VOL. 111, NO. 2 | QUARTER 2, 2018

Tennessee Medicine

Journal of the Tennessee Medical Association

The Facts About TMA's Efforts on "Doctor of Medical Science"

2018 Day on the Hill Recap

General Assembly Passes Physician-Friendly MOC Bill

Editorial: Literacy and Tennesseans' Health

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DAY ON THE HILL

Hundreds of White Coats at Day on the Hill

New Location and Format No Deterrent for Passionate Advocates

More than 300 physicians and healthcare advocates gathered in Nashville on March 6 for TMA's biggest annual lobbying event. Day on the Hill gives physicians, practice administrators and other healthcare professionals a chance to share their expertise with lawmakers who make important public policy decisions affecting the delivery of healthcare in Tennessee.

TMA members and guests lobbied throughout the day at the Cordell Hull Building—the General Assembly's new home in the state's capitol—and attended an evening legislative reception at the nearby DoubleTree Hotel. Doctors spoke to their Representatives and Senators about several bills including: opioids, episodes of care, balance billing, maintenance of certification, prohibition of indoor tanning for minors and advanced academic degrees for PAs, among others. For a more in-depth review on the advanced academic degrees for PAs (Doctor of Medical Science), see page 12.







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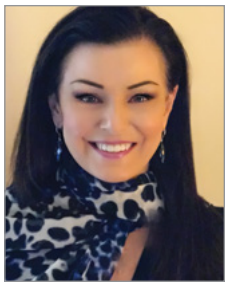

PRESIDENT'S COMMENTS

We've Only Just Begun

By Nita W. Shumaker, MD

I had one clear goal in mind when I began my term as your President last spring: *achieve some measurable difference in Tennessee's opioid abuse epidemic.*

Immediately after my installation I started 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 as physicians so I — through the platform and support of TMA — could be a change agent for the medical community.

In order to protect our patients, 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've 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, medial students and residents and other organizations. It is imperative that physicians are represented wherever and whenever people talked about the crisis and how to solve it. Raising awareness around safe storage and proper disposal is a critical part of the solution.

By November, TMA had partnered with the Department of Health to organize a super summit with the entire healthcare community — physicians, hospitals, nurses, pharmacists, government agencies and other stakeholders — to share best practices and talk about what we can do to "turn the tide." We came away with four main actionable initiatives, one of which (prescriber education) I volunteered to lead. I vow to continue working on provider education to help physicians and extenders learn how to treat pain without using opioids, especially in primary care settings.

Earlier this year, TMA dedicated a special edition of this 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, including how to safely wean patients off high doses of opioids and benzodiazepines.

I'm proud of what we've accomplished in such a short time. I've also come to realize through all these efforts just how much work still needs to be done on Tennessee's number one public health crisis.

All of our efforts are paying off. A report just released in April shows that opioid prescriptions at retail pharmacies in Tennessee dropped nearly 9 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.

(Continued on page 24)

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EDITORIAL:

Reading, Writing, Arithmetic… and Tennesseans' Health

By John W. Lacey, III, MD with input from Tennessee's First Lady Crissy Haslam

Ninety million U.S. adults, including 36% of adult Tennesseans, have basic or below basic ability to obtain, process, and understand the fundamental health information and services needed to make appropriate health decisions—the Institute of Medicine's definition of health literacy. The financial impact of low health literacy is an astounding $200 billion in annual excess U.S. healthcare expenditures, of which $3.8 billion is attributable to low population health literacy in Tennessee (*International Journal of Health Policy and Management*, 2015). If the costs and the underlying health problems are to be mitigated, physicians and other key stakeholders must begin to actuate impactful interventions through leadership, advocacy, and role modeling.

A fully health-literate person is able to access healthcare services, analyze relative risks and benefits from recommended treatment plans, and calculate dosages and health insurance cost options. Such patients are able to communicate with healthcare providers by articulating their health concerns, accurately describing symptoms, asking pertinent health questions, and understanding spoken medical instruction. Full health literacy enhances test result interpretation and facilitates locating health information from a variety of sources.

