HOUSE OF DELEGATES

May 5, 2018
Nashville Airport Marriott
Nashville, Tennessee
MEMORANDUM

TO: TMA House of Delegates

FROM: Edward W. Capparelli, MD, Speaker, House of Delegates
       Charles E. Leonard, MD, Vice-Speaker, House of Delegates

DATE: May 5, 2018

Welcome to Nashville
and the 183rd Annual Meeting
of the
Tennessee Medical Association

As an elected delegate from your component medical society, medical specialty society, Young Physician Section, Resident/Fellow, or Student Section of the TMA, your participation in the Tennessee Medical Association House of Delegates’ sessions is important. You are part of the decision-making process that will set policy and direction for the medical profession in Tennessee next year.

The credentialing process and seating arrangement for members of the House of Delegates is in place to accommodate the increasing number of delegates who attend, as well as the number of alternate delegates who are available to substitute for their elected delegates. Please give yourself sufficient time to be properly credentialed before the session starts.

Your handbook has been condensed to focus on the business of the House and includes only officer’s reports, amendments to the Constitution and Bylaws, and resolutions to be considered. Committee reports that are informational only (requiring no action by the House) have not been reproduced; however, they are available at tnmed.org/hod. The entire set of meeting materials can be downloaded on your iPad or tablet by visiting this site as well. Assistance with downloading the materials is available at the registration desk.

If there is any way we can be of assistance to you in better understanding your role, please call on us.
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TENNESSEE MEDICAL ASSOCIATION ANTITRUST STATEMENT

The Tennessee Medical Association (“TMA”) is a non-profit, professional association organization committed to enhancing the effectiveness of physicians throughout the state and protecting the health interests of patients by defining and promoting quality, safe and effective medical care; advancing public policy to protect the sanctity of the physician-patient relationship and improve access to and the affordability of quality medical services; supporting ethics and competence in medical education and practice; and maintaining open communications between the medical profession and the public, fostering a better understanding of the capacities of medical practice.

TMA has a strict policy of compliance with federal and state antitrust laws. The antitrust laws prohibit agreements among competitors that restrain trade, and TMA members can be considered to be competitors for purposes of antitrust challenges even if their professional medical practices are not in the same geographic areas or in the same professional service lines. The penalties for violations of the antitrust laws are severe for medical associations and their members.

In all TMA activities, each member, as well as TMA staff, shall be responsible for following the TMA’s policy of strict compliance with the antitrust laws. TMA officers, trustees, board, council and committee chairs, and executive staff shall ensure that this policy is known and adhered to in the course of activities pursued under their leadership. Antitrust compliance is the responsibility of every TMA member and staff.

General Antitrust Compliance Principles

The TMA will not become involved in the competitive business decisions of its individual members, nor will it take any action that would tend to restrain competition. The TMA is firmly committed to the principle of competition served by the antitrust laws, and good business judgment demands that every effort be made to assure compliance with all applicable federal and state antitrust laws and trade regulations.

TMA members cannot come to understandings, make agreements, or otherwise concur on positions or activities that in any way tend to raise, lower, or stabilize prices or fees, allocate or divide up markets, or encourage or facilitate boycotts. Individual TMA members must make such business decisions on their own and without consultation with their competitors or the TMA.

In general, TMA activities and communications shall not include any discussion or action that may be construed as an attempt to: (1) raise, lower, or stabilize prices; (2) allocate markets or territories; (3) prevent any person or business entity from gaining access to any market or to any customer for goods or services; (4) prevent or boycott any person or business entity from obtaining services freely in the market; (5) foster unfair trade practices; (6) assist in monopolization or attempts to monopolize; or (7) in any way violate applicable federal or state antitrust laws and trade regulations. The actual purpose and intent of TMA’s policies and programs are important in this regard. They cannot be aimed at accomplishing anti-competitive objectives.

The antitrust laws are complicated and often unclear. If any member on TMA business is concerned about being in a “gray area,” the member should consult with the TMA General Counsel. If the conversation among competitors at a TMA meeting turns to antitrust-sensitive issues, participants should discontinue the conversation until legal advice is obtained or leave the meeting immediately and request that their absence from the remainder of the meeting be recorded in the minutes.
Discussions of pricing or boycotts as part of TMA scheduled programs or at TMA sponsored meetings could implicate and involve the TMA in extensive and expensive antitrust challenges and litigation. In addition, the United States Supreme Court has determined that an association can be held liable for statements or actions in antitrust-sensitive areas by volunteer leaders who claim to speak for the association, even if they are not authorized to speak in that area. **Trustees and officers of the TMA must, therefore, make clear whether they are speaking in their official capacity when they address such issues. If they are making personal remarks outside of a TMA setting, the speaker should clearly state that he or she is speaking for him or herself, and not on behalf of the TMA.**

To assist the TMA staff, officers, trustees and committee chairs in recognizing situations that may give the appearance of an antitrust concern, the Board of Trustees shall provide to each such person, copies of this Antitrust Statement. Committees and task forces will be instructed on this policy during the first meeting of each calendar year and when new members are added.

Any violation of the antitrust policy will be brought to the attention of the Board of Trustees, and the Board will deal with it in a timely and appropriate manner. The Board of Trustees will consult with the TMA General Counsel, and/or its outside counsel, when questions arise as to the manner in which the antitrust laws may apply to the activities of TMA.

**Specific Rules of Antitrust Compliance**

1. TMA activities shall not be used for the purpose of bringing about, or attempting to bring about, any understanding or agreement, written or oral, formal or informal, expressed or implied, among competitors with regard to prices or fees, terms or conditions of sale, discounts, territories or customers. For example, any agreement by competitors to “honor,” “protect,” or “avoid invading” one another’s geographic areas, practice specialties, or patient lists would violate the law.

2. TMA activities and communications shall not include discussion or actions, for any purpose or in any fashion, of prices or pricing methods or other limitations on either the timing of services or the allocation of territories or markets or customers in any way. For example, TMA members cannot come to understandings, make agreements, or otherwise concur on positions or activities that are directed at fixing prices, fees, or reimbursement levels. Likewise, TMA members cannot make agreements as to whether they will or will not enter into contracts with certain managed care plans. Even if no formal agreements are reached on such matters, discussions of prices, group boycotts, or market allocations followed by parallel conduct in the marketplace can lead to antitrust scrutiny or challenges. Members may, however, consult with each other and freely discuss the scientific and clinical aspects of the practice of medicine.

3. TMA shall not undertake any activity that involves exchange or collection and dissemination among competitors of any information regarding prices, pricing methods, cost of services or labor, or sales or distribution without first obtaining the advice of legal counsel, when questions arise as to the proper and lawful methods by which these activities may be pursued. For example, caution should be exercised in collecting data on usual and customary fees, managed care reimbursement levels, workforce statistics, and job market opportunities. While the mere collection of data on such matters is permissible if certain conditions are met, antitrust concerns may arise if the data become the basis for collective action.
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<td>V. Sreenath Reddy, MD</td>
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<td></td>
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<td>Adrian Rodriguez, MD</td>
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<td>Nicole Schlechter, MD</td>
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<td>Jane Siegel, MD</td>
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<tr>
<td>Component Society</td>
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<tr>
<td>Nashville Academy of Medicine (cont.)</td>
<td></td>
<td>Michael K. Smith, MD</td>
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<td>K. Shannon Tilley, MD</td>
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<td>Joseph Wieck, MD</td>
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<td>Mary Yarbrough, MD</td>
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<tr>
<td>NW Tennessee Academy of Medicine</td>
<td>2</td>
<td>Selena Dozier, MD</td>
<td>Susan Lowry, MD</td>
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<td></td>
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<td>James Shore, MD</td>
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<tr>
<td>Roane-Anderson</td>
<td>2</td>
<td>George Smith, MD</td>
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<td></td>
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<td>David Stanley, MD</td>
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<tr>
<td>Robertson</td>
<td>1</td>
<td>Jonathan Kroser, MD</td>
<td>Keith Goldberg, MD</td>
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<tr>
<td>Scott</td>
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<td>Trent Cross, MD</td>
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<td>Stones River</td>
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<tr>
<td>Sullivan</td>
<td>6</td>
<td>Landon Combs, MD</td>
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<td>Joseph DeStefano, MD</td>
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<td>Donald Lovelace, MD</td>
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<tr>
<td>Tipton</td>
<td>1</td>
<td>Vincent Kent, MD</td>
<td>Joshua Dillon, MD</td>
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<td>TMA Direct</td>
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<tr>
<td>Upper Cumberland</td>
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<td>James McKinney, MD</td>
<td>Eric Fox, MD</td>
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<td></td>
<td></td>
<td>Ralph Saunders, MD</td>
<td>F. Bronn Rayne, MD</td>
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<td></td>
<td></td>
<td>C. Gray Smith, MD</td>
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<tr>
<td>Washington-Unicoi-Johnson County Medical Association</td>
<td>8</td>
<td>Faith A. Aimua, MD</td>
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<tr>
<td></td>
<td></td>
<td>Christine Moore, DO</td>
<td>Timothy Smyth, MD</td>
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<tr>
<td>Williamson</td>
<td>3</td>
<td>John Binhlam, MD</td>
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<tr>
<td></td>
<td></td>
<td>Amy Suppinger, MD</td>
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<tr>
<td>Wilson</td>
<td>1</td>
<td>Wayne Wells, MD</td>
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<tr>
<td>Total Eligible Members</td>
<td>174</td>
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## TMA Sections

### Medical Student Section

<table>
<thead>
<tr>
<th>Delegate</th>
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<tbody>
<tr>
<td>Zachary Sherman</td>
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### Resident and Fellow Section

<table>
<thead>
<tr>
<th>Delegate</th>
<th>Alternate Delegate</th>
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<tbody>
<tr>
<td>Steven Woods, Jr., MD</td>
<td>Lesley Jackson, MD</td>
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### Young Physician Section

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<thead>
<tr>
<th>Delegate</th>
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### Medical Specialty Society Delegates

