transparency in health plans sold on the Federal Exchange, first-time ever regulations on e-cigarettes and the elimination of the $200 occupational tax on Physicians. For greater detail on all these successes please refer to www.texmed.org under the Legislative update panel.
- Our visit to the State capitol on the first Tuesdays in April was exceptional, had opportunities’ to meet many State representatives. It is very important to meet in person and convey our needs and how to improve and continue to strive to make a better State to practice the art of medicine. In these changing times it is imperative that physicians take time in their busy day to day practices and get involved in the politics of medicine. Once again we all must become members of the El Paso County Medical Society, as numbers speak for themselves and it is easier to convey a message as we speak for the majority.

I would like to thank our delegation for taking the time out of their busy practices to attend TEXMED May 1-2. Also, thank all of the Physician “soldiers” that participate on TMA committees. Special Congratulations to Dr. Angel Rios-Counselor, and Dr. Gilbert Handal-Vice-Counselor for being re-elected to the TMA Board of Councilors by the House of Delegates.

I would also like to recognize Dr. Richard McCallum who recently received the Chancellor’s Council Distinguished Research award. This award is recognizing his excellence in teaching and research. Dr. McCallum also serves on the El Paso County Medical Society’s Delegation to the Texas Medical Association.

Recently, the Greater El Paso Chamber of Commerce has partnered with us to help recruit and the retention of new physicians in the community. We are in the process of some new ideas with the help of the Chamber, and would like to thank them for their help.

I would like to invite you to join us in the Border Health Caucus for the 10th Annual Border Health Conference August 5-6, 2015, will be attended by Tom Garcia, MD, President TMA, Congressman Beto O’Rourke, and Congressman M. Burgess, MD. Please make this a successful conference by your participation for El Paso to show commitment for our future. For further information on the event please contact the EPCMS at 533-0940. RSVP’s are underway at borderhealthcaucus@gmail.com. We would appreciate your attendance.

Once again, we as members of the El Paso County Medical Society must remain highly active to address our concerns, and needs in medicine to continue this great noble profession.
When you need a strong defense, think TMLT. We’ve been defending health care professionals for more than 35 years, and we have resolved more than 48,000 claims. We fight for you, and never settle a claim without consent. Learn more at www.tmlt.org or call 800-580-8658.

PROTECTION FOR A NEW ERA OF MEDICINE.
Dear AAOS Fellow:

Congressman Ted Poe (TX-R) recently introduced H.R. 2126, the Cutting Costly Codes Act of 2015, which would prohibit the Secretary of Health and Human Services from replacing the current International Classification of Diseases-9 (ICD-9) diagnostic code set with ICD-10 this October. As you know, ICD-10 would be both costly to implement and detract from patient care. Adding to the already burdensome administrative changes, orthopaedic surgeons will be required to continue using ICD-9 for workers’ compensation patients while implementing ICD-10 for Medicare patients.

I encourage you to contact your member of Congress today and urge them to cosponsor this important legislation. Prohibiting the transition to ICD-10 will enable physicians and other stakeholders to assess an appropriate alternative to this burdensome regulatory requirement, will help reduce costs weighing on physician practices, and will allow for new, more efficient models of health care delivery and payment to stay on track.

Sincerely,

David D. Teuscher, MD
President
American Association of Orthopaedic Surgeons

All El Paso physicians are encouraged to sign an online petition (the link is listed below) that urges our Congressman, Beto O’Rourke, to co-sponsor HR 2126. The bill would stop the October 1, 2015 ICD-10 implementation.

http://www.ipetitions.com/petition/hr2126-icd10-reform
“Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it is the only thing that ever has.”

----Margaret Mead, 1901-1978

This summer, all Texas physicians, and those who see Medicare patients, in particular, have reason to celebrate: The SGR formula has been “immediately and permanently” repealed as of the most recent congressional session! After many months of lobbying, building relationships and presenting testimonies by doctors in front of congress, a change has been effected that allows many in Texas to breathe a sigh of relief. The bill approving this repeal of SGR also contains a fee schedule conversion factor that will increase by 2.5% as of July 1, 2015 and by 0.5% more on July 1, 2016. In place of the SGR there will be a Merit Based Incentive Payment (MIP) which will give eligible providers the ability to receive annual payment increases (or decreases) based on performance.

Despite this great political achievement in the area of Medicare, we still have many hurdles to overcome, especially in the area of Medicaid. The ACA gave primary care physicians a temporary reprieve from low Medicaid rates by increasing Medicaid to Medicare parity for services provided by doctors from Jan 1, 2014 to December 31, 2015. For those of us who received this increase in payments, it has been a welcome relief. However, if there is no action by Federal or local legislation, these higher payments will expire at the end of this year. During the same session that repealed SGR, there was a bill to continue Medicaid payments to the level of Medicare payments. This was not approved or extended.

Another medical issue in Congress is that of the ICD-10 transition planned for October 2015. Initially planned for October 2014, this change was tabled until this year due to the number of people who were unprepared for change. According to TMA and CMS, “ICD-9 diagnosis codes cannot be used for services provided on or after October 1, 2015. Claims that do not use ICD-10 diagnosis codes cannot be processed for reimbursement.” It appears as though this is one fight we won’t win as easily; the transition seems inevitable. However, we can take steps to prepare ourselves for the onslaught of unfamiliar codes. Check out the info at http://www.texasmedicalassociation.org/Template.aspx?id=33873&terms=icd%2010 OR http://www.cms.gov/Medicare/Coding/ICD10/index.html?redirect=/ICD10/

Other achievements for Texas physicians during this legislative session include:
- Expansion of graduate medical education (GME) funding and resident training positions
- More money for women’s health and mental health services
- Fairer rules governing Medicaid fraud investigations
- Elimination of the Department of Public Safety (DPS) Controlled Substances Registration permit (only DEA will be required in future)
- Greater transparency in health plans sold on the federal exchange
- The first-ever regulation of e-cigarettes

For more detail on these achievements, go to http://www.texmed.org/Template.aspx?id=33799

If you have been meaning to get more politically involved but haven’t been able to make the trip to Austin for First Tuesdays or to Washington, DC for previous Border Health Caucus meetings—here is your chance. This year, the Border Health Caucus will be held in El Paso on August 5-6th! A welcome reception will be held on August 5 at 5:30 pm at the Double Tree Hotel. Please come to meet and greet participants including Congressman Beto O’Rourke and TMA President, Dr. Tom Garcia. On August 6th, the conference will run from 8 am to 12:45 pm and will have several panels discussing topics such as Immigration, Emerging Diseases, Post-SGR Landscape, Physicians and New Technology, and much more. The location is the El Paso Natural Gas Convention Center at UTEP. Call 512-370-1352 for any questions or to RSVP. Please make plans to join us at this very important conference.

In this issue of El Paso Physician, you will find abstracts from the 2015 Texas Tech Research Colloquium, Public Health updates, and pharmacy guidelines for diabetic medicines, along with other excellent articles. Please also note the Letter to the Editor describing the need for volunteers by the free Baptist Clinic.
Dear Colleagues:

I am writing to you in behalf of the free Baptist Clinic with the blessing and support of the El Paso County Medical Society. The Clinic has recently had problems recruiting physicians and nurses to work at the Clinic seeing patients without insurance and limited access to any medical care.

If you volunteer, it would require only a Saturday morning or afternoon every 3 to 4 months. Liability is not a problem because it is charity work. The patients are very grateful and personnel satisfaction is great and this is a chance to give back to the community with the talents we are all blessed with. The Clinic needs Primary Care M.D., Nurse Practitioners, Physician Assistants, Nurses and all specialists.

If you would like to help out, please call Sylvia Woakley at 867-1522. You also may contact me at 532-1620.

Sincerely,

John M. Tune, M.D.       Syed Yussoff, M.D.
Chairman                  President
Baptist Clinic            El Paso County Medical Society
Background
Four new oral anticoagulants (NOA) have been approved in the United States over the last five years: dabigatran, rivaroxaban, apixaban and edoxaban. Each NOA directly targets key coagulation factors and have different pharmacodynamic and pharmacokinetic properties.

Purpose
To describe a renal risk stratification guideline that uses the estimated glomerular filtration rate (eGFR) and stages of chronic kidney (CKD) when using the new oral anticoagulants.

Data Source
The prescribing information guidelines from the pharmaceutical manufacturer’s data approved by the U.S. Food and Drug Administration.

Results
In a Table we present the suggested dosing guidelines for the four NOA based on eGFR and CKD stages using a formula that is more accurate than the Cockcroft Gault equation used in prior clinical trials.

Limitations
Potential publication bias, adaptation of current prescribing information to CKD stages and eGFR. This guideline has not been validated for clinical use. More data are needed from actual clinical experience.

Conclusions & Relevance
The renal risk stratification should complement the fixed dose regimens and help to decrease NOA-associated adverse side effects and improve their safety and therapeutic use.

Four new oral anticoagulants (NOA) have been approved by the United States Food and Drug Administration (FDA) over the past five years. The NOAs approved are dabigatran (Pradaxa; Boehringer Ingelheim), rivaroxaban (Xarelto; Bayer and Janssen R&D), apixaban (Eliquis; Pfizer and Bristol-Myers Squibb) and recently edoxaban (Savaysa; Daiichi Sankyo Inc.) The NOAs directly target key coagulation factors and act within hours. Dabigatran targets Factor IIa and rivaroxaban, apixaban and edoxaban target Factor Xa. Each NOA has different indications, mechanisms of action, different protein binding, drug interactions and renal elimination profiles (dabigatran 80%, rivaroxaban 66%, apixaban 27%, and edoxaban 50%. In contrast warfarin has more than 80% renal elimination). The NOAs also have different pharmacokinetic and pharmacodynamic characteristics that affect their indications, dosing and side effects. The NOAs exert the anticoagulant effect within hours and have shown promising effects on thrombophrophylaxis in atrial fibrillation, venous thromboembolism, with favorable bleeding risk profiles. The NOAs are gradually replacing warfarin, a vitamin K antagonist (VKA) which has been the standard of care for more than 50 years.

Typically, the VKA are used for atrial fibrillation in patients with prosthetic heart valves, mitral valve stenosis, severe valvular disease or severe renal dysfunction, whereas the NOAs are mostly indicated for nonvalvular atrial fibrillation (Table 1) but additional indications are continually being added. The current prescribing information (PI) for the approved NOA virtually ignores the stages of CKD and its potential impact in adverse side effects and costs. The PI does not adjust well the dose of the NOA to the stage of renal dysfunction. Most NOA studies have not included in their trials patients with severe renal dysfunction (see below) and have attempted to use fixed-dose regimens for all patients ignoring the need of renal, biochemical, hematological and drug monitoring with potentially dire consequences. The 2011 post marketing experience with dabigatran was relatively successful but also was marred with serious adverse side effects. The initial FDA approval of dabigatran in October 2010 was based mostly on the RE-LY trial that randomized participants to either warfarin or one of two doses of dabigatran (110 mg or 150 mg twice daily). The FDA did not approve the 110 mg dose. The FDA approved the dose of 150 mg orally twice daily in all patients, including patients with a creatinine clearance of 15 to 30 ml/min/1.73 m2. This corresponds to an estimated glomerular filtration rate (eGFR) of 15-29 ml/min/1.72m2 or patients with chronic kidney disease stage 4 (CKD4). This dosing scheme is in stark contrast to doses used in more than 70 countries worldwide where the 150 mg doses are contraindicated in CKD4. It should also be noted that patients with CKD4 were excluded in the RE-LY trial. Not surprisingly, 3781 serious adverse effects were noted in the 2011 U.S. post marketing experience with dabigatran. These
The Need for Renal Risk Stratification When Using The New Oral Anticoagulants (Continued)

included death (452 cases), hemorrhage (2367 cases), acute renal failure (291 cases), stroke (644 cases) and suspected liver failure (15 cases).6 Thirteen months after dabigatran’s initial approval in the United States, Boehringer Ingelheim (BI) changed the dosage and product guidelines. The new dosage is 75 mg twice daily for patients with a creatinine clearance of 15-30 ml/min/1.73 m2 or CKD4.6,9 The field of NOAs is evolving and new indications, boxed warnings, and precautions have been added since their initial approval by the FDA.3-5

To avoid some of the clinical problems noted with dabigatran, a simple renal risk stratification guideline was proposed which includes the determination of eGFRcr and CKD stage.11 This formula is more accurate than the Cockcroft Gault equation1 (CGe) described 39 years ago which was used in the RE-LY trial.7 The CGe was developed prior to use of standardized creatinine assays and it is estimated this results in a 10 to 40 percent overestimate of creatinine clearance.13 Indirect support in using renal risk stratification comes from a recent study by Reilly et al. They reported that renal function was the most important determinant of dabigatran concentration, and age is the most important covariate.14 Both variables are included in our renal risk stratification guideline which uses serum creatinine for the MDRD formula.11 The latter is used by the majority of U.S. laboratories and includes four variables: serum Cr, age, sex and race. For additional information please see: NKDEP Suggestions for Laboratories: www.nkdep.nih.gov/resources/laboratory_reporting.htm. Other formulas have been used including cystatin, noted as eGFrCyst and a systematic review was just published by Levey et al.12

Most US laboratories now provide an eGFRcr and the stage of chronic kidney disease. Thus, if dabigatran is used, one should follow current manufacturer dosing guidelines for CKD stage 1 through 3, i.e. 150 mg twice daily. If stage 4 CKD is detected, the updated recommended dosage is 75 mg twice daily. If Stage 5 is noted (eGFR < 15 ml/min), dabigatran is not indicated (Table 2). Similar steps can be followed for the other NOA’s and we need to adhere to their respective prescribing information guidelines.11

This simple renal risk stratification should help to avoid some of the problems noted in the dabigatran post marketing experience. Serious dabigatran side effects were aggravated by a lack of approval of the 110 mg dose, lack of antidote and by misleading advertising, which claimed that no blood monitoring was required.8-11 By the end of May 2014, BI agreed to pay $650 million to settle about 4,000 US lawsuits that alleged BI hid Pradaxa’s risks and $95 million in a whistleblower case that alleged BI was using improper marketing techniques to promote Pradaxa.15 Recently, it has become apparent that the original strategy by BI for dabigatran (Pradaxa®) was flawed with errors of omission and commission. Despite internal concerns at BI pharmaceuticals about potential risks, dabigatran was developed and marketed to be used in fixed dose regimens without the need for dose titration or monitoring of blood levels.16

Thus, If NOAs are to be used in non valvular atrial fibrillation the CHA2DS2 VASC scores should be determined. These scores give special attention to patients with congestive heart failure, hypertension, age 75 and older, diabetes, women, and patients with history of stroke, transient ischemic attacks or systemic embolism.11 A score of 2 is assigned to patients who have a stroke or are 75 year old or older. A score of 1 is assigned to each of the remaining risk factors, if present. A total score of 0 requires no treatment. A score

<table>
<thead>
<tr>
<th>Oral Anticoagulants</th>
<th>Dose / Formulations</th>
<th>Fraction eliminated by kidneys</th>
<th>FDA-approved indications</th>
</tr>
</thead>
</table>
| dabigatran [Pradaxa®] direct-acting thrombin Factor IIa inhibitor | 75 mg / cap 150 mg / cap | 80 % | • nonvalvular AF, to reduce risk of systemic embolism  
• DVT and PE treatment and prevention |
| rivaroxaban [Xarelto®] direct-acting Factor Xa inhibitor | 10 mg / tab 15 mg / tab 20 mg / tab | 70 % | • nonvalvular AF, to reduce risk of systemic embolism.  
• DVT treatment  
• DVT prophylaxis in patients undergoing hip or knee replacement surgery  
• Reduction in the risk of recurrent DVT and/or PE, following initial 6 months of treatment of DVT or PE |
| apixaban [Eliquis®] direct-acting Factor Xa inhibitor | 2.5 mg / tab 5 mg / tab | 30 % | • nonvalvular AF, to reduce risk of systemic embolism.  
• DVT treatment following initial therapy  
• DVT prophylaxis in patients undergoing hip or knee replacement surgery  
• PE treatment following initial therapy |
| edoxaban [Savaysa®] direct-acting Factor Xa inhibitor | 15 mg / tab 30 mg / tab 60 mg / tab | 50 % | • nonvalvular AF, to reduce risk of systemic embolism.  
• DVT and PE treatment |
| warfarin [Coumadin®, Jantoven®] Indirect inhibitor of vitamin K-dependent synthesis of factor II, VII, IX, X, Protein C and Protein S | 1 mg / tab 2 mg / tab 2.5 mg / tab 3 mg / tab 4 mg / tab 5 mg / tab 7.5 mg / tab 10 mg / tab | > 80 % | • thromboembolic disorders (PE and venous thrombosis) prophylaxis and treatment  
• atrial fibrillation in valvular & nonvalvular heart disease  
• prosthetic heart (mechanical and tissue) valves  
• post-myocardial infarction, to prevent systemic embolism |

Continued on page 9
The Need for Renal Risk Stratification When Using The New Oral Anticoagulants