The consequences of low health literacy affect people across all demographics but especially those of lower socioeconomic and minority groups, limited educational attainment and lower cognitive ability, as well as those at the poles of age and those for whom English is a second language. Only 13% of English-speaking adult Americans have fully proficient health literacy skills according to the United States Department of Education. Tennessee is not statistically different.

What makes improving health literacy so critical in Tennessee is reflected in our overall health ranking in 2017—an all too consistent 45th among states in "America's Health Rankings." The imperative to engage fully any malleable factors that can bend Tennessee's health curve in a positive direction is clear. Literacy/health literacy are such factors.

Where then should we begin? Health literacy begins with literacy, so a logical point of embarkation is at the earliest steps in our children's journey toward literacy—a set of reading, writing, basic math, speech, and comprehension skills. These building blocks of literacy are first laid in early childhood. Eighty percent of brain development occurs by age three, and 90% of synapses are formed by kindergarten. Tennessee children who haven't developed some basic literacy skills by the time they begin school or are not reading proficiently by end of the third grade have a fourfold increased risk of not completing high school. Two-thirds of children who don't read proficiently by the end of the fourth grade will be on welfare or experience incarceration at some point in their future. Having Tennessee's children prepared for success in education and health matters because of the direct impact on the future of all Tennesseans—our workforce, economy, and the kind of place where we will live, work, and raise families. The reality we face in 2018 is that only 34% of Tennessee's third graders are reading proficiently (Tennessee Department of Education).

Development of literacy/health literacy is affected by multiple factors including age, language, culture, health status and experiences, as well as cognitive and psychosocial abilities that evolve from early childhood forward. However, some of the most powerful influences emanate from adult caregivers—parents, grandparents, teachers, coaches, other adults in the home. As illuminated by research that directly measures literacy levels, childhood health literacy is shaped to a significant degree by parents' health literacy, knowledge, health system experiences, attitudes, and behavior. These ultimately affect both childhood health literacy development and health outcomes. Examples of such health outcomes include the impact of maternal literacy on child glycemic control. Low maternal literacy portends compromised control. Children are much more likely to manifest symptoms of depression and withdrawal when their mothers have depressive symptoms and low health literacy, as opposed to the scenario when mothers have depression and proficient health literacy. Low health literacy is implicated in reduced prenatal screening, lower immunization rates, poor dental health, improper medication dosing and diminished understanding of consent forms and

process management of diseases, including asthma and diabetes. Low parental health literacy is associated with the child experiencing an increase in all-cause hospitalization and total health service usage, substance abuse, pre-teen alcohol use, and behavior such as gun carrying and fighting. If the family environment is one of abuse or household dysfunction resulting in exposure of the child to adverse childhood events (ACE), the risk of chronic disease and disability is compounded.

A home environment that fosters health literacy helps pediatric patients reach the achievement-guided independence to co-manage their health. This transition most often emerges between 11 and 15 years of age. Data gathered by the Tennessee Office of Coordinated School Health gives urgency to defining and deploying interventions that support this transitional advancement of childhood health literacy. More than 233,000 or 23% of Tennessee public school students (K-12) have a chronic condition or disability diagnosis—the most common being asthma (30%), ADHD/ADD (21%), and severe allergies (14%). Some 3,700 children or 1.5% have a diagnosis of diabetes. Chronic illness and disability diagnoses have increased by 209% since the 2004-2005 school year. More than 12,000 students receive a daily health procedure by a licensed healthcare provider while at school (such as blood glucose monitoring) with another 4,300 performing their own monitoring without assistance.

