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Volume 40 Number 3



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protect the physician and serve the patient”

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President's Comment

Gilbert A. Handal, MD

President, El Paso County Medical Society



As you are aware County Medical Societies in concert with TMA were instrumental in implementation of the Tort Reform in 2002, this meant that for every one of us less malpractice litigation and huge savings in medical liability insurance. The preservation of Tort Reform has been a continuous effort. However, there are many interventions, some of which may go unnoticed, that require every physicians' support that take place in every legislative session that are extremely important for preserving the integrity of our profession and for the protection of our patients.

The Texas legislative session began January 10th, below we have captured a few of the many interventions that will demonstrate the importance of our interventions.

1. Passing of Senate Bill (SB) 507 which provides a fair resolution to the problems on balance billing for out of network physicians.
2. Passing of SB 680 and House Bill (HB) 1404 which provides step therapy override, especially important for oncology patients.
3. Passing of SB 1076 which states that a patient will pay the lesser cost for medication when comparing co-pays or the cost of medication.
4. TMA has also assisted in the defeat of bad bills such as SB 1675 and HB 411, which would have restricted the physicians' ability to report a non-paying patient to credit bureaus.
5. TMA was successful in the approval of HB 2468, which covers the screening for maternal depression and HB 1600 which allows for physicians to be reimbursed for yearly mental health screenings, to name a few.

Our TMA team has worked with Texas lawmakers to dramatically scale back the MOC requirements in SB 1148 and SB 1107, which establishes the statutory definition for telemedicine. TMA has also been our advocate to clearly articulate our concerns with span of control especially as it pertains to medications prescribed by psychologist and independent practice by Nurse Practitioners, who we believe should be required to have physician consent and/or supervisor to ensure quality of care is maintained.

During the special session TMA was influential in the reautho-

rization of the Texas Medical Board and Medical Practice Act. So, why support and participate? Because without your support we would not be able to effectively move bills that benefit us and defeat bills that will impact our ability to function.

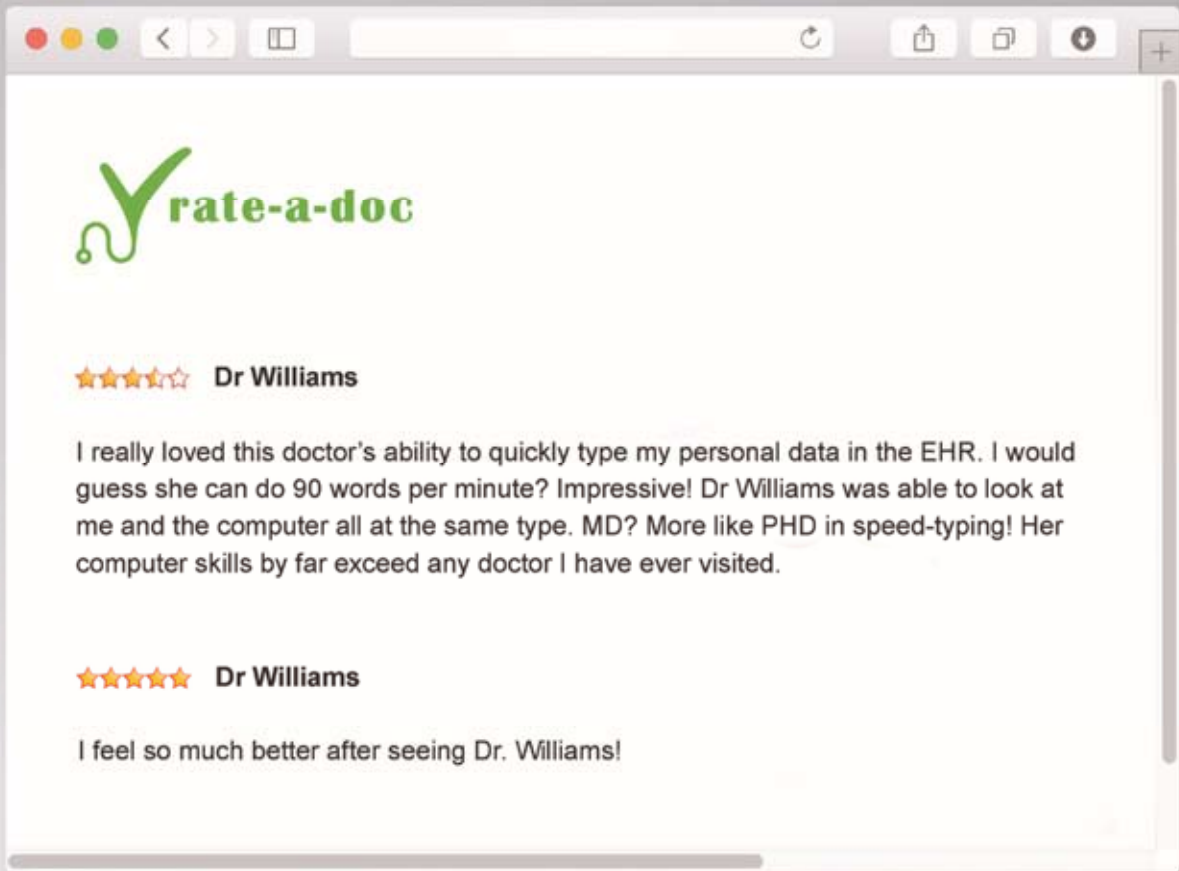
"What does my contribution and involvement support"? Through your efforts you can educate our local legislators, contribute time and effort to participate in Committees and Councils, and with your membership support the professional, dedicated, committed, and focused TMA team. This legislative session was particularly difficult because of the Texas budgetary shortfalls and concerns about the education and protective services in Texas. There was also an increase of patients depending on Medicaid as well as the \$426 million dollar public health decrease in funding for Medicaid programs, it is expected that the Commissioner will present a report to the legislator in early December about the areas that will be affected.

In short, we are they only ones that fully understand the true impacts of proposed legislative initiatives on our profession. So, I beseech you to support the El Paso County Medical Society and TMA either through your membership and/or active participation in initiatives. We understand that busy practices and time commitments limit the amount of time you have to put forth, but I assure you that even a small percentage of your time will benefit our profession, our patients, and our community.

Gilbert A. Handal, MD
President, El Paso County Medical Society

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Editorial Comment

Alison L. Days, MD
Editor
El Paso Physician, EPCMS



There are people in every time and every land who want to stop history in its tracks. They fear the future, mistrust the present, and invoke the security of a comfortable past which, in fact, never existed.

---Robert Kennedy

A people without the knowledge of their past history, origin and culture is like a tree without roots.

---Marcus Garvey

This issue will mark almost 40 years of the El Paso Physician Magazine! We are blessed and honored to still be in publication after all these years and to continue to have the opportunity to provide new articles, case reports and political updates to the medical community of El Paso. On this momentous occasion, we have a guest editorial—the first editorial, in fact—written in 1977 by Editor and El Paso County Medical Society President, Gordon L. Black, M.D.

There are 2 ironies to this editorial, the first being that Dr. Black passed away this year after many years of service to El Paso patients in the field of Radiology. He was an El Pasoan to the core, having grown up here, practiced here and now laid to rest here. We will miss his contributions to our medical society, our magazine and to our community, but we hope to honor his memory with this re-publication of his original editorial. His obituary is published in this issue, as well.

The second irony is that many of the points in his editorial are still as true today as they were when he wrote them. For instance, he notes, “We are in the midst of a social revolution which is having a profound effect on all institutions of our culture.....the politically motivated social planners in Washington have lots of ideas about healthcare delivery, and it is the concern of the doctors that many of their proposals will not result in improving the quality of medical care.”

And also, “If we persistently speak out publicly about the need for quality in healthcare, we can re-establish our credibility in the public mind as the patients’ advocate.”

Please enjoy this historical editorial and continue to read the

rest of the issue where we look at current articles about “A Surprisingly Under-Recognized Cause of Gastroparesis”, “Leprosy in Texas”, and “Medicare and Chip Reauthorization Act.”

Alison L. Days, MD
 Editor, El Paso Physician Magazine

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A Message from the Editor

by Gordon L. Black, M.D.



El Paso Physician - Volume 1 Number 1 - November 1977

Why another journal? Because this one is to be our own magazine and will be dedicated to the improvement of the quality of medical care in our area. It should keep us informed about proposed legislation that may have impact on medical matters; it should stimulate us to participate in the political process so that we may have the opportunity to express our opinions during legislative sessions.

It should strengthen our collective voice as we deal not only with our elected representatives, but also with the boards and agencies of government.