(Continued)

Table 2: Dosing of New Oral Anticoagulants Based on the Stages of Chronic Kidney Disease

<table>
<thead>
<tr>
<th>Stages of Chronic Kidney Disease (CKD)</th>
<th>Estimated Glomerular Filtration Rate (eGFR)</th>
<th>Description</th>
<th>Dabigatran (Pradaxa) Dose for NVAF &amp; for DVT/PE*</th>
<th>Rivaroxaban (Xarelto) Dose for NVAF, DVT/PE/Stroke Prophylaxis</th>
<th>Apixaban (Elitis) Dose For NVAF &amp; DVT/PE* &amp; Reduction of Embolism/Stroke Treatment</th>
<th>Edoxaban (Savaysa) Dose for NVAF &amp; for DVT/PE Treatment</th>
</tr>
</thead>
<tbody>
<tr>
<td>CKD1</td>
<td>&gt;90 ml/min per 1.73 m²</td>
<td>Renal injury without decreased eGFR</td>
<td>150 mg twice daily</td>
<td>20 mg daily</td>
<td>HR: 10 mg daily</td>
<td>KR: 10 mg daily</td>
</tr>
<tr>
<td>CKD2</td>
<td>60-89 ml/min per 1.73 m²</td>
<td>Mildly decreased eGFR</td>
<td>150 mg twice daily</td>
<td>20 mg daily</td>
<td>HR: 10 mg daily</td>
<td>KR: 10 mg daily</td>
</tr>
<tr>
<td>CKD3</td>
<td>30-59 ml/min per 1.73 m²</td>
<td>Moderately decreased eGFR</td>
<td>150 mg twice daily</td>
<td>15 mg daily</td>
<td>HR: 10 mg daily</td>
<td>KR: 10 mg daily</td>
</tr>
<tr>
<td>CKD4</td>
<td>15-29 ml/min per 1.73 m²</td>
<td>Severely decreased eGFR</td>
<td>75 mg twice daily</td>
<td>15 mg daily</td>
<td>HR: 10 mg daily</td>
<td>KR: 10 mg daily</td>
</tr>
<tr>
<td>CKD5</td>
<td>&lt; 15 ml/min per 1.73 m²</td>
<td>Renal failure</td>
<td>Avoid</td>
<td>Avoid</td>
<td>Avoid</td>
<td>Avoid</td>
</tr>
</tbody>
</table>

Abbreviations: NVAF: non valvular atrial fibrillation; DVT: deep venous thrombosis; PE: pulmonary embolism; HR: prophylaxis of DVT following hip replacement; KR: prophylaxis of DVT following knee replacement; HD: hemodialysis; Rx: treatment. a. Dabigatran dose for DVT and PE Rx following 5-10 days of initial Rx with parenteral anticoagulant. It is also approved for RRR (reduction in the risk of recurrence) of DVT and PE for CKD 1-3 but not dose provided for CKD 4-5. b. Xarelto for the Rx of DVT, PE & RRR dose is 15 mg bid for first 21 days. Thereafter, 20 mg daily. c. Eliquis for Rx of DVT & PE: 10 mg bid for 7 days, followed by 5 mg bid. For RRR DVT & PE following initial Rx is 2.5 mg bid. d. Savaysa dose for DVT & PE: following 5-10 days of initial Rx with parenteral anticoagulant; P-gp: permeability glycoprotein.

*Adapted and modified from reference 11 and from the Prescribing Information for Pradaxa, Xarelto, Eliquis and Savaysa

of 2 or more requires treatment. A score of 1, treatment is decided on an individual basis. Moreover, a renal risk stratification should be done for all NOA using a comprehensive metabolic panel before starting and one week after using the NOA, or if there is a change in the patient’s clinical condition. It should be noted that the suggested dosing of the new oral anticoagulant based on CKD stages has not been validated for clinical use. However, the actual dosing is the same for equivalent stages of renal dysfunction based on the current NOA’s prescribing information.23 The guideline highlights the need of CKD staging to prevent adverse side effects. As we accumulate more experience with the NOAs, we will have a better understanding of the proper selection of side effects. Because of the narrow therapeutic indices of the NOA18 use of the proposed renal risk stratification is strongly suggested to avoid some of the risks, morbidity, mortality and expense in managing serious NOA adverse side effects.9,11

Grant Support: Nephrology, Internal Medicine & Hypertension (NIH) Center, El Paso,

REFERENCES


Patricio Pazmiño PhD MD FACP FASN is a nephrologist in private practice and Medical Director of the Nephrology, Internal Medicine & Hypertension (NIH) Center, 1701 N. Mesa, El Paso, Texas 79902-3503
ABSTRACT
In 2013, there were over 38,000 deaths related to pancreatic cancer in the United States, which resulted in pancreatic cancer being the fourth most common cause of cancer-related deaths in the US. Studies have reported that patients with hereditary pancreatitis were 87 times more likely to develop pancreatic cancer at the age of 55. Patients with hereditary pancreatitis are also susceptible to dependency on scheduled analgesics such as opioids. Here, we report the case of a patient diagnosed with idiopathic pancreatitis with a strong family history of pancreatitis.

INTRODUCTION
Chronic pancreatitis is a disease in which continuous or episodic pancreatic inflammation irreversibly destroys local and contiguous tissue. Though associated with many etiologies, it is most often attributed to alcohol abuse, ductal obstruction, autoimmune disease, or idiopathic origin. Our understanding of idiopathic pancreatitis, which represents one fourth of all patients with chronic pancreatitis, has been enhanced over the past decade by studies exploring the role of genetics. Mutations and gene locations have been identified which are associated with increased risk of the disease (e.g. SPINK1, PRSS1). The long-term management of patients with idiopathic and hereditary pancreatitis (HP) presents a daunting challenge for healthcare providers. Patients with idiopathic and hereditary pancreatitis often have an unpredictable course and experience significant comorbidity.

CASE PRESENTATION
A forty-five-year-old Hispanic male with type 2 diabetes mellitus and a seventeen-year history of chronic pancreatitis presented to the emergency department with a one-day history of epigastric pain, nausea, and vomiting. The patient reported diarrhea of one month in duration. The epigastric pain was described as constant, sharp, and with radiation to the back and hip. There was no antecedent trauma, change in medications, heavy alcohol use, or any other inciting events. Furthermore, there was no fever, cough, palpitations, or acid reflux symptoms. The patient had experienced similar episodes in the past resulting in multiple hospitalizations. The patient was taking gabapentin and metformin at home and was allergic to ketorolac. The patient’s family history consisted of pancreatitis among his twin brother, father, and paternal grandfather. The father and grandfather had both died of pancreatic cancer. On physical examination there was epigastric tenderness to palpation, there was no abdominal distention, and no Murphy or Psoas signs. The body temperature was 36.9° Celsius, the pulse was 78 beats per minute, the arterial blood pressure ranged 146-160/62-90 mmHg, and the respiratory rate was 20 breaths per minute.

The patient was admitted to the hospital, his oral intake was stopped, and he was given IV hydration, as well as treatment with analgesics and anti-emetics. The laboratory work-up included a complete blood count, complete metabolic panel, serum lipase, glycated hemoglobin, cardiac enzymes, C-reactive protein, gram & leukocyte stains of the stool, fecal occult blood testing, stool ova & parasite and bacterial cultures, urinalysis, and C. difficile toxin testing. Peptic ulcer disease, perforated ulcer, acute coronary syndrome, and infection were ruled out as etiologies of the patient’s abdominal pain and diarrhea.

The patient’s symptoms continued with no improvement of his nausea and vomiting. Unable to achieve adequate pain management, he developed insomnia and worsened anxiety. He was treated with alprazolam with minimal relief.

The abdominal ultrasound revealed a round mass at the junction of the pancreatic body and tail. A fine needle aspirate showed a typical ductal cells suspicious, but not diagnostic, of malignancy. The patient subsequently required a patient-controlled hydromorphone pump and a celiac plexus block for pain control. After the celiac plexus block, the patient was maintained on a liquid diet and then advanced to 1800-Calorie diabetic/lownutrient diet.

After a 37-day stay at the hospital, the patient was eventually discharged to his home with ketorolac, hydroxyzine, and pancrelipase. He was instructed to follow up with his gastroenterologist in one-to-two weeks after hospital discharge.

DISCUSSION
For patients with idiopathic pancreatitis, hereditary pancreatitis (HP) should be in the differential since patients with HP present in the same way as those with sporadic pancreatitis but at an earlier age. The diagnosis of HP typically relies upon clinical features: a positive family history spanning two generations with at least two others diagnosed with pancreatitis. Although HP is inherited in an autosomal dominant fashion, obtaining genetic studies appears not to be cost effective because the clinical management is similar to that for non-hereditary pancreatitis.
The clinical management involves pain management, counseling for tobacco and alcohol cessation to decrease the disease progression to pancreatic cancer. The benefit of diagnosing hereditary pancreatitis is the ability to detect pancreatic cancer at an earlier stage. The annual incidence to death ratio for patients with pancreatic cancer is high at 0.92 because it is always detected at a late stage.

**CONCLUSION**

The diagnosis of HP, even if made clinically, should always be in the differential diagnosis for patients presenting with recurrent pancreatitis. It is important for healthcare providers to provide patient education focusing on the progression of the hereditary pancreatitis to pancreatic cancer, the autosomal dominant pattern of inheritance, the importance of screening for pancreatic cancer, and for conscious control of analgesics.

**REFERENCES**


---

Kanika Monga, MSIV, Department of Internal Medicine, Texas Tech University Health Sciences Center - Paul L. Foster School of Medicine, El Paso, Texas.

Mark Hall, MSIV, Department of Internal Medicine, Texas Tech University Health Sciences Center - Paul L. Foster School of Medicine, El Paso, Texas.

Diego De La Mora, MD, Assistant Professor, Division of General Medicine, Texas Tech University Health Sciences Center - Paul L. Foster School of Medicine, El Paso, Texas.
ABSTRACT

51 y/o man with a clinical presentation of severe abdominal pain for several weeks localized to lower abdomen progressively worsening with defecation. Associated symptoms include: hematochezia, a 30 lb weight loss, and change in caliber of stool described as “pencil like”. On CT abdomen, the patient had a heterogeneously enhancing mass 7.8 x 5.4 x 6.6 cm along the sigmoid colon. Colonoscopy evaluation showed a completely obstructing mass in the sigmoid colon that was unable to be traversed by the colonoscope. Pathology showed adenomatous polyp, negative for high grade dysplasia or malignancy. Due to his severe pain and large bowel obstruction on clinical presentation, as well as the clinical suspicion of malignancy, the patient underwent a Laparoscopic laparotomy where the surgeon identified retroperitoneal fibrosis which involved the left ureter and pelvic side wall along with the sigmoid colon. The dissected and resected sigmoid mass showed pathology consistent with a fibrotic tissue mass with no evidence of malignancy. This case is an unusual presentation of Retroperitoneal Fibrosis presenting as a colon mass and suspicious for malignancy. Due to its rarity we decided to share this experience as a case report and learning experience.

CASE PRESENTATION

51 y/o Hispanic male presented with severe 10/10 abdominal pain progressively worsening and associated with a change in bowel movements for several weeks. He also reported a 30 lb weight loss and a change in the caliber of his stool described by the patient as “pencil like” form. He had associated symptoms of hematochezia, loss of appetite and fatigue. He denied fever, chills, melena, or hematemesis. He denied a family history of colon malignancy. He has never had a previous colonoscopy before. Upon physical examination of the patient he had stable vital signs with a temperature of 36.8, respiratory rate of 18, blood pressure of 112/77, pulse of 87 and oxygen saturation of 96% at room air. He was in no acute distress and had a remarkable abdomen examination which included tenderness to left lower quadrant and suprapubic area, no masses palpated, and no rebound. HEENT, Cardiovascular, pulmonary and neurological exams were unremarkable. Laboratory data findings were: WBC 11,000, Hemoglobin 14 mg/dL, Hematocrit 41, Platelet count 279,000. The comprehensive metabolic panel was unremarkable except for an albumin of 3.3.

Imaging studies included a CT abdomen and CT thorax. The CT abdomen showed a 7.8 x 5.4 x 6.6 heterogeneously enhancing mass arising along the wall of the sigmoid colon with diffuse mural thickening noted along the descending and sigmoid colon. Mesenteric fat stranding was noted along the distal descending and sigmoid colon. The liver showed multiple well-circumscribed hypodense lesions within the hepatic segments 2, 5, 6 and 8 with the largest diameter of 1.2 cm on the lesion within hepatic segment 2. The CT thorax showed multiple non-calcified pulmonary nodules noted within the right middle and left lower lobes, measuring 0.6 cm and 0.4 cm respectively.

The Gastroenterology service was consulted for further evaluation. After examination and assessment of the patient’s case it was decided to proceed with colonoscopy to evaluate the colon mass and obtain tissue for pathological diagnosis as there was a high suspicion for malignancy. Colonoscopy evaluation showed a completely obstructing sigmoid mass at 40 cm from anal verge described as friable, irregular and fungating. (Image 1) The endoscopist was unable to traverse the lesion with the colonoscope. Biopsies were taken of the lesion. Pathology showed an adenomatous polyp without findings of high-grade dysplasia or malignancy. Prior to obtaining pathology results the patient had been discharged on the basis of presumed malignancy and need to see oncology and his Primary care physician to determine further treatment plans. However, the patient returned 6 days later to the hospital due to worsening pain. Surgery was immediately involved in the case due to the presume diagnosis of malignancy, despite pathology results. Due to the clinical presentation being consistent with a large bowel obstruction the decision was made by the surgeon to proceed to the operating room for sigmoid mass resection. Operative examination revealed a large amount of adhesive tissue hard to dissect as it involved the left sided pelvic wall and the left ureter along with the sigmoid colon. After careful dissection of the sigmoid colon from the other anatomical structures a fresh frozen pathology sample was examined and preliminary results showed fibrotic tissue without malignancy. (Image 2) The sigmoid mass within a 22 cm long segment of sigmoid colon was removed. Sigmoid-rectal anastomosis was performed afterwards and was examined endoscopically to ensure no anastomotic leaks. The Official report of pathology of sigmoid mass confirmed a fibrotic lesion with acute
Colons Tumor Malignancy vs. Retroperitoneal Fibrosis?

(Continued)

Image 1: Irregular, friable and fungating sigmoid mass at 40 cm from anal verge seen on colonoscopy evaluation.

Image 2: Fibrotic lesion, including acute/chronic inflammation with a diverticula (picture to the left). Negative for neoplasia. High power magnification of the fibrotic lesion showing fibroadipose tissue array. (picture to the right)

Image 3: Fibroadipose tissue showing acute and chronic inflammation in high power magnification (picture to the left) and in low power magnification. (picture the right)

on chronic inflammation findings and crypt abscesses and crypt architectural distortion with acute inflammation, findings consistent with inflammatory colitis. (Image 3)

DISCUSSION
Retroperitoneal fibrosis is a spectrum of rare diseases with the hallmark of aberrant fibro-inflammatory tissue that most commonly develops around the infra-renal portion of the abdominal aorta and iliac arteries and frequently entraps neighboring structures such as ureters and the inferior vena cava. Rarely, other anatomical structures such as the colon may also be involved. Retroperitoneal fibrosis is subdivided into two categories either Idiopathic or Secondary. Idiopathic accounts for two thirds of the cases while the remaining third are secondary to other causes such as malignancy, infection, inflammatory disease, trauma, radiotherapy, surgery and intake of certain medications (eg. infliximab, etanercept, hydralazine, pergolide among others). The diagnosis is mainly obtained by means of radiographic imaging (eg. Abdomen computed tomography or magnetic resonance imaging) and biopsies. The diagnosis of this disease still remains challenging as it can clinically present as an obstruction of an organ such as the colon and often requires surgery and evaluation of full tissue to achieve the diagnosis while definitely excluding malignancy.

Secondary retroperitoneal fibrosis can be multifactorial. It has been described to involve other anatomical structures, but rarely presents as a bowel obstruction. Because of this reason we have decided to present our case as an unusual presentation of a man with a large bowel obstruction and a sigmoid mass concerning for malignancy but discovered to be fibroadipose tissue on pathological examination. In addition our patient was not taking any of the medications that have been incriminated in this entity.

Only one case similar to this, but localized to the rectum, has been described before in 1998 making this a very unusual presentation. In that Case presentation a male with a chief complaint of constipation and found on abdomen computed tomography to have a rectal mass suspicious for rectal malignancy had an exploratory laparotomy with findings consistent with retroperitoneal fibrosis. Unlike our case this patient had a needle biopsies confirming retroperitoneal fibrosis but as malignancy could not be excluded a surgical approach was performed.

Our case is also unusual, unlike the case described above, due to an underlying finding of ulcerative colitis on pathology. Could this be purely coincidence or is this a true association. It has been proposed that retroperitoneal fibrosis could be associated with ulcerative colitis as a secondary cause. Unlike our case, the three cases with ulcerative colitis and retroperitoneal fibrosis in the literature had the main presentation of ureteral involvement with urologic obstructive symptoms. In addition our patient had an otherwise normal rectum and sigmoid colon plus no past history or family history of ulcerative colitis.