Tennessee has established excellent health education and lifetime wellness standards for K-12, divided into three grade bands (K-5; 6-8; 9-12). The standards define developmentally appropriate learning experiences and knowledge that support our children's journey toward health literacy, with skills for self-care participation and a framework for life-long health learning and wellbeing—if these standards are fully implemented and resourced. This school year only 40% of school districts are providing comprehensive health education for all students (K-12). This underachievement, in conjunction with our low rate of reading at grade level, augurs poorly for enhancing health literacy—much less health outcomes—for Tennessee's children. Now is as late as we dare wait to pursue meaningful course corrections if we are to reach the health targets we desire and our children deserve.

Tennessee ranked 42nd for the health of women and children in 2017, 40th in immunizations for children 19 to 35 months, 37th in adolescent immunizations and 38th in infant mortality. Seeds sown in childhood for poor health literacy bear the expected fruit. Tennessee ranks 44th for senior health and premature death (years lost before age 75 per 100,000 population). While we rank 9th in high school graduation, estimates suggest more than 60% of graduates have basic or below-basic health literacy.

A compendium of research on health outcomes for adults afflicted by low health literacy includes lower general health status, reduced participation in health insurance, higher rates of hospitalization and hospital readmission, lower use of preventive health services, more unnecessary ER visits, higher morbidity and mortality for heart failure, less effective self-care for chronic conditions, more medication adverse effects and improper use including opioids, and decreased understanding of nutritional labels and informed consent. The Knoxville Academy of Medicine's Project Access Program has found low health literacy second only to transportation among the frequency of socioeconomic barriers hindering optimum health care coordination.

So at a time of rapidly advancing medical knowledge and technology as well as the possibility of bringing these to bear on our most intransigent health challenges, low health literacy remains a sinister stumbling block: Too many around us are unable to seize the moment of improving their own or their children's health.

Since publication of the "National Action Plan to Improve Health Literacy" (U.S. Department of Health and Human Services 2010) and "Healthy People 2020" (U.S. Office of Disease Prevention and Health Promotion 2010), focus has intensified on the role and responsibility of practitioners and other components of our healthcare system in addressing low health literacy. Evolving payment methodologies (including Medicare and TennCare); growing racial, ethnic and cultural diversity; and broadening definitions of healthcare quality have contributed as well. For hospitals, new imperatives to define and inculcate countermeasures have arrived via the Joint Commission's linking health literacy to patient safety and the introduction of the concept of health-literate organizations by the Institute of Medicine.

Multiple organizations representing physician interests such as the AMA, the American Academy of Pediatrics, the Academy of Family Physicians, the American College of Emergency Physicians and others have published research, reviews, or recommendations

Health literacy begins with literacy, so a logical point of embarkation is at the earliest steps in our children's journey toward literacy—a set of reading, writing, basic math, speech, and comprehension skills. These building blocks of literacy are first laid in early childhood.

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to guide physician practices regarding approaches to the low health literacy challenge.

So where should Tennessee physicians begin? Which practical tactics are supported by research of acceptable methodological strength to consider in your practice? Consider beginning at home. As adult caregivers—parents, grandparents and volunteer mentors—reading to children daily from birth is meaningful in fostering and reinforcing brain development and literacy. Supplement school health offerings with grade-appropriate "home use" friendly programs that take advantage of your knowledge to fill in gaps in progression toward health literacy. The OrganWiseGuys materials (*organwiseguys.com*) have been thoroughly vetted with good outcome p-values and are reasonably priced.

In your practice, consider employing the 2017 AHRQ Health Literacy Universal Precautions Tool Kit (*ahrq.gov/literacy*). The information includes approaches to improve spoken and written communication as well as patient self-management tactics. This tool kit includes 21 realistic, evidence-based interventions ranging from a "brown bag" review of medications to effective implementation of teach-back methodology. These practices move from assuming that all patients understand what we communicate to embracing that they often don't understand essential information when they leave the office. The AHRQ kit tools can help physician practices meet Patient Medical Home certification/recognition standards for NCQA, the Joint Commission, and URAC. A crosswalk between the tools and related standards is available. Support and lead the deployment of similar tactics at your hospital.