Increased sophistication in medicine often involves, at least initially, only a narrow field of application but causes considerable increase in cost of medical care. Medical progress in the United States has resulted in a marked increase in longevity and in the quality of life. But this very success has made medicine vulnerable to many social and political problems. Progress alone did not create these problems, but progress combined with the promises of aspiring politicians that all this new sophistication should be immediately available to everyone has led to widespread unfulfilled expectations. The blame for not keeping these campaign promises has been laid on the doctors and the hospitals. Our present system of health care delivery has been criticized as being a non-system, a cottage industry and Senator Edward Kennedy even called it a Ma & Pa Kettle operation.

We are in the midst of a social revolution which is having a profound effect on all the institutions of our culture such as education and even the family structure. It is, therefore, not realistic to assume that medical care will not also be under pressure to change. The politically motivated social planners in Washington have a lot of ideas about health care delivery, and it is the concern of the doctors that many of their proposals will not result in improving the quality of medical care. We want to be sure that there is adequate input by physicians in formulating any major changes in the health delivery system. Once when asked what he wanted during a Labor-Management arbitration session, Samuel Gompers replied, "More". Walter Reuther later elaborated on this idea by comparing the economy to a pie. He pointed out that as pie grows, so does Labor's slice of the pie. As long as the economy is expanding, there is plenty of money for every need including Labor's demand and also the requirements for expanding medical care. But what happens when the economic growth stops? More money to finance expanding health care costs must come from funds that would have otherwise been allocated to other projects and programs. This then, is the reason why medical care institutions are to be increasingly subjected to governmental scrutiny called public accountability. We must be prepared to justify our needs and document our expenditures to ensure that there is no wasting of these funds made available by curtailment of other programs.

Campaign rhetoric calling for complete access by everyone to all the new medical sophistication on the one hand, may effectively be denied on the other, through the recent concept of cost containment.

Cost containment is designed to cause a reduction in hospital costs and physicians fees, but one of the results of cost containment will be a slowing of the use of new procedures and technology because

this will require additional funds. But as new technology is discovered, there will certainly be pressure from physicians and patients to make it a part of the more conventional health care. In order to do this without additional funds, there will have to be a reduction in the overall quality of medical care.

This situation, though gloomy in prospect now, may give us the opportunity we need to take the initiative. If we persistently speak out publicly about the need for quality in health care, we can re-establish our credibility in the public mind as the patients' advocate. We have always been interested in quality medical care. If we assume our traditional role and continue to speak to this issue, we should be able to convince the public that we are the ones most concerned about quality while the government is interested primarily in cost.

All of this discussion points out that we are confronted by problems of great magnitude and we feel frustrated and angry that there are no easy solutions. We have learned something of the difficulties of finding answers to hard problems during our recent foray into political and legislative arena while working with the malpractice crisis. We didn't achieve all we wanted, but our political activity did get the attention of our elected representatives. Senator Tati Santiesteban at the recent appreciation reception given by the El Paso County Medical Society, said that the doctors were potentially the most powerful political group in El Paso. Now that we have gotten our feet wet politically we should not just wait for another crisis, but we need to keep on contributing our time and money to elect representatives sympathetic to our point of view. Our elected representatives are hearing us better now than ever before when we make suggestions during the legislative decision-making process.

The doctor's lounge has traditionally been our favorite place to exchange ideas--both great and small. Often these conversations have contained ideas of real merit that never made any impact because there was no readily available forum through which these ideas could be presented to the rest of the Society. It is the hope of the editorial board that the El Paso Physician will be that forum. If you hold a strong opinion or if you hear one being expressed by a colleague, consider a letter to the editor or even an article. This is our magazine, just how valuable it will be depends on how we use it. Please feel free to write or call any of us on the editorial board. We welcome your criticism, advice, and encouragement.



Gordon L. Black was born to Clyde and Louise Yates Black, July 6, 1919 in Pecos, TX. and began his eternal life June 19, 2017. Dr. Black grew up in El Paso, TX was an Eagle Scout, graduating from Austin High School, Texas College of Mines and Metallurgy (now UTEP) in 1940. He graduated with honors from University of Texas Medical Branch, Galveston in 1943. He did his internship at Philadelphia General Hospital and Radiology residency at Strong Memorial Hospital, Rochester, NY. He served in the Navy for 2 years including a year in the Pacific during WWII. He was honorably discharged. Dr. Black practiced medicine, was a Fellow of American Board of Radiology and American Board of Nuclear Medicine. His service included private practice with the original "Rainbow Clinic": Mason, Hart, Boverie, Black, Clayton, Green and White, Chief of Radiology at Hotel Dieu Hospital and Providence Memorial Hospital and was Medical Director of El Paso Cancer Treatment Center. He was a Board member and later life Honorary Lifetime Board Member of the Rio Grande Cancer Foundation and served eight years on the Texas Radiation Advisory Board. Dr. Black was President of the El Paso County Medical Society, founding Editor of the El Paso Physician Magazine, and President of the Texas Radiological Society. His community activities included being a Board member of the El Paso Independent School District, Outstanding Ex-student from Austin High School and Outstanding Ex-student from UTEP, and the ST Turner Physician of the Year (chosen by the physicians of El Paso).



A Surprisingly Under-Recognized Cause of Gastroparesis

Bernadette Tan
Tamis Bright, MD

Richard McCallum, Md, FACP, FRACP (Aust), FACG, AGAF

Abstract

Untreated hypothyroidism is an uncommon cause of gastroparesis that manifests with abdominal pain, nausea and vomiting that can mimic gastrointestinal obstruction, especially in a patient with extensive bowel surgery. This article details the workup that led to the diagnosis of hypothyroid-induced gastroparesis, and subsequent management of a patient who presented with the aforementioned symptoms, along with a complicated history of bowel resection, total parental nutrition (TPN) use, and multiple systemic infections.

Introduction

Thyroid hormone status affects gastrointestinal function. Gastroparesis secondary to a hypothyroid state can evoke non-specific symptoms including nausea and weight gain. An extensive history of gastrointestinal surgeries and associated complications made this case of hypothyroid-induced gastroparesis especially challenging.

CASE REPORT

Prior Hospital Course:

A 63-year-old female was referred from a nearby hospital and admitted to our gastroenterology service at University Medical Center for severe refractory nausea and vomiting that had persisted for several days following successful treatment of central line-associated septicemia in the referring hospital.

Past Medical and Surgical History:

This patient had a colectomy with ileostomy eight years ago for colonic inertia that had not responded to sigmoidectomy. A later attempt to reverse the ileostomy failed. Ensuing enterocutaneous fistulas necessitated multiple small bowel resections that left her with twelve inches of small bowel exteriorized to a jejunostomy ring and bag. Consequent development of short bowel syndrome rendered her TPN-dependent, for which a vascular catheter and port were placed. Chronic central line use resulted in several subsequent bouts of septicemia.

A gastric emptying study was performed to ascertain whether short bowel syndrome could entirely explain her large stool volume. It showed dramatically rapid gastric emptying with 53% emptied by 30 minutes, (normal: <30% emptied by 30 minutes) 82% emptied by 1 hour, (normal: <60% emptied by 1 hour) and 97% by 2 hours (normal: <80% emptied by 2 hours). Inadequate bioavailability of oral thyroxine with such rapid

transit along just twelve inches of bowel necessitated parenteral administration.

Admission to Our Service:

On admission to our service, her condition was stable with nasogastric tube in place. Despite mucosal signs of dehydration, she was alert, oriented, and her vital signs were unremarkable. The stoma and the skin surrounding the jejunostomy appeared healthy. She had multiple abdominal surgical scars. Review of systems was positive for nausea, vomiting and intermittent non-radiating epigastric abdominal pain that was not associated with meals. Labs: BUN 68 mg/dL, creatinine 1.6 mg/dL attributable to emesis and dehydration, and ALP 937 units/L, AST 87 units/L, ALT 164 units/L were consistent with a cholestasis secondary to three years of TPN-dependence.

Investigations:

Suspicion of small bowel obstruction based on clinical presentation and the history of extensive bowel surgery prompted an upper GI series, which ruled out obstruction [Figure 1]. Thyroid function: TSH 151mIU/L (normal range 0.5-5.0 mIU/L) and free thyroxine 0.29 ng/dL (normal range 0.7-1.9 ng/dl). That prompted consultation with the endocrinology service. It was discovered from those investigations after admission to UMC that thyroxine replacement per IV TPN line had not been continued at the referring hospital.