<table>
<thead>
<tr>
<th>Specialty</th>
<th>Eligible Delegates</th>
<th>Delegate</th>
<th>Alternate Delegate</th>
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<tbody>
<tr>
<td>TN Chapter, American College of Physicians</td>
<td>6</td>
<td>Tracey Doering, MD</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>Richard Lane, MD</td>
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<td></td>
<td></td>
<td>Fred Ralston, Jr., MD</td>
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<td></td>
<td></td>
<td>Bob Vegors, MD</td>
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<tr>
<td>TN Academy of Family Physicians</td>
<td>8</td>
<td>William Bates, III, DO</td>
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<tr>
<td></td>
<td></td>
<td>Peggy Sue Brooks, MD</td>
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<td></td>
<td></td>
<td>Walter Fletcher, MD</td>
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<td></td>
<td></td>
<td>Katherine Hall, MD</td>
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<tr>
<td></td>
<td></td>
<td>Terry Holder, MD</td>
<td></td>
</tr>
<tr>
<td>TN Radiological Society</td>
<td>2</td>
<td>Francis G. Curtin, MD</td>
<td></td>
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<tr>
<td></td>
<td></td>
<td>James Martin, MD</td>
<td></td>
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<tr>
<td>TN College of Emergency Physicians</td>
<td>1</td>
<td>Kenneth Holbert, MD</td>
<td></td>
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<tr>
<td>Ex-Officio Delegates to the TMA House of Delegates – 2018</td>
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<tr>
<td>(Ex-Officio Delegates Are Voting Delegates in the TMA House of Delegates)</td>
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<table>
<thead>
<tr>
<th>Officers</th>
<th>TMA Former Presidents</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nita W. Shumaker, MD, President</td>
<td>John B. Dorian, MD (1978-79)</td>
</tr>
<tr>
<td>Matthew Mancini, MD, President-Elect</td>
<td>George W. Holcomb, Jr., MD (1982-83)</td>
</tr>
<tr>
<td>Keith Anderson, MD, Immediate Past President</td>
<td>James T. Galyon, MD (1987-88)</td>
</tr>
<tr>
<td>Edward Capparelli, MD, Speaker House of Delegates</td>
<td>Howard L. Salyer, MD (1991-92)</td>
</tr>
<tr>
<td>Charles W. White, Sr., MD (1993-94)</td>
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<tr>
<th>Board of Trustees</th>
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<tr>
<th>Vice-Speaker House of Delegates</th>
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<tbody>
<tr>
<td>J. Mack Worthington, MD (2007-08)</td>
<td>Richard J. DePersio, MD (2009-10)</td>
</tr>
<tr>
<td>B. W. Ruffner, Jr., MD (2010-11)</td>
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<table>
<thead>
<tr>
<th>Councilors</th>
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<tbody>
<tr>
<td>F. Michael Minch, MD (2011-12)</td>
<td>Wiley T. Robinson, MD (2012-2013)</td>
</tr>
<tr>
<td>John W. Hale, Jr., MD (2015-2016)</td>
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<thead>
<tr>
<th>AMA Delegates</th>
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<tbody>
<tr>
<td>John J. Ingram, III, MD, Vice Chair</td>
<td>Chief Medical Officer</td>
</tr>
<tr>
<td>Richard J. DePersio, MD</td>
<td>David R. Reagan, MD</td>
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<table>
<thead>
<tr>
<th>Region 1</th>
<th>Justin Monroe, MD</th>
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<tbody>
<tr>
<td>Wiley T. Robinson, MD (2012-2013)</td>
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<thead>
<tr>
<th>Region 2</th>
<th>Pamela D. Murray, MD</th>
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<tr>
<td>Chris E. Young, MD (2013-2014)</td>
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<tr>
<th>Region 3</th>
<th>Omar L. Hamada, MD</th>
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<tr>
<th>Region 4</th>
<th>Richard G. Soper, MD</th>
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<tr>
<td>John W. Hale, Jr., MD (2015-2016)</td>
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<thead>
<tr>
<th>Region 5</th>
<th>James C. Gray, MD</th>
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<tbody>
<tr>
<td>Editor of Tennessee Medicine</td>
<td>David G. Gerkin, MD</td>
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<thead>
<tr>
<th>Region 6</th>
<th>Shauna Lorenzo-Rivero, MD</th>
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<tr>
<th>Region 7</th>
<th>Richard M. Briggs, MD</th>
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<tr>
<th>Region 8</th>
<th>Charles E. Leonard, MD</th>
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<tr>
<th>Department of Health</th>
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<tr>
<td>John J. Dreyzehner, MD</td>
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<tr>
<th>Donald B. Franklin, Jr., MD, Chair</th>
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<tr>
<td>or</td>
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<tr>
<td>John J. Ingram, III, MD, Vice Chair</td>
<td>Chief Medical Officer</td>
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<tr>
<td>Richard J. DePersio, MD</td>
<td>David R. Reagan, MD</td>
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COMMITTEES OF THE HOUSE

Credits Committee
Wm. Kirk Stone, MD, Union City, Chair
Elise Denneny, MD, Knoxville
Fred Ralston, Jr., MD, MACP Fayetteville

The Credentials Committee should meet at the credentialing desk on Saturday prior to the House sessions to pass on the eligibility of those seeking a seat in the House of Delegates. All duly certified and elected delegates or their alternate delegates and ex-officio delegates are entitled to be seated.

Any other persons presenting themselves as delegates must have documentation of election signed by their component medical society President or Secretary to present to the Credentials Committee for approval. The chair of the Credentials Committee should use the list of delegates and ex-officio delegates in the Handbook to check the attendance of all persons at each session of the House and file the same with the Chief Executive Officer at adjournment.

Special Committee on Resolutions
Wiley Robinson, MD, Memphis, Chair
Richard Lane, MD, Franklin
Andrew Watson, MD, Germantown

With the demise of reference committees it became necessary to establish a group at each House of Delegates meeting to be on standby to discuss any resolutions that cannot be resolved by the House. Unresolved resolutions are referred by the speaker to the Special Committee on Resolutions. If needed, the committee will convene during a recess of the House to discuss all resolutions in controversy. It does not file a report but drafts an amended resolution for submission to the House with a recommendation that the resolution be adopted, adopted as amended, or that the resolution not be adopted.
Order of Business

First Session of the House of Delegates
Saturday, May 5, 2018
Nashville Airport Marriott, Nashville, TN

Edward W. Capparelli, MD, Speaker  Charles E. Leonard, MD, Vice-Speaker

<table>
<thead>
<tr>
<th>Time</th>
<th>Event</th>
<th>Location</th>
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<tbody>
<tr>
<td>7:00 AM – 8:30 AM</td>
<td>DELEGATE CREDENTIALING</td>
<td>Ballroom Foyer</td>
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<tr>
<td>8:30 AM – 10:30 AM</td>
<td>TMA HOUSE OF DELEGATES</td>
<td>Salons D &amp; E</td>
</tr>
</tbody>
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1. Call to Order .................................................................................................................. Speaker
2. Invocation/National Anthem/Pledge of Allegiance................................. Bob Vegors, MD/Speaker
3. Introduction of Distinguished Guests .................................................................................. Speaker
4. Memorials Report .................................................................................. Jerome Thompson, MD
5. Housekeeping Announcements................................................................. Speaker
6. Declaration of a Quorum ............................................................................ Wm. Kirk Stone, MD
7. Approval of Actions of Last Session................................................................. Speaker
   (As reported to members via email and on tnmed.org)
8. Guest speaker ................................................................................................ David Reagan, MD
9. Ratification of Outstanding Physician Awards............................................. Nita Shumaker, MD
10. Reports of Officers
    (A) President............................................................................................ Nita Shumaker, MD
    (B) Chair, Board of Trustees................................................................. James K. Ensor, Jr., MD
    (C) Secretary-Treasurer ..................................................................... Tedford S. Taylor, MD
    (D) Chairman, Judicial Council .......................................................... Charles E. Leonard, MD
    (E) Chief Executive Officer................................................................ Russell E. Miller, Jr., CAE
11. Reports of Committees
   No. 1 Committee on Constitution & Bylaws .................................Robin Williams, MD
   No. 2 Insurance Issues Committee.............................................Charles E. Leonard, MD
   No. 3 Committee on Public Health .............................................Adele M. Lewis, MD
   No. 4 Committee on Legislation ...............................................Ronald H. Kirkland, MD
   No. 5 IMPACT ..................................................................................Newt Allen, MD
   No. 6 Professional Relations Committee ....................................Thomas Pollard, MD
   No. 7 Membership & Recruitment Committee ..........................Jerome W. Thompson, MD
   No. 8 Education Committee ........................................................Pete Powell, Jr., MD
   No. 9 Tennessee Delegation to the AMA .................................Donald B. Franklin, Jr., MD

12. Informational Reports
   No. 1 Tennessee Medical Foundation .................................Michael J. Baron, MD
   No. 2 Board of Medical Examiners ..............................................Subhi D. Ali, MD
   No. 3 Tennessee Medical Education Fund ..................................Subhi D. Ali, MD
   No. 4 Report of the Editor ..........................................................David G. Gerkin, MD
   No. 5 John Ingram Institute .........................................................John J. Ingram, III, MD

13. Consent Calendar
   - Resolutions to Sunset and Become Permanent Policy ..............................Speaker
   - Resolutions to Sunset ....................................................................Speaker

14. Introduction of Amendments ............................................................Speaker
   (a) to the Constitution
   (b) to the Bylaws

15. Introduction of Resolutions .............................................................Speaker

16. Introduction of Additional Amendments and Resolutions, if any ........................Speaker
   (In emergency only and requiring 51% approval of the House)

17. Report of the Nominating Committee .............................................Nita Shumaker, MD

18. Report of the TMA Alliance President..................................................Kristi Bonvallet

19. Announcements

20. Recess until 1:45 PM Saturday, May 5, 2018
Order of Business

Second Session of the House of Delegates
Saturday, May 5, 2018
Nashville Airport Marriott, Nashville, Tennessee

Edward W. Capparelli, MD, Speaker                              Charles E. Leonard, MD, Vice-Speaker

1:00 PM – 1:45 PM DELEGATE CREDENTIALING                       Ballroom Foyer
1:45 PM TMA HOUSE OF DELEGATES                                 Salons D & E

1. Call to Order .................................................................................................................. Speaker
2. Declaration of a Quorum ................................................................. Wm. Kirk Stone, MD
3. Introduction of Distinguished Guests .................................................. Speaker
4. Guest speakers ........................................................................... David O. Barbe, MD, President
   American Medical Association
5. Announcement of Tellers........................................................................ Speaker
6. Housekeeping Announcements ................................................................. Speaker
7. Introduction of Additional Amendments and Resolutions, if any ................ Speaker
   (In emergency only and requiring 51% approval of the House)
8. Procedures of the House of Delegates .................................................. Speaker
9. Announcement of Special Committee on Resolutions.......................... Speaker
10. Consideration of Constitutional Amendment (if any) ............................. Full House
11. Consideration of Bylaw Amendments ................................................. Full House
12. Consideration of Resolutions ................................................................. Full House
13. Election of Speaker and Vice-Speaker ........................................ Nita Shumaker, MD
14. Announcement of Place and Dates of Annual Meeting 2019 ................. Speaker
15. Other Business .......................................................................................... Speaker
16. Installation of Matthew L. Mancini, MD, 164th President of the Tennessee Medical Association ......................................................... Nita Shumaker, MD
17. Adjourn
Last spring, I stood before the House of Delegates following my installation and communicated one clear goal for my term as your President: making some measurable difference in Tennessee’s opioid abuse epidemic.

I started immediately touring the state to talk to doctors and other healthcare providers. I listened to them and learned as much as I could about our prescribing patterns so I – through the platform and support of Tennessee Medical Association (TMA) – could be a change agent for the medical community.

I championed non-opioid pain management therapies, following Tennessee and CDC chronic pain guidelines, weaning patients to less addictive medications, and limiting initial dosage and days’ supply when opioids are necessary.

I tried to take every opportunity to educate patients and the general public about the dangers of these medications, making regular comments in media across the state and speaking to civic groups, medical students, residents, and other organizations. I wanted to be sure physicians were represented wherever and whenever people talked about the crisis and how to solve it, and that TMA had a hand in raising awareness around safe storage and proper disposal.

In November 2017, I participated in a statewide summit led by the Department of Health. The entire healthcare community – physicians, hospitals, nurses, pharmacists, government agencies and other stakeholders – gathered to share best practices and talk about what we can do to “turn the tide” on the opioid crisis. We came away with four main actionable initiatives, one of which I volunteered to lead. I will continue working on provider education that helps physicians and extenders learn how to treat pain without using opioids, especially in primary care settings. We seek innovative ways to help primary care providers understand how to identify and treat pain differently. The stakeholders who participate in the summit, including state agencies and large insurance companies, are beginning to work with us to get information to doctors about their prescribing patterns and which patients are at risk. We need to make this transition easier for doctors with real, actionable ideas that help change the culture within Tennessee’s healthcare community.

Earlier this year, at my request, we dedicated a special edition of Tennessee Medicine magazine to the opioid epidemic. That publication is meant to serve as a reference for doctors and other prescribers who want to follow safe and appropriate guidelines for pain. TMA staff is also in the process of developing a public-facing online repository that will include these and other resources.

The opioid epidemic turned out to be the highest priority for TMA in the 2018 legislative session, despite several other big items on our agenda. We’ve had an outstanding year in the General Assembly (see: MOC, balance billing, tanning beds, and more), traveled to D.C. to work on federal
healthcare issues and took on a number of advocacy initiatives related to the practice and/or business of medicine. We continue to make gains in membership and train doctors to lead team-based healthcare delivery teams. Our organization is on firm financial footing, thanks in part to a successful building move in Nashville and responsible management by our Board and staff, with special thanks to Secretary-Treasurer, Dr. Ted Taylor.

I’m proud of what we’ve accomplished. A report just released in April shows that opioid prescriptions at retail pharmacies in Tennessee dropped nearly nine percent in 2017 compared to 2016, and has decreased 21.3 percent from 2013. Tennessee outperformed most of our neighboring states during this period and is on par with the national average for year-over-year improvements and five-year trends.

I’m also aware of just how much work still needs to be done on our state’s number one public health crisis. The same report shows that Tennesseans filled 6.7 million opioid prescriptions in 2017. The public and government agencies expect us to police ourselves, yet despite years of attempts we still cannot seem to get the data we need to identify who is overprescribing in our state. If we can do this, and find ways to better leverage the Controlled Substance Monitoring Database to compare ourselves to each other in a quality assurance manner, then we can truly focus our efforts to better impact the things we can control.