At community and school district levels, leverage your authority and credibility in health matters to advocate for full implementation of Tennessee's robust health education and lifetime wellness standards for grades K-12—including the developing focus on opioid misuse. Also, use your credibility to encourage young parents to support development of health literacy in their children and to enhance their own acumen/proficiency.

Seek allies such as the Office of Coordinated School Health, The Institute of Agriculture at The University of Tennessee, and local libraries. The Executive Director of Healthy Schools, Lori Paisley, reports that, "Tennessee is the only state in the nation that funds a Coordinated School Health presence in every school district. This program is an effective approach designed to connect health with learning. It encourages healthy lifestyles, provides needed supports to at-risk students and helps to reduce the prevalence of health problems that impair academic success." This represents an important step, but more steps must follow. The Extension at The University of Tennessee's Institute of Agriculture has agents across the state in each county providing programs aimed at equipping parents of young children and child care providers with tools to enhance reading capabilities for Tennessee's children. These agents will welcome your input, support, and participation.

As we look around our communities and understand the lost opportunities for health and wellbeing for many of our neighbors and recognize the challenges that many of our children face in achieving and sustaining wellness, we must recommit ourselves to bending the health-outcome curve toward enhanced lives for all Tennesseans. Physicians wielding accelerating advances in knowledge and technologies while simultaneously improving the basics like effective communication and health literacy can and must be among those leading the way. ■

Proposal for Expanded Primary Care Role for PAs Ends in a Flash

What Happened with the Legislative Session's Most Misunderstood Issue, and the Facts About TMA's Efforts on "Doctor of Medical Science"


Sen. Richard Briggs, MD


Ron Kirkland MD, MBA

An ongoing debate about how to solve Tennessee's shortage of access to primary care reached a critical juncture in the General Assembly earlier this year as lawmakers considered a bill that raised important questions around appropriate scope of practice for midlevel providers.

The dialogue within Tennessee's medical community actually began in 2016 when Lincoln Memorial University (Harrogate, Tenn.) approached the TMA Board of Trustees to pitch their concept for a new, advanced academic degree for physician assistants and ask for TMA's endorsement.

The Board initially tabled the discussion to gather more information and converse with other stakeholders. TMA later notified LMU that the state's largest professional organization for doctors could not and would not endorse any measure if it allowed PAs who earned the doctorate-level degree to expand their scope of practice and call themselves "doctors." TMA was at the same time embroiled in a legislative battle with a faction of advance practice registered nurses who repeatedly pushed for APRN independent practice in Tennessee. LMU's program called for a new type of license for PAs and was a perceived threat for many Tennessee physicians who feel that advance degree midlevel practitioners are not adequately trained to lead safe, effective, high-quality healthcare delivery teams.

LMU moved forward without TMA's knowledge or support and in 2017 worked with State Senate bill sponsor, Sen. Richard Briggs, MD (R-Knoxville) to introduce a bill that would create a new state licensure for PAs who completed the LMU Doctor of Medical Science program.

While the bill clearly did not allow for PA independent practice, it created heartburn among TMA physician leaders and other members who felt it would be confusing to patients in a clinical setting if PAs were allowed to use the term (or acronyms for) "Doctor of Medical Science." TMA officially opposed the bill as filed.

The parties negotiated amendments during the 2017 legislative session but could not reach a compromise. The TMA Board made clear it would remain opposed unless or until specific provisions were made, including adding or revising language to clarify physician-to-PA oversight and removing the term "doctor."

Sen. Briggs, a Knoxville surgeon and TMA member, and LMU agreed to pull the bill and work with TMA to address physicians' concerns. During the summer and fall of 2017, TMA facilitated meetings with the large Metropolitan-area medical societies to give Sen. Briggs and other proponents a forum to explain their concept and try to persuade doctors that it was a solution to primary care access issues.