One of the main problems of this entity it’s the challenge of diagnosis as it can appear radiographically and clinically concerning for malignancy. Despite technological advances there are still no specific approaches or criterion for diagnosis. Therefore many cases could end up in with surgical resection for final diagnosis. Other treatment approaches in the literature are corticosteroids medications. The aims of treatment in this disease are to induce regression of fibro-inflammatory reaction and to relieve obstruction of the ureters and others retroperitoneal structures, and to avoid recurrence. Induction therapy with the use of high doses steroids (1mg/kg/day for the first month) is the best option to curb disease activity. Reevaluation of disease after a month is needed for further treatment management with a medical management approach of prednisone tapering to 5-10 mg daily with 3 to 4 months if steroid-responsive and maintenance for an additional 6 to 9 months.

CONCLUSION
In conclusion Retroperitoneal fibrosis is a rare entity that warrants an early diagnosis in order to promptly start systemic therapy and to treat obstructive complications. Retroperitoneal fibrosis...
fibrosis is a challenging diagnosis that may require exploratory or laparoscopic laparotomy in order to exclude malignancy as in our patient whose disease mimicked colon cancer. Further investigation to create a list of criteria and imaging clues that can aid in the diagnosis of this disease is needed.

REFERENCES

Arleen M. Ortiz, MD, First Year Gastroenterology Fellow, Texas Tech University Health Sciences Center - Paul L. Foster School of Medicine, El Paso, Texas.
Brian Davis, MD, Clinical Associate Professor, Department of Surgery, Texas Tech University Health Sciences Center - Paul L. Foster School of Medicine, El Paso, Texas.
Osvaldo Padilla, MD, Assistant Professor, Department of Pathology, Texas Tech University Health Sciences Center - Paul L. Foster School of Medicine, El Paso, Texas.
Richard W. McCallum, MD, FACP, FRACP (Aust), FAG, AGAF, Professor, Division of Gastroenterology, Texas Tech University Health Sciences Center - Paul L. Foster School of Medicine, El Paso, Texas.
HIV-1 Evolution under Low CCR5 Selection Pressure

Anjali Joshi, PhD

Introduction
CCR5 co-receptor expression levels play an important role in HIV infection and pathogenesis by regulating virus entry and disease progression. This is related to the CCR5 expression levels in the host which is regulated both via CCR5 gene and promoter polymorphisms. While CCR5 levels play a complex role in HIV infection and disease progression, it remains unknown how HIV evolves in the presence of varying CCR5 levels.

Materials and Methods
Long term HIV replication studies were conducted in T cells lines expressing different levels of CCR5. Virus evolution was monitored genotypically via sequencing and phenotypically for various virion characteristics like co-receptor switch, changes in CD4/co-receptor binding affinity, altered fusion capacity, resistance to Maraviroc and changes in the virion infectivity in the presence of low CCR5 levels.

Results
HIV replication studies in T cells expressing low levels of CCR5 resulted in the emergence of an adapted virus harboring the mutations E170K in V2 loop and N298Y in the V3 loop. The adapted virus maintained CCR5 tropism while exhibiting an increase in Maraviroc IC50 presumably by evolving higher affinity for CD4 and/or CCR5. Changes in the V2 and V3 loop may be important in predisposing the virus to co-receptor switch.

Conclusions
HIV adaptation to low CCR5 levels may drive the virus towards CXCR4 usage via an intermediate phenotype that maintains CCR5 tropism and renders the virus more fit in the presence of low co-receptor levels.

Protocol for Early Detection and Treatment of Schizophrenia in Children and Adolescents

Mohamed Ataalla, MD; Cecelia Devargas, MD

Introduction
Detection of early developing psychotic illnesses in children and adolescents could be quite challenging. However, different non-psychotic symptoms that usually arise during the early prodromal phase of the disease, for example early cognitive decline, can be helpful for the early detection and subsequently to a chronic illness, where early intervention could improve the long term prognosis.

Materials and Methods
1. Patients inclusions: criteria of inclusions and referrals
2. Assessment for schizophrenia/schizoaffective: clinical, psychometric, structured interviewing and neuropsychological testing, functional imaging
3. Treatment of diagnosed case: education, medication, therapy (individual, group and family)
4. Long term follow up of cases to recognize different patterns

Continued on page 16
of early presentations and effectiveness of different treatment interventions.

Results

Goals-
1. Detection of early onset schizophrenia at its prodromal stage
2. Providing treatment early in course to improve long term prognosis
3. Raising the standards of mental health services for children and adolescents in the great El Paso area.

Pulmonary Thromboembolism as a Complication of Systemic Lupus Erythematosus and Antiphospholipid Syndrome

Komola Azimova, BS; Mohamed Teleb, MD; Debabrata Mukherjee, MD

Introduction
Antiphospholipid syndrome (APS) is characterized by antiphospholipid antibodies (lupus anticoagulant, anticardiolipin antibodies) in the presence of arterial or venous thrombosis. These autoantibodies are often detected in systemic lupus erythematosus (SLE), and thus APS and SLE may coexist. APS may lead to pulmonary manifestations such as thromboembolism and pulmonary hypertension. While acute pulmonary thromboembolism is a more common presentation, chronic thromboembolism only occurs in a small percentage of patients with antiphospholipid antibodies.

Materials and Methods
We present a case of a 47 year old female who presented with chronic pulmonary thromboembolism as a complication of SLE and APS. The results from the laboratory, serology and imaging tests performed were used for the diagnosis and management of this patient’s condition. She was under the care of our medical team at University Medical Center. No personal identification information was used nor was it necessary for this care report.

Results/Conclusions
Chronic pulmonary thromboembolism is a rare initial presentation as a complication of APS and coexisting SLE. We have presented a case of a 47 year old female with chronic pulmonary thromboembolism with no prior medical history. She was then diagnosed with APS and SLE based on positive serologic results. She was placed on long term oral anticoagulation as prophylactic treatment for recurrent thrombosis to prevent further complications such as chronic pulmonary hypertension. Chronic thromboembolism frequently causes progressive pulmonary hypertension in APS and has a poor prognosis. Therefore, early diagnosis and intervention is necessary to prevent further long-term complications and improve prognosis.

Effect of Moderate Exercise in Diabetic Neuropathy

Munmun Chattopadhyay, PhD; Vikram Thakur, MS; Mayra Gonzalez, BS

Introduction
Peripheral neuropathy is a significant complication of diabetes and it interferes with the quality of life. Unfortunately, available medical treatment is relatively ineffective. Emerging research indicates that moderate physical activity provides health-related benefits. Previously we have shown that proinflammatory cytokines play a role in pain perception. In this study, we found that regular exercise decreased painful neuropathy in the Type 1 model of diabetic (T1D) animals by reducing inflammation in the nervous system.

Materials and Methods
T1D animals were placed in motorized running wheels for 60 min/day, 5 days/week for six weeks. Behavioral measures of thermal pain threshold, cold allodynia and mechanical hyperalgesia were performed at two-weeks intervals. Finally, animals were euthanized for analysis of inflammatory mediators.

Results
There was a decrease in mechanical pain threshold in the diabetic sedentary group compared to control group and it was improved in the diabetic exercise group. Diabetic exercise group showed altered withdrawal latency to cold stimulus compared to the diabetic sedentary group. There was also significant change in the thermal hyperalgesia between control and diabetic sedentary group. Exercise improved thermal pain threshold in diabetic animals.

Conclusions
On the basis of biochemical analyses of the tissues, this study shows exercise reduced the up-regulation of proinflammatory cytokines, which may directly correlate with the pain in the diabetic animals. Overall, this research suggests that exercise may provide an alternate route of treatment for painful neuropathy in Type 1 diabetic and provide a more efficient way of management of pain.

The Psychiatric and Neurocognitive Manifestations of Sheehan’s Syndrome: A Case Report

Ana Jaramillo, MD; Daniel Stein, MD; Andres Viñuela, MD; Henry Weisman, MD; Robert Gonzalez, MD

Introduction
Sheehan’s Syndrome is a state of hypopituitarism classically associated with postpartum necrosis of anterior pituitary occurring secondary to hypotension or hemorrhage. Although not the classic presentation for the illness, Sheehan’s Syndrome may present with psychiatric symptomatology such as psychosis, mood lability, and cognitive dysfunction.

Case Report
The patient was a 59 year-old Hispanic female with a recently di
agnosed history of bipolar disorder and dementia that was brought to the emergency room for evaluation of psychosis as well as mood and behavioral disturbances. While no history of previous psychiatric symptoms was initially reported, further questioning revealed a history of mood lability and cognitive disturbances secondary to severe postpartum hemorrhage during the birth of the patient’s second child. Glucocorticoid and thyroid supplementation was required to treat this condition. Additional information revealed a history of significant medication noncompliance. Sheehan’s syndrome was suspected. Laboratory Findings were significant for hypokalemia, and low levels of TSH, free T3, free T4, and cortisol. Brain MRI findings were consistent with empty sella. Treatment with glucocorticoid and thyroid supplementation in addition to a small dose of antipsychotic medication resulted in resolution of psychiatric symptoms. Cognitive disturbances, however, remained.

Discussion
The case highlights neurocognitive and neuropsychiatric abnormalities associated with Sheehan’s Syndrome. While some acute psychiatric symptoms may improve with correction of the presenting endocrinopathies, cognitive dysfunction may persist. Further research examining the relationship between psychosis, dementia, mood disturbances, and chronic hypopituitarism in the context of Sheehan’s Syndrome is warranted.

A CRISPR-Cas9-based Screen for Human Genes Essential for West Nile Virus-induced Cell Death
Hongming Ma, PhD; Ying Dang, PhD; Yonggan Wu, MSc; Junli Zhang, MSc; Edgar Anaya, BSc; Sojan Abraham, PhD; Jang-Gi Choi, PhD; Premlata Shankar, MD; N. Manjunath Swamy, MD; Haoquan Wu, PhD

Introduction
West Nile virus (WNV) causes an acute neurological infection attended by massive neuronal cell death. However, the mechanism(s) behind the virus-induced cell death is poorly understood.

Materials and Methods
Using the Cas9/CRI SPR tool, we conducted a genome wide screening of host genes involved in WNV infection induced cell death. We screened a library containing 77,406 sgRNAs targeting 20,121 genes, followed by a second screen with a sub-library.

Results
Among the genes identified, seven novel genes, EMC2, EMC3, SEL1L, DERL2, UBE2G2, UBE2J2, and HRD1, stood out as having the strongest phenotype, whose knockout conferred almost complete protection against WNV-induced cell death. Interestingly, knockout of these genes converted acute infections into chronic infections with persistent viral replication but no cell death.

Conclusions
These genes are part of a missing connection between WNV replication and the downstream cell death pathway(s). In addition, the fact that all of these genes belong to the ERAD pathway suggests that ERAD might be the important driver of WNV induced cell death.

Suicide Prevention: A Culturally Sensitive Approach to Determine Best Prevention Program for the El Paso Area
Emily Moody, BA, MBS; Marie Leiner, PhD

Background
Suicide is one of the leading causes of death in adolescents and the rates are continuing to increase. Adolescent suicide is an extremely complex problem that is influenced by many different factors. Adolescent Hispanics are found to attempt suicide at a much higher rate than their white counterparts.

Methods
Phase 1 of this study included a retrospective review of suicide methods data from the Office of the Medical Examiner for the city of El Paso Texas that occurred in the last five years. Phase 2 of this study included a qualitative component including interviews with key experts in regards to: a) their experience of current suicide prevention programs in El Paso b) their thoughts on what type of culturally sensitive adolescent suicide prevention program would be most successful for this area.

Results
A total of 312 suicides were reported in El Paso County from 2009-2013. Adolescents suicides include 46 subjects mean age = 18.6 (SD = 2.23) range 15-21 years of age. A total of 10 people were interviewed, 6 female and 4 male. In answering the question, “What would be the ideal suicide prevention program you would support for this area?” 34 of 45 responses (76%) dealt with education. 47% supported an in home parent involvement educational prevention program.

Discussion
Adolescent suicide rate in El Paso is significantly lower than the National average, but still reported suicides occur in the Hispanic population. A culturally sensitive prevention program might be necessary for this area.

Inhibition of Breast Cancer Cell Growth and Sensitization to Chemotherapeutic Agents by the Carotenoid Lutein
Joshua R. Smith; Xiaoming Gong, PhD; Lewis P. Rubin, MD

Introduction
Certain dietary carotenoids have been shown to have anti-cancer effects, but this phenomenon is not well studied in breast cancer. The present study tests the hypotheses that: (1) carotenoids sele-
Materials and Methods
Breast cancer cell lines (MCF-7; MDA-MB-468 [triple negative]), an immortalized breast cell line (MCF-10A), and primary mammary epithelial cells (PmEC) were exposed to carotenoids (β-carotene, lycopene, lutein, astaxanthin) alone or with taxanes (paclitaxel or docetaxel). Cell proliferation was analyzed by MTT and EdU assays. Carotenoid-induced changes in cell cycle, apoptosis, intracellular ROS, gene expression, and cell signaling were also measured.

Results
Lutein and lycopene significantly inhibited breast cancer but not normal breast epithelial cell proliferation (threshold: <0.5 μM, similar to that induced by taxanes [paclitaxel and docetaxel]). The combination of taxane and lutein produced greater inhibition of cell proliferation than did either agent alone. Lutein treatment increased intracellular ROS, induced G0/G1 arrest, and altered expression of apoptosis-related genes. β-Carotene and astaxanthin had no effects on cancer cell growth.

Conclusions
Lutein and lycopene: (1) selectively inhibit cell growth in immortalized and breast cancer cells, independent of cell hormone receptor status, and (2) exhibit nearly equimolar growth inhibition to taxanes. These carotenoid-mediated effects appear to involve inducing cell cycle arrest, and increasing apoptosis. Nontoxic lutein and lycopene may be important in prevention or as adjuncts in breast cancer chemotherapy.

A Boy with Facial Edema and Hypertension
Jacob Smith, MSIII; Gemmie Devera, MD; German Lozano, MD

Introduction
The most common cause of nephritis in the pediatric population is post streptococcal glomerulonephritis (PSGN). It typically follows an acute infectious process with an incubation period of one to three weeks. The clinical presentation of PSGN includes the onset of tea colored urine, hypertension (HTN), edema, and variable proteinuria. The UA was positive for blood and 1+ protein with protein-creatinine ratio of 0.4. Complement C3 and C4 were low.

Conclusions
Treatment of PSGN is mainly supportive. Symptoms tend to resolve within one week but microscopic hematuria can remain present for 6 to 12 months. Patients with suspected PSGN need follow up C3 levels in 6 weeks. If the C3 level does not normalize by this time a kidney biopsy should be performed.

Characterization of Geriatric ED Patients by Sex
Susan Watts, PhD

Introduction
In general, geriatric (>65 yo) Emergency Department (ED) patients are more severely ill, have uncommon presentations, and greater occurrence of co-morbid disease than younger patients. Consequently many experience prolonged ED stays, require more laboratory/imaging tests, and larger proportion are admitted. However, little is known about differences in diagnosis and treatment of female vs male geriatric ED patients. Objective of this project was to identify some of those differences.

Materials and Methods
2010 National Hospital Ambulatory Medical Care Survey for Emergency Departments (NHAMCS-ED) was analyzed using appropriate weighting variables to derive population-based results.

Results
59% of geriatric ED patients were female and their odds of being admitted were slightly less than men’s (OR 0.91). Women’s odds were similar to men’s for having cerebrovascular disease or diabetes (OR’s 0.94 and 0.98, respectively) while odds of having CHF or requiring dialysis were less than men’s (OR’s 0.76 and 0.79, respectively). Women’s odds of having urinary infection were nearly double that of men (OR 1.89) while odds of other diagnostics were 14-30% higher (CBC, electrolytes, glucose, OR 1.14 to 1.30). Odds of bladder catheterization were ~40% greater (OR 1.39) and central line placement ~20% greater (OR 1.19). Odds of having CT imaging were similar but ultrasound exams in women were nearly three times higher (OR 2.87). Conversely, women’s odds of having CPR were 47% less than men’s (OR 0.53) and odds of dying in ED were 28% less (OR 0.72).

Conclusions
Differences in ED presentation, diagnosis, and treatment of geriatric women and men exist, and further study is needed.
The Centers for Disease Control and Prevention’s most updated statistics on diabetes reports approximately 29.1 million people in the United States have diabetes and 8.1 million of which are undiagnosed. As of 2012, the incidence of diabetic cases in people over the age of 20 has been estimated to be around 1.7 million people per year. Diabetes is found to be the 7th leading cause of death in the United States and can lead to major complications including renal disease, blindness, and amputation. With an estimated 245 billion dollars in direct and indirect medical costs, proper diagnosis and management of diabetic patients become imperative. Therefore, the question remains: which guidelines to use?