Management:

IV Synthroid was re-instituted to correct the marked thyroid hormone deficiency. TPN continued with vitamin and fluid volume supplementation. Teduglutide [Gattex®], a newly approved therapy for short bowel syndrome, was also initiated. Resumption of IV Synthroid (dose: 100 mcg daily) normalized thyroid function and resulted in substantial clinical improvement. Increased oral fluid intake contributed to cessation of nausea and vomiting. She was discharged home eight days after admission.

Follow Up:

At a five week outpatient follow up visit, she reported that mild nausea was well controlled with sublingual odansetron [Zofran®]. Symptoms of hypothyroidism have not returned since parenteral thyroxine replacement was instituted. She was eating her usual diet and maintaining weight. Follow up thyroid function tests: TSH 0.16 uIU/mL (nl: 0.35-5.50) and ft4 1.8 ng/dL (nl:

Continued on page 7

**A Surprisingly Under-Recognized Cause of Gastroparesis
(Continued)**



Figure 1: This upper GI series shows normal emptying of the contrast from the stomach into the duodenum and proximal small bowel. In addition, there is no evidence of small bowel obstruction. Rods can be seen in the thoracic vertebrae from previous spinal surgery. A spinal cord stimulation, which is addressing ongoing back pain, is also pictured.

0.9-1.8 ng/dL), adequately approximate euthyroid status. In the absence of concerning gastroparetic symptoms, a repeat gastric emptying test was unwarranted.

DISCUSSION

Hypothyroidism is defined by subnormal serum free T4 concentration with feedback increased pituitary serum thyroid stimulating hormone secretion.¹ Typical clinical features of hypothyroidism include fatigue, cold intolerance, dry skin, coarse brittle hair & nails, pretibial myxedema, hoarseness, weight gain, and constipation.² Reports of persistent nausea and vomiting are uncommon, and reports of hypothyroid-induced gastroparesis are rare. Those nonspecific symptoms can confound a diagnosis. TSH and free T4 are important to narrow in on the diagnosis.¹

After the confirmatory thyroid function tests in the context of other lab investigations and an upper GI series, ascertainment of the etiology for our patient's nausea and vomiting can be accorded to an understanding of hypothalamic-pituitary-thyroid axis regulation [Figure 2]. Clinical features and symptoms resolved with thyroid hormone replacement therapy and clinical improvement was sustained at follow up.³

Gastroparesis is defined as delayed gastric emptying in the absence of upper GI obstruction, and presents with nausea, vomiting, early satiety, bloating and/or abdominal pain.⁴ Approximately 30% of gastroparesis cases are a consequence of diabetes, 20% result from intended or iatrogenic surgical interruption of the

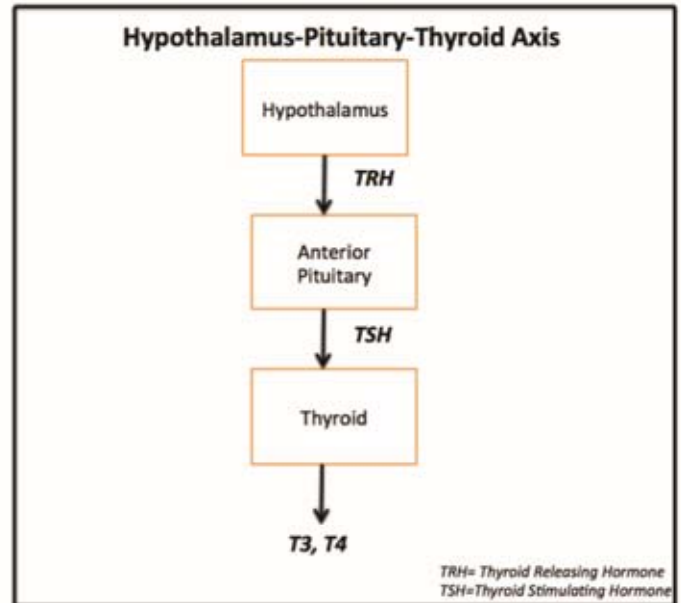


Figure 2: Figure 2 summarizes our understanding of the hypothalamus-pituitary-thyroid axis that is relevant to interpretation of the patient's thyroid profile.

vagal nerve, and up to 50% of cases are deemed idiopathic.⁵

In general, the etiologies of gastroparesis can be organized into two categories: reversible and non-reversible. In this case, non-reversible gastroparesis possibilities that might have reasonably been entertained included vagal nerve injury in light of the history of extensive abdominal surgeries, and chronic idiopathic intestinal pseudo-obstruction, which could also have occurred in consequence to her previous surgeries. Potentially reversible etiologies included hypothyroidism, electrolyte abnormalities with acidosis, critical illnesses such as diabetic ketoacidosis, shock, adrenal insufficiency, sepsis, drugs, and narcotics in particular.⁶

Severe nausea and vomiting were nonspecific symptoms of hypothyroidism, but also the most common symptoms of severe gastroparesis.^{5,4} The voluminous nasogastric output in the absence of upper GI obstruction was further indicative of gastroparesis.

Ultimately, the diagnosis of hypothyroidism-induced gastroparesis was based on finding TSH 151 mIU/mL to uncover the history of inadvertent interruption of thyroid hormone replacement. In a study performed with 76 patients with overt hypothyroidism, a positive correlation was found between their serum TSH concentration and the percentage of positive hypothyroid symptoms reported.⁶ Due to the complexity of this case, weight gain was not present, and other signs and symptoms of hypothyroidism were overshadowed. Her rapid clinical improvement following resumption of thyroid hormone replacement established hypothyroidism as the cause of gastroparesis.

CONCLUSION

Diagnosis of hypothyroidism is usually straightforward, but this

Continued on page 8

**A Surprisingly Under-Recognized Cause of Gastroparesis
(Continued)**

case illustrates that in the absence of other typical symptoms of hypothyroidism, acute gastroparesis can be a less conspicuous manifestation. Include hypothyroidism in the differential diagnosis of nausea and vomiting in severe gastroparesis.

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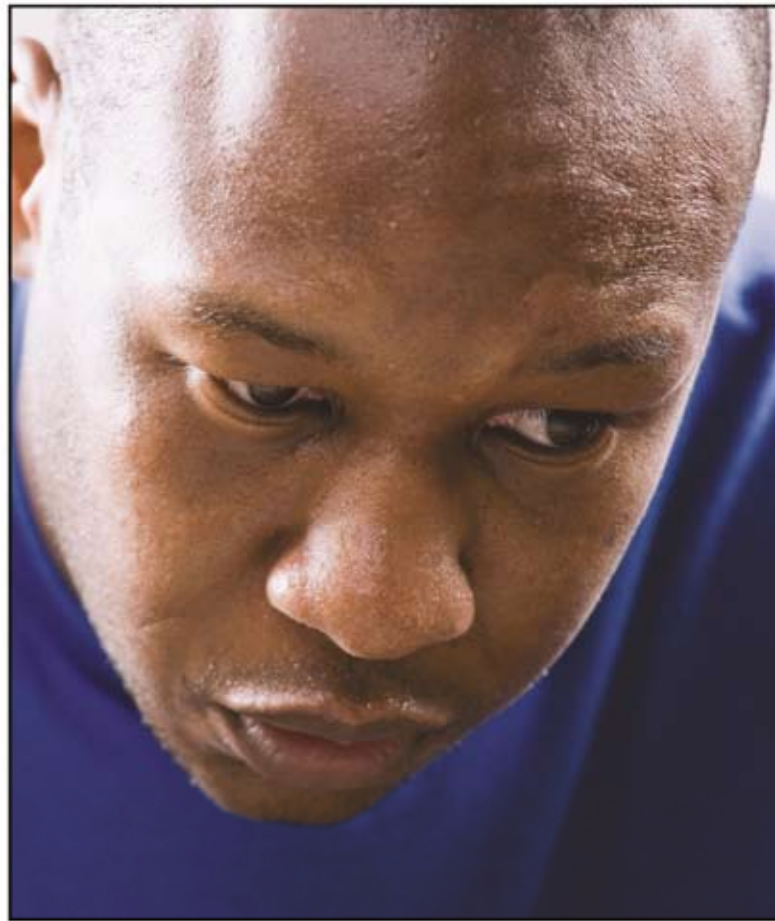
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A Survey of Biocide Resistance Determinants in *Staphylococcus aureus* Strains Collected from Hospitals in the Southwest U.S.-Mexico Border Region

Samantha Meza
Alexis Ramos

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Delfina C. Dominguez, MT (ASCP), MS, PhD

Abstract

Staphylococcus aureus clinical isolates carrying multidrug resistant genes encoding efflux pumps pose a serious health concern in the hospital environment. The activity of these pumps can reduce susceptibility to antibiotics, increase bacterial survival and nosocomial infections. We investigated the susceptibility profile and prevalence of biocide determinants among a collection of methicillin resistant (MRSA) and methicillin-susceptible (MSSA) *Staphylococcus aureus* isolates obtained from two border cities located in the southwest region of the U.S.-Mexico border. Striking differences in susceptibility patterns were found. A significant higher prevalence of MRSA was documented in El Paso, Texas than in Cd. Juárez México. The prevalence for *qacA* (42.8%) and *smr* (17.8%) was intermediate compared to other geographical locations.