The opioid abuse epidemic is multi-faceted and is going to take ongoing, coordinated efforts from frontline professionals in healthcare, law enforcement, and mental health. Physicians can help keep our patients from getting addicted and ultimately reduce and eliminate those pathways that destroy lives and lead to accidental overdose, or death.

Thank you for giving me the opportunity to serve as your TMA President. While my brief term is coming to a close, I am going to stay involved and carry the torch for doctors on the opioid epidemic. I hope all of you will join me in staying the course.

I also hope you will continue educating your peers and colleagues on the value of organized medicine. We are navigating significant transitions in how doctors practice medicine and how we are paid for our services, including the ongoing issues with the TennCare episodes of care initiative, yet the medical community is increasingly divided. We need ALL doctors to participate in TMA so that we as a profession can maintain a single, influential voice about how healthcare is delivered in Tennessee.

Thank you for your membership and support.

Respectfully Submitted,

Nita W. Shumaker, MD
Greetings, Delegates to the 183rd meeting of the House of Delegates representing the House of Medicine. During the last year I have had the privilege of serving as the Chair of your Board of Trustees. I very much appreciate that you are taking your time today to help lead this Association, as we are stronger together than alone. Those of you who have been following our progress this year, note that we have had quite a few successes; as always, a few stressors remain. This has been made immensely easier by the magnificent leadership of our CEO Mr. Russ Miller and his very capable staff. The members of the Board – which are elected by region – have worked very hard, with long hours and diligently, under the ever watchful eye of our president, Dr. Nita Shumaker, who has also devoted her energies to remedy the opioid crisis.

This past year the Board oversaw the move to our third TMA headquarters and capitalizing on the appreciation of the old building which had become a “money pit.” We now have a newly renovated and much better designed headquarters of which we can all be proud. This move has required an immense amount of planning and energy, which in addition to his usual duties, Mr. Miller succeeded.

A special thanks should be extended to Dr. Ted Taylor and Mr. Miller for their extremely diligent work which has given us finally a very simple and easy to understand budget. I am happy to report to you that we are in a very positive financial state.

It is our Association’s responsibility to advocate on behalf of our members, and on occasion when the need is clear, to include a few non-members. I am speaking of the Medicaid primary care “clawback” issue where we successfully represented hundreds of physicians. Later, it came to our attention that the Medicare intermediary has been surreptitiously terminating physicians without notice from reimbursement based on perception of misfiling as little as three charts over five years. The Board voted to use our resources to help defend doctors against such action and our new President has met with the new intermediary to hopefully prevent this behavior from persisting.

In addition to our defense of physicians, a very important and major activity is your Association’s lobbying for legislation that directly affects our physicians, and lobbying against bills that pose harm to us, our profession or our patients. Of the roughly 350 potential bills brought before the Legislative Committee, the staff on careful review made a
recommendation of three to five of immediate and pressing importance. Legislative priorities are ratified by the Board and Executive Committee which debates and instructs the lobbyists as to what action to pursue. Our work brought about and maintains the moratorium on independent practice for nurse practitioners. We actively participated in the debate around the governor’s opioid legislation and successfully negotiated several important amendments, though there is more work to be done. We won this year on maintenance of certification and again defeated bad proposals in the balance billing debate.

In summary, our strength is in our numbers. The more members we have, more resources we will have to represent us on the Hill.

Thank you for not sitting on the sidelines.

Respectfully submitted,

James K. Ensor, Jr., MD, FACP Chair

2017-2018 Board Members
Nita W. Shumaker, President
Matthew L. Mancini, MD, President-Elect
Keith Anderson, MD, Immediate Past President
James K. Ensor, Jr., MD, FACP Chair
Peter Swarr, MD, Vice-Chair
Tedford S. Taylor, MD, Secretary/Treasurer
Edward Capparelli, MD, Speaker, House of Delegates
James H. Batson, MD
Elise Denneny, MD
Mr. Troy Nold
Michael Bright, MD
Wm. Kirk Stone, MD
John D. McCarley, MD
Rodney P. Lewis, MD
Resolutions 1-17 and 4-17 were reaffirmations and no further reports are due. However, TMA President, Dr. Nita Shumaker and senior TMA staff met with the Board of Medical Examiners (BME) and its staff to report the House’s reaffirmation of Resolution 4-17, Board of Medical Examiners’ Independence. The members of the BME were asked to contact TMA’s liaison if it wished for TMA to pursue implementation of the Resolution. Otherwise, TMA assumes that the BME no longer has a desire for quasi-independence and no further action is necessary. To date, the BME has not indicated a desire for quasi-independence. The action required by these resolutions should be considered completed.

Substitute Resolution No. 2-17 Uniform Physician Credentials Verification

**Action:** TMA staff has worked closely with Tennessee Physicians Quality Verification Organization (TPQVO) on its software updates designed to simplify the credentialing process for physicians applying with hospitals and health insurance plans. Rollout is expected on April 1, 2018. It will allow physicians to store all of their credentialing information, populate credentialing applications, and submit them seamlessly.

Resolution No. 3-17 Mid Level Provider Supervision

**Action:** TMA President, Dr. Nita Shumaker, and senior TMA staff, met with the Tennessee Board of Medical Examiners on July 18, 2017, to report TMA’s position and encourage more supervision of mid-levels, especially with respect to opioid prescribing.

The TMA legislative committee discussed this resolution at its May and June meetings and chose not to pursue legislation in 2018 because of a three-year moratorium on nurse scope of practice issues negotiated with nursing organizations.

At Dr. Shumaker’s request, TMA Communications staff sent an email to all members on October 16, 2017, regarding supervision of PAs and APRNs with a link to TMA’s online toolkit for supervising physicians.

Resolution No. 5-17 Tennessee State Parks, “Healthy Parks, Healthy People”

**Action:** TMA met with Dr. Womack and representatives from the Tennessee State Parks to learn more and offer our assistance in promoting their initiative. Information was sent directly to all primary care members and TMA reached out to the specialty organizations and the THA, encouraging them to meet with the Parks. Information was widely disseminated via email and a special webpage.

Resolution No. 6-17 Media Campaign for Physician-Led Team Model

**Action:** TMA communications staff launched a public education campaign on this topic in January 2018 including a webpage (tnmed.org/knowyourprovider), press release (Jan. 15) with exposure in a couple of community newspapers, and social media activity using the #knowyourproviderTN hashtag. Future plans include a media tour/editorial board meetings with papers and TV stations in larger markets around the state.

Resolution No. 7-17 Discontinuation of Association Grievance Process
Action: The groundwork for implementation of Resolution 07-17 is complete. All component societies have been notified that TMA and component medical societies will no longer conduct grievance procedures; complaints against all physicians will be referred to the appropriate state medical licensing board. Written instructions as to how to handle complaints received and templates for communications with complainants have been distributed to all component societies, metro executive directors, and to TMA staff. On July 18, 2017, senior TMA staff met with the Tennessee Board of Medical Examiners and its staff to inform it of this action.

The only remaining work is to complete the actual repeal of the Bylaw language provisions dealing with grievances. That will take place during the 2018 TMA House of Delegates. The Constitution & Bylaws Committee approved a draft bylaw amendment resolution during its October 2017 conference call meeting. To be clear, the 2018 resolution is a housekeeping measure only; the grievance process is officially abolished by the adoption of Resolution 07-17.

Resolution No. 8-17 Faith and Mental Health
Action: The Public Health Committee counseled the sponsor to withdraw the resolution in favor of a new resolution that would be easier to implement. Dr. Appareddy should be producing a resolution to the HOD with the input of the Public Health Committee.

Resolution No. 9-17 Definition of a Doctor
Action: The Professional Relations Committee’s discussion of this resolution was in concert with Resolution 06-17. Efforts will coincide.

Resolution No. 10-17 Medical Trainee Wellness
Action: The Education Committee requested we investigate education at the medical schools, the BME rule about disclosure and medical resident resources. The board met again on January 8 to review the outcome of the investigations. The medical schools have comprehensive confidential resources for medical students at each university. The BME language was reviewed by Yarnell and Katie Dageforde and their legal opinion was that it was so vague that the requirement to disclose should not keep physicians from seeking treatment. It does appear that the residents are underserved. The resolution suggested an online confidential screening tool. The Tennessee Medical Foundation (TMF) is the best resource to offer appropriate resources and assume that liability. They are happy to do so but need funding. The TMA drafted a letter of support and ask to Department of Health Commissioner Dr. John Dreyzehner requesting approval of the grant funding the TMF has requested. TMA will fully support the TMF in their efforts to fill this need.

Resolution No. 11-17 Unfair Reimbursement by Insurance Companies
Action: The Insurance Issues Committee members voted to elicit feedback from membership about the prevalence of this issue and report back to the Board. In the December 13 edition of TMA Weekly e-newsletter, TMA staff included information about the Resolution and requested feedback from physician members who have experienced the issues addressed in the resolution. So far no
information has been received. On February 6, 2018, the Insurance Issues Committee voted not to take any action on this resolution.

**Resolution No. 12-17**  
The Impact of Virtual Violence on Children in Tennessee  
*Action:* This resolution was adopted as amended and referred to Chattanooga Hamilton County Medical Society.

**Resolution No. 13-17**  
Weaning Programs and Addiction as a Part of Opioid Prescribing Course  
*Action:* The TMA is in the process of updating its opioid education program and it will include weaning and resources as part of the program. Also, the TMA is partnering with the Tennessee Pain Society to offer an additional series of modules which also include weaning education.

**Resolution No. 14-17**  
Texting as Approved HIPAA Form of Communication  
*Action:* This resolution was created in preparation for the AMA annual meeting in June 2017. A number of similar resolutions have been submitted on this subject matter unsuccessfully in previous years. For this reason, Tennessee did not seek to introduce it again at this time.

**Resolution No. 16-17**  
Primary Care in Rural Tennessee  
*Action:* This resolution received a positive recommendation from the Public health Committee.

**Resolution No. 18-17**  
Hospital Overcrowding  
*Action:* Met with resolution author to discuss next steps. This resolution was intended to have TMA policy and initiate conversations. TMA has reached out to the Tennessee Hospital Association to inquire as to current projects or pending initiatives to address the issue. Based on information received, TMA will take steps to engage hospitals and the State Department of Health.

**Resolution No. 19-17**  
Opioid Prescriber Responsibility  
*Action:* The Professional Relations Committee discussed the third resolved and felt that public education efforts spearheaded by Dr. Shumaker satisfied the requirements of the resolution, as proper disposal is an integral part of patient communications. The Department of Health’s “Turning the Tide” summit in November 2017 in Nashville is notable, as is Dr. Shumaker’s ongoing efforts with physician and patient education, including a special opioid edition of Tennessee Medicine magazine released in Q1 2018.

**Resolution No. 20-17**  
Modifying the AMA Mission Statement  
*Action:* Introduced to the AMA House of Delegate in June 2017. Did not pass.

**Resolution No. 22-17**  
CME Credit for Physician Participation in Leadership Activities  
*Action:* The AMA does not recognize serving on a board, attending TAG meetings or serving on a planning or steering committee to qualify as CME Category I credit. Currently it is not activities recognized by the AMA as continuing education but more of normal activities/responsibilities of a physician.

**Resolution No. 23-17**  
GME Support of Leadership Training
Action: Steps to take to resolve:

- Create an advisory group with resolution author as chair. Send an email to residents stating what we are working on and ask for volunteers. Meetings to be calls and possible webex if need be. May need a few to go on site visit meetings when appropriate.
- Contacting chair of resident programs in Tennessee to initially gauge interest in the concept of adding a leadership track within training programs and see if something already exists.
- Initially, TMA will provide information on LEAD and ask for their increased awareness, share the resolution from the Resident and Fellow Section (RFS) asking TMA to encourage more support by training programs of leadership training.
- Gauge interest in further discussion on how we can collaborate on this issue.
- Work with John Ingram Institute to identify what is currently available that would be transferable to residents.
- Contact AMA and national residency officials to learn if there are model programs in place.
- Meet with those programs that are interested in working with us.
- Continually report out to TMA Board and RFS Governing Council and all resident members. Consider social media posts.