Both the American Diabetes Association (ADA) and the American Association of Clinical Endocrinologists (AACE) produce guidelines for the diagnosis and management of diabetes. The ADA was founded in 1940 and published the first edition of Standards of Medical Care in Diabetes in 1989. The organization prides itself on funding research, delivering diabetes care, and providing credible diabetes information to both laypeople and professionals. The AACE was founded in 1991 through the efforts of 26 clinical endocrinologists and has since grown to be an international organization boasting a membership exceeding 6,500 with a common goal of providing quality and cost-effective care for patients suffering from endocrine disorders such as diabetes. This article will strive to summarize the updates made in the most recent 2015 ADA guidelines and the major differences between the guidelines produced by both organizations.

The ADA recently updated their clinical guidelines, Standards of Medical Care in Diabetes, in early January 2015. Significant changes from last year include the addition of a new section covering pregnancy and diabetes incorporating preconception, gestational, and postpartum care. Some other notable updates can be reviewed in Table 1.

According to the ADA guidelines, including 2015 updates, the management for diabetes can be summarized as follows. Patients with impaired glucose tolerance (IGT= 140-199 2 hours post meal), impaired fasting glucose (IFG = 100-125mg/dL), or an A1c of 5.7-6.4% are considered pre-diabetic and should be managed on an intense diet, with increased physical activity, and counseling. These efforts should target a weight loss of approximately 7%. Metformin may be considered in these patients to prevent the development of type II diabetes, though it is not FDA approved for this indication. Patients thought to have pre-diabetes should be monitored annually for glucose control. Glycemic targets for non-pregnant adults with diabetes include an A1c <7%, pre-prandial plasma glucose of 80-130mg/dL, and a peak postprandial plasma glucose of <180mg/dL. The guidelines suggest that higher pre-prandial glucose better correlates with A1c targets.

Patients with type I diabetes should be treated with insulin and those with type II are recommended to have metformin as their initial agent unless they are symptomatic in which case insulin is preferred. Oral monotherapy at a maximum dose does not achieve the targeted A1c value after three months, a second oral agent should be added. Glucagon like peptide-1 (GLP1) agonists and basal insulin are highly recommended as add on therapies.

The AACE’s most recent guidelines were produced in 2013, however, they have recently published new treatment algorithms for 2015. AACE’s 2015 treatment algorithms have been reformatted to allow for easier interpretation and their updates can be seen on Table 2.

The recommendations from AACE are consistent from 2013 to 2015. There is an emphasis on lifestyle modifications and patient education for all patients with diabetes. An A1c target of <6.5% is considered desirable for most patients. There is an increased focus on A1c targets as opposed to fasting blood glucose (FBG) or postprandial levels in patients with diagnosed diabetes. Oral monotherapy is recommended in patients initially diagnosed with an A1c of <7.5% and dual therapy is recommended for patients initially diagnosed with an A1c of >7.5%. Patients diagnosed with an A1c >9.0% should begin dual or triple therapy if they are not symptomatic or insulin if they experience symptoms. Figure 2 provides further information regarding available pharmacotherapeutic therapies available for diabetic patients. The AACE also promotes the use of rapid acting insulin analogs as opposed to regular insulin due to increased predictability. Additionally, long acting insulin analogs are preferred over NPH due to their pharmacokinetic reproducibility and consistency. The effectiveness of therapy is recommended to be evaluated every three months and adjusted as necessary for optimal outcomes.

The ADA and AACE provide quality information supported by sufficient evidence. The guidelines produced by both organizations are similar in multiple aspects. Promoting a healthy lifestyle...
PHARMACY CORNER

Diabetes Guidelines: Updates, Similarities, and Disparities

(Continued)

is encouraged in both guidelines as the best way to prevent type II diabetes as well as an initial treatment strategy. Ranges for fasting plasma glucose and impaired glucose tolerance are equivalent and glycemic targets for gestational diabetes are also similar in both documents. An A1c <6.5% is preferred if it is safe and appropriate for the patient. Metformin is the first line medication for management of type II diabetes and may be utilized in patients with pre-diabetes. Both guidelines also have sections for special populations such as geriatrics and pediatrics.

Despite so many similarities, careful analysis of both documents reveals some notable differences. AACE states that A1c should not serve as a definite diagnosis for pre-diabetes like IGT and IFG, whereas A1c is diagnostic for ADA. The AACE incorporates more background data and guidance on which medications to initiate after metformin by providing evidence grading in each algorithm. The ADA tends to provide more information and specific recommendations for patients with concomitant comorbidities such as monogenic diabetes syndromes, fatty liver disease, and cystic fibrosis. Guideline recommendations differ between the two organizations for diabetic patients with hypertension and hyperlipidemia. The 2013 AACE guidelines still utilize LDL levels for hyperlipidemia treatment, while the ADA guidelines have updated their recommendations to reflect those of the most current lipid guidelines produced by the American College of Cardiology/American Heart Association. The ADA also does not recommend combining lipid-lowering agents due to a lack of evidence showing benefit, but the 2013 AACE guidelines suggest that multiple anti-hyperlipidemic agents may provide better outcomes. As far as hypertension, the ADA recommends a blood pressure goal of 140/90mmHg, whereas 2013 AACE guidelines prefer more stringent control with 130/80mmHg.

Considering the new updates from ADA and AACE, it is still uncertain which guideline should be utilized. The American Pharmacists’ Association references the ADA guidelines in their training and certification programs, but does not make a concrete recommendation. Other major organizations such as the American Medical Association and the Association of American Physicians and Surgeons, make no mention of which guideline is preferred. ADA guidelines provide detailed information regarding patients with comorbid conditions and how to manage diabetes throughout different stages of treatment (initiation, maintenance, titration). However, AACE guidelines appear to be more comprehensive when describing drug therapy options and the evidence behind their use. Therefore, healthcare practitioners should individualize therapy for each patient and decide which guideline is best suitable for the patient’s situation.

REFERENCES


Continued on page 21
Diabetes Guidelines: Updates, Similarities, and Disparities (Continued)

Figure 2. American Association of Clinical Endocrinologists Glycemic Control Algorithm 2015


Table 1. American Diabetes Association Guideline Comparison: 2014 versus 2015

<table>
<thead>
<tr>
<th>2014</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Did not present a stance on E-cigarettes</td>
<td>• E-cigarettes are not supported as an alternative to smoking or to help with cessation despite their increased popularity</td>
</tr>
<tr>
<td>• Target of 70-130mg/dL for premeal blood glucose</td>
<td>• Premeal blood glucose target is 80-130mg/dL to better correlate with A1c targets</td>
</tr>
<tr>
<td>• Diastolic blood pressure was targeted at 80mmHg</td>
<td>• Goal for diastolic blood pressure is 90mmHg for patients with diabetes and hypertension to reflect controlled trial data</td>
</tr>
<tr>
<td>• Target of LDL&lt;100mg/dL is preferred</td>
<td>• Treatment initiation for statin is now driven by atherosclerotic cardiovascular disease (ASCVD) risk status</td>
</tr>
<tr>
<td>• Patients with LDL&gt;100mg/dL should be considered for statin therapy</td>
<td>• Patients with insensitive feet, feet deformities, or feet ulcers should have their feet checked at each visit</td>
</tr>
<tr>
<td>• Made no recommendation on frequency of foot examination in patients with insensitive, deformed, or ulcerated feet</td>
<td>• A1C target of &lt;7.5% for all pediatric ages due to new evidence</td>
</tr>
<tr>
<td>• Ages 0-6 A1c target of &lt;8.5%</td>
<td>• New section on pregnancy and diabetes that covers preconception, gestational, and postpartum care for diabetic patients all in one location</td>
</tr>
<tr>
<td>• Ages 6-12 A1c target of &lt;8%</td>
<td></td>
</tr>
<tr>
<td>• Ages 13-19 A1c target of &lt;7.5%</td>
<td></td>
</tr>
<tr>
<td>• Scattered information throughout the guidelines and one subsection on gestational diabetes</td>
<td></td>
</tr>
</tbody>
</table>

Continued on page 22
Diabetes Guidelines: Updates, Similarities, and Disparities

(Continued)

<table>
<thead>
<tr>
<th>2013</th>
<th>2015</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Medical Therapy for obese patients include phentermine, orlistat,</td>
<td>• Liraglutide and naltrexone/bupropion added as Medical Therapy for</td>
</tr>
<tr>
<td>lorcaserin, phentermine/topiramate ER</td>
<td>obese patients</td>
</tr>
<tr>
<td>• A1c&gt;6.5% preferred to move onto dual therapy</td>
<td>• “Patient is not at goal” to reflect patients who may have a lower</td>
</tr>
<tr>
<td></td>
<td>goal than 6.5% are able to advance to dual therapy if necessary</td>
</tr>
<tr>
<td>• SGLT2 inhibitors were categorized as drugs to use with caution</td>
<td>• Sodium-glucose co-transporter 2 (SGLT2) inhibitors now ranked as</td>
</tr>
<tr>
<td>and fifth choice on the list of monotherapy agents</td>
<td>the third option for monotherapy after metformin and GLP-1</td>
</tr>
<tr>
<td></td>
<td>agonists</td>
</tr>
<tr>
<td><strong>Insulin Titration Over 2-3 Days</strong></td>
<td><strong>Insulin Titration Over 2-3 Days for Prandial Control</strong></td>
</tr>
<tr>
<td>• Increase basal TDD as follows:</td>
<td>• Increase prandial dose by 10% for any meal if the 2-hr postprandial</td>
</tr>
<tr>
<td>o Fixed regimen: Increase TDD by 2 U</td>
<td>or next premeal glucose is &gt; 180 mg/dL</td>
</tr>
<tr>
<td>o Adjustable regimen:</td>
<td>• Premixed: Increase TDD by 10% if fasting/premeal BG &gt; 180 mg/dL</td>
</tr>
<tr>
<td>▪ FBG &gt; 180 mg/dL: add 4 U</td>
<td>• If fasting AM hypoglycemia, reduce basal insulin</td>
</tr>
<tr>
<td>▪ FBG 140–180 mg/dL: add 2 U</td>
<td>• If nighttime hypoglycemia, reduce basal and/or pre-supper or</td>
</tr>
<tr>
<td>▪ FBG 100–139 mg/dL: add 1 U</td>
<td>pre-evening snack short/rapid-acting insulin</td>
</tr>
<tr>
<td>• Initiation of Basal Insulin - Titration</td>
<td>• Initiation of Basal Insulin - Titration</td>
</tr>
<tr>
<td>• Adjustable regimen:</td>
<td>• Adjustable regimen:</td>
</tr>
<tr>
<td>o FBG &gt; 180 mg/dL: add 4 U</td>
<td>o FBG &gt; 180 mg/dL: add 20% of TDD</td>
</tr>
<tr>
<td>o FBG 140–180 mg/dL: add 2 U</td>
<td>o FBG 140–180 mg/dL: add 10% of TDD</td>
</tr>
<tr>
<td>o FBG 110–139 mg/dL: add 1 U</td>
<td>o FBG 110–139 mg/dL: add 1 U</td>
</tr>
<tr>
<td>• Intensify (Prandial Control)</td>
<td>• Under the intensify( prandial control) SGLT-2i are now preferred</td>
</tr>
<tr>
<td>o Add GLP-1 Agonists</td>
<td>over DPP4-1 after GLP-1 Agonists</td>
</tr>
<tr>
<td>o or DPP4 inhibitor</td>
<td>• “Profiles of Antidiabetic Medication” have been amended to reflect</td>
</tr>
<tr>
<td>• Use SGLT-2i with caution</td>
<td>the acceptance of SGLT-2i therapy as efficacious and acceptable.</td>
</tr>
</tbody>
</table>

---

JoAnne Savage, Pharm.D., Candidate 2016, UTEP/UT Austin Cooperative Pharmacy Program.

Michael B. Lugo, Pharm.D., Candidate 2016, UTEP/UT Austin Cooperative Pharmacy Program.

Celeste M. Vinluan, Pharm.D., B.S., Clinical Assistant Professor, UTEP/UT Austin Cooperative Pharmacy Program.
We stand with doctors. When shady litigants challenge the good name of one of our members, we are fierce and uncompromising. Our powerful attorneys have well-earned reputations for unyielding defense and aggressive counter-action. Our relentless defense of the practice of good medicine is just one of the reasons we are the nation’s largest physician-owned medical malpractice insurer, with 76,000 members.

Join your colleagues—become a member of The Doctors Company.

CALL OUR AUSTIN OFFICE AT 888.896.1868
OR VISIT WWW.THEDOCTORS.COM
High-quality Images you expect on High Field MR imaging with the open design.

Diagnostic Confidence with Superior Patient Comfort.

1.2 TESLA OPEN MRI

NO SEDATION • OPEN MRI
AT SOUTHWEST X RAY
HIGH FIELD-1.2 TESLA- OPEN MRI

CLAUSTROPHOBIC?

Southwest X Ray
Affordable ADVANCED TECHNOLOGY

(915) 544-7300
www.swxrayonline.com
High-quality Images you expect on High Field MR imaging with the open design.

**Diagnostic Confidence with Superior Patient Comfort.**

- High field strength, **super conducting** for excellent image quality
- A comfortable patient experience - patients can see all around
- Fast scans and RADAR motion compensation to minimize patients’ study time
- **650 lbs** Table weight capacity

**1.2 TESLA OPEN MRI** system sets a high standard for patient-centric care. A unique achievement in high-performance imaging with truly open design.
SUNS HEALTH FAIR INTRODUCES PEOPLE TO ALL THINGS HEALTHY AND-DOGS
Community health fairs are all about helping people. The Paul L. Foster School of Medicine SUNS (Students United Para Nuestra Salud) health fair was held on Saturday, February 28 at the Texas Tech Physicians Northeast Family Medicine Center on Kenworthy it provided a variety of screenings to participants and added yet another dimension to the event. It also helped dogs. For the second year in a row, the students invited staff from the El Paso Humane Society who brought along 12 dogs available for adoption—and 10 went home with new families in just three hours.

According to Anil Reddy, one of the medical students who helped plan the yearly event, the health fair was well attended with 70 vendors participating. A variety of informational materials and free health care services were provided to participants including blood pressure and glucose monitoring, dental screenings, BMI calculations, EKG tests, and glaucoma screenings. This year, 20 people attending the fair used the opportunity to support and donate blood to United Blood Services (UBS) which had their mobile blood unit at the fair. Students say this is the most that has ever been collected compared to previous fairs.

“Every year the services offered grows and the fun attractions offered is really entertaining,” said Charmaine Martin, M.D., associate professor in the Dept. of Family Medicine and one of the faculty volunteers at the health fair. “The medical students continually surpass themselves every year. The planning and organization that goes into such a huge event is incredible. Garrett Simmons, Paul L. Foster School of Medicine Class of 2013 attended this year and helped with the very first SUNS fair. He is currently a second year radiology resident in Houston and he was very impressed with the growth. It was great to have him and the current students together,” said Dr. Martin.

“This year was another exciting and successful year for the milestone Fifth Annual SUNS Health Fair and the El Paso community,” said medical student Monisha Parikh. “As the health fair grows each year, new services are added. Hearing, speech, and cognitive assessments, massages, and pharmacy consults were added this year. Books for Gems also generously donated 125 books to give away to promote literacy in...
the community,” she said.

The students awarded Dr. Martin a plaque to recognize “her dedication to the SUNS Health Fair and her selfless service to the El Paso community each year,” said Parikh. “A special thanks goes to our largest sponsor this year, Amerigroup. Without support from local businesses like Amerigroup our fair would not be possible each year,” she said.

Students gave away 75 pounds of fresh produce to promote healthy eating and participants were able to try out classes in Zumba, Salsa, CrossFit and Parkour. A giant inflatable informational colon which traveled to El Paso from New Mexico, featured the different stages of colon cancer.

The Paul L. Foster SOM Texas Medical Association (TMA)/American Medical Association (AMA) Student Chapter helped fit 150 children’s-sized bike helmets to kids to raise awareness against head injury and promote physical activity in children. The TMA partnered with the Department of Public Health to provide free child and adult immunizations to attendees as part of the Texas Bee Wise - Immunize program. Funding for TMA's Be Wise - Immunize was provided by the TMA Foundation thanks to H-E-B and TMF Health Quality Institute, and gifts from physicians and their families.

Azadeh Narazadani, PhD, MS4, Department of Internal Medicine, Texas Tech University Health Sciences Center - Paul L. Foster School of Medicine, El Paso, TX.

AED FOR THE CLINIC

Dr. Francis and I would like to thank the first-year students of the Blue College for their gift of an Automated External Defibrillator for the Medical Student Run Clinic. The AED was delivered to the Medical Directors at a brief ceremony at the medical school.

Gordon Woods, MD, MHPE, FACP, College Master, Associate Professor of Internal Medicine in Medical Education, Texas Tech University Health Sciences Center - Paul L. Foster SOM.