Key words: MRSA, biocides, multidrug efflux pumps, multidrug resistance

Introduction

Staphylococcus aureus is a versatile pathogen that can cause a wide variety of infections. Of particular interest is Methicillin resistant *S. aureus* (MRSA), which has the ability to develop resistance to numerous antimicrobial compounds, including antibiotics and biocides. The increased numbers of MRSA infections cause a high burden on health care resources, since these infections have a poor prognosis and prolong hospital stay.¹⁻⁴

Although the resistance developed by MRSA strains may be due to different resistance mechanisms, efflux pumps play a major role in mediating cross-resistance to antibiotics and biocides.^{1,5} Several multidrug efflux genes have been described and characterized from *S. aureus*, including chromosomally encoded genes (*norA*, *norB*, *norC*, *mepA*, *sepA*, *lmrS*) and plasmid encoded genes (*qacA*, *qacB*, *smr*, *qacH*, *qacG*).^{1,4,6} However, a direct link to clinical implications has not been elucidated. To date, more than 20 putative efflux pumps have been identified in the chromosome of *S. aureus*.⁷

The prevalence of biocide genes (*qacA/B*, *smr*) varies widely in the world. Whereas low prevalences were reported from North America 2%-7%, much higher prevalences were reported from China 61%, Europe 63%, Australia, 78% and Brazil 80%.^{5,8-13} As of today, there is no data reported from the U.S.-Mexico border. Until recently, antibiotics were readily purchased over the counter in Cd. Juárez. In both El Paso and Cd. Juárez, biocides are widely

used in infection control, skin decolonization and hand washing.

In the present study, we investigated the susceptibility profile, prevalence of biocide determinants and efflux activity among a collection of MRSA and Methicillin susceptible *S. aureus* (MSSA) clinical isolates obtained from two hospitals from El Paso, Texas and two hospitals from Cd. Juárez, México.

Materials and Methods

Sample collection, Identification and Anti-microbial Susceptibility.

Specimens were collected from patients seen and treated for infections at two hospitals in El Paso, Texas and two hospitals in Cd. Juárez, México. Institutional Review Board approval was obtained from all hospitals as well as from the University of Texas at El Paso. Identification and susceptibility testing was performed using the Microscan® system according to the National Committee for Clinical Laboratory Standards.¹⁴

Bacterial DNA extraction

Bacterial DNA was obtained by using the DNeasy Tissue Kit (Qiagen Inc., Valencia, CA). All procedures were done according to the manufacturer's instructions. The integrity of the genomic DNA was assessed by electrophoresis.

MecA gene

Presence of the *MecA* gene was confirmed by PCR. *MecA* gene amplification was done using the primers and protocols according to Al-Haddad et al. (2001).¹⁵ PCR products were visualized in a 2% agarose gel in TAE with ethidium bromide.

Efflux Activity

The Ethidium Bromide (EtBr) cartwheel method was used to screen all the isolates for efflux activity according to the methods of Martins et al. (2011).¹⁶ Trypticase soy agar plates (150 mm x 15 mm) containing EtBr at different concentrations: 0 µg/ml, 0.5 µg/ml, 1.0 µg/ml, 1.5 µg/ml and 2.0 µg/ml were prepared the same day and stored in the dark. Each plate contained a set of controls. *S. aureus* ATCC 25923 was used as negative control, and *S. aureus* ATCC 25923 EtBr as positive control. Plates were examined under a UV light transilluminator. The capacity of each bacterial strain to efflux EtBr was graded relative to the reference strain.

PCR amplification of efflux pump genes

Nucleotide sequences of primers used to amplify seven efflux

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A Survey of Biocide Resistance Determinants in *Staphylococcus aureus* Strains Collected from Hospitals in the Southwest U.S.-Mexico Border Region
(Continued)

pump genes are shown in Table 1. Amplification conditions were done following methods of Noguchi et al. (1999).¹¹ PCR reactions and conditions for the efflux pump genes for *mepA*, *norA*, *norB*, *norC* and *lmrS* were done according to the protocol of Couto et al. (2008). *lmrS* amplification had an initial denaturation step of 94°C for 1 minute; 35 cycles of 94°C for 1 minute, 55°C for 1 minute and 72°C for 1 minute; and a final extension step at 72°C for 1 minute.⁶ PCR products were analyzed by electrophoresis.

Table 1. Primer sequences used in this study and expected band sizes.

Primer	Sequence (5'-3')	Size of band (bp)	Reference
qacA-Fw	ATGCCTTATATTTATTAATAAATAGCC	321	11
qacA-Rv	ATGCGATGTTCCGAAAATGTTAAC		
smr-Fw	CTATGGCAATAGGAGATATGGTGT	417	11
smr-Rv	CCACTACAGATTCTTCAGCTACATG		
norA-Fw	TTCACCAAGCCATCAAAAAG	620	19
norA-Rv	CTGCTTTCTCCAGCAATA		
norB-Fw	AGCGCGTTGTCTATCTTTCC	213	19
norB-Rv	GCAGGTGGTCTTGCTGATAA		
norC-Fw	AATGGGTCTAAGCGACCAA	216	19
norC-Rv	ATACCTGAAGCAACGCCAAC		
mepA-Fw	ATGTTGCTGCTGCTCTGTTCC	718	19
mepA-Rv	TCAACTGTCAAACGATCAG		
lmrS-Fw	ATGGCTAAAAGTTGAATTAACAAC	1,443	This paper
lmrS-Rv	ACCTAAAGAAATAGAAAAGTAATAGAA GGAAATTTTAA		

Results

A total of 56 *S. aureus* isolates, MRSA and MSSA, were identified from three main sources: skin/soft tissue, respiratory tract and blood. 43 isolates were obtained from El Paso, Texas and 13 from Cd. Juárez, México. All 43 (100%) *S. aureus* isolates from El Paso, Texas were oxacillin resistant. Presence of the *mecA* gene was confirmed by PCR. All 13 (100%) *S. aureus* isolates from Cd. Juárez, México were oxacillin susceptible and were negative for *mecA*.

Susceptibility profile evaluated by Microscan® system showed co-resistance for ceftriaxone and erythromycin in all 43 (100%) El Paso, Texas isolates. 34 (79%) of these isolates were resistant to levofloxacin and ciprofloxacin. 12 (92%) of the organisms collected from Cd. Juárez, México were susceptible to ceftriaxone, erythromycin and all 13 (100%) were susceptible to levofloxacin and ciprofloxacin. All 56 (100%) *S. aureus* isolates collected from both sides of the border showed susceptibility to linezolid, rifampin, gentamicin and vancomycin.

The *qacA* gene was found in 24/56 (42.8%) *S. aureus* isolates: 17 (39.5%) MRSA and 7 (53.8 %) MSSA isolates. Both *qacA*/*smr* were found concomitantly in 10/56 (17.8%) *S. aureus* isolates: 7 (16.2%) MRSA and 3 (23 %) MSSA isolates. Amplification of *qacA* and *qacA*/*smr* genes are shown in Fig. 1 (lanes 2 and 3).

Efflux activity was screened by the ability of the organism to extrude EtBr using the

cartwheel method as described in materials and methods. Bright orange fluorescence was exhibited by organisms unable to efflux the dye whereas no fluorescence indicated extrusion of EtBr (Fig. 2). Efflux activity was ranked relative to reference strains as indicated in materials and methods. 9 (21%) of the MRSA isolates obtained from El Paso, Texas showed efflux activity whereas none of the MSSA isolates collected from Cd. Juárez, México extruded EtBr as indicated by fluorescence. We searched for other genes encoding efflux pumps in the 9 isolates that showed efflux activity. The presence of 5 additional genes, *norA*, *norB*, *norC*, *mepA* and *lmrS* was investigated by PCR (Fig 1). All 9 (100%) isolates showing efflux activity contained *mepA*, *lmrS*, and *norC*; 7 (78%) contained *norA*, and 8 (89%) *norB*. Table 2 summarizes the results obtained for the efflux positive isolates.