Proponents were unable to alleviate doctors' concerns, however, about the name of the degree and the perceived implications for doctors and patients. A brand new bill was introduced but TMA remained officially opposed when the 2018 session began in January.

"TMA and the county medical societies worked with us to make sure we had the chance to talk to doctors about the intent behind the bill. I felt like we had some good dialogue and heard some passionate opinions. I can honestly say that everyone involved approached this session with a genuine desire to work together to find ways to address physicians' biggest issues," said Sen. Briggs.

TMA remain opposed to the 2018 version of the bill but proactively worked with sponsors to advocate for improvements, focusing on addressing two primary concerns: 1) making sure the bill in no way allowed for independent practice for PAs but called for a physician-led, team-based healthcare delivery model, and 2) trying to persuade the sponsors to change the name "Doctor of Medical Science" to something more palatable to MDs and DOs and less confusing for patients.

By late February, the sponsors amended the bill to address these and other concerns and the TMA Legislative Committee changed its position to neutral on SB 1926 (Briggs) / HB 2122 by Rep. Ryan Williams (R-Cookeville).

All of TMA's previously stated reasons for opposition were addressed satisfactorily in the amended bill. Graduates of LMU's doctor of medical science program would be called/referred to as "Essential Access Practitioners" in clinical practice. References to "doctor" or "medical" in their titles were removed. Further, EAPs would be trained in the medical model and their scope of practice on a physician-led primary care team would be licensed, defined and regulated by the medical board.

Essentially, the bill as amended followed TMA's "A Blueprint for a Team-Based

Healthcare in Tennessee" white paper released in 2015 (tnmed.org/teambased).

"After the bill was amended, many of us felt that it was a good solution to the perceived access to primary care shortage in Tennessee. Other states were watching to see how we handled this issue, and we had an opportunity to positively affect our national healthcare delivery system. These graduates, licensed as EAPs, would have practiced within a physician-led primary care team just as TMA has been advocating for the last few years. This bill would have allowed physicians to remain in control of the emerging model of team-based healthcare delivery," said Ron Kirkland, MD, MBA, Chair of the TMA Legislative Committee.

In early March, TMA had even secured a commitment from the sponsors to insert the language "physician-led" into the bill.

Still, many physicians across the state who were mistaken or misinformed about the contents of amended SB 1926/ HB 2122 and its practical implications mistook the bill for a pathway to independent practice for PAs.

The Tennessee Academy of Family Physicians sent a letter expressing its outright opposition to the bill. The Tennessee Osteopathic Medical Association and American Osteopathic Medical Association were also on record opposing the bill.

Even some TMA members who attended Day on the Hill on March 6 told their legislators that they opposed the bill, despite TMA's neutral position.

"Our legislators are under pressure from their constituency to solve our perceived primary care shortage in Tennessee. The political reality is that they are going to pass something in the near future. Simply saying 'no' without offering a solution is not a viable long-term or even short-term strategy. We wanted to make sure physicians had a voice in what happens in this debate, but ultimately we came up short," said Dr. Kirkland. "What happens in the next year or two may be much less desirable than what we just lost."

On March 15, LMU abruptly withdrew its support of the legislation to license DMS graduates. Sen. Briggs and Rep. Williams withdrew their bills from committees the next week.

"I was disappointed because I genuinely felt from the beginning that this model was the best way for us to help [not solve] the primary care issue and do it in a way that allowed physicians to influence the process," said Sen. Briggs. "You can look at the number of physicians being trained in primary care and compare it to the number of nurse practitioners and physician assistants and see that, at some point, we are going to be overwhelmed by mid-level providers wanting to practice independent of physicians. The train has left the station on that issue. Physicians have a choice—we can either lead and be part of every aspect of mid-level training from selection to training to licensing to lifelong oversight, or do nothing and let others determine the future of primary care. I sponsored this bill because only physicians have the education, training, and experience for leadership in that role. Saying 'no' is no longer an option."