Continued on page 28
The American Medical Association Medical School Section (AMA-MSS) annual meeting took place this year June 4-6th in Chicago. Students came from medical schools all across the US to share ideas regarding policy, community service, and medical school life. This year, for our involvement with the RotaCare/Texas Tech Clinic, the Paul L. Foster School of Medicine Chapter of AMA cabinet members and affiliates won the Largest Community Impact Award in Region III (which encompasses medical schools in Texas, Oklahoma, Kansas, Louisiana, Arkansas, and Mississippi). Since the inauguration of the clinic last September with the goal of treating minor injury, chronic illness, and screening for high blood pressure, diabetes, and communicable diseases, the RotaCare/Texas Tech Clinic has served over 200 patients from the Ysleta community and surrounding areas. The clinic offers ancillary services with social workers, dietitians, vaccinations, and medical specialists, seeking to address the specific needs of the underserved on the border. In addition to being able to provide basic labs in house (such as urine analysis, completed metabolic panel, lipids, HbA1C, glucose, and STD/pregnancy testing), the clinic has set up a contract with LabCorp that provides testing for complete blood counts, thyroid function tests, and Hepatitis C antigens at a discounted rate. These results are then forwarded to Dr. McCallum, who meets with patients at the next clinic to discuss major findings, long-term goals, and case management on an individual basis. Major contributions of funding for this clinic were provided by the Rotary Club and San Pablo Mission in El Paso. Currently open every other Saturday, the clinic hopes that with increased faculty and medical student participation it will be able to operate every Saturday starting in the fall. We wanted to thank everyone involved with making this project possible and a success!
Chikungunya (pronunciation: ‘chik-en-gun-ye) is an emerging mosquito-borne viral disease first described during an outbreak of febrile illness during 1952 in southern Tanzania. The name ‘chikungunya’ derives from a word in the Kima-konde language, meaning "to become contorted" and describes the stooped appearance of sufferers with joint pain (arthralgia). Chikungunya is characterized by abrupt onset of fever frequently accompanied by joint and muscle pain, headache, nausea, fatigue and rash. The joint pain is often debilitating, usually lasting for a few days or may be prolonged for weeks, months or even years; thus the virus can cause acute, subacute or chronic disease. Serious complications are uncommon, but the disease can contribute as a cause of death among the elderly. Often symptoms in infected individuals are mild and the infection may go unrecognized or is misdiagnosed in areas where dengue occurs.

Since the discovery of chikungunya, outbreaks have occurred in 60 countries in Africa, Asia, Europe, and the Indian and Pacific Oceans. In late 2013, chikungunya virus was introduced for the first time into the Americas on an island in the Caribbean. Since then, the virus has spread extensively and caused more than a million cases in the Americas, including locally acquired cases in southern Mexico and a few in Florida. There is grave concern that the virus will continue to spread to new areas, including US-Mexico border communities during the summer of 2015. The virus is transmitted to humans by the bites of infected Aedes aegypti and Aedes albopictus female mosquitoes that also transmit dengue and yellow fever viruses. Aedes aegypti is among the most prevalent mosquito species in the El Paso-Juarez border communities, thus presenting a mechanism for the introduction of chikungunya virus into these communities.

There is no vaccine to prevent or medicine to treat chikungunya infection. The only methods of preventing chikungunya are public health mosquito control measures and personal protection measures to avoid the bite of infected mosquitoes, such as the application of insect repellents to exposed skin, wearing long sleeves and pants, and using window and door screens. Treatment is directed primarily at relieving symptoms, including the joint pain using anti-pyretics, optimal analgesics and fluids. Serological tests, such as enzyme-linked immunosorbent assays can be used to make a diagnosis by detecting chikungunya IgM and IgG antibodies in blood samples collected during the first week after the onset of symptoms. Chikungunya is a national reportable disease, the El Paso Department of Public Health can facilitate reference laboratory testing of clinical samples and the El Paso Vector Control Program can implement mosquito control measures. Early detection of chikungunya cases is critical to implementing effective vector control measures to prevent the spread of the virus in the El Paso-Juarez community. Since the first cases will most likely be detected among patients of primary care and/or ER physicians, these, as well as other physicians, can play an important role by informing public health authorities, who can inform the community about how to avoid mosquito bites and coordinate with vector control to implement mosquito control measures.
I appreciate the time spent by those of you attending TexMed in Austin May 1-2. I will be attending the AMA Annual Meeting in Chicago in June representing once again Reference Committee D (Public Health). The committee will address recommendations on supermagnetic toys, sunglasses labeling, concussion and youth sports, the promotion of food recovery efforts in hospitals, altering school days to alleviate adolescent sleep deprivation, toy gun safety measures and the CDC fall prevention guide. Immigrant Health Disparities, Jail Diversion and community based treatment options for mental illness, e-cigarette regulation, headphone public awareness and a proposal to increase the smoking age to 21 will be discussed.

Resolution 411 directs the AMA support federal, state and local efforts to reduce homelessness among veterans and improve their access to health care. Proposed AMA policy urging automobile manufacturers to develop sensors alerting key holders that unattended persons (children) are in the vehicle will be discussed. Country road intersections, food allergies and restaurants, taxation of tobacco products, banning the use of artificial trans fats and even a ban on powdered alcohol distribution and sale are topics on the agenda.

The Council on Medical Service explores a California resolution addressing the gross interest accrual on Medicare overpayments, creating a fair Medicare and Medicaid RAC Program. The International College of Surgeons resolves that the AMA adopt policy eliminating the three day rule for the receipt of Medicare rehab, skilled nursing or ltac services. California addresses Medicare non-payment of physician administered medication and proposes the AMA study the effect of ACA Medicaid expansion. Florida takes the lead on a proposed voucher system for veterans to obtain health care outside the VA system. Missouri proposes the AMA study recent generic pharmaceutical price increases in order to educate Congress on its impact to the marketplace. A Washington delegate resolves that the American Medical Association oppose attempts by the government to directly or indirectly compel physicians to participate in any payment methodology. New York addresses the threat of nonpayment for out of network services and site of service parity. Wisconsin calls for a study of the high deductible, high coinsurance insurance policies to see how they affect immediate and distant cost of care.

It has been brought to my attention that physicians experience distress caused by internet sites publishing incorrect information about their practices. I encourage the El Paso Delegation to craft a resolution aimed to dissolve or at least counter/examine this activity. I urge you to become an AMA member because the TMA cannot tackle these topics alone.

We must join forces with the other states in combating forces working against our prosperity and overall viability as independent business owners. If you have any questions about the activities of the AMA, you can go to the website and enter your password to review the House of Delegates reference committee reports. Defend yourself, your beloved patients and your fellow physicians-join AMA.

The El Paso County Medical Society is once again, updating our files. In this ever changing technological world, we realize emails and phone numbers change frequently. Please assist us by sending us your current: Practice Name, Address, Phone numbers, Email, and if you have a current photograph please email to epmedsoc@aol.com

Our email is for our use only and it will not be shared.
THE 84TH TEXAS LEGISLATURE
It’s that time of the session when living bills make their way to the governor’s office, and bill authors and sponsors hope to see Gov. Greg Abbott’s signature on their hard work.

BUDGET UPDATE
The House and Senate both gave final approval to the $203 billion state budget for 2016-17. As regular Hotline readers will recall, the budget includes $53 million for graduate medical education (GME) expansion grants over the biennium, up from the current $14.3 million. It also appropriates $4 million in additional dollars for existing family medicine residency programs (a 31-percent increase over current funding) and $3 million to revitalize the Statewide Primary Care Preceptorship Program. TMA is extremely disappointed that our push for Medicare parity for Medicaid payments for primary care services fell short. The House version of the budget had included $460 million in state funds to reinstate the parity payments. They had been established and paid for with federal funds for two years under the Affordable Care Act, but that funding ran out Jan. 1. The final budget included no money for the reinstatement. The budget does, however, include significant increases for women’s health and mental health programs, and it maintains funding for the Texas Department of State Health Services’ tobacco cessation programs — all of these were TMA priorities. The full budget now goes to the governor, who does have line-item veto authority.

Governor Abbott signed three TMA priority bills into law on Thursday, May 28, 2015:

- **E-cigarettes**: Senate Bill 97 by Sen. Juan “Chuy” Hinojosa (D-McAllen) and Rep. Carol Alvarado (D-Houston) will outlaw minors’ ability to buy e-cigarettes and similar vapor products. It regulates e-cigarettes similarly to tobacco products and prohibits students or others from using vapor products at school-related or school-sanctioned events, on or off campus. It takes effect Oct. 1.

- **Direct Primary Care**: House Bill 1945 by Rep. Greg Bonnen, MD (R-Friendswood), and Sen. Kelly Hancock (R-North Richland Hills) applies to physicians and patients who contract for primary care outside the structure, restrictions, and hassles of a health insurance plan. The bill clarifies the definition of “direct primary care” and provides important protections for physicians and patients who use this model of health care. It takes effect Sept. 1.

- **Epinephrine**: Senate Bill 66 by Senator Hinojosa and Rep. Myra Crownover (R-Denton) allows schools to stock epinephrine auto-injectors (like EpiPens®) for school personnel to use on any student who suffers an anaphylactic reaction at school. The measure includes appropriate liability protections for physicians and health care providers. It takes effect immediately.

BILL UPDATE
These bills all earned final approval in the House or Senate this week and are on their way to the governor’s office:

- **Controlled Substances**: Senate Bill 195 by Sen. Charles Schwertner, MD (R-Georgetown), and Representative Crownover would eliminate the state’s Controlled Substance Registration (CSR) permit program. It also would move the Prescription Drug Monitoring Program from the Texas Department of Public Safety to the Texas State Board of Pharmacy, and broaden physicians’ authority to delegate who can access the info.

- **Insurance Card Transparency**: House Bill 1514 by Rep. J.D. Sheffield, DO (R-Gatesville), and Sen. Brandon Creighton (R-Conroe) would require issuers of Affordable Care Act (ACA) exchange plans (known as qualified health plans) in Texas to display the acronym “QHP” on the plan ID card. The bill’s intent is to help physicians’ offices easily identify patients who are covered by ACA health plans and eligible for the ACA’s 90-day grace period, so doctors and staff can educate patients about the importance of continuing to pay their insurance premiums.

- **GME Expansion**: Senate Bill 18 by Sen. Jane Nelson (R-Flower Mound) and Rep. John Zerwas, MD (R-Simonton), would grow GME in the state to achieve the target of 1.1 entry-level GME positions for each Texas medical school graduate. This would be accomplished through new residency programs as well as refinements to those already in place. SB 18 establishes a permanent

Continued on page 32
**Immunizations:** House Bill 2171 by Representative Sheffield and Sen. Judith Zaffirini (D-Laredo) would prevent the automatic deletion of an 18-year-old’s immunization records from the ImmTrac state registry, instead preserving them until the person turns age 26 (at which time he or she would need to take action to preserve them). Right now, 18-year-olds must submit in writing a request to preserve their own records before they turn 19, or their records are destroyed.

**Medicaid HMO Networks:** Senate Bill 760 by Senator Schwertner and Rep. Four Price (R-Amarillo) would improve oversight and accountability of Medicaid HMOs’ physician networks.

**Medicaid Reforms:** Senate Bill 200 by Senator Nelson and Representative Price makes significant changes to the operation of the Texas Health and Human Services Commission (HHSC). The doctors in the House added several amendments to strengthen how HHSC approaches certain costly disease states. Representative Sheffield added an amendment directing HHSC to develop a strategic plan for reducing the morbidity and mortality from chronic respiratory diseases, including asthma and chronic obstructive pulmonary disease. Another amendment, by Representative Zerwas, would have the agency develop a plan to reduce morbidity and mortality from human papillomavirus-associated cancers.

**Out-of-Network Billing:** Senate Bill 481 by Rep. John Smithee (R-Amarillo) and Senator Hancock sets a $500 threshold for out-of-network balance bills eligible for mediation. As initially passed in the Senate, it would have eliminated the threshold altogether. TMA negotiated and supported the revised plan.

**Health Disparities:** House Bill 3781 by Representative Crownover and Sen. Kirk Watson (D-Austin) would create the Texas Health Improvement Network, a collaborative, multi-entity initiative, housed within The University of Texas System, to address the significant health disparities and challenges in our state. To address public health challenges including high obesity rates, chronic health problems, and infectious disease outbreaks, TMA physicians have advocated for such population-based health policies.

**Mental Health Workforce:** Senate Bill 239 by Senator Schwertner and Representative Zerwas would establish an additional loan remittance program to medical graduates choosing to practice as psychiatrists or other mental health professionals in an underserved Texas county.

**Perinatal Advisory Council:** House Bill 3433 by Representative Sheffield and Sen. Lois Kolkhorst (R-Brenham) will add additional rural representation to the Perinatal Advisory Council and delay by one year each the timeframes for implementing the neonatal and maternal standards of care.

**Telemedicine:** House Bill 3519 by Rep. Bobby Guerra (D-Mission) and Senator Watson would allow Medicaid to pay for home telemonitoring services for patients with two or more specific medical conditions and a history of frequent hospital admissions or emergency department visits.

**State Employee Insurance:** House Bill 966 by Representative Crownover and Senator Hancock would create an optional consumer-directed health plan for state employees and their dependents through the Employees Retirement System of Texas.

**CMV:** Senate Bill 791 by Senator and Representative Zerwas would increase the availability of educational material on congenital cytomegalovirus (CMV) in infants. TMA worked to remove language that would have dictated standards of care by requiring birthing centers to perform CMV testing on every newborn that fails his or her first hearing screening.

**Tax Cuts:** The House voted to accept Senate amendments to House Bill 32 by Rep. Dennis Bonnen (R-Angleton) and Senator Nelson, which cuts the state franchise tax rate by 25 percent. That measure now goes to the governor. Both chambers adopted Senate Bill 1 by Senator Nelson and Rep. Dennis Bonnen, which will increase the property tax homestead exemption from $15,000 to $25,000. And House Bill 7 by Rep. Drew Darby (R-San Angelo) and Senator Nelson, which includes the repeal of the $200-per-year occupation tax that physicians and most other professionals in Texas pay, is also on its way to the governor.

**Medicaid Fraud:** The final version of Senate Bill 207 by Senator Hinojosa and Rep. Larry Gonzalez (R-Round Rock), the Medicaid Office of Inspector General (OIG) reform bill won approval in both the House and Senate Saturday, May 30, 2015. The measure improves OIG’s accountability and institutes fair rules and processes for physicians accused of waste, fraud, or abuse. It specifically states that “fraud” does not include unintentional technical, clerical, or administrative errors; requires probable cause of fraud for payment holds; and keeps informal settlement meetings with physicians and providers under investigation confidential.

**Health Information Exchanges:** The Senate gave final approval to House Bill 2641 by Representative Zerwas. The bill would bolster the state’s health information exchanges to protect health exchanges in cases when information is stolen or when a physician or provider fails to get information through an exchange or gets inaccurate information. The bill requires state agencies to make their systems interoperable with electronic health records. The bill came out of conference committee Saturday, May 30th.

Continued on page 33
Texting Bill Dead: House Bill 80 by Rep. Tom Craddick (R-Midland) and Sens. Zaffirini and Kevin Eltife (R-Tyler) won’t be finding its way into law this session. The bill to ban texting statewide on handheld phones while driving couldn’t muster enough votes to come up for debate in the Senate. “It is always disappointing when good legislation does not get enacted,” Representative Craddick said in a statement, “but it is especially tough to tell the families that have lost loved ones because of a texting-while-driving crash.” The bill had the strong support of TMA and the Texas Public Health Coalition. It passed in the House in March 104-39.

Health Plan Directories: The Senate passed a bill on Wednesday, May 27, 2015 that would stiffen requirements for health plans to post accurate and up-to-date drug formularies and network directories on publicly accessible Internet pages. The measure is House Bill 1624 by Representative Smithee and Sen. Kel Seliger (R-Amarillo). It now returns to the House for consideration of amendments added in the Senate.

Utilization Review Appeals: Also on Wednesday, May 27th the Senate passed House Bill 1621 by Rep. Greg Bonnen and Senator Seliger. It requires a 30-day advance notice of an adverse utilization review determination involving prescription drugs or IV infusions. It also requires expedited appeals of such a determination by a reviewer of the same or similar specialty who was not previously involved in the case. This bill also now returns to the House for consideration of amendments added in the Senate.

CPRIT: Senate Bill 197 by Senator Schwertner and Rep. Jim Keffer (R-Eastland) was among the bills the House failed to adopt in time earlier this week. The bill would have required the Cancer Prevention and Research Institute of Texas to become financially self-sufficient, operating largely without state funding, by 2021.

Medicaid Eligibility: House Bill 839 by Rep. Elliott Naishtat (D-Austin) and Sen. Jose Rodriguez (D-El Paso) also won passage in the Senate Wednesday, May 27th. It will require the Texas Health and Human Services Commission to suspend, rather than terminate, Medicaid or Children’s Health Insurance Program coverage for a child admitted to a juvenile detention facility and reinstate coverage within 48 hours of the child’s release. This will help prevent gaps in coverage for these children, many of whom have ongoing behavioral and/or physical health conditions. This bill, which TMA supports, also goes back to the House for consideration of changes the Senate made.