Discussion

In the present study we examined the antimicrobial susceptibility profile, prevalence of *qacA* and *smr* genes and efflux activity in a collection of MRSA and MSSA clinical isolates obtained from two border cities, El Paso, Texas and Cd. Juárez, México, located in the southwest region of the U.S.-México border. To our knowledge, this is the first report of biocide determinants in this geographic region.

We found striking differences in antimicrobial susceptibility profile between the *S. aureus* isolates collected from El Paso, Texas and Cd. Juárez, México. While all the *S. aureus* isolates from El Paso, Texas were MRSA, all isolates from México were MSSA. The susceptibility profile also revealed a big contrast in resistance patterns as almost all isolates from El Paso were resistant to ceftriaxone, ciprofloxacin, levofloxacin and erythromycin. We consider that these findings could be due to several factors. 1) Therapy in Cd. Juárez is more conservative due perhaps to limited economic resources 2) The use of carbapenems and beta-lactam/beta lactamase inhibitors and fluoroquinolones in Cd. Juárez's hospitals was minimal compared to El Paso's hospitals and 3) The possibility of many El Paso residents purchasing antibiotics from Cd. Juárez exist, which may increase antibiotic usage and resistance.

It is known that the geographic distribution of biocide genes such as *qacA* and *smr* in MRSA and MSSA varies greatly worldwide. In contrast to the low prevalence (0.6-0.9%) of *qacA/B* genes previously reported in the U.S. (18,19), our findings show a much higher prevalence (56/24) 42.8% for *qacA* and (56/10) 17.8% for

Continued on page 13

Table 2. Efflux pump genes amplified from isolates showing positive efflux by the Cartwheel method

Code	Source	qacA	qacA/smr	mepA	norA	norB	norC	lmrS
EASA 61	Blood	-	-	+	+	+	+	+
EBSA 59	N/A	+	-	+	-	+	+	+
EBSA 54	Bronchial	+	-	+	+	+	+	+
EBSA 68	Other	-	-	+	+	-	+	+
EBSA 91	Ss Tissue	-	-	+	+	+	+	+
EBSA 88	Sputum	-	+	+	+	+	+	+
EBSA 85	Ss Tissue	-	-	+	+	+	+	+
EBSA 82	Blood	-	-	+	-	+	+	+
EBSA 78	Blood	-	-	+	+	+	+	+

EASA: El Paso, Texas Hospital A; EBSA: El Paso, Texas Hospital B; N/A= Not available; Number indicates strain number.

A Survey of Biocide Resistance Determinants in *Staphylococcus aureus* Strains Collected from Hospitals in the Southwest U.S.-Mexico Border Region
(Continued)

smr for all *S. aureus* collected from our border region. In contrast to other geographic locations where *smr* is sporadically reported (Malaysia 1.6%, Japan 3% and African countries 3.7%)^{5,20,21} we found that the prevalence of *smr* is much higher 10/56 (17.8%) in our border region. Our results however, are in agreement with Kosmidis et al (2012),²² who reported a high proportion of strains possessing the *smr* gene in Houston, TX. Moreover, there are few reports on the occurrence of both *qacA/smr* genes being carried by the same strain. Here we found that 10/56 (17.8%) *S. aureus* isolates carry both *qacA* and *smr* concomitantly. Comparable results have been reported by Mayer et al (2001) and Damavandi et al (2016).^{23,24}

Ethidium bromide is a useful substrate to investigate mechanisms associated with multi drug resistant (MDR) phenotype. We used the EtBr cartwheel method to screen our *S. aureus* collection for efflux activity. This method is simple, easy to perform, rapid and allows the screening of multiple isolates per plate. Only MRSA isolates (21%) showed efflux activity. None of the MSSA isolates were positive for efflux despite some of these isolates carrying *qacA* or *qacA/smr* genes. According to Marchi et al. (2015) *qacA*-positive strains have high heterogeneity for EtBr efflux and con-

clude that EtBr efflux assay is appropriate to assess efflux efficiency but is not suitable to cluster strains based on their genotype.²⁵ We acknowledge several limitations in our study: 1) Lack of data about antiseptic use on both sides of the border and antiseptic susceptibilities, 2) Limited data on antibiotic use in El Paso, Texas and Cd. Juárez, México hospitals, 3) Antibiotic sales in Mexican pharmacies and 4) Infection control data to compare prevalence of hospital-acquired *S. aureus* and MRSA infections.

Acknowledgements

We are grateful to Dr. Isabel Couto's (Facultade de Ciências e Tecnologia, UNL, Portugal) generosity for providing control organisms (*S. aureus* 25923 and *S. aureus* 25923ET) needed for the Cartwheel method. We also like to acknowledge Jose C. Rodriguez, CPHT, CCRP for data collection, entry and management.

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Figure 1. Amplification of efflux pump genes by the polymerase chain reaction. PCR products were analyzed in a 2% agarose gel as described in Materials and Methods section. Amplicons of some MRSA isolates are shown in lanes 2 to 8. Lane (1) Precision molecular standards (Bio-Rad) 100 bp, 200 bp, 500 bp, 700 bp and 1000 bp. Lane (2) Isolate harboring *qacA*, Lane (3) isolate harboring *smr* and *qacA*, lane (4) isolate carrying *norA*, Lane (5) *norB*, lane (6) *norC*, lane (7) *mepA* and lane (8) *lmrS*.

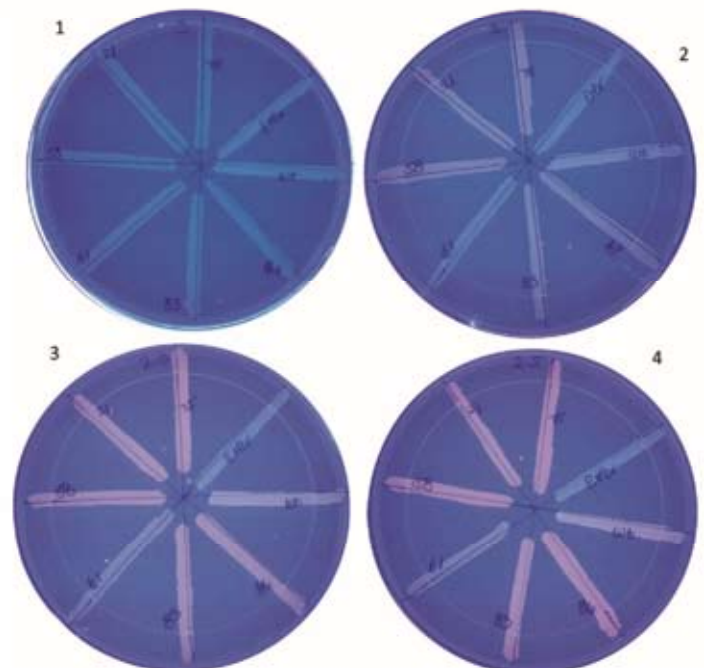


Figure 2. Evaluation of efflux activity by the Cartwheel method. Clinical isolates were swabbed onto TSA plates containing increasing concentrations of ethidium bromide as described in Materials and Methods section. After overnight incubation (16-18 h) at 35°C fluorescence was detected under UV light. Plate 1(0 µg/ml), plate 2 (1.0 µg/ml), plate 3 (2.0 µg/ml) and plate 4 (2.5 µg/ml). Isolates with no efflux activity show a bright orange fluorescence.



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Health Care Collaboration to Enhance Patient Care in Region

Texas Tech University Health Sciences Center El Paso (TTUHSC El Paso) and Tenet, the parent company of The Hospitals of Providence, have teamed up to create the latest health care center in West Texas.

The Hospitals of Providence Transmountain Campus, the nation's newest teaching hospital, and Texas Tech Physicians of El Paso (TTP El Paso) at Transmountain, TTUHSC El Paso's newest clinical site, both promise to serve the communities of El Paso and Southern New Mexico, and provide cutting-edge treatment options in the same location.

"The strength of this initiative is the co-location of inpatient and outpatient services and training opportunities to provide a seamless transition of care," said Michael Romano, MD, MBA, associate dean, Office of Clinical Affairs - Transmountain. "This unique public-private collaboration facilitates ease of access and a continuum of care. TTUHSC El Paso faculty physicians work side by side with Tenet physicians and community providers at the hospital. After discharge, patients return to their primary care providers. Patients without PCPs can be seen at TTP El Paso at Transmountain."



The 110,000-square-foot clinical space and 106-bed, full service community hospital serve as both a treatment center for patients and a training site for budding health care professionals.

"The new training site also adds learning opportunities for TTUHSC El Paso students by providing another type of practice setting, which provides diversity and enhances the educational experience," said Romano.