Resolution No. 24-17  The Creation of Innovative Opportunities to Improve Health Literacy

Action: Dr. Jack Lacey of Knoxville, the sponsor of the resolution, worked with First Lady Chrissy Haslam on an article to be published in the Q2 2018 issue of Tennessee Medicine magazine (available April 2018). While this communication may not constitute “innovative opportunities to improve health literacy,” as the title suggests, it satisfies the resolved.

Resolution No. 25-17  Independent Practice of Physician Assistants

Action: Complete. No specific action is necessary in order to implement Resolution 25-17 so it should be considered complete. It is merely instructional to staff and leadership in TMA’s advocacy when/if the issue arises. The resolution has been reviewed with the Board of Trustees, the Legislative Committee and TMA advocacy and communications staff. If, at any point in the future, legislation is introduced at the state or federal level to give PAs independent practice, TMA will actively oppose it.

TMA President, Dr. Nita Shumaker, and senior TMA staff, met with the Tennessee Board of Medical Examiners on July 18, 2017, to report TMA’s position against independent practice of PAs and encourage more supervision of mid-levels, especially with respect to opioid prescribing.

Resolution No. 26-17  Emergency Funding for Vital Patient Care Service

Action: The Legislative Committee discussed this resolution at its May 2017 meeting and chose not to add it to TMA’s 2018 legislative package due to other priority issues.

Resolution No. 27-17  Cost of Prescription Drugs
Action: The Legislative Committee discussed this resolution at its May 2017 meeting and chose not to add it to TMA’s 2018 legislative package due to other priority issues.

Resolution No. 28-17 Protecting the Professionalism of Hospital Employed Physicians

Action: TMA is in the process of resurrecting the TMA OMSS by identify physicians to serve on a founders’ governing counsel. The council will review mission and purpose of the section and create a target list of participants for outreach. The initial communications will be to promote the existence of the section and explain its purpose, vision and extend an invitation to participate.

Steps to be taken:
1. Resurrect the TMA OMSS
   a. Identify a core founders’ governing counsel
   b. Devise/review mission and purpose
   c. Determine core target audience
   d. Reconfirm governance documents
2. Market the existence of the OMSS to target physicians
   a. Invite and overview letter
   b. How to participate
   c. What is expected?
   d. When it meets
   e. Goals/vision
3. Hold an annual meeting to elect officers
   a. According to bylaws
   b. Ratify projects such as what is called for in this resolution
   c. Determine outreach and communication strategies to engage more target members
4. Have OMSS leaders set up meeting with THA leaders to discuss employment issues and professional responsibilities
5. Select representatives to the AMA OMSS
6. Evaluate in 2022

Resolution No. 29-17 Prior Approval Process Reform

Action: Insurance Issues Committee members have discussed the resolution and were unclear as to the prevalence of this issue amongst member practices. Members agreed to elicit feedback from colleagues and report back during the next committee meeting. During the February 6, 2018, meeting of the Insurance Issues Committee, members voted to continue pushing Blue Cross Blue Shield of Tennessee to improve their prior authorization policies.
OFFICER’S REPORT C

REPORT OF THE SECRETARY/TREASURER

May 5, 2018

TO: HOUSE OF DELEGATES
    TENNESSEE MEDICAL ASSOCIATION

SUBMITTED BY: TEDFORD S. TAYLOR, MD, SECRETARY/TREASURER

The annual audit for the fiscal (and calendar) year ending December 31, 2017, has been completed and is now available for review. The customary examination of the Association’s records and accounts was conducted by Blankenship CPAs, our certified public accountants, appointed by the TMA Board of Trustees.

The attached financial statements have been extracted from the complete audit. They show the revenue and expenditures during 2017 as well as the assets, liabilities, and fund balance at the end of the year.

A budget deficit of $76,838 had been projected for 2017 with revenue projected at $3,414,128 and expenditures projected at $3,490,966. The actual revenue was $3,515,299 against actual expenses of $3,373,961, resulting in $141,338 surplus.

The excess revenue was a result of extraordinary increase in unrealized and realized capital gains to the sum of $457,302. Our budget was $100,000 gain.

In 2016, the board approved a new investment directive to focus our reserves and investments for appreciation and growth versus preservation. The Board also approved directives for the Finance Committee to strive to increase reserves to equal one year’s operation total. TMA had a long held fiscal policy to keep six months operating capital in reserves.

To meet its financial goals, the TMA sold its headquarters building in September 2016 for net proceeds of $5.5 million. In January 2017, our strategy for appreciation and growth lead to the $2.45 million purchase of a new building and land at 701 Bradford Avenue. Improvements were also made. The remaining funds are deposited in a separate building reserve fund with annualized returns greater than 10% at the end of 2017 with a balance of $2.35 million.

TMA’s General Reserve Investment account, managed by Aldebaran Financial, had an annual increase of 14% at the end of 2017 with a balance of $1.01 million. All investments and withdrawals were made within the parameters of the TMA’s Investment Policy.
I wish to thank the other members of the Finance Committee, Drs. John McCarley and Rodney Lewis, for their assistance and guidance during the past year. It has been a pleasure for me to serve on the Board of Trustees and an honor to serve as chairman during the last year.

Respectfully submitted,

Tedford S. Taylor, MD, Secretary/Treasurer and Chair

TMA Board of Trustees Finance Committee
John McCarley, MD, Chattanooga
Rodney P. Lewis, MD, Nashville
David L. Kieu, TMA Staff Accountant
Russell E. Miller, Jr., CAE, TMA Assistant Secretary/Treasurer

Copies of the Independent Auditor’s Report can be provided by request made to CEO.
OFFICER’S REPORT D

REPORT OF THE JUDICIAL COUNCIL

May 5, 2018

TO: HOUSE OF DELEGATES
TENNESSEE MEDICAL ASSOCIATION

SUBMITTED BY: CHARLES LEONARD, MD, CHAIR

The Judicial Council met once in person and several times electronically since last year’s House of Delegates. I, Charles Leonard, MD, served as Chairman and Pamela Murray, MD, served as Vice Chair.

Revocation of the Cumberland County Medical Society

The Cumberland County Medical Society, located in Region 5, last sent a delegate to the TMA House of Delegates in 2007. It has not submitted any required officers’ reports since 2011. There is no record, report, or knowledge that the society has met in the last five or more years. It was placed on dormant status in 2013 but has not complied with any of the requirements to hold a component society charter from TMA since then.

When TMA membership staff ran a report of physicians in Cumberland County in late 2017, the report revealed there are eighty-six (86) physicians living or practicing in Cumberland County. Of those, twenty-three (23) are TMA members; one of whom is in retired status. Of the 23 TMA members, seventeen (17) have membership through the dormant society, one (1) is a direct TMA member, and four (4) are members of the Upper Cumberland Medical Society (UCMS).

Under Article I, Chapter B.3, the charter of a medical society that has been on dormant status for five (5) consecutive years is automatically revoked. Since the Cumberland County Medical Society has been on dormant status for five (5) consecutive years, 2013 – 2018, as of the conclusion of this 2018 House of Delegates session, the TMA charter of the Cumberland County Medical Society will be automatically revoked. The Judicial Council recommends that the House allow the charter to be automatically revoked without further action. Members can join the Upper Cumberland Medical Society or join directly, unless the House takes action to subsume Cumberland County into the Upper Cumberland Medical Society in which case, members’ only option for continued membership would be joining through the Upper Cumberland Medical Society.

Action Required:
1. Petition for Merger of Cumberland County into the Upper Cumberland Medical Society
2. Petition for Merger of White County Medical Society into the Upper Cumberland Medical Society
Action Item: Petition for Merger of Cumberland County into the Upper Cumberland Medical Society

Based on the automatic revocation of the Cumberland County Medical Society Charter at the conclusion of this 2018 House of Delegates, the House must decide if it is more advantageous for former Cumberland County Medical Society members to join TMA directly, through the Upper Cumberland Medical Society, or give members an option to join through either avenue.

TMA and the Upper Cumberland Medical Society are pursuing membership in Region 5 through deals with hospital systems in the region. The medical society is active and trending upwards in membership. In 2017, eighty (80) participants attended the inaugural Society legislative dinner. The UCMS nominated several physicians to participate in the State Innovations Initiative technical advisory groups (TAGs). The Society is the only component society that routinely sends representatives to the TMA House of Delegates and Day on the Hill and conducts monthly CME meetings to serve the needs of the region’s physicians. In short, the UCMS is the only mechanism by which physicians in Region 5 have a voice. Membership in UCMS should be strongly encouraged.

Based on the filing of its petition for merger with the Judicial Council, the Upper Cumberland Medical Society is desirous of merging Cumberland County into the UCMS.

The Judicial Council, therefore, recommends that this 2018 House of Delegates merge Cumberland County into the Upper Cumberland Medical Society.

Action Item: Petition for Merger of White County Medical Society into the Upper Cumberland Medical Society

On December 30, 2017, the TMA Judicial Council received a Petition for Component Society Merger on behalf of the Upper Cumberland Medical Society. The Petition requested that White County be subsumed into the Upper Cumberland Medical Society.

The TMA charter of the White County Medical Society was placed in “dormant” status in 2010. Its charter was automatically revoked in 2015 pursuant to TMA Bylaw Article I, Section B.3, which states that a society on dormant status for five consecutive years is automatically revoked at the end of the fifth year.

There are eighteen (18) physicians in White County, ten (10) of whom are TMA members. Two (2) are direct members and eight (8) have joined TMA through the Upper Cumberland Medical Society.

Because the overwhelming number of TMA members have joined the Upper Cumberland Medical Society, and because the Society is the only active voice for physicians in the region, the Judicial Council recommends that this 2018 House of Delegates merge White County into the Upper Cumberland Medical Society.
Report on the Putnam County Medical Society (Now Upper Cumberland Medical Society)  
Membership Pilot Project.
Resolution 07-16 created a pilot membership program in the Upper Cumberland Development District. The project required TMA to submit dues statements to direct members located in the Upper Cumberland Development District counties and include in the statement the option to join TMA through the Putnam County (now Upper Cumberland) Medical Society. The resolution further required the Judicial Council to submit a report to this House of Delegates as to whether regional membership grew and became more involved as a result of the pilot project.

As of December 31, 2017, TMA had 166 members in those counties; up from 147 at the end of 2016. In addition, members from those counties are more active. This activity is evidenced by the region hosting its first ever regional legislative dinner on December 5, 2017 with seven legislators and eighty (80) people participating. Five (5) physicians from the region participated in TMA’s Day on the Hill in 2017; five (5) participated in 2018. The region hosts monthly CME and membership meetings that average twenty (20) in attendance. Several physicians from the region participated in episodes of care technical advisory groups (TAGs). It is clear that regional membership is more engaged and the pilot program seems to be an effective model in the region to promote physician engagement in organized medicine.

Finally, the resolution required the Judicial Council to report to this House of Delegates as to whether a similar pilot project should be initiated statewide. Of TMA’s eight regions, four are staffed metro regions and one is a staffed rural region (Region 8). Region 2 in West Tennessee was a staffed rural region and TMA leadership is currently evaluating whether to replace departed staff in that region. That leaves only Regions 2 and 3 as possibilities for a similar pilot project. The success in Region 5 is primarily due to a group of core leaders who expended a significant amount of time to recruiting physicians, planning activities, and spearheading grassroots activity. It remains to be seen whether this type of physician “champion” will step up in Region 2 and 3. TMA staff is asked to look at recent and future Ingram Institute graduates for that leadership. Until that time, it is not recommended that the pilot project be replicated elsewhere.

The Judicial Council conducted no grievance peer reviews this past year because the member peer review provision in the TMA Bylaws was repealed by the 2017 House of Delegates.

In the TMA elections held in February 2018, regions 1, 3, 5 and 7 elected Councilors for the 2018-2020 terms. The following Councilors were elected and will assume their new terms on May 6, 2018: Justin Monroe, MD (1); Omar Hamada, MD (3); James Gray, MD (5); and John Lacey, III, MD (7). Regions 2, 4, 6, and 8 will be up for election in 2019.