We believe it is our duty to warn policy makers when initiatives threaten the health of our communities as does HB 91. … If the state relaxes the current restrictions on the sale of raw milk, it is a fact more people will become ill from raw milk consumption. This will result in greater costs to the state and local government for investigation, inspection, and the care of those who will need to be hospitalized. These illnesses and hospitalizations are preventable.

TMA Legislative News (Continued)

Why Is TMA Membership Important to Me?

Because only a strong, unified physician voice can shape an environment that supports the practice of medicine.

TMA fights to ensure physicians are in charge of medicine.

We deliver advocacy, knowledge, and resources to help you, your practice, and your patients.

Join TMA today at join.texmed.org.

Questions? Call the TMA Knowledge Center at (800) 880-7955.
Health Information Technology (health IT) is foundational to the pursuit of the triple aim of achieving better care, better health, and reducing costs. Despite the potential benefits of health IT, adoption of electronic health records (EHRs) had been slow. In 2008, only 8 percent of hospitals, and 13 percent of physicians practicing in ambulatory settings had adopted at least a basic EHR. Small practices and critical access hospitals (CAHs) historically have had lower rates of EHR adoption, raising concerns of a “digital divide” in access to health IT among rural and underserved populations. In order to bridge this gap, the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009 spurred the adoption of health IT by offering financial incentives and technical assistance for the adoption and meaningful use (MU) of EHRs as well as the exchange of health information. HITECH appropriated $2 billion to Office of the National Coordinator (ONC) for health IT, and the Secretary of Health and Human Services delegated authority to ONC to establish the health IT Regional Extension Center (REC) program.

As of February 2015, REC success has shown:

- Over 157,000 providers are currently enrolled with a REC. Of these, more than 144,000 are now live on an EHR and more than 112,000 have demonstrated Meaningful Use
- 47% of PCPs nationwide are enrolled with an REC; 55% of rural PCPs are enrolled
- 92% of REC-enrolled providers are live on an EHR vs. 62% live on an EHR in the general provider population
- 1,403 CAHs/RRHs are enrolled with an REC. Of these, 84% have demonstrated Meaningful Use

The success of the REC program has allowed for a transition and new focus known as Practice Transformation. Currently RECs are part of eight working groups on emerging business lines in support of practice transformation including: privacy and security, accountable care organizations, patient centered medical home, health information exchange, and patient engagement. Across these business lines, REC support has resulted in over 100 million patients having access to evidence-based care recommendations based on quality measures and indicators.

With changes in physician fee schedules, migration from pay-for-performance to value based care, and other payment reform activities, RECs are responding to advanced primary care providers with regional, optimized support. Recently, the West Texas Health Information Technology Regional Extension Center (WTxHITREC) became a founding member of the Texas Coalition for Practice Transformation (TCPT), a group of organizations and individuals who have come together, as a cohesive whole, to participate in Texas communities as they seek to transform themselves. TCPT’s mission is to create a statewide quality improvement mechanism, culture, and environment that administers and sustains high-impact leadership and practices and makes a meaningful and substantial impact on the Triple Aim.

TCPT is a collaboration led by the Texas Hospital Association Foundation (THAF) that exhibits and fosters a transparent boundary less environment while remaining relentlessly committed to:

1. Patient- and family-centered care across the continuum of care,
2. Engaging and supporting clinicians and front-line staff in work to achieve transformation; and
3. Improving health outcomes for all Texans.

More than ten Texas health organizations, including all four Texas Regional Extension Centers, have partnered to create the Texas Coalition for Practice Transformation (TCPT). Bringing together quality improvement organizations, hospitals, medical schools, physician groups, and other health care providers, the TCPT is uniquely positioned to achieve the goals laid out by the Centers for Medicare & Medicaid Services’ Transforming Clinical Practice Initiative.

TCPT and its collaborative partners have the insight, expertise and resources necessary to successfully implement the most ambitious and most effective peer-based clinical practice improvement initiative in Texas. Serving as trusted partners, TCPT will provide best practices, coaching, technical assistance, QI training and support to practices across the state as they prepare and begin clinical and operational practice transformation.

To learn more about this initiative visit: [http://innovation.cms.gov/initiatives/Transforming-Clinical-Practices/](http://innovation.cms.gov/initiatives/Transforming-Clinical-Practices/)

**REFERENCES**


The following is a list of new/re-instated members of the El Paso County Medical Society. Congratulations to all new members!!!
EL PASO PHYSICIAN TAKES TOP HONORS IN TMA ACADEMIC AWARD

Jose Manuel de la Rosa, MD, MSc, El Paso, received the Platinum Award, the top honor in the Texas Medical Association (TMA) Award for Excellence in Academic Medicine. Dr. de la Rosa received the award today during TexMed, TMA’s annual conference, in Austin.

“I am honored to be recognized for doing what I love,” said Dr. de la Rosa. “As a pediatrician, I felt compelled to teach – not only the families I cared for – but the students navigating their way through medical school. This award is icing on a career I truly have been blessed to live.”

The multilevel award program is designed to recognize academic physicians who are consummate teachers, role models, and medical professionals. The TMA Council on Medical Education’s Subcommittee for Academic Physicians created the award in 2012 to recognize Texas physician leaders who have simultaneously dedicated their lives to the care of patients and to the preparation of the physician workforce of tomorrow.

Dr. de la Rosa is such a physician. Throughout his more than 25-year career, the board-certified pediatrician has mentored a host of medical students, residents, and physician faculty.

Dr. de la Rosa currently serves as provost and vice president for academic affairs at Texas Tech Health Sciences Center-El Paso, where he continues to teach. Dr. de la Rosa also oversees Student Services, Educational Affairs, the Office of Diversity Affairs, and the Office of Global Health Affairs. He was the founding dean of the Paul L. Foster School of Medicine, leading the school’s accreditation process. Prior to the medical school’s creation, he served as regional dean of the El Paso regional academic health center. And, for several years, he oversaw residency training at his institution.

Arthur Islas, MD, MPH, of El Paso, a former student of Dr. de la Rosa’s, said, “Manny is my mentor and friend. He has encouraged me to advance and develop my career since college.”

As founding dean of the first medical school on the U.S.-Mexico border, Dr. de la Rosa has been instrumental in developing a unique curriculum that prepares students to practice medicine on the border and beyond, said Kathryn Horn, MD, an associate professor at the health sciences center who nominated him for the award.

Dr. de la Rosa helped establish the Kellogg Community Partnership Clinics, school-based clinics run by medical students that provide services to colonia residents in the El Paso area. He also designed a community medicine curriculum, now a nationwide model, that teaches cultural sensitivity, awareness, and competence in medicine and championed a medical Spanish requirement in the medical school’s curriculum.

“Dr. de la Rosa works tirelessly to meet the health care needs in El Paso and beyond,” said Dr. Horn. “He strives to eliminate social barriers so that all residents have access to the health care they need.”

Former President George Bush appointed Dr. de la Rosa to the United States/Mexico Border Health Commission in 2003, and he continues to serve. He is a frequent spokesperson for border health issues.

Dr. de la Rosa has been a delegate from the El Paso County Medical Society to the TMA House of Delegates and has served as a consultant to TMA’s Council on Medical Education. Dr. de la Rosa was named Physician of the Year by the National Hispanic Medical Association in 2013 and also received the organization’s Distinguished Service Award.

In his community, Dr. de la Rosa helps recruit local youth into health professions through his involvement with Comunidades en Accion of El Paso, and he serves as a volunteer member of the El Paso Independent School District’s community curriculum review committee. He was inducted into the El Paso Business Hall of Fame in 2010.

Surenda Varma, MD, of Lubbock, last year’s platinum award winner, said, “I have had the privilege of knowing Dr. de la Rosa since he was a medical student. He is a most talented physician and a great teacher.”

Dr. de la Rosa received his medical degree from Texas Tech University Health Sciences Center School of Medicine in Lubbock. He completed his residency at Baylor College of Medicine in Houston. He received a master of science in clinical epidemiolo-
ogy from Harvard School of Public Health.

Dr. de la Rosa was among 18 physicians who were recognized by TMA at its annual meeting through the academic award program. Physicians can self-nominate for the Bronze, Silver, and Gold levels. A TMA physician committee selects the Platinum Award winner from the eligible Gold-level recipients. (See attached list of 2014-15 award winners.)

TMA is the largest state medical society in the nation, representing more than 48,000 physician and medical student members. It is located in Austin and has 110 component county medical societies around the state. TMA’s key objective since 1853 is to improve the health of all Texans.

Dr. de la Rosa will be recognized at the House of Delegates’ business meeting and will receive a $5,000 cash award generously provided through a grant from the Texas Medical Association Foundation.

2014-15 TMA Award for Excellence in Academic Medicine Recipients

2015 Platinum-Level Award Winner:
Jose Manuel de la Rosa, MD, Texas Tech University Health Sciences Center, El Paso

2015 Recipients of Gold-Level Recognition:
Jose Manuel de la Rosa, MD, Msc, Texas Tech University Health Sciences Center, El Paso
(Note: Dr. de la Rosa was also selected for the sole Platinum Award)
Charletha Guillory, MD, Baylor College of Medicine, Houston
Carlos R. Hamilton Jr., MD, The University of Texas Health Science Center at Houston
Gilbert Handal, MD, Texas Tech University Health Sciences Center, El Paso
Arlon F. Wetlge, MD, MPH, The University of Texas Health Science Center at Houston

2015 Recipients of Silver-Level Recognition:
Patricia M. Butler, MD, The University of Texas Health Science Center at Houston
Charles E. Cowles Jr., MD, MBA, The University of Texas MD Anderson Cancer Center, Houston
Troy Fiesinger, MD, Memorial Family Medicine Residency Program, Sugar Land
Shkelzen Hoxhaj, MD, MBA, MPH, Baylor College of Medicine, Houston
Felix Hull, MD, Community Preceptor, The University of Texas Medical Branch at Galveston-Austin Programs
Girish Premji Joshi, MBBS, MD, The University of Texas Southwestern Medical Center
Christine E. Koerner, MD, The University of Texas Health Science Center at Houston
David Mercier, MD, The University of Texas Southwestern Medical Center
Elizabeth A. Nelson, MD, (formerly) Baylor College of Medicine, Houston

Carl David Rowlett, MD, The University of Texas Health Science Center at Tyler
Richard Strax, MD, Baylor College of Medicine, Houston
Lucas Wong, MD, Baylor Scott & White/Texas A&M Health Science Center, Temple

2015 Recipient of Bronze-Level Recognition:
Lindsay K. Botsford, MD, Memorial Family Medicine Residency Program, Sugar Land

2014 Recipients of Gold-Level Recognition Eligible for 2015 Platinum-Level Award:

Jose Sullivan Dunnington, MD, The University of Texas MD Anderson Cancer Center, Houston
Lewis E. Foxhall, MD, The University of Texas MD Anderson Cancer Center, Houston
John J. Fraser Jr. MD, JD, MPH, The University of Texas Medical Branch at Galveston
Alice K. Gong, MD, The University of Texas Health Science Center at San Antonio
Robert Greenberg, MD, Baylor Scott & White/Texas A&M Health Science Center
Raymond Moss Hampton, MD, Texas Tech University Health Sciences Center, Permian Basin, Odessa
John C. Jennings, MD, (formerly) Texas Tech University Health Sciences Center, Permian Basin, Odessa
Kevin W. Klein, MD, The University of Texas Southwestern Medical Center
Evan G. Pivalizza, MBChB, The University of Texas Health Science Center at Houston
Rajam S. Ramamurthy, MD, The University of Texas Health Science Center at San Antonio
Michael E. Speer, MD, Baylor College of Medicine, Houston
V.O. Speights Jr., DO, Baylor Scott & White/Texas A&M Health Science Center, Temple
Rodney B. Young, MD, Texas Tech University Health Sciences Center, Amarillo

DR. GILBERT HANDEL RECEIVES TEXAS MEDICAL ASSOCIATION’S AWARD OF EXCELLENCE IN ACADEMIC MEDICINE – GOLD LEVEL
Gilbert Handal, MD, received a TMA Award for Excellence in Academic Medicine at the Gold Level, on April 30, 2015, at the TMA Council on Medical Education meeting. This meeting was held as part of TMA’s TexMed 2015 conference at the Hilton Austin.

Dr. Handal is a professor of pediatrics infectious disease and holds the Maria Cuellar Chair for Child Advocacy at the Texas Tech Health Sciences Center, Paul Foster Medical School in El Paso. He has been involved in teaching for 44 years. In Dr. Handal’s nomination for the award, he was described as an advocate for children’s health who has shared his passion for adequate health care for children with many students. He is a great example of a teacher who inspires his students.

The multilevel award program, created in 2012 by TMA’s Sub-Continued on page 38
committee for Academic Physicians, is designed to recognize academic physicians who are consummate teachers, role models, and medical professionals. Physicians can self-submit applications or nominate others for bronze-, silver- and gold-level recognition, based on their years in an academic position and professional accomplishments.

Dr. Handal was among 18 physicians who were recognized by TMA at its annual meeting through the academic award program. A total of 45 academic leaders have been recognized through the program over the past three years.

Website; http://www.texmed.org/TMA_Academic_Award/

DONATION INVESTS IN A HEALTHY FUTURE
El Paso County Medical Society is helping to create a healthy future for more Texans by providing generous support to one of nine students with the dream of becoming a physician. Samuel Garcia will start at Texas Tech University Health Sciences Center Paul L. Foster School of Medicine this fall thanks to a $5,000 scholarship provided through the TMA Minority Scholarship Program. Additional donors to Samuel Garcia’s scholarship include Hidalgo-Starr Counties Medical Society, Roberto and Aguiela Bayardo, physicians and their families.

The TMA Educational Scholarship, Loan, and Awards Committee chose winners from a competitive field of promising future physicians who were selected for their academic achievement, commitment to community service and deep desire to care for Texas’ increasingly diverse population.

TMA created the Minority Scholarship Program to help diversify the physician workforce to fulfill the needs of Texas’ diverse population. The scholarship encourages minority students to enter medicine by lightening their medical school financial burden. Since 1999, TMA has awarded 100 scholarships totaling $500,000, thanks to a grant from TMA Foundation which is made possible through gifts from generous physicians and individuals and institutions who are friends of medicine.

For more information on how to support future physicians with a donation to TMAF, visit www.tmaf.org or call Lisa Stark Walsh, executive director, at (512) 370-1666. Read more about this year’s scholarship winners on the TexMed website.

PHYSICIAN OF THE DAY 21 MAY 2015
The physician of the day at the Capitol is David Palafox, MD, of El Paso. Dr. Palafox graduated from Texas Tech University Health Sciences Center. He is a member of TMA, has served on TMA’s Council on Medical Education and Committee on Physician Distribution and Health Care Access, and is a member of TMA’s Border Health Caucus. Dr. Palafox is a past president of the El Paso County Medical Society (EPCMS) and current EPCMS delegate to TMA.

CHANGES PHYSICIANS SHOULD KNOW IN THE SGR REPEAL LAW
When the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA) was signed into law in April, it didn’t just repeal the Medicare sustainable growth rate (SGR) formula that had been plaguing physicians for nearly two decades. The bill contained other provisions that will impact how physicians deliver care now and in the future.

Here are several provisions that should be beneficial for physicians:

Medicare payment rates will be stable.
MACRA prevented an impending physician payment cut under the SGR and increased the Medicare conversion factor, part of the
formula for calculating physician payments. As a result, Medicare physician pay this year will be 27 percent greater than under SGR.

The bill also provides for positive payment updates of 0.5 percent, starting July 1 this year and then on Jan. 1 annually through 2019. Over the next decade, MACRA is projected to increase Medicare funding for physician services by roughly $150 billion.

**Quality reporting programs will be consolidated.**

Medicare’s current quality reporting programs will be simplified into one merit-based incentive payment system, referred to as “MIPS.” This means the current web of penalties under the Physician Quality Reporting System (PQRS), meaningful use electronic health record (EHR) program and the value-based payment modifier will expire at the end of 2018 and will be replaced with the MIPS.

Beginning in 2019, physicians who score well in the MIPS could receive substantial bonuses.

Performance under the MIPS will be based upon four categories—quality, resource use, meaningful use and clinical practice improvement activities. The MIPS also would build and improve upon current quality measures and concepts in existing programs.

Physicians will be encouraged to report quality measures through certified EHR technology or qualified clinical data registries. Participation in a qualified clinical data registry would also count as a clinical practice improvement activity.

**Alternative payment models will be rewarded.**

Physicians who participate in qualified alternative payment models will receive a 5 percent bonus starting in 2019. These physicians also will be exempt from participating in MIPS. Technical support will be provided to help smaller practices participate in alternative payment models.