Rotations for Paul L. Foster School of Medicine students began in mid-May and students in the Gayle Greve Hunt School of Nursing began conducting clinical rotations in July.

"We have two organizations coming together to do something that this community desperately needs—and that's to improve access to well-trained physicians and nurses who serve our community," said Nicholas Tejeda, FACHE, the hospital's chief executive officer.

Only 7 percent of hospitals in the U.S. serve as teaching hospitals. This means that physicians serving in the hospital are constantly learning about the most specialized and up-to-date services for illnesses and injuries.

"Teaching hospitals are typically associated with the highest quality of care," explained Richard Lange, MD, MBA, president of TTUHSC El Paso. "We can bring state-of-the-art teaching, which is state-of-the-art knowledge, and oftentimes that means state-of-the-art research as well."

What's even more exciting for West Texas is the draw this collaboration is expected to have on future physicians. It's no secret that the Paso del Norte region is woefully underserved when it comes to medical care and specialists. But with the opening of the teaching hospital and new clinical site, up to 100 new residency slots will be created in El Paso.

Residency placement often has lasting impacts on where the nation's medical talent is concentrated. Data show that doctors often stay and practice medicine in the community where they completed their residency. By expanding the number of residency slots available in El Paso, the number of doctors who learn and stay in the community to practice will increase.

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Texas Tech Physicians of El Paso (TTP El Paso)'s latest clinic location, TTP El Paso at Transmountain, provides health care services in pediatrics, psychiatry, internal medicine, family medicine, ophthalmology, general surgery, colorectal surgery, pulmonary medicine, and obstetrics and gynecology. In the future, TTP El Paso at Transmountain is expected to expand and offer more health care specialties.

TTP El Paso is the region's largest multi-specialty medical group practice, with approximately 250 specialists and subspecialists, and provides multispecialty care for the entire family. As the medical practice of the Paul L. Foster School of Medicine, the physicians who comprise TTP El Paso each hold faculty appointments at the Paul L. Foster School of Medicine, where they teach the next generation of physicians and are committed to excellence in patient care.



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★ The RotaCare Clinic Needs Your Help ★

The RotaCare El Paso Medical Clinic is in need of volunteers. They need volunteer physicians from the outset, and would welcome any member of the El Paso County Medical Society who could offer his or her services in teaching. Three hours a week chosen by the volunteer physician. Rotary members of the advisory committee include Dr. Lyndon Mansfield, Committee Chair, and Dr. Paul Huchton, Past Committee Chair.

The clinic, located at 301 S. Schutz in Ysleta, is open from 9 a.m. until noon each Saturday. The site was chosen to serve an underserved population and has good public transportation nearby. It provides free medical care to all comers, regardless of ability to pay. Its funding is entirely non-governmental.

The clinic mission is to "provide free medical care in El Paso for those who have the greatest need and the least access". They provide adult and pediatric basic medical services.

If you are interested in volunteering please contact Dr. Paul Huchton at (575) 332-4133 or email phuchton@elp.rr.com.

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American Medical Association Alternate Delegate Report

Roxane Tyroch, MD, FACP



It is with great sadness that I must report that a previous member of the El Paso County Medical Society has left town to practice in another community. Dr. Roger Belbel studied liberal arts at Boston University and graduated from Kansas University of Medicine and Biosciences before doing his internship and residency at William Beaumont Army Medical Center (WBAMC). He completed his Cardiovascular Fellowship at Brooke Army in San Antonio and Interventional and Nuclear at WBAMC. He served in Desert Storm in an evacuation hospital. Upon return to El Paso, he held leadership roles at WBAMC, Las Palmas, VAMC and Physicians Health Associates. He founded Elite Cardiology in 2011, serving his community and extremely loyal patients until 2017. Dr. Belbel has been a role model to many, demonstrating professionalism and service to county and community. He is greatly missed by his patients and colleagues.

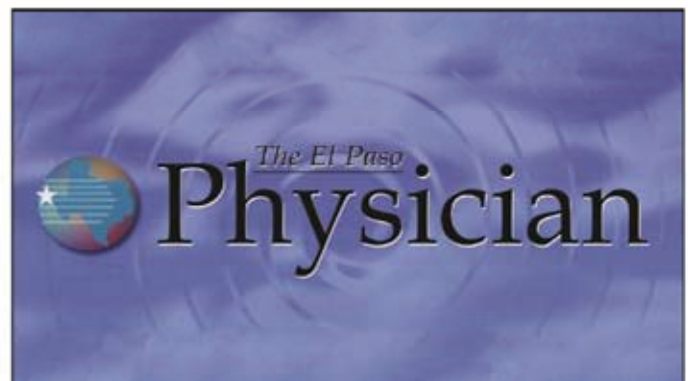
Each year we elect a member to join the executive board. This elected member works their way through the leadership pathway. If you have an interest in leadership please let a board member know. Paid members are welcome to attend board meetings on the second Tuesday of each month. We all help one another and the environment is candid and friendly.

I am extremely proud of the work that the TMA has been doing during this legislative session on behalf of Texas physicians. They continue to work hard on your behalf during the special session. As your AMA alternate delegate, I will report on the focal points at the Chicago Annual meeting in June. Much debate ensued about the attractiveness/unattractiveness of block grants for the management of Medicaid at the state level. AMA leadership has written to congressional leaders regarding the American Health Care Act expressing concerns about rating patients based on pre-existing conditions and high-risk pools with lifetime caps/limits. The AMA evaluates legislative proposals as they advance in Congress to determine impact on patients, physicians and the stability of the insurance market. The health reform objectives of the AMA are to ensure currently covered individuals do not lose coverage, ensure low/moderate income patients can afford coverage, ensure Medicaid, CHIP and other safety net programs are adequately funded, reduce regulatory burdens, provide for cost transparency and to continue advancement of delivery reforms and physician led payment models.

The US Court of Appeals for the DC Circuit upheld a lower court ruling blocking the proposed merger of Anthem and Cigna on an-

titrust grounds. This action sent a clear message to the health insurance industry. I am grateful to the AMA Litigation Center for the amicus brief filed on behalf of physicians and patients. Take a moment to give thanks. TMA and specialty societies cannot fight these battles alone. I strongly believe it is the civic duty of all physicians benefiting from this legislative surveillance and the swift actions taken by the AMA to pay their dues. You have a voice within the organization.

Roxanne Tyroch, MD, FACP, AMA Alternate Delegate, El Paso County Medical Society Delegate.



If you would like to see past episodes of the El Paso Physician TV show, go to the following link

<http://www.pbs.org/show/el-paso-physician/episodes/>

or our web page at www.epcms.com

1. Introduction

Hansen's disease (HD), a.k.a. Leprosy, has affected humanity for ages.¹ The disease results from infection with *Mycobacterium leprae*, an intracellular acid-fast bacillus, which produces a chronic infection in humans and presents as a spectrum of clinical phenotypes.² The clinical outcomes of the disease are greatly influenced by the genetic background,³ and most people are not genetically susceptible to the disease. The role of a healthy carrier is unknown, and the transmission mechanisms of *M. leprae* are not yet fully understood.⁴

2. Epidemiology

Despite an important decline in the global incidence and prevalence of Leprosy in the beginning of the 21st century, both seem to have plateaued since 2005.⁵ A similar phenomenon has been observed in the U.S., where the number and type of new cases of Hansen's Disease reported in 2015, as well as their geographical origins and distribution, have remained practically unchanged since 2005.⁶ Despite the fact that HD patients in the U.S. have origins in many different countries, the greatest number of new cases come from the U.S. itself.⁶ Molecular epidemiological studies have shown that patients with foreign exposure generally are infected with genotypes of *M. leprae* that reflected their country of origin or travel history.⁷