It has been enjoyable to serve as Chairman of the Judicial Council this past year and work with this group of dedicated Councilors. The Council’s recommendations, and the House’s actions,
with respect to troubled component medical societies over the past few years have emphasized the need for the TMA leadership to continue to focus on growing TMA’s membership through other models besides small single-county rural medical societies.

I wish to thank all of the members of the current Judicial Council for their willingness to serve TMA in this important capacity as well as the TMA staff who support the Judicial Council, specifically Yarnell Beatty who is our staff liaison, and Nikki Hamlet, who has furnished the Council valuable membership reports to support our work.

Respectfully submitted,

Charles Leonard, MD, Chairman

2017-2018 Councilors:

Pamela D. Murray, MD (Region 2)  Shauna Lorenzo-Rivero, MD (Region 6)
Richard M. Briggs, MD (Region 7)  Richard G. Soper, MD (Region 4)
Charles E. Leonard, MD (Region 8)  Omar Hamada, MD (Region 3)
James C. Gray, MD (Region 5)  Justin Monroe, MD (Region 1)

A. Yarnell Beatty, JD, Staff Liaison
This is the report of the chief executive officer of the Tennessee Medical Association (TMA). Details of this report encompass activities and events from April 2017 through March 2018.

At the beginning of 2017, we were all anticipating sweeping changes in healthcare under President Trump with the promise of rollback of the Affordable Care Act (ACA). While many changes have occurred around the edges, many challenges still remain for medicine today in the form of value-based reimbursement. Allied health professions continue to assault the practice of medicine as the self-proclaimed answer to a shrinking supply of primary care physicians. The percentage of the gross domestic product consumed by health care continues to increase as governments and businesses struggle to manage costs and coverages for employees and the citizenry.

Internally, there has been a continued focus to complete our plans to stabilize TMA’s finances and begin to see growth in assets to give it a solid base to fund and operate the initiatives for the membership. Additionally, we had a number of staffing changes due to ordinary personnel ebbs and flows. Outwardly, we faced a multitude of high profile and highly emotional issues leading into the legislative session of 2018.

Improving financial position

In 2016, the Board of Trustees made a bold, but wise, decision to sell the TMA building in Nashville and ‘right size’ the work space for operations. TMA has occupied a three-story, 21,000 square foot building on a major street in Nashville since 1991. The building was in need of substantial renovation. It was determined that it was time to sell the building, purchase a smaller building to hold TMA operations only, and invest the profit.

The sale was completed in January 2017. TMA leased back space while we purchased and renovated a new headquarters building. TMA officially moved to its new headquarters on June 26, 2017. The transition was without incident. The purchase and renovations were completed within budget.

The ending financial impact was that TMA was able to lower its annual operating costs by more than 50%; owns a newly renovated 10,000 square foot building debt free; and was able to add the remaining funds from the sale to reserves.

In 2016, the TMA Finance Committee indicated that TMA needs to grow its reserves to at least one year of operations or $3.4 million. At the time, TMA had one million dollars in reserve. With the building balance and change in investment management, TMA has achieved the goal of $3.4 million in reserve.
Also in 2017, TMA changed its relationship with its long time CPA firm and hired a new agency, Blankenship CPAs. Blankenship is currently completing its second consolidated audit of all TMA and affiliated subsidiaries. This consolidation provides our leaders with a more transparent view of all TMA related financial activities.

Staffing
Throughout 2017, it became increasingly apparent that TMA was not making headway with the TennCare Bureau or the Administration to inflict meaningful change to the Episodes program. In mid-2017, our contract employee Jackie Woeppe left TMA for another position within the TennCare Bureau and gave leadership pause to reconsider TMA’s direction with continued direct work with the Bureau and Episodes. The Board elected to terminate the grant with the State for a consulting position on Episodes and shifted resources to greater and more general reimbursement and insurance advocacy for all members. With that directive, and with knowledge that our Associate General Counsel would be relocating in 2018, we hired Karen Baird to serve as our Director of Insurance Affairs and cross-train with Katie Dageforde Hartig prior to her departure. Karen was winding down a 30-year career as a practice manager and has a wealth of experience and knowledge working with the various insurance plans operating in Tennessee.

Katie Hartig was our Associate General Counsel for the last five years. She was our authority on all things ACA, worked daily with the Administration on a multitude of issues, like Episodes and other TennCare related issues. And she has facilitated our TMA insurance workshops for the last several years. She and her family relocated to Iowa in March 2018.

In our Communications department, we bid farewell to Katie Brandenburg who had served as the Managing Editor to Tennessee Medicine in addition to serving as our Communications specialist. This position has been capably filled by Julia Couch since October 2017.

At the beginning of the year, Kelley Hess, who has served as our legislative department support and administered IMPACT operations, became our contract fundraiser. This staff position in our Advocacy Division was filled by Meg Book-Smith. Also, in January, JD Rye who has served as TMA Accounting Manager since 2014, left our employ to move to South Carolina to join a family business. David Kieu joined our staff to fill this role in February 2018. David has worked with a CPA firm in Chattanooga and most recently with Blue Cross Blue Shield Tennessee in its audit department.

In our IT department, Randy Kaufman retired at the end of 2016 and contracted back with TMA for a period of time to assist with our transition to a remote hosting and management arrangement for our database needs. In July 2017, the transition was completed thereby eliminating a staff position for database management. This function is now served through a contract with the Texas Medical Association, who performs similar work for eight other state medical associations and county medical societies.

For the last four years, TMA has partnered with the medical societies in Region 2 to staff the needs of the leadership and members throughout the regions. Carolyn Kolbaba and family moved to Pennsylvania in December. We are currently working on new strategies to fill this vacancy and assist other medical societies in need of local staffing assistance and management.
As a result of these staff departures, hires and work realignments, we are adequately staffed to fulfil the work of the membership, down two full-time employees from last year (25 to 23).

Opioids
Dr. Nita Shumaker, TMA’s incoming president in 2017, wasted no time launching into our state’s greatest public health threat – opioid abuse. She had a three-pronged message to deliver across the state as she toured tirelessly meeting with groups of physicians and practice administrators. Her message - reduce initial prescriptions and seek alternative therapies; know and follow the CDC guidelines, and employ protocols to wean patients off opioids or significantly reduce dosages.

While preaching her message she tackled the primary hindrance to the profession in its efforts to police itself—a dearth of data. What seemed like a logical and simple ask, became notably the most frustrating challenge. Insurance companies, health systems, groups, the state all have data on prescribers. This data can help us all focus limited resources on true problem areas. There was almost total agreement but zero cooperation. When Dr. Shumaker began her term, there was some public health data and there were definitely some news headlines, but Dr. Shumaker’s dogged determination helped focus the energies of TMA and the State on the issue at hand, culminating in legislation crafted by the Governor’s office to limit opioid prescriptions. What should have been the remedy to our concerns took on a life of its own as TMA had to reprioritize its own legislative agenda to work overtime to modify the initial legislation in order to reduce abuse but protect physicians’ medical decision making.

TMA has worked with the legislature to bring forth a number of provisions in the last several years to impact opioid abuse and the fruits of labor are beginning to show. We await the next state reports to show what previous efforts are producing and what new efforts produce – good and bad.

Doctors of Medical Science (DMS) issues and nurses
TMA was opposed to the regulation but agreed to help Senator Briggs and proponents meet with physicians across the state to provide more information and receive market feedback. One of the central sticking points was the use of the term ‘doctor’ by the graduates. This was eliminated in the final bill draft.

The other points of the bill mirrored TMA’s physician-led team-based care model, keeping physician oversight regulations and placing licensure control under the Board of Medical Examiners (BME). As this bill was seemingly destined to pass in the waning weeks of the session, the sponsors abruptly withdrew the bill.

There was great miscommunication and resistance to this bill in any form from many organizations. TMA expended a great deal of resources to gain member input, and worked with sponsors to make the bill acceptable to TMA leaders. Ultimately TMA’s neutral position
was viewed as support by many. TMA was not supportive, and similarly not opposed, but had altered the bill enough to make it at the least tolerable.

Maintenance of Certification (MOC)

TMA successfully crafted legislation to eliminate the ability of insurers to strike physicians from plans using MOC as a sole determinant for continuing education. Hospital medical staffs have the ability to set their own individual credential measures that may include MOC but that is determined by the physicians themselves. Tennessee’s new law is viewed as one of the most physician friendly in the country.

Rate bump audit win

TMA scored a major victory for its physicians in a case that could have national implications. TMA collaborated in a lawsuit involving 21 Tennessee physicians who were asked to repay the incentives for services performed in 2013 and 2014. A federal court judge struck down a federal regulation preventing the government from reclaiming more than $2.4 million in Medicaid payments from primary care physicians, ruling the regulation was contrary to Congress’ intent in the ACA.

The Court opined that the intent of the ACA was to encourage physicians to improve access to primary care services for vulnerable populations in areas with limited access to medical care and that these audits were contradictory.

Episodes of Care

As noted, the Board elected to alter TMA’s course of action with regard to the Episode program after numerous attempts to work with the Bureau to

• collaborate on the creation and education of episodes,
• promote engagement of member physicians and in the process in hopes of creating a fair and workable program that could actually meet the goals of improving care while reducing costs.

As time marched on and more episodes were readied for deployment, we became increasingly aware that input from physicians was not being considered in earnest and frustrations mounted among members and leadership.

TMA held a number of meetings with the Tennessee Hospital Association to compare our mutual challenges and concurred that this experiment was not meeting market expectations.

In 2017 TMA changed its cooperative stance to one of opposition, bringing our issues directly to the Commissioner of Finance and Administration, the deputy governor, The TennCare Bureau and finally to the members of the state legislature. Bills were readied for the session but a slew of overriding issues dominated the time and attention of the legislature.

TMA will continue its effort to pause the rollout of new episodes, focusing efforts on the gubernatorial candidates and next administration. Until that time, we will stress to members
to participate in episode feedback sessions and ‘listening events’ conducted by TennCare, as these are the most effective means to inject the sentiments and criticisms of providers and be ‘on record’ at this point.

Balance billing
At the end of last year’s legislative session a number of bills surfaced to fix the ‘surprise medical bill’ issue. Most proposed remedies sought to eliminate balance billing by physicians. TMA met continuously over the summer to find better solutions that would help patients that face these unfortunate situations but protect a physician’s right to collect their fees without losing their negotiation position with insurance plans. With the focus on other health care-related legislation in this session, lawmakers simply ran out of time to address this issue, leaving additional time this summer to continue to improve solutions. TMA’s goal is to focus the discussion on network adequacy regulations verses fees.

Grant work
TMA currently receives two grants from the Physicians Foundation – one for physician leadership promotion and one for a pilot project to help bridge the leadership gap between hospital administrators and employed physicians. Our facility partner is TriStar StoneCrest in Smyrna, Tennessee, between Nashville and Murfreesboro. The goal of the project underway is to reduce ICU vent days and create more efficient patient throughput. The goal for TMA in this endeavor is to create a program of tangible value to the facility CEOs and CFOs who are increasingly in a position to influence the payment of memberships for physicians in organized medicine.

TMA continues to press forward with its stellar leadership curriculum for physicians under the John Ingram Institute in collaboration with the Tennessee Medical Education Fund. Entering its 11th year, the John Ingram Institute for Physician Leadership currently offers two tracks for applications -- the Leadership Immersion class teaches physicians various leadership skills not learned in medical school or residency; and the Leadership Lab which trains physicians to lead and excel in team-based care settings.

Non-dues revenue
For a number of years, I have been sounding the alarm that TMA needs to reduce its reliance dues dollars for the majority of its operating revenue. TMA Physician Services (TMAPS) exists to develop programs, services and partnerships to provide members with product they regularly use at a discounted rate or avail members to benefits not presently available. We have been working for years to turn this business model, change the offerings portfolio and regain momentum. In 2017, TMAPS turned its first profit in many years. While we are heading in the right direction, we have a way to go to significant profitability. With our TMA Medical Banking offer, group health insurance captive, and our general insurance lines offered through TMA Insurance, TMAPS is anticipating a breakthrough year in 2018.
Looking ahead

Nurse and allied scope battles
For the last 20 years, physicians have been in constant defensive mode to confront non-physicians seeking to expand their scope of practice and encroach on the practice of medicine. This year saw us entangled with the physician assistants and the DMS issue. There is one more year in the moratorium with the nursing industry and its push for independence. We experienced some regulatory language changes last year but the table needs to be set now to recalibrate on the looming situation with the nurses.