The AMA is engaging with medical specialty societies and other organizations to help develop and get payers to support implementation of physician-designed alternative payment models. Results from a recent AMA study conducted by the RAND Corporation found that doctors want to improve patient care delivery through new payment models but need help successfully managing the transition. That includes being able to resolve the diverse priorities and quality metrics of different payers and securing more timely and accurate clinical data to ensure long-term success.

Through its Professional Satisfaction and Practice Sustainability initiative, the AMA is taking on this challenge. Visit the Web page on Medicare alternative payment models for more information, http://www.ama-assn.org/ama/pub/advocacy/topics/understanding-medicare-physician-payment-reform-page including fact sheets on the impact of MACRA in each state. More resources include:

- Comparison between MACRA and prior law (log in)
- Summary of the bill (log in)
- FAQs about the bill (log in)
- MACRA implementation timeline (log in)

**RIOS, HANDAL REELECTED TO TMA BOARD OF COUNCILORS**

The Texas Medical Association board of counselors has reelected Angel Rios, M.D., as councilor and Gilbert A. Handal, M.D., as vice councilor. Rios, an obstetrician-gynecologist, has been practicing for 23 years. Handal, an infectious disease specialist, has been practicing for 45 years. The association elected the physicians during the TexMed 2015 annual meeting in May. Both physicians are members of the El Paso County Medical Society.

**LEADERSHIP DAY ON CAPITOL HILL - MAY 20-21, 2015**

ACP Services Inc. holds an annual advocacy day on Capitol Hill in Washington D.C. This two-day event, which is typically held in the spring, provides an opportunity for the College and its members to increase their presence in Washington and bring visibility to issues of common concern. Participants receive a comprehen-

Continued on page 40
sive orientation and briefing on the College’s top legislative priorities and then have an opportunity to meet with legislators and the staff on Capitol Hill.

Leadership Day is open only to members of the College. Those wishing to participate should contact their chapter governor and express their interest. Chapter governors and staff will be notified of event details and registration as Leadership Day approaches.

ALL MOBILE-FRIENDLY CME discounted 20 percent the month of July
Need continuing medical education (CME)? Now’s the perfect time to visit the TMA Education Center!

For the entire month of July, you can take an additional 20 percent off all mobile-friendly CME courses, which can be completed anywhere, anytime, and on any device. This includes PDF publications, on-demand webinars, and podcasts. Dozens of courses are eligible for the discount, including popular programs covering ethics, risk management, coding, and practice operations. To take advantage of the sale, visit the TMA Education Center and enter the coupon code MOBILE20 at checkout to activate the discount.

FEDERAL JUDGE SIDES WITH TELADOC, BLOCKS TMB TELEMEDICINE RULE
On May, U.S. District Judge Robert Pitman granted Teladoc’s request for a temporary restraining order (TRO) and preliminary injunction that blocks the Texas Medical Board’s (TMB’s) recently adopted telemedicine rule, which prohibits prescription of dangerous drugs or controlled substances without a “defined physician-patient relationship.” That includes a physical examination via face-to-face visit or in-person evaluation, as TMB defines those terms in the rules. TMB adopted the rule on April 10, and it was set to take effect June 3.

In its application for a TRO, Teladoc argued TMB has engaged in anticompetitive actions that would put the company out of business in Texas and lead to “higher prices, reduced choice, reduced access, reduced innovation, and reduced overall supply of physician services.” In response, TMB argued the rule is consistent with “sound medical practice” and is “reasonably necessary for and beneficial to patient welfare.” In the order, Judge Pitman concludes “the balance of respective interests of the parties and the public weigh in favor of granting [Teladoc’s] application for a preliminary injunction.”

TMA, Southwest Pharmacy Solutions, the American Osteopathic Association, the Texas Osteopathic Medical Association, and the Federation of State Medical Boards filed briefs in opposition to the application for TRO and preliminary injunction.

The injunction will continue until Teladoc’s federal antitrust lawsuit against TMB is resolved.

TMA President Tom Garcia, MD, said in a statement that “TMA is sorely disappointed with the court’s decision allowing the writing of prescriptions for dangerous drugs without first establishing a patient-physician relationship. Protecting patient health and safety and improving the quality of patient care are the Texas Medical Board’s responsibilities. TMA supports the challenged rules and believes they fulfill the board’s mission.”

AMA CALLS FOR TWO-YEAR ICD-10 GRACE PERIOD IF CODING TRANSITION IMPLEMENTED
The American Medical Association House of Delegates unanimously adopted the Texas-backed proposal to ask the federal government to adopt a two-year, penalty-free grace period following the expected Oct. 1 mandatory implementation of the new ICD-10 coding system.

Delegates voted without objection in support of the grace period plan, which the Reference Committee on Legislation cobbled together based on suggestions from the Alabama and Texas delegations, as well as other states, at the AMA House of Delegates Annual Meeting last week in Chicago.

As the reference committee noted in its report, “Our AMA will continue to prioritize our existing AMA policy that first seeks to stop the implementation of the ICD-10 code set and, only if a delay is not feasible, seek mitigation strategies.”

The adopted language reads: “If a delay of ICD-10 implementation is not feasible, that our American Medical Association ask the Centers for Medicare & Medicaid Services (CMS) and other payers to allow a two-year grace period for ICD-10 transition, during which physicians will not be penalized for errors, mistakes, and/or malfunctions of the system. Physician payments will also not be withheld based on ICD-10 coding mistakes, providing for a true transition where physicians and their offices can work with ICD-10 over a period of time and not be penalized.

“That our AMA educate physicians of their contractual obligations under Medicare and insurance company contracts should they decide to not implement ICD-10 and opt to transition to cash-only “practices which do not accept insurance.

“That our AMA aggressively promote this new implementation compromise to Congress and CMS since it will allow implementation of ICD-10 as planned, and at the same time protect patients’ access to care and physicians’ practices.

“That our AMA provide the needed resources to accomplish this new compromise ICD-10 implementation and make it a priority.

“That our AMA seek data on how ICD-10 implementation has affected patients and changed physician practice patterns, such as physician retirement, leaving private practice for academic settings, and moving to all-cash practices and that, if appropriate, our AMA release this information to the public.”

The policy represents an effort by AMA to help U.S. physicians dodge a dangerous bullet.

Continued on page 41
Thanks to strong lobbying from AMA, TMA, and other physician groups, the original Oct. 1, 2013, ICD-10 deadline has been pushed back twice.

TMA and AMA still formally oppose ICD-10. They’ve pointed out that many physicians, especially those in small practices, are still not ready to use the new coding language. Some cite the high cost of transition; others blame electronic health record vendors that have not yet made ICD-10-compliant software available. Those who aren’t ready run the risk of having all or some of their Medicare, Medicaid, and commercial insurance claims going unpaid.

TMA supports HR 2126, the Cutting Costly Codes Act of 2015, by U.S. Rep. Ted Poe (R-Humble), which would prohibit the government from requiring physicians and health care providers to use ICD-10.

Texas physicians at the AMA meeting spoke out about the dangers they foresee, especially for primary care practices. Greg Fuller, MD, a family physician from Keller, said the wide array of medical problems primary care physicians treat is forcing them to try to learn thousands of new codes.

“We need to stop ICD-10,” Dr. Fuller told the Reference Committee on Legislation. “Any delay in pay is going to kill these practices.”

E. Linda Villarreal, MD, an internist in the Rio Grande Valley, said she is concerned about the ramifications for access to care in South Texas, many parts of which already face a dire shortage of physicians. “I’ve taken three courses in ICD-10, and I still don’t get it,” Dr. Villarreal said.

But Washington watchers say Congress has no stomach for delaying the implementation date one more time. “The ICD-10 Coalition has done a better job than [medicine has] over the past four years,” one delegate said.

That leaves organized medicine in a tough spot, said Fort Worth pediatrician Gary Floyd, MD, a member of the TMA Board of Trustees. Groups like AMA and TMA must continue to push for a last-minute reprieve and at the same time work to protect their members from the likely upheaval that will come with ICD-10, he explained.

“Our message is this,” Dr. Floyd said, “don’t give up the ship, but make sure the lifeboats are manned and at the ready.”

TMA offers extensive ICD-10 coding training materials http://www.texmed.org/icd10/, including specialty-specific online ICD-10 documentation training, on-demand webinars, and customized on-site ICD-10 training.

**VICTORY! CSR PERMIT PROGRAM TO BE ELIMINATED NEXT YEAR**

Thanks to the Texas Medical Association’s advocacy this legislative session, the controlled substances registration (CSR) permit program will be eliminated, effective Sept. 1, 2016. Senate Bill 195 by Sen. Charles Schwertner, MD (R-Georgetown), and Rep. Myra Crownover (R-Denton) also moves the Prescription Drug Monitoring Program from the Texas Department of Public Safety (DPS) to the Texas State Board of Pharmacy and broadens physicians’ authority to delegate who can access the information.

But until the CSR program is eliminated, established physicians must maintain — and newly licensed physicians must obtain — a permit. A physician’s ability to prescribe medications hinges on possession of a valid CSR, which is necessary to obtain a permit from the Drug Enforcement Administration. Just as critical, a physician whose CSR permit lapses faces (at least) temporary suspension of hospital privileges, as maintaining current certifications is a requirement to retain medical staff privileges in Texas.

Fortunately, the CSR permit renewal process already had been streamlined due to TMA advocacy in the 2013 legislature. Physicians can now renew their CSR permits on the Texas Medical Board (TMB) website http://www.tmb.state.tx.us/page/licensing. Doing so will align the permit and medical license expiration dates.

Before renewing either, check the DPS website http://www.dps.texas.gov/csr/index.aspx to see when the CSR permit expires. If it has the same expiration date as the medical license, renew both on the TMB website for quicker service.

**START THE PQRS GPRO REGISTRATION PROCESS NOW**

The Physician Value-Physician Quality Reporting System (PV-PQRS) registration system is open through June 30. This registration applies to group practices with two or more eligible professionals (EPs) interested in participating in the 2015 PQRS program year under the group practice reporting option (GPRO).

According to the Centers for Medicare & Medicaid Services (CMS), physician groups of all sizes and physician solo practitioners will be subject to payment adjustments in 2017 based on quality and cost performance in 2015. Failure to report data on quality measures to Medicare for the 2015 PQRS program year will result in an automatic 2-percent pay cut under PQRS, plus another automatic 2-percent to 4-percent pay cut under Medicare’s Value-Based Payment Modifier program, all in 2017. The payment adjustments will apply to all Part B covered professional services under the Medicare physician fee schedule.

To access the PV-PQRS registration system, you will need to obtain an Individuals Authorized Access to the CMS Computer Services (IACS) account. It takes at least 24 hours for CMS to process an IACS account request. This step should be completed now or as soon as possible to avoid last-minute delays before the deadline.

Continued on page 42
To determine if the GPRO is right for your practice, visit the GPRO webpage http://www.cms.gov/Medicare/Quality-Initiatives-Patient-Assessment- Instruments/PQRS/Group_Practice-Reporting_Option.html. To learn about the registration process, review the 2015 PQRS GPRO Registration Guide https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Downloads/2015-PQRD-GPRO-Registration-Guide.pdf or visit the PQRS GPRO Registration webpage https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/PhysicianFeedbackProgram/Self-Nomination-Registration.html. Group practices that previously reported under the GPRO and plan on reporting PQRS data again via GPRO must register every year. If you plan to report your data on quality measures as an individual EP and not under the GPRO, you do not need to sign up or register anywhere to participate in the 2015 PQRS program year.

If you are not sure where to begin for the 2015 PQRS program year or do not know which reporting mechanism to select, visit the CMS How To Get Started webpage. And watch this CMS video presentation for an overview of PQRS and to learn how your participation in PQRS in 2015 will determine how the value modifier will be applied to physicians’ payment in 2017.

For free consulting services on Medicare’s quality reporting programs, turn to the TMF Quality Innovation Network Quality Improvement Organization, http://www.tmfqin.org/ an offshoot of the TMF Health Quality Institute. Under contract with Medicare, TMF has created several educational networks you can join:

• For help with PQRS and the Value-Based Payment Modifier program, join the Value-Based Improvement and Outcomes Network http://www.tmfqin.org/Networks/Value-Based-Improvement-and-Outcomes.
• For help with health information technology, join the Meaningful Use Network http://www.tmfqin.org/Networks/meaningful-use.
• Or contact Tracy Swoboda by phone, (361) 285-1053, or email tracy.swoboda@area-b.hcqis.org.

Stay informed about the latest PQRS news by subscribing to the PQRS listserv. For questions, contact the CMS QualityNet Help Desk, Monday through Friday, 7 am to 7 pm CT by phone, (866) 288-8912, or email Qnetsupport@hcqis.org. You also can contact the TMA Knowledge Center by phone, (800) 880-7955, or email knowledge@texmed.org.

TMA TELLS FEDS TO SCRAP MEANINGFUL USE RULE
TMA’s comments to the Centers for Medicare & Medicaid Services (CMS) on proposed meaningful use Stage 3 rules offer a number of suggestions, including dismantling the program and “adopting reasonable baseline rules that physicians can meet to avoid penalties under the meaningful use program and additional requirements they may meet to receive incentive payments.” TMA’s strongest comments are related to the patient engagement measures. TMA asserts that CMS continues to push patients toward electronic interaction with their physicians, which some patients may not prefer. TMA stresses CMS should honor patient preference for communication.

TMA expects CMS to issue a final rule for the third and final stage of meaningful use later this summer or in early fall. TMA will be ready to educate physicians on changes to the meaningful use program, scheduled to take effect in 2017.

Questions about the meaningful use program or other health information technologies may be emailed HIT@texmed.org to TMA’s Health Information Technology Department.

TMA, AMA SUPPORT SUNSHINE ACT OPEN PAYMENTS REPORTING EXCLUSION
TMA and the American Medical Association want to ensure certain educational programs and materials are excluded from Open Payments System reporting. In a letter, TMA, AMA, and dozens of medical organizations and specialty societies assert their support for HR 293 by Texas Congressman Michael C. Burgess, MD.

The legislation would make the current regulatory exemption for independent continuing medical education (CME) permanent. In addition, medical textbooks and journal reprints would be added to the list of exempt transfers of value.

The letter states the Centers for Medicare & Medicaid Services has concluded in its interpretation of the Sunshine Act “that medical textbooks, reprints of peer reviewed scientific clinical journal articles, and abstracts of these articles are not directly beneficial to patients, nor are they intended for patient use. This conclusion is inconsistent with the statutory language on its face, congressional intent, and the reality of clinical practice where patients benefit directly from improved physician medical knowledge.”

The letter concludes: “The Sunshine Act was not passed to limit or construct additional barriers to the dissemination of new medical knowledge that improves patient health outcomes. H.R. 293 is needed to ensure patients benefit from the most up-to-date and relevant medical knowledge.”

SUPREME COURT RULING MAINTAINS SIX-YEAR LIMIT ON DAMAGE CLAIMS
A U.S. Supreme Court ruling has physicians who care for patients enrolled in federal health care programs breathing easier. The ruling in KBR v. United States of America Ex Relator Benjamin Carter prevents doctors from facing civil lawsuits for an unlimited period of time and maintains the six-year limitation on damage claims under the False Claims Act.

The Litigation Center of the American Medical Association and State Medical Societies filed an amicus curiae brief last year.
that said doctors could be “forced to defend against stale, repetitive, and frequently meritless claims” if the statute of limitations were removed.


REVISED STUDENT VACCINE REQUIREMENTS AVAILABLE
The revised 2015-2016 Texas Minimum State Vaccine Requirements for Students Grade K-12 is now available from the Texas Department of State Health Services (DSHS) Immunization Branch.

School administrators, health personnel, and parents will receive letters regarding the revised immunization requirements, which play a vital role in maintaining the health and well-being of Texas students.

Contact the DSHS Immunization Branch at (800) 252-9152 for more information.

AMA, AHA PRINCIPLES GUIDE SUCCESSFUL PHYSICIAN-HOSPITAL RELATIONSHIPS

The new Principles of Integrated Leadership for Hospitals and Health Systems (AMA log-in required) from AMA and the American Hospital Association can help physicians “bring clinical skills and business insights together at the leadership level to foster more collaborative and cohesive decision-making at hospitals and health systems,” according to the June 3 edition of AMA Wire.

AMA lists six principles of success for integrated leadership between hospitals and physicians:

1. Physician and hospital leaders who are united.
2. An interdisciplinary structure that supports collaborative decision-making.
3. Clinical physician and hospital leadership present at all levels of the health system.
4. A partnership built on trust.
5. Open and transparent sharing of clinical and business information.
6. A clinical information system infrastructure that is useful.

TMA provides education and services to help employed physicians, including the publications A Comprehensive Guide for Physician Employment and Business Basics for Physicians, as well as the on-demand webinar Business Boot Camp: Take Charge of Your Finances.

For additional resources, visit the TMA Employed Physicians Resource Center http://www.texmed.org/employedphysicians/.

PARTICIPATE IN MEDICAID HIT SURVEY
The Texas Health and Human Services Commission (HHSC) has partnered with the F. Marie Hall Institute for Rural and Community Health of the Texas Tech University Health Sciences Center to survey Texas physicians regarding various health information technology (HIT) programs.