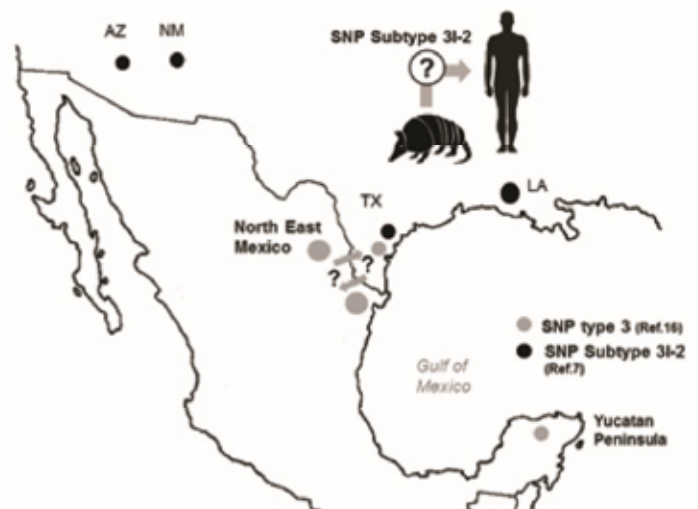
3. Armadillo-borne Leprosy

Armadillos in parts of Louisiana and Southern Texas are a large natural reservoir for *M. leprae*, and leprosy may be a zoonosis in this region.^{4,7,8} *M. leprae* is intensively transmitted among armadillos in this area, with prevalences ranging between 3.8 - 16% depending on the detection method.⁹ Through molecular genotyping, it has been established that many patients with leprosy in the southern U.S. are infected with the same strain of *M. leprae* found in wild armadillos.⁷ Exposure to armadillos is quite common in this region, and includes not only direct contact but consumption of their flesh,⁹ which may help explain the persistent autochthonous transmission in this area. We have personally witnessed this practice in endemic areas for Leprosy such as the Texas Gulf coast and the Amazon. The CDC currently advises to avoid contact with armadillos whenever possible, and to inform your healthcare provider if you had a contact with an armadillo.¹⁰

4. Leprosy in Texas

Texas ranks third in the number of HD cases in the U.S. in 2015 after Florida and California. It ranks fourth for cumulative number of cases between 2005-2014, after California, Hawaii, and Flori-

da.⁶ The earliest published report of Leprosy in the state of Texas dates from 1947, describing an endemic foci of HD in Galveston with records from 1920.¹¹ This focus in counties along the Gulf of Mexico continued to exist through the seventies,¹² eighties,¹³ and nineties.¹⁴ This correlates with northeastern Mexican states that reported an increasing Leprosy detection rate,¹⁵ although the directionality of these geographical spread is uncertain. The predominant genotype in this area or Mexico, determined by using single nucleotide polymorphisms (SNPs) is SNP type 3,¹⁶ which includes the genomes derived from U.S. cases.⁷ Several other aspects, such as socioeconomic, environmental, and behavioral factors that may contribute to Leprosy transmission, need to be taken into account when aiming to eliminate this disease.^{5,17}



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Foreword to Hansen's Disease Article

Leprosy (Hansen's Disease) conjures images of social outcasts with disfigured faces, toes and fingers. Most of these mental pictures come from Hollywood films about biblical times.

It is still true that, if untreated, advanced Hansen's Disease can result in loss of fingers and toes. However, such disfigurement

is preventable. Fortunately, effective antibiotic therapy is now available to arrest the nerve damage and cure the disease.

Though India, Brazil, and Indonesia accounted for 81% of the world's 200,000 cases in 2015, Hansen's Disease is not just a problem for others in the world. 178 cases were reported in the United States in 2015.

As noted by Drs. Manuel Garza and Jorge Cervantes, this month's guest authors from Texas Tech, many of these U.S. cases especially in the southwest, are associated with the handling or consumption of armadillos which naturally harbor the mycobacterium.

There is no need for this worldwide scourge to continue. International drug assistance programs are available to help countries and patients who cannot afford the antibiotic regimen.

Together, we can relegate Hansen's Disease to dusty film cans in some movie archive.

Bruce Parsons, Assistant Health Director at City of El Paso Department of Public Health.



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Medical Students Update

Meenakshi Manivannan, MS2



"Wherever the art of medicine is loved, there is a love for humanity"

– Socrates

The AMA/TMA Leadership and RotaCare leadership team have had an eventful year thus far. Paul L Foster School of Medicine recently welcomed a new class of medical students while current students have been progressing through their medical education. The RotaCare clinic has continued to operate most Saturdays and has had the opportunity to host many events to promote the health of local citizens. TMA/AMA members continue to travel throughout the state and country to represent El Paso and the Paul L Foster School of Medicine.

Members of the TMA/AMA student organization, Micah Ellowitz and Meenakshi Manivannan, traveled to the state capitol in Austin, Texas for First Tuesdays in April. This allowed for medical students from throughout the state of Texas to voice their opinions regarding various bills that were being heard during the Texas 85th legislative session. In conjunction with the El Paso County Medical Society, local medical students had the opportunity to speak with law makers about the legislative priorities of El Pasoans. After successful meetings, medical students were able to host a local meet and greet with Representative Mary Gonzalez at the medical school. Representative Gonzalez spoke about the importance of political involvement for individuals in the medical community, especially right now with talks of various changes in healthcare policy.

In the spirit of political action, TMA representatives Jake Wilson and Derrick Oaxaca were able to successfully have a resolution passed at the TexMed conference held in May in Austin, Texas. Their coauthored resolution called for support of Next Generation 9-1-1, which would advocate for statewide expansion of technology for advanced features related to emergency communications. They also had the opportunity to listen and vote on behalf of the Paul L Foster School of Medicine student body on other resolutions written by medical students that were heard during the TexMed conference. Our AMA representative, Amar Patel, attended the AMA interim meeting in Chicago and voted on several resolutions from medical students around the country about topics ranging from medical education to the opioid epidemic.

Our membership chair, Arezo Nasrazadani, has been involved

with a regionwide AMA project in conjunction with the Rescue Mission of El Paso in effort to tackle issues regarding homelessness and poverty. The goal of the project was to collect donations to assemble medical packs, which were distributed to homeless individuals. The medical packs were compiled through various donations and a fundraiser held at Gufo di Milano on February 24th. A total of 40 medical packs have been collected and donated to the Rescue Mission of El Paso.

The RotaCare Clinic continues to be open every Saturday and serves El Paso and other local communities. The clinic serves as a primary point of medical contact for a diverse group of individuals, ranging for people who were recently uninsured to those who have not seen a doctor in years or decades. The RotaCare Clinic is a wonderful opportunity for local physicians to not only give back to the community in which they are a part of, but also mentor medical students and help cultivate and foster a culture of service. The clinic will also soon have a community health worker aboard to follow up with patients receiving vouchers through the city health department for preventative services. Another exciting addition coming up to the RotaCare clinic are two volunteer nutritionists who will begin nutrition classes that will not only educate patients about healthy eating, but also teach exercises

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Fundraiser at Gufo di Milano on February 24th 2017



Medical Packs that have been donated to the Rescue Mission of El Paso

for patients to perform at home. The nutritionists will also teach cooking classes to make culturally competent, yet healthy meals using ingredients that can be from local grocery stores. The RotaCare clinic not only provides primary care services but also hosts specialty clinics. A Womens' specialty clinic was held on August 5th and an Orthopedic and Ophthalmology specialty clinic was held on August 26th. The RotaCare clinic works with medical providers in the El Paso area to make sure the citizens of this region are healthy.

If interested in volunteering your services, please contact our student director: Christina Alvara. christina.a.alvara@ttuhsc.edu

Meenakshi Manivannan, MS2, AMA/TMA Secretary, TTUH-SC-PLFSOM, El Paso.



CDC **recommendation:**

Test everyone born from 1945-1965 for Hepatitis C

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

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





Medicare and Chip Reauthorization Act (MACRA)

Bruce Edmonds, M Ed., CHTS - IS, IM, PW



There has been a lot of talk this year about changes in health care laws and regulations – from repealing and replacing the Affordable Care Act to letting Obamacare fail. However, one piece of legislation has retained bi-partisan support – the Medicare and Chip Reauthorization Act (MACRA). The clock for MACRA performance has already started ticking, so physicians should be preparing now because MACRA is unlikely to disappear.

MACRA aims to transition Medicare to quality-based payments by requiring most physicians to take one of two paths:

1. Alternative Payment Models (APMs) – Incentivizes participation in alternative payment models (eg, certain accountable care organizations).
2. Merit Based Incentive Payment System (MIPS) – Measures physicians' performance, rewarding good performance with bonuses and punishing bad performance with financial penalties.

Most physicians will be in the MIPS track in 2017. However, you can check your status now at <https://qpp.cms.gov/> to see if you qualify for either the APM track or an exemption.

MIPS will look familiar to most physicians because it combines several existing programs into four new performance categories. See below.