While the DMS bill died in session, the three-year moratorium that TMA negotiated with nurses on scope of practice legislation expires after next year's legislative session. State and national advocacy groups are already mobilizing for a renewed push for APRN independent practice in Tennessee in 2020, spending advertising dollars to sway public opinion in key areas of the state. About half of U.S. states now allow APRNs to practice independently, without physician oversight.

TMA will continue advocating for physician-led, team-based healthcare delivery in Tennessee. ■

SUMMARY OF SB 1926 / HB 2122

as amended prior to withdrawal.

WHAT THE BILL DID	WHAT THE BILL DID NOT DO
Require PAs to practice with a collaborating physician in a team-based delivery model	Allow PAs to practice independently, without physician oversight
Create a new license for some PAs to be called "Essential Access Practitioners" by license and in a clinical setting	Put PAs on par with doctors, in license or in a clinical setting
Ensure that PAs who earn the new licensure through advanced academic degrees and clinical training would be **regulated** by the Tennessee Board of Medical Examiners	Allow PAs to establish independent primary care clinics without regulatory oversight by the medical board
Require PAs who have already earned a master's degree to complete a minimum of two years of advanced graduate study at an accredited medical school, taught by physicians	Allow any PA to complete a few online courses and call himself or herself a "doctor" in Tennessee
Require applicants to have a minimum of three (3) years of clinical practice experience and be able to continue in primary care as part of a patient care team including a sponsoring primary care physician	Allow newly graduated, inexperienced PAs to independently treat patients in any specialty area
Require 100 hours of accredited CME and documentation of ongoing affiliation with physicians as members of the patient care team to renew licensure every two years	Create a "one and done" academic program without defined parameters for ongoing competency and/or physician collaboration

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Tennessee Legislature Approves Physician-Friendly MOC Bill

TMA Advocated for State Laws to Eliminate Mandatory MOC Requirements

Physician members of the Tennessee Medical Association are praising a new law that will ease the costly, burdensome and in many cases mandatory requirements for doctors to maintain specialty board certification. The Tennessee General Assembly unanimously approved the measure after a two-year effort by TMA to persuade state lawmakers to take action on what has become a hot button issue for physicians across the U.S.

The Tennessee Senate passed the bill (SB1824) by a vote of 33-0 after the House unanimously passed the companion bill (HB1927) last week. The bill was signed into law by Governor Bill Haslam on April 9.

Sen. Richard Briggs, MD (R-Knoxville) sponsored the Senate bill while House Republican Caucus Chairman Ryan Williams (R-Cookeville) led the effort in the larger chamber.

Sen. Briggs and Rep. Williams worked with TMA in 2017 to pass another law that prevents MOC from being required for state licensure. That same bill created a task force to study MOC as it relates to hospital hiring practices, admitting privileges and insurance networks. Legislators who served on the task force returned to session in 2018 ready to give Tennessee physicians some relief and ensure the arbitrary MOC process no longer interferes with Tennesseans' access to care.