Your response to this survey guides Texas Medicaid, HHSC, and their partners when planning HIT programs aimed at benefiting the Texas health care community.

The survey https://www.surveymonkey.com/r/?sm=GAerWjie2eKbLPe1k5x7EQ%3d%3d should take less than 10 minutes to complete.

COLLECTIONS: ICD-10 IMPLEMENTATION COMPLIANCE

BACKGROUND
All HIPAA-covered entities must implement the new ICD-10 code sets with dates of service, or date of discharge for inpatients, that occur on or after Oct. 1, 2015. Covered entities should plan to complete the steps required to implement ICD-10-CM/PCS on Oct. 1, 2015.

REGULATING BODY
CMS http://www.cms.gov/Medicare/Coding/ICD10/Provider-Resources.html

COMPLIANCE DATE
10/1/2015

CONSEQUENCES
ICD-9 diagnosis codes cannot be used for services provided on or after October 1, 2015. Claims that do not use ICD-10 diagnosis codes cannot be processed for reimbursement.

NEXT STEPS
For practices who have not yet started the transition to ICD-10, below are the action steps:

1. Establish a transition team or ICD-10 project coordinator;
2. Develop a plan for making the transition;

Continued on page 44
3. Determine how ICD-10 will affect your practice;
4. Review how ICD-10 will affect clinical documentation requirements and EHR templates;
5. Communicate the plan, timeline, and changes to process to staff;
6. Develop a budget;
7. Talk to payers and business associates about their preparedness; and
8. Test.

Find out how TMA can help! [http://www.texmed.org/icd10/](http://www.texmed.org/icd10/)

**HIT: FIRST-YEAR PARTICIPANTS’ LAST DAY TO BEGIN 90-DAY REPORTING PERIOD OF MEANINGFUL USE FOR THE 2015 MEDICARE AND MEDICAID EHR INCENTIVE PROGRAMS**

**BACKGROUND**
Medicare physicians who are first-year participants in 2015 will not receive incentives but will avoid the 2017 penalty. Medicaid physicians can still begin participation to earn an incentive for 2015.

**REGULATING BODY**

**COMPLIANCE DATE**
10/3/2015

**CONSEQUENCES**
A 3-percent penalty begins Jan. 1, 2017, for physicians who are not meaningful users of certified EHRs during the 2015 calendar year.

**NEXT STEPS**
Register to participate in the Medicare or Medicaid EHR Incentive Program at [https://ehrincentives.cms.gov/hitech/login.action](https://ehrincentives.cms.gov/hitech/login.action). You can begin collecting meaningful use data on your encounters for the 2015 payment year on Jan. 1, 2015. You should collect data for a consecutive 90-day period.

Find out how TMA can help! [http://www.texmed.org/EHRIncentive/](http://www.texmed.org/EHRIncentive/)

**E-TIPS RSS FEED**
TMA Practice E-Tips, a valuable source of hands-on, use-it-now advice on coding, billing, payment, HIPAA compliance, office policies and procedures, and practice marketing, is available as an RSS feed [http://www.texmed.org/Template.aspx?id=3569](http://www.texmed.org/Template.aspx?id=3569) on the TMA website [http://www.texmed.org/](http://www.texmed.org/). Once there, you can download an RSS reader, such as Feedreader, Sharpreader, Sage, or NetNewsWire Lite. You also can subscribe to the RSS feeds for TMA news releases and for *Blogged Arteries*, the feed for Action.
### Upcoming Live Activities

**Office of Continuing Medical Education**

**Upcoming Live Activities**

**July – December 2015**

#### Live Activities/ Grand Rounds July 2015

<table>
<thead>
<tr>
<th>Department/Center/ Topic</th>
<th>Date</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pediatrics Grand Rounds: CANCELLED</td>
<td>Wednesday, July 1, 2015 CANCELLED</td>
<td>Academic Education Center Auditorium A and B 4800 Alberta Avenue El Paso, Texas 79905</td>
</tr>
<tr>
<td>Pediatrics Grand Rounds: CANCELLED</td>
<td>Wednesday, July 15, 2015 CANCELLED</td>
<td>Academic Education Center Auditorium A and B 4800 Alberta Avenue El Paso, Texas 79905</td>
</tr>
<tr>
<td>Diversity and Global Health Perspective Lecture Series: CANCELLED</td>
<td>Wednesday, July 15, 2015 CANCELLED</td>
<td>Clinical Sciences Center A3500 4801 Alberta Avenue El Paso, Texas 79905</td>
</tr>
<tr>
<td>Surgery/Trauma Grand Rounds: Brian Davis, MD Topic: TBD</td>
<td>Thursday, July 16, 2015 7:00am-8:00am</td>
<td>Academic Education Center Auditorium A 4800 Alberta Avenue El Paso, Texas 79905</td>
</tr>
<tr>
<td>Women in Medicine and Science Lecture Series: CANCELLED</td>
<td>Wednesday, July 22, 2015 12:00pm-1:00pm CANCELLED</td>
<td>Clinical Sciences Center A3500 4801 Alberta Avenue El Paso, Texas 79905</td>
</tr>
<tr>
<td>Internal Medicine Grand Rounds: W. Strader, MD Thyroid Cancer</td>
<td>Wednesday, July 22, 2015 12:00pm-1:00pm</td>
<td>Academic Education Center Auditorium A 4800 Alberta Avenue El Paso, Texas 79905</td>
</tr>
</tbody>
</table>

**Note:**

Texas Tech University Health Sciences Center El Paso reserves the right to cancel these activities in the event of unforeseen or extenuating circumstances.

### Conferences

<table>
<thead>
<tr>
<th>Title</th>
<th>Date</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Children’s Environmental Health on the Border: Protecting Children Where They Live, Learn, and Play</td>
<td>September 24-25, 2015</td>
<td>TBD</td>
</tr>
<tr>
<td>3rd Annual Clinical Simulation Conference of West Texas: Bridging Education and Practice Gaps to Improve Patient Outcomes</td>
<td>October 8-9, 2015</td>
<td>Medical Education Building: Aud. 1200 5001El Paso Drive El Paso, Texas 79905</td>
</tr>
<tr>
<td>3rd Annual Infectious Disease Symposium</td>
<td>November 2, 2015</td>
<td>Medical Education Building: Aud. 1100 5001El Paso Drive El Paso, Texas 79905</td>
</tr>
<tr>
<td>2nd Annual Neurosciences Conference</td>
<td>December 4, 2015</td>
<td>Medical Education Building: Aud. 1200 5001El Paso Drive El Paso, Texas 79905</td>
</tr>
<tr>
<td>16th Annual Rio Grande Trauma Conference &amp; Pediatric Update</td>
<td>December 3-4, 2015</td>
<td>Academic Education Center Auditorium A and B 4800 Alberta Avenue El Paso, Texas 79905</td>
</tr>
</tbody>
</table>

5001 El Paso Drive ★ El Paso, Texas 79905
Phone: (915) 215-4880 ★ Fax: (915) 783-6220

These activities has been approved for *AMA PRA Category 1 Credit™.*

**Note:**

Texas Tech University Health Sciences Center El Paso reserves the right to cancel these activities in the event of unforeseen or extenuating circumstances.
Physicians’ Directory
“Your card makes a difference!”

Open to All Members

BARIATRIC SURGERY

BENJAMIN L. CLAPP, MD, PA, FACS
Bariatric and General Surgery
1700 N. Mesa
El Paso, TX 79902
(915) 351-6020

EAR, NOSE & THROAT

EL PASO EAR, NOSE & THROAT
ASSOCIATES, P.A.

JORGE J. ARANGO, MD, FACS
PATRICK J. GOMEZ, MD, FACS
KENNETH R. KORZEC, MD, FACS
RAFAEL I. GARCIA, MD, FACS
GARY NANEZ, MD, FACS
JORGE I. CONTRERAS, MD
5959 Gateway West, Ste 160
201 Bartlett, Ste. A
1600 N. Lee Trevino, Ste A-2
(915) 779-5866 Fax (915)779-8604

FAMILY PRACTICE

HECTOR LOPEZ, DO
Family Practice/Sports Medicine
Community Medical Clinic, PA
9955 Dyer Street
751-1249

NEUROLOGICAL SURGERY

HELSON PACHECO-SERRANT, M.D.
BRAIN & SPINE SURGEON
1700 N. Oregon, Ste 660
El Paso, Texas 79902
Telephone: (915) 351-1444
Fax: (915) 533-3285
www.neurosurgicalspecialistofelpaso.com

GEORGE J. MARTIN, MD, FAANS
SOUTHWEST NEUROSPINE INSTITUTE, PA
American Board of Neurological Surgeons
Fellowship Trained Spine Surgeons
Robotic Spine Surgery / Brain Surgery
www.swnsi.com
1725 Brown Street Phone 590-2225
El Paso, TX 79902 Fax 590-2229

OBSTETRICS / GYNECOLOGY

ANGEL M. RIOS, MD
Obstetrics & Gynecology
Diplomate of the American Board of Obstetrics and Gynecology
Fellow of the American College of Obstetricians and Gynecologists
1250E.Cliff,Ste.3D Phone:(915)577-9100
ElPaso,Texas79902 Fax:(915)577-9977

OPHTHALMOLOGY

SCHUSTER EYE CENTER
STEPHEN A.D. SCHUSTER, MD
Diplomate American Board of Ophthalmology
Diseases and Surgery of the Eye
Sierra Tower Building
1700 Curie, Suite 2100
El Paso, Texas 79902
533-3461

LOUIS M. ALPERN, MD
MPH, FACS, PA
Diplomate, American Board of Ophthalmology
Diseases and Surgery of the Eye
4171 N. Mesa, Bldg. D #100
1030 N. Zaragosa, Ste Y
545-2333

DAVID R. SCHECTER, MD
DANIEL G. BLUMENFELD, MD
Diplomate, American Board of Ophthalmology
1220 N. Oregon 545-1484
1200 Golden Key, Ste 163 593-1226

SOUTHWEST EYE INSTITUTE

MARC ELLMAN, MD
JAVIER DE LA TORRE, MD
STEPHEN PURDY, OD
CANDACE OTTO, OD
1400 Common Drive
(By the Golden Corral on Lee Trevino)
El Paso, TX 79936
595-4375

__________________________________

Classified
### Ophthalmology (continued)

**VISTA SURGERY CENTER**

1400 Common Drive  
(Behind the Golden Corral on Lee Trevino)

Open to all specialties  
High patient satisfaction  
Friendly, efficient staff

Medical Director: Marc Ellman, M.D.  
(915) 490-1766

**ORTHOPAEDIC SURGERY**

**JOSE L. DIAZ-PAGAN, M.D.**  
**AMERICAN BOARD OF ORTHOPAEDIC SURGEONS**

Arthroscopy, Fractures, and Replacements  
Shoulder Specialist, Fellowship Trained

8230 Gateway East Blvd  
El Paso, Texas  79907  
Phone: (915) 593-6700  
Fax: (915) 593-6703

**PATHOLOGY**

**GYN PATH SERVICES, INC.**

**PHILIP A. MILES, M.D., FACOG, FCAP**  
**Medical Director**

Cytology, Virology, Microbiology and Pathology  
**Only local laboratory offering**

ThinPrep® Pap Test using Image-Directed Cytology™

Northpointe Professional Center  
8815 Dyer Street, Suite 200  
El Paso, TX 79904  
Office: 755-8478  
Fax: 755-7331  
www.gynpathservices.com  
Fax: (915) 598-8121

**PHYSICAL MEDICINE AND REHABILITATION**

**PM & R ASSOCIATES OF EL PASO, P.A.**

**KEVIN J. SANDBERG, M.D.**  
**ERIC T. SPIER, M.D.**

American Board of Physical Medicine & Rehabilitation  
Electrodiagnostic Medicine (EMG/NCS)  
Acquired Brain Injury  
Spasticity Management  
Pain and Disability  
Workers Compensation

Two Locations:  
**East:** 1393 George Dieter, Ste. A  
**West:** 6955 N. Mesa, Ste. 105

Phone: (915) 598-8120  
Fax: (915) 598-8121

**SLEEP MEDICINE**

**TURKISH NEURODIAGNOSTIC, HEADACHE & SLEEP DISORDERS CENTER PA**

**BORIS KAIM, MD, FAAN, FAASM**

Board Certified in Neurology, Psychiatry and Sleep Medicine  
Neurology, Neuropsychiatry, Sleep Medicine - Sleep Studies  
Nerve Conduction, EMG, EEG - 24 hour Ambulatory EEG  
Deep Brain Stimulation for Parkinson’s Disease  
Vagus Nerve Stimulation for Treatment of Epilepsy  
Autonomic Testing (Dizziness and Syncope)

2311 N. Mesa, Bldg F  •  El Paso, TX 79902  
(915) 544-6400

**THORACIC CARDIOVASCULAR SURGERY**

**EL PASO SOUTHWESTERN CARDIOVASCULAR ASSOCIATES**  
**ADULT AND PEDIATRIC**

**JOE N. KIDD, MD, FACS**  
**KENNETH EISENBERG, MD, FACS**  
**ROBERT SANTOSCOY, MD, FACS**  
**IAN T. LYN, MD**  
**HECTOR A. FLORES, MD**

1600 Medical Center Dr., Ste 212  
532-3977
The El Paso Physician provides a forum for the scholarly presentation and discussion of issues which are of importance and interest to the El Paso community. Scientific contributions may include scientific reviews, case reports, original research, historic contributions, financial updates, legislative and medical practice issues, border-health and others.

Manuscript Preparation - The material should be submitted with the authors name, article title and phone number. The title page should list the authors’ names, degrees, institutional affiliations, and phone and fax numbers. A short abstract of 125-150 words should accompany the article. The manuscripts should be limited to no more than 1500 words.

Submitting Case Reports
1. Follow the following format:
   a. Title
   b. Authors
   c. Background information
   d. Case presentation
   e. Discussion
   f. References
   g. Figures

The total number of words should not exceed 1000 (not including references). Please try to attach 1 or two figures only. Be sure that your departmental chairs are aware of the submission.

Figures - All tables and figures must be cited in the text and numbered in order of appearance, and must not be submitted via fax.

Tables - Tables should be understandable without reference to the text and should not be repetitive of descriptions in the text. Cite all tables in the text and number them in order of appearance. Tables may not be submitted by fax.

References - References are listed at the end of the article by order of appearance and should be numbered. In the text, indicate reference numbers with a superscript numeral. Unpublished data, personal communications, and other materials not accessible to the reader should not be listed as references but given in parenthesis in the text.


Permissions - To use tables and figures borrowed from another source, you must obtain permission from the copyright holder (usually the publisher). Give the source of the borrowed table in a footnote and of a borrowed figure in the legend. Use the exact wording required by the copyright holder. Send copies of the letter granting permission along with your manuscript.

MANUSCRIPT SUBMISSION
The El Paso Physician
epmedsoc@aol.com
July 15th, 2015
6 PM- 7:30 PM
Sierra Medical Center
1625 Medical Center Drive
Doctor’s Dinning Room
Lower Level

Presenter
Mari Robinson, J.D., is the Executive Director for the Texas Medical Board (TMB). Ms. Robinson has served in this role for more than seven years, administering the agency in general, with particular focus on the TMB’s legal and administrative issues. Since joining the TMB in 2001, she has held various positions including Manager of Investigations, and Director of Enforcement that included managing the Investigations, Litigation and Compliance Departments.

Accreditation and Designation Statements
This continuing medical education (CME) presentation is recognized by the Texas Medical Board (TMB) for licensed physicians to meet up to the two required formal hours of study in medical ethics and/or professional responsibility based on the length of the presentation. This presentation is also recognized by the Texas Physician Assistant Board for physician assistants to meet up to two informal hours of CME based on the length of the presentation.

Use of this presentation to satisfy any other continuing education requirements is not guaranteed by the TMB and is at the sole discretion of the entity requiring the continuing education.

RSVP
Please register by July 13th

Email: Pamela.Emmert@tenethealth.com
Phone: 915-577-6106

* Refreshments will be served

Educational Objectives
The presentation will cover the following key issues related to a physician’s professional responsibilities and the practice of medicine in Texas:

- Legislation passed in the 84th Legislative Session
- Key areas of regulation
- TMB Enforcement Process
- Common types of violations
Other MRIs

3 Tesla MRI

1.5 Tesla MRI
Open MRI
16-slide CT
2 Ultrasounds
Digital Mammography
Digital Radiography
Dexa Bone Densitometry

Our new Toshiba 3 Tesla MRI is to imaging as HD is to television. Once you try, you'll never go back. Available now at Diagnostic Outpatient Imaging.

Open Days, Nights and Saturdays
Monday–Thursday 7 a.m.–9 p.m.
Friday 7 a.m.–6 p.m.
Saturday 8 a.m.–12 p.m.
6065 Montana, Ste A-6, El Paso, TX
www.dximaging.com | 915.881.1900