Quality	<ul style="list-style-type: none"> ▪Replaces PQRS and Quality Portion of Value Modifier ▪Report on subset of quality measures
Advancing Care Information	<ul style="list-style-type: none"> ▪Replaces Meaningful Use ▪Participate in electronic exchange of information
Improvement Activities	<ul style="list-style-type: none"> ▪Develop initiatives that improve clinical practice
Cost	<ul style="list-style-type: none"> ▪CMS assesses Medicare claims data ▪Measures previously used in: <ul style="list-style-type: none"> ▪Physician Value-Based Modifier program ▪Quality and Resource Use Report (QRUR)

Success under previous programs will not guarantee success under MIPS, however, because physicians will be graded on a

curve. Physicians will report on performance across these four categories and scores will be calculated on a scale of 0 to 100. Then physicians will be compared to their peers across the country. The top performers will receive financial bonuses, which will be directly funded by financial penalties on the low performers. In other words, the losers will pay the winners.

There is a lot of money on the table too. The potential incentives/penalties can be up to 4% for the 2017 performance year and the maximum increases to over 9% by 2020. To understand how much is at risk for your practice, take your average Medicare part B claims collected in a year and multiple it by the maximum bonuses/penalties per year.

It is not too late to prepare for MACRA if you haven't started yet. You can still likely avoid a penalty for the 2017 performance year by preparing to report on some performance data. Start with the following key steps:

- Determine whether you are in the APM or MIPS track by going to <https://qpp.cms.gov/>
- Prepare to report in 2017 to avoid a penalty
- Develop a strategy to maximize your scores annually
 - Focus on low hanging fruit first
 - Evaluate complexity and cost of other initiatives
- Track your performance regularly by identifying technology and tools that will help you

Many electronic health records (EHRs) offer assistance and technology to support MIPS, but there are other options that will plug-in with your existing EHR though. Don't invest in your EHR's MIPS functionality without looking around. In some cases, EHR platforms for MIPS can be expensive and fail to include all of the tools that you need to succeed.

There are local experts that can help. PHIX is a non-profit health information exchange based in El Paso that offers one-on-one support to physicians preparing for MACRA.

Call PHIX at 915-242-0674 to get started.

Bruce Edmonds, M Ed., CHTS - IS, IM, PW, Director of Physician Engagement, Paso Del Norte Health Information Exchange Board of Directors.

N

NEWS

E.P.C.M.S.

The following is a list of new/re-instated members of the El Paso County Medical Society. Congratulations to all new members!!!

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BARRETT, LISA S., MD
PM
University of Texas Health Sciences Center, San Antonio, 2006
1393 George Dieter, Ste. A
El Paso, TX 79935
(915) 598-8120

CHEN, BRIAN S., MD
OTO NO
Uniformed Services University of the Health Sciences, 2009
1600 Medical Center, Ste. 101
El Paso, TX 79902
(915) 544-1350

ESCONTRIAS, ADRIAN M., MD
AN
UT Southwestern Medical Center, 1997
5959 Gateway Blvd West, Ste. 120
El Paso, TX 79925
(915) 772-2617

FUNKHOUSER, TODD A., MD
AI A
University of New Mexico School of Medicine, 1999
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El Paso, TX 79912
(915) 777-7207

GARZA, BRIANNA C., MD
PD
UT Medical Branch, 2014
650 Belvidere
El Paso, TX 79912
(915) 533-1441

GAUR, SUMIT, MD
IM HEM
JLN Medical College Rajasthan University, 1998
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El Paso, TX 79905
(915) 215-5195

JABARA, BENJAMIN J., MD
VIR DR
Tulane University School of Medicine, 2008
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JULIAN, MARILYN P., MD
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KHAIR, TARIF H., MD
CD IM
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LEE, JEANNE, MD
PLM HOS
Duke University, 2006
1625 Medical Center
El Paso, TX 79902
(915) 747-2617

MULUKUTLA, VENKATACHALAM, MD
CD MPD
Baylor College of Medicine, 2005
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News (Continued)

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SCHAFFER, MICHAEL G., MD
OBG
University of Florida College of Medicine, 1988
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STEWART, KEVIN L., MD
PHL FM
UT Southwestern Medical Center, 1988
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El Paso, TX 79902
(915) 533-5100

TANO, SHEEBA V., DO
IM
University North Texas Health Sciences Ctr., 2010
1901 Grandview Ave.
El Paso, TX 79902
(915) 544-6750

VIADO, EMMA S., MD
PD
Faculty Medicine/Surgery University Santo Tomas, 1976
300 S. Zaragosa
El Paso, TX 79907
(915) 790-5700

WESTBROOK, BENJAMIN J., MD
OTO
Uniformed Services University of the Health Sciences, 2007
1600 Medical Center, Ste. 101
El Paso, TX 79902
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MIPS: LAST DAY OF THE 2017 MIPS PERFORMANCE YEAR UNDER THE CMS QUALITY PAYMENT PROGRAM

Background

Due to the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), the Centers for Medicare & Medicaid Services (CMS) designed a new Quality Payment Program that has two payment pathway options: the Merit-Based Incentive Payment System (MIPS) and advanced alternative payment models (APMs). The CMS Quality Payment Program began on Jan. 1, 2017, and performance in the pathway you choose this year will affect your Medicare payment in 2019.

Regulating body

CMS Quality Payment Program <https://qpp.cms.gov/>

Compliance date

12/31/2017

Consequences

Under the CMS Quality Payment Program framework, if you do not participate in an Advanced APM in 2017, you may be subject to MIPS this year. To find out if you are required to submit data to MIPS or if you are exempt this year, refer to the letter CMS sent to your practice or access the online lookup tool on the Quality Payment Program website at <https://qpp.cms.gov/learn/eligibility>. If you are not exempt and choose not to participate in either pathway in 2017, you will receive an automatic 4-percent pay cut on a per claim basis to your Medicare Part B payments in 2019.

Next steps

If you are required to participate in MIPS for the 2017 performance year, you may pick your pace to participation by submitting data to MIPS representing a full calendar year (Jan. 1-Dec. 31) or partial year (any 90-day period), or by submitting a minimum amount of data for any point in time in 2017. The data submission timeframe for the 2017 MIPS performance year ranges from Jan. 1 to March 31, 2018, and reporting deadlines within this timeframe vary depending on the reporting mechanism you use for each MIPS category. To avoid the 2019 payment penalty, you must report at least one quality measure/one patient for the quality category, one improvement activity for the improvement activities category, or the required measures for the base score for the Advancing Care Information category. For complete details about 2017 MIPS participation and reporting options, click on the CMS link above to visit the Quality Payment Program website. For questions, contact the CMS Quality Payment Program Service Center by phone at (866) 288-8292 or by email at QPP@cms.hhs.gov.

Find out how TMA can help at <https://www.texmed.org/macra/%20>

YourTexasBenefitsCard gives providers access to Medicaid health information

It's free and only requires a one-time registration!

If you are a registered Medicaid Provider in Texas, you can have free access to an online portal, YourTexasBenefitsCard.com (YTBC).

This portal aggregates data from disparate sources into one central hub - for managed care and fee-for-service plans. All of this information is collected and displayed in a consolidated Health Summary form with the ability to see more details. The YTBC portal helps patients and providers by improving quality of care and reducing duplication of services, it provides a centralized tool to manage sharing patient consent, and it complements provider's clinical information providing patient's current prescription medicines or serious health conditions before performing procedures.

The YTBC portal lets providers:

- View Medicaid patients' available health information including past Medicaid visits, health events, vaccines, prescription drugs and lab data; this information is primarily claims and encounter based
- View THSteps Alerts
- Verify Medicaid patient eligibility and view patient program information
- Authorize provider-level functionality to a delegate
- Use the Blue Button to request a Medicaid patient's available health information in a single tool
- Check-in and check-out patients at time of appointment
- View and print the patient's Medicaid ID card
- Use the YTBC portal on mobile devices — The portal adjusts to view available information from your tablet or smart phone
- Access the MCNA Dental and DentaQuest portals through a link



Texas Medicaid is currently conducting a pilot to integrate the YourTexasBenefitsCard.com (YTBC) provider portal with participating managed care organizations' (MCOs) and dental management organizations' (DMOs) provider portals. The integration is not intended to replace functions already existing in the current MCO/DMO portals, but rather to expand the functionality those portals provide by making the YTBC provider portal accessible through a single 'click.' To get more information regarding this pilot, visit www>YourTexasBenefitsCard.com and click on the [HHS Pilot Packet](#).

In addition, an online portal is available for Medicaid patients, seamlessly accessed (via SAML Token) from the State's Self Service Portal. They can view their benefit and case information, print or order Medicaid ID cards, set up and view Texas Health Steps alerts and email notifications, choose whether to allow others to view their health information. Adult patients can view their available health information online and use the Blue Button to download their health information in various formats. Encourage your Medicaid patients to visit www>YourTexasBenefits.com to learn more and sign up.

Need help or have questions about YourTexasBenefitsCard?

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