Value Based Reimbursements Episodes
We need to remain vigilant and proactive regarding value-based reimbursements. The headwind we face is the fact that episodes are producing significant financial savings and arguably improved care. There is definitely room for process improvement and better, more granular, data analytics. Words are lost on this administration, so we need to stay in the trenches, gather our data and evidence, and work on the next regime.

Telemedicine
In the debate on how to improve access to care, integrate best practices and increase efficiencies, I don’t regularly see telemedicine and telehealth services coming to the forefront as solutions in the general context. It is out there and being used regularly, but the future deployment of mass use of telservices may be very close and something TMA needs to consider the role it could play for members and the public.

Autonomy within integration
With the continued mergers and acquisitions in medicine and the prospects that most new medical students and residents plan to work for another rather that go into private practice, there remains the challenge as to the value proposition for employed physicians. We need today’s answer to ‘What’s in it for me’ (WIIFM)? While physicians are becoming more comfortable in their employment roles, they have needs. Are those needs aligned with services and skills of TMA and organized medicine today? Physicians may be integrated but the desire for autonomy and the ability to practice medicine their way remains. TMA needs to capitalize on this fact.

Big election year
In this election, at least one-third of the Tennessee State House seats will change next session (most likely many more). There is a golden opportunity to strengthen old and create new beneficial relationships, but members need to be involved locally to seize the day. Supporting IMPACT is a good start.

New strategic direction
This summer, the TMA will reconsider its strategic direction. Beginning in 2008, the TMA Board of Trustees has been following a strategic process that gives the organization clear
direction for a four-year glance, with annual opportunities to review and correct course. The
work product from its July board meeting will be made widely available to the membership.

Conclusion
It is a great privilege to work for such an astute and revered profession and an honor to carry
out that work alongside my fellow staff members. The accomplishments reported here are
not possible without their diligence and dedication and the road ahead will be much
smoother with their help and professionalism.

Yarnell Beatty  Sr. Vice President, General Counsel
Dave Chaney  Vice President
Karen Baird  Director of Insurance Affairs
Julie Griffin  Director, Government Affairs
Michael Hurst  Director, Business Development
Angie Madden  Director, Practice Solutions
Ben Simpson  Assistant Director, Government Affairs
Doug Word  Director of Regional Development
Angela Allen  Specialty Societies Management
Ann Anderson  Accounting Services
Sara Balsom  Events & Marketing
Julia Couch  Communications Specialist
Amy Campoli  Executive Assistant to the CEO
Nikki Hamlet  Membership and Office Administrator
Beth Lentchner  Leadership College / CME
Meg Book-Smith  Advocacy Assistant
Becky Morrissey  Paralegal
Christy Reeves  Membership Manager
David Kieu  Staff Accountant
Pam Slemp  Manager, Region 8
Debbie Utzig  Accounting
Rebecca Woods  Grassroots Manager

Respectfully submitted,

Russell E. Miller, Jr., CAE
2011 Resolutions to Sunset and Become Permanent Policy

Resolution No. 4-11
TMA POLICY ON PAYMENT TO PHYSICIANS FOR CALL COVERAGE
RESOLVED, That the following be adopted as official policy of TMA:

1) Each hospital organized medical staff should adopt bylaws, policies and procedures to address the question of responsibility for unassigned call; both on an emergent basis and non-emergent inpatient basis, to make sure that these patients receive proper care.

2) The Tennessee Medical Association supports the development of core credentials for each specialty, approved by hospital medical staffs, in an attempt to balance the need for general call coverage and specialization, and to ensure a clear understanding of what is expected of credentialed physicians regarding call coverage;

3) The Tennessee Medical Association supports the right of organized hospital medical staffs to make best efforts to schedule physician members to take unassigned call in their core privilege areas; however, the TMA opposes any requirement for care beyond stabilization and appropriate referral of patients requiring care that is beyond the normal practice parameters of physicians who have limited their practice to a subspecialty;

4) The Tennessee Medical Association supports payment by hospitals to physicians who are on-call to provide care to indigent and unassigned patients in hospital emergency departments.

5) The Tennessee Medical Association supports payment by hospitals to physicians who provide on call care to indigent and unassigned patients in hospital emergency departments.

Resolution No. 12-11
AESTHETIC MEDICAL AND SURGICAL PROCEDURES AS THE PRACTICE OF MEDICINE IN THE STATE OF TENNESSEE
RESOLVED, That the Tennessee Medical Association support actions to expand the definition of the practice of medicine in the State of Tennessee to specifically include all actions which treat or profess to diagnose, treat, operates on or prescribes for any physical ailment or any physical injury to or deformity of another or to enhance the aesthetic appearance of another and be it further RESOLVED, That the legislative committee of the Tennessee Medical Association make the identification and regulation of medical spas which are not part of a physician’s office or part of a regulated outpatient surgical center a priority item for legislative action in 2012.
2011 Resolutions to Sunset

Resolution No. 1-11
[Reaffirmation of Resolution No. 14-04]
THIRD PARTY PAYER NON-PHYSICIAN OPERATED TRIAGE HOTLINES
RESOLVED, That the Tennessee Medical Association adopt a policy position opposing nurse telephone consultation/symptom evaluation services sponsored by third party payers; and be it further
RESOLVED, That the Tennessee Medical Association support programs or legislative initiatives which would prohibit nurse and other personnel telephone consultation/symptom evaluation services sponsored by third party payers.

Resolution No. 2-11
BAN ON THE DESIGNER DRUG “BATH SALTS”
RESOLVED, That if one of the “bath salts” bills is not enacted during the 2011 session, the Tennessee Medical Association Committee on Legislation, when developing its 2012 legislative package, consider submitting a bill to the Tennessee General Assembly that would prohibit the sale or use of the designer drug commonly referred to as “bath salts” in Tennessee.

Resolution No. 3-11
TMA POLICY ON A PHYSICIAN’S OBLIGATION TO ACCEPT NON-EMERGENT INPATIENT CONSULT REQUESTS
RESOLVED, That the TMA adopts as policy that a physician asked by another to consult on a case in a non-emergent inpatient setting does not have an ethical obligation to agree to the consultation request; and be it further
RESOLVED, That the TMA encourage hospital medical staffs to provide for adequate specialty coverage when other staff members request non-emergent inpatient medical consultations. In doing so, these principles should apply:

1) The physician requested to provide consultation has the right to refuse to treat the patient unless obligated by contract or otherwise to do so.
2) Hospitals should fairly compensate physicians who provide non-emergent inpatient consultation.
3) Physicians who provide consultation should not be obligated to take over the care of the patient from the primary requesting physician.
4) Physicians requesting specialty consultations should not attempt to “dump” the patient into the care of the physician providing the consultation service because the patient is uninsured, underinsured, the physician is out-of-network, or for any other reason.
5) At all times, the physicians involved should make it clear to the patient what the roles are of the primary treating physician and the physician providing the medical consultation.

Resolution No. 5-11
RESPONSE TO PROPOSED CHANGES TO TNENCARE II DEMONSTRATION
RESOLVED, That the Tennessee Medical Association offer an alternate proposal to the proposed amendment to the TennCare II Demonstration that:

1) Patients with chronic medical illnesses such as diabetes, heart disease, chronic lung disease, etc., shall be enrolled in a local patient-centered medical home as defined by state and federal regulations.
2) The annual limits of eight (8) days per person for inpatient hospitalization; non-emergent outpatient hospital services; and physician and nurse practitioner office visits be waived as long as a patient is enrolled in a patient-centered medical home, and

3) That provider services for patients enrolled in a patient-centered medical home be reimbursed at a higher rate to cover the time and cost of more intense patient management.

Resolution No. 6-11
REQUIRED MEETINGS OF TMA STANDING COMMITTEES
RESOLVED, That all Tennessee Medical Association standing committees be required to meet in person, or electronically at least quarterly; or if no activity is necessary that staff notify the members of the committee that no meeting is required; and be it further
RESOLVED, That an official report of quarterly meetings of all Tennessee Medical Association standing committees be submitted to the Board of Trustees (BOT) no later than one week prior to the quarterly meeting of the BOT.

Resolution No. 7-11
TMA POLICY ON CERTIFICATE OF NEED LAWS
RESOLVED, That the Tennessee Medical Association adopts as policy that Certificate of Need (CON) laws do not promote or encourage competitive markets, economic efficiencies, or the continued development or quality of the health care industry.

Resolution No. 8-11
TMA POLICY ON RESTRICTIONS ON THE PRACTICE OF MEDICINE
RESOLVED, That the Tennessee Medical Association adopts as policy that physicians, by virtue of their medical license, have the right to offer any medical service, for which they have been trained by demonstration of their qualification, to their own patient; and be it further
RESOLVED, That Tennessee Medical Association advocate against health plans’ efforts to discriminate in their reimbursement policies for services such as imaging, based on the physician’s medical specialty certification or setting where the service takes place; and be it further
RESOLVED, That the Tennessee Medical Association support the expansion of the Tennessee Board of Medical Examiners’ authority over all aspects of medical practice including supervision of mid-level providers.

Resolution No. 11-11
TENNESSEE MEDICAL EDUCATION FUND, INC
RESOLVED, That the Tennessee Medical Association suggests that the Tennessee Medical Education Foundation include the charitable purpose to “developing leaders to serve in organized medicine.”

Emergency Resolution No. 1-11
INSURANCE CONTRACTS
RESOLVED, That all provisional insurance contracts and amendments that require review and analysis by physicians must be noticed to providers at least 90 days in advance before becoming effective.
TENNESSEE MEDICAL ASSOCIATION HOUSE OF DELEGATES

Bylaw Amendment No. 01-18

INTRODUCED BY: COMMITTEE ON CONSTITUTION AND BYLAWS
ROBIN WILLIAMS, MD, CHAIR

SUBJECT: BYLAW AMENDMENTS TO MEMORIALIZE REPEAL OF ASSOCIATION GRIEVANCE PROCESS

Whereas, Resolution 07-17 passed the 2017 TMA House of Delegates; and

Whereas, Resolution 07-17 repealed the grievance (peer review) procedure regarding review of physician conduct that was previously in place for the Association, Judicial Council, and component medical societies; and

Whereas, Although repealed, language addressing the former grievance procedure remains in TMA’s Bylaws because specific Bylaw provisions were not technically removed from the Bylaws by passage of Resolution 07-17 as required in Bylaw Chapter XI; and

Whereas, In order for the Bylaw language which remains, but is unenforceable, to be removed from the TMA Bylaws, the TMA House of Delegates must pass this Resolution by a two-thirds majority; and

Whereas, Enacting the Bylaws amendments as proposed in this Resolution, TMA’s Bylaw language will be consistent with its repeal of the grievance procedure in Resolution 07-17; Now, therefore be it

RESOLVED, That TMA Bylaw Chapter I, Section B.7 be transferred to the appropriately numbered section of Bylaw Chapter VI, simultaneously with the amendment by deletion of the current language of that provision so as to read as follows:

Sec. 7. Component societies are empowered to conduct peer review of their members, and shall have authority to exercise original jurisdiction to review peer review complaints, in most cases, should they choose. The Judicial Council shall have original jurisdiction only in:

a) cases involving physicians who have joined the Association directly pursuant to Bylaw Chapter I, Parts A, Section 2, and B, Section 3;
b) cases in which the component medical society’s peer review committee has an irresolvable conflict of interest (as determined by either the component medical society or the Judicial Council); 

c) cases involving questions of membership eligibility due to loss or lack of Tennessee licensure for cause; and

d) cases in which the relevant component society has chosen to waive its right to conduct its own peer review proceeding, thus deferring to the authority of the Judicial Council.

Finally, should a component society fail to adhere to the notice and limitation period requirements set forth in policy handbook referred in Bylaw Chapter VI, Section 4(b) jurisdiction for the relevant case shall be transferred automatically to the Judicial Council. Should a component society choose to waive original jurisdiction and relinquish peer review decision-making authority to the Judicial Council, the society shall inform the Association of such decision in writing. Component medical societies that waive original jurisdiction of peer review cases may choose to re-establish original jurisdiction over such cases by following the procedures outlined in the policy handbook referenced in Bylaw Chapter VI, Section 4(b). Whether a component medical society chooses to exercise original jurisdiction or not, the society is required to report all peer review complaints considered by the society to the Tennessee Medical Association. If, after proceeding with the peer review process, the component medical society determines that a complaint requires review by a particular medical specialty physician and the component society does not have adequate membership in the specialty to provide peer review, then the component medical society may refer the matter to the Judicial Council which shall handle the complaint in the same manner as it would if the respondent physician joined the Association directly. When a component society, or the Judicial Council, determines that a professional review action is warranted, they shall follow the notice requirements and due-process procedures which substantially comply with the policy handbook referenced in Bylaw Chapter VI, Section 4(b). Appeals from component society decisions may be perfected and filed with the Judicial Council within thirty days of the component society’s final decision on the matter. Any physician aggrieved by an action of the component society resulting in the physician being denied membership, or involving the physician suspension or expulsion from the component society, shall have the right to appeal to the Judicial Council; and be it further

RESOLVED, That TMA Bylaw Chapter I, Section B.8 be deleted in its entirety.
Sec. 8. In hearing appeals, the Judicial Council may admit oral or written evidence, as in its judgment will best and more fairly present the facts, but in the case of every appeal, both as a board and as individual councilors in district and county work, efforts at conciliation and compromise should precede all such hearings. Hearings will be conducted as set forth in Chapter VI, Section 4 of these Bylaws.; and be it further

RESOLVED, That TMA Bylaw Chapter VI, Section 2 be amended by deletion to read as follows:

Sec. 2. The Judicial Council shall have the power to censure, suspend, expel, or to take such other disciplinary action with respect to members, members serving as officers, of this Association; or component societies as in the exercise of its discretion it may deem proper under the circumstances. The Judicial Council may recommend that the House of Delegates place a component society on dormant status pursuant by Bylaw Chapter 1, Section B.3.; and be it further

RESOLVED, That TMA Bylaw Chapter VI, Section 4(a) be amended by deletion and insertion to read as follows:

Sec. 4. (a) The Judicial Council shall hold hearings on all matters relating to the censure, suspension, expulsion or other disciplinary action, including the removal from Association office for cause, of any member. The Judicial Council also shall hold hearings with respect to the censure of any component society, with respect to the revocation or suspension of its charter, or with respect to any other matter affecting its relationship with the Association. The Judicial Council also may review, or appoint an ad hoc peer review committee to review matters involving unnecessary admissions, excessive length of inpatient stay, delays in the use of x-ray, laboratory, and other diagnostic and therapeutic services, and delays in consultation and referral. In the event of an unavoidable conflict of interest, the Judicial Council shall appoint a peer review committee to hear a peer review one of these matters. Such hearings shall be conducted by the Judicial Council pursuant to a process approved by the Board of Trustees extant policy handbook as described below in Section 4(b).; and be it further

RESOLVED, That TMA Bylaw Chapter VI, Section 4(b) be deleted.

(b) In the event the Judicial Council, any other Association entity, component society (on appeal), or committee thereof, shall pursue a peer review action, then the procedures to be followed will be those published by the Board of Trustees, in the form of a policy handbook, as
amended from time to time, to comply with legal requirements. The Board of Trustees shall draft the policy handbook in reference to the American Medical Association’s extant grievance and disciplinary manual. Peer review action shall be taken only in good faith, when there is a reasonable belief that health care quality would be furthered or the Association’s integrity maintained, and after reasonable efforts have been made to obtain the facts of the case before professional review occurs. Once an action has been proposed, the member physician (or other entity as the case may be) under review shall be provided all notice and hearing rights set forth in the policy handbook as promulgated by the Board of Trustees; and be it further

RESOLVED, That TMA Bylaw Chapter VI, Section 4(c) be amended by insertion and deletion so as to read as follows:

(c) The Judicial Council shall make a written report of its decision within thirty days after the conclusion of the hearing and shall mail a copy of the report to the member officer or component society with respect to whom the matter relates, and a copy of the president chief executive officer of the Association; and be it further

RESOLVED, That TMA Bylaw Chapter VI, Section 5 be deleted:

Sec. 5. The president of the Association or the president’s designee shall notify the Board of Medical Examiners of the state of Tennessee of any final decision of the Judicial Council which involves a finding that a member has been guilty of unprofessional or dishonorable conduct as defined in Tennessee Code Annotated Section 63-6-214 (or any newly codified section of similar subject matter and effect), or as may be required under the Health Care Quality Improvement Act (42 U.S. Code §§11111 to 11152); and be it further

RESOLVED, That all other remaining Bylaw provisions be renumbered accordingly consistent with these amendments.

CODE: changes in wording signified by underline ________________
deletion of wording signified by strikethrough ________________
INTRODUCED: ROBIN WILLIAMS, MD, CHAIR
COMMITTEE ON CONSTITUTION AND BYLAWS

SUBJECT: COMPONENT SOCIETY ANNUAL REPORTING

Whereas, TMA Bylaw Chapter I, Section B.14 currently requires each chartered TMA component medical society to annually file with TMA headquarters a roster of its members; and

Whereas, TMA receives submitted membership applications, initial dues payment, and renewal membership dues for TMA and most component societies; for societies that collect component society and TMA dues, TMA dues are forwarded to TMA with membership information; and

Whereas, TMA has a membership database that tracks member history including dues payment for TMA and most component societies as well as membership category; for societies that collect their own dues, membership information is entered into TMA’s membership database; and

Whereas, Only staffed metro component societies have access to TMA’s membership database; and

Whereas, Since TMA collects most dues and tracks membership in its database, and since societies that collect their own dues enter membership data directly to the membership database, and since rural and suburban societies do not have access to TMA’s database, therefore, TMA has the best access to current component society rosters; and

Whereas, Since TMA has the best access to membership rosters and membership categories, it is duplicative for component societies to have to file an annual report to TMA listing its roster of members; Now, therefore be it

RESOLVED, That TMA Bylaw Chapter I, Section B.14 be amended so as to read as follows:
The secretary of each component society shall keep a roster of its members and shall furnish an official report of the membership to the Association at least once a year and more often if circumstances require.

CODE: changes in wording signified by underline _______________
deletion of wording signified by strikethrough ------------------
INTRODUCED BY:  TMA BOARD OF TRUSTEES
   JAMES K. ENSOR, JR., MD, CHAIR

SUBJECT:  HEALTH INSURANCE COMPANIES’ USE OF BEERS CRITERIA IN PHYSICIAN RATING SYSTEMS (A.K.A. BABY BOOMERS AREN’T DEAD YET)

Whereas, The Beers Criteria was first introduced in 1991 as a means of identifying potentially harmful prescriptions for older adults; and

Whereas, The Beers Criteria was recently updated by the American Geriatric Society (AGS) in 2012, which acknowledged that the criteria are not meant to be used by health insurance companies as a punitive measure against prescribers and that prescribing decisions must take into account multiple factors; and

Whereas, Many persons over 65 years of age have not left the workforce and may take medications on the Beers Criteria list without harm; and

Whereas, Insurance companies utilize the Beers Criteria within their physician quality rating systems, negatively impacting physicians’ ratings who do not strictly follow the criteria and thus affecting their reimbursement; Now, therefore be it

RESOLVED, That Tennessee Medical Association’s (TMA) American Medical Association (AMA) House of Delegates (HOD) delegation be directed to amend AMA HOD H-185.940, “Beers or Similar Criteria and Third Party Payer Compliances Activities” to actively advocate with health insurance companies not to utilize the Beers Criteria within their physician rating mechanisms, such as STARs and HEDIS quality measures; and be it further

RESOLVED, That TMA advocate with health insurance companies in Tennessee, in particular Humana, to change the manner in which they utilize the Beers Criteria as a rating tool for physicians.

Sunset: 2025

Fiscal Note: Minimal financial impact
TENNESSEE MEDICAL ASSOCIATION HOUSE OF DELEGATES

May 5, 2018

Resolution No. 02-18

INTRODUCED BY: TMA BOARD OF TRUSTEES
JAMES K. ENSOR, JR., MD, CHAIR

SUBJECT: CMS REQUIRED PROVIDER DIRECTORY UPDATES

Whereas, Effective January 1, 2016, the Centers for Medicare and Medicaid Services (CMS) issued regulations requiring all Medicare Advantage plans to conduct outreach to providers to verify providers’ directory information every 90 days; and

Whereas, Provider directory information includes a long list of business and practice information; and

Whereas, Entering such information for multiple insurance plans four times per year is both redundant and time consuming; and

Whereas, Physicians are already required to keep their information up-to-date in the Coalition for Affordable Quality Healthcare (CAQH) portal due to health plan credentialing requirements; Now, therefore be it

RESOLVED, That Tennessee Medical Association’s (TMA) American Medical Association (AMA) House of Delegates (HOD) delegation be directed to seek change that would require Centers for Medicare and Medicaid Services (CMS) to obtain all needed information through Coalition for Affordable Quality Healthcare (CAQH) instead of requiring physicians to make quarterly entries for Medicare and Medicare Advantage Plans.

Sunset: 2025
Fiscal Note: Minimal financial impact
INTRODUCED BY: GLENN HARRIS, STUDENT DELEGATE
NASHVILLE ACADEMY OF MEDICINE

SUBJECT: INVESTIGATION OF POTENTIAL BENEFITS AND HARMs OF 1332 WAIVERS

Whereas, 73 of 95 counties in Tennessee have only one insurer in the marketplace; and

Whereas, All of the current marketplace-supported health plans are running deficits; and

Whereas, Said deficits stem from the state’s high risk score (i.e., high healthcare costs relative to the national average) and claims; and

Whereas, Deficits have persisted despite annual rate increases of as much as 62%; and

Whereas, Said premiums have gone from second lowest in the US in 2014, to 15th highest in 2017; and

Whereas, High risk patients, price banding, and high coverage standards have been identified as drivers of insurance premium prices; and

Whereas, The 1332 waiver program allows states to waive certain requirements of the Affordable Care Act (ACA) in order to experiment with new coverage models; and

Whereas, The 1332 waiver does not allow states to waive certain requirements, such as the statute preventing insurers from denying coverage based on pre-existing conditions; and

Whereas, The state of Alaska, through a 1332 waiver, was permitted to set up a reinsurance program covering claims in the individual market for individuals with one or more of 33 high cost conditions; and

Whereas, As a result of the waiver approval, more consumers in Alaska may have coverage, and premiums may fall by as much as 20%; and
Resolution No. 03-18

Whereas, The use of the 1332 waiver would also allow our Tennessee Medical Association to propose alternative insurance models, such as a reinsurance program, which may be helpful for both practitioners and patients; Now, therefore be it

RESOLVED, That our Tennessee Medical Association investigate the potential benefits and harms of Tennessee submitting a 1332 waiver to allow Tennessee to waive key requirements of the Affordable Care Act (ACA) in order to pilot alternative healthcare models.

Sunset: 2025
Fiscal Note: To be determined, $0-$5,000

1 Collins M. In the face of Trump threats to end subsidies, Tennessee’s insurance chief says they are critical to health care. Tennessean. September 6, 2017.
TENNESSEE MEDICAL ASSOCIATION HOUSE OF DELEGATES

May 5, 2018

Resolution No. 04-18

INTRODUCED BY: C. GRAY SMITH, MD, DELEGATE
UPPER CUMBERLAND MEDICAL SOCIETY

SUBJECT: INSURANCE FEE SCHEDULES

Whereas, A large number of patients have health insurance and depend on it for payment of their medical bills; and

Whereas, Physicians are contractually bound by health insurance companies to abide by fees which the companies set; and

Whereas, Knowledge of these schedules is necessary for accurate and timely billing of claim and transparency is a worthwhile aim; and

Whereas, Access to insurance company fee schedules would greatly facilitate the physician’s ability to accurately and in a timely fashion process insurance company billing for the patient; Now, therefore be it

RESOLVED, That the Tennessee Medical Association request the Tennessee State Legislature to require all health insurance companies doing business in Tennessee to make available to physicians (either easily accessible online or in print) copies of their fee schedule to include lab and x-ray, in addition to evaluation and management codes.

Sunset: 2025
Fiscal Note: Undetermined
TENNESSEE MEDICAL ASSOCIATION HOUSE OF DELEGATES

May 5, 2018

Resolution No. 05-18

INTRODUCED BY: RICHARD LANE, MD, DELEGATE
TENNESSEE CHAPTER AMERICAN COLLEGE OF PHYSICIANS

SUBJECT: REDUCTION OF FIREARM VIOLENCE

Whereas, Mass shootings at schools have become commonplace (e.g. Columbine, Newton, Parkland); and

Whereas, Mass shootings at public gatherings have become commonplace (e.g. Orlando, Las Vegas); and

Whereas, Firearm-related suicides in 2015 reported by the Centers for Disease Control (www.cdc.gov) numbered 22,018 or 6.7 deaths/100,000 population compared to all suicides numbering 44,193 or 13.7/100,000 population; and

Whereas, Gun-related deaths in 2016 in the U.S. numbered greater than 38,000 up 4,000 from 2015 of which about two-thirds were suicides (Time magazine Nov 6, 2017); and

Whereas, Firearm violence (fire-arm-related injuries or death) is not only a criminal justice issue but a public health threat; and

Whereas, Assault weapons and large-capacity magazines are not protected by the Second Amendment, as recently ruled by a federal judge April 6, 2018 upholding Massachusetts’ ban on the weapons saying assault weapons are military firearms that fall beyond the reach of the constitutional right to “bear arms.” (Tennessean (USA section) Saturday April 7, 2018); and

Whereas, A comprehensive, multifaceted approach is necessary to reduce the burden of firearm-related injuries and deaths on individuals, families, communities, and society in general; and

Whereas, Strategies to reduce firearm violence will need to address culture, substance use and mental health, firearm safety, and reasonable regulation consistent with the Second Amendment, to keep firearms out of the hands of persons who intend to use them to harm themselves and others, as well as measures to reduce mass casualties associated with certain types of firearms; Now, therefore be it

RESOLVED, That the Tennessee Medical Association (TMA) work with the Tennessee Legislature to recognize firearm violence as a public health threat that has become epidemic and recommends a public health approach to firearm-related violence and the prevention of firearms injuries and deaths; and be it further
RESOLVED, That TMA adopts the following as policy regarding the purchase of legal firearms:

1. Sales of firearms should be subject to completion of a criminal background check and proof of completion of an applicable educational program on firearm safety based on the firearm being purchased;

2. A background check system should be instituted with the aim to prevent the sales of firearms to felons, persons with mental illnesses that put them at a greater risk of inflicting harms to themselves or others, persons with substance abuse disorders, and others who are already prohibited from owning guns;

3. The sale and manufacture of firearms for civilian use that have features to increase their rapid killing capacity and large-capacity ammunition should be prohibited by law.

4. The current ban on automatic weapons for civilian use should continue.

5. Waiting periods not already in place before the purchase of firearms should be instituted as part of a comprehensive approach to reducing preventable firearm-related suicide deaths which account for nearly two-thirds of firearm deaths.

Sunset: 2025
Fiscal Note: Less than $500

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TENNESSEE MEDICAL ASSOCIATION HOUSE OF DELEGATES

May 5, 2018

Resolution No. 06-18

INTRODUCED BY: JUSTIN CALVERT, MD, DELEGATE
CHA gadget, HAMILTON COUNTY MEDICAL SOCIETY

SUBJECT: LESSENING THE STIGMA AND POTENTIAL FOR NEGATIVE PROFESSIONAL CONSEQUENCES TO PHYSICIANS SEEKING MENTAL HEALTH CARE SERVICES

Whereas, In order to gain medical licensure, employment, and the ability to bill insurance carriers, physicians are usually required to disclose private physical or mental health issues that might impact the applicant's ability to practice medicine; and

Whereas, The Americans with Disabilities Act specifically prohibits job discrimination against applicants and employees with disabilities, including mental health issues; and

Whereas, The American Medical Association identifies a number of barriers that prevent physicians from seeking mental health care, including:
- Privacy and confidentiality concerns
- Stigma
- Fear of losing or having restrictions placed on their medical license or other practice privileges
- Concerns about losing health, life, disability, and professional liability insurance
- Concerns about permanent documentation on their work or student records
- Concerns about subsequent professional advancement; and

Whereas, In a study of female physicians appearing in the journal General Hospital Psychiatry (December 2016), almost 50 percent of subjects believed they meet or have met the criteria for mental illness, but had not sought treatment; and

Whereas, There is a need to balance both public safety and the health and wellness of physicians in the process of licensing, credentialing and employment; and

Whereas, These processes, which are often opaque to the physician who has disclosed or experienced mental health issues, may contribute additional emotional uncertainty and stress; and

Whereas, The widely adopted Triple Aim healthcare goals of enhancing patient experience, improving population health, and reducing costs has placed an inordinate burden of work on physicians; and
Whereas, Given the high and growing rates of burnout, depression, suicide and other mental health concerns among physicians, it is critical that physicians are able to acknowledge their need for and seek care for mental health conditions without fear of inappropriate restrictions on their license or practice; and

Whereas, Physicians are unclear how disclosure of having sought mental health services might affect their standing with various institutions and employers because of a lack of transparent processes; Now, therefore be it

RESOLVED, That the Tennessee Medical Association supports fair and transparent processes for the evaluation of a physician’s mental health during licensure, credentialing and hiring or retention processes to reduce the stigma and potential for inappropriate negative professional consequences for physicians who disclose mental health conditions; and be it further

RESOLVED, That the Tennessee Medical Association will work with stakeholders to improve policies, rules and procedures and the communication about them for the evaluation of a physician’s mental health during licensure, credentialing and hiring or retention processes to reduce the stigma and potential for inappropriate negative professional consequences for physicians who disclose mental health conditions; and be it further

RESOLVED, That the Tennessee Medical Association encourages the proactive use of mental health services by physicians as part of a normative lifestyle of self-care in consideration of the unique stressors they face; and be it further

RESOLVED, That the Tennessee Medical Association adopts as policy, the Quadruple Aim, which adds the goal of “improving the work life of health care providers, including clinicians and staff” as a key plank in healthcare delivery systems which have adopted the Triple Aim.

Sunset: 2025
Fiscal Note: $1000-$1500
INTRODUCED BY:  NITA SHUMAKER, MD, EX-OFFICIO DELEGATE

SUBJECT:  INCLUSION OF METHADONE IN PRESCRIPTION DRUG MONITORING DATABASES

Whereas, State and federal legislators across the country are increasing the regulation of prescribing of controlled substances and mandating the use of Prescription Drug Monitoring Programs (PDMPs) to collect patient-specific data on various controlled prescription medications and to enable prescribers, pharmacists, regulatory boards, and, in some states, law enforcement agencies, to access this information under state law.; and

Whereas, PDMPs are valuable tools to improve patient safety and health outcomes; and

Whereas, PDMPs can aid the care of patients with chronic conditions and help identify persons engaged in high-risk behavior, such as doctor shopping and prescription forgery, indicating possible abuse of or dependence on controlled substances; and

Whereas, Physicians need timely access to all prescribing information to ensure that individuals with substance abuse disorders receive comprehensive, safe, and efficacious treatment, and to prevent inadvertent prescribing of contraindicated medications; and

Whereas, Physicians cannot provide the best and safest care for patients if they do not have timely accurate information about all controlled substances a patient is using, including Methadone; and

Whereas, Requiring Methadone and other medication-assisted treatment modalities to be reported to PDMPs; and

Whereas, Federal law currently prohibits opioid treatment programs (OTPs) and the Department of Veterans Affairs from reporting patient data in PDMP; and

Whereas, Methadone accounted for one in three prescription painkiller overdose deaths in the US (CDC, 2012); and

Whereas, State Attorneys General in 33 states, including Tennessee, have petitioned the Department of Health and Human Services to modify federal statutes to permit opioid treatment programs (OTPs) to submit dispensing data to state prescription drug monitoring programs (PDMPs); Now, therefor be it
Resolution No. 07-18

RESOLVED, That the Tennessee Medical Association will urge the American Medical Association (AMA) to promote federal action requiring opioid treatment programs (OTPs) to submit dispensing data to prescription drug monitoring programs (PDMPs) in accordance with state laws; and be it further

RESOLVED, That the Tennessee Medical Association will urge federal legislators to require that all healthcare entities, including opioid treatment programs (OTPs), be required to report controlled substance prescribing to prescription drug monitoring programs (PDMPs).

Sunset: 2025
Fiscal Note: Less than $500
TENNESSEE MEDICAL ASSOCIATION HOUSE OF DELEGATES

May 5, 2018

Resolution No. 08-18

INTRODUCED BY: CHRISTIN GIORDANO MCAULIFFE, MD, DELEGATE
NASHVILLE ACADEMY OF MEDICINE

SUBJECT: GRADUATE PHYSICIANS

1 Whereas, There is a shortage of primary care physicians throughout Tennessee and
in the United States; and

2 Whereas, Every citizen deserves to have physician-led care regardless of
geographical location; and

3 Whereas, There were 37,100 applicants in the 2018 residency match for first year
residency program positions with only 33,000 positions offered, with
approximately 1,800 of those unmatched having graduated from a medical
school in the United States\(^1\); and

4 Whereas, The numbers of medical school graduates are increasing without increased
federal funding for further residency positions; and

5 Whereas, Graduates of medical school are otherwise unable to be employed in their
trained role due to current licensing laws; Now, therefore be it

RESOLVED, That the Tennessee Medical Association support the enactment of state
legislation that proposes a role for medical school (MD and DO) graduates,
“graduate physicians,” in Tennessee to practice in geographical areas with
a primary care physician shortage, and be it further

RESOLVED, That the Tennessee Medical Association (TMA) delegation to the American
Medical Association (AMA) House of Delegates (HOD) introduce a
resolution in the AMA HOD urging Congress to develop a primary care role
at the federal level for medical school graduates who are unmatched in
residency programs.

Sunset: 2025
Fiscal Note: $0-1500

INTRODUCED BY: MAX KEELING, STUDENT DELEGATE
KNOXVILLE ACADEMY OF MEDICINE

SUBJECT: TENNESSEE MEDICAL ASSOCIATION PUBLIC EDUCATION ON OPIOIDS USING MEDIA CAMPAIGNS

Whereas, Tennessee is 4th in the United States for overdose deaths; and

Whereas, In 2016, there were at least 1,631 overdose deaths, a 12% increase from 1,451 in 2015; and

Whereas, Educating the public and bringing greater awareness to the life-threatening adverse effects of abuse, may assist in reducing the demand for the drug and lead to more frequently prescribed alternatives; and

Whereas, Most educational efforts made to the public are on an individual basis to those seeking prescriptions and many victims of opioid abuse are individuals for whom the prescription was not written; and

Whereas, An educational media campaign targeting the general public would encompass the individuals at risk who did not have any education associated with their treatment, including those who seek to obtain opioids illegally; and

Whereas, An educational media campaign, targeting the general public, would encompass the individuals at risk who are inadequately educated; and

Whereas, Educational/marketing campaigns have been funded in the past to educate the general public and were successful; and

Whereas, CDC pilot studies of opioid ad campaigns in four states have showed promising results in bringing awareness to the opioid epidemic and the addictive properties of opioids; Now, therefore, be it

RESOLVED, That the Tennessee Medical Association seek funding from the state of Tennessee (Tennessee Department of Health (TDOH) and the Tennessee Mental Health and Substance Abuse Services (TMHSAS)) to partner in creating prevention media campaigns; and be it further

RESOLVED, That the Tennessee Medical Association to develop a media campaign, through social media, YouTube and Google ads, to educate adolescents in the dangers of opioids, alternate ways to manage pain and the impact addiction is having in Tennessee; and be it further
RESOLVED, That the Tennessee Medical Association seek strategic partnerships to cooperatively develop media campaigns that target adolescents in a preventative effort to educate them on what opioids are, their adverse effects and current detriment that the abuse of these drugs is currently causing the State of Tennessee.

Sunset: 2025
Fiscal Note: $30K-$50K

8 Co-Authored by Austin Zearley, David Bastawrous, and Karla Allen, all of Lincoln Memorial University