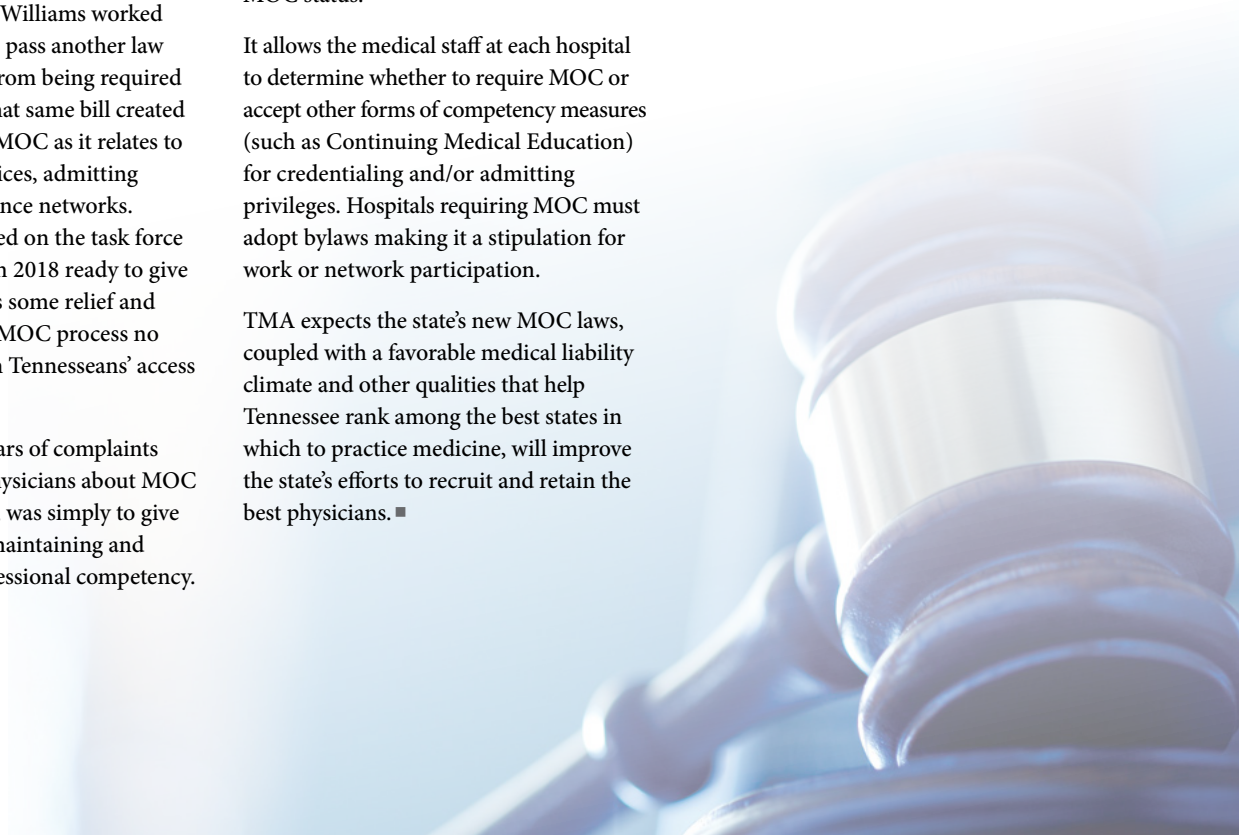
"TMA's goal, after years of complaints from our member physicians about MOC testing requirements, was simply to give doctors options for maintaining and improving their professional competency. Doctors should not be forced by hospitals or insurance companies to participate in an arbitrary certification process that has not been shown to improve quality of care. This bill gives much-needed relief for doctors who may choose Continuing Medical Education or other forms of ongoing learning. Thanks to Sen. Briggs, Rep. Williams and the other members of our state legislature, Tennessee is now one of few states developing real solutions to this national issue," said Nita W. Shumaker, MD, TMA President 2017-2018.

The new law carries two important provisions for doctors who have pleaded for relief from the MOC requirements levied by the American Board of Medical Specialties, insurance companies, hospitals and health systems.

It prohibits health insurance companies from excluding physicians from health plan networks based solely on a physician's MOC status.

It allows the medical staff at each hospital to determine whether to require MOC or accept other forms of competency measures (such as Continuing Medical Education) for credentialing and/or admitting privileges. Hospitals requiring MOC must adopt bylaws making it a stipulation for work or network participation.

TMA expects the state's new MOC laws, coupled with a favorable medical liability climate and other qualities that help Tennessee rank among the best states in which to practice medicine, will improve the state's efforts to recruit and retain the best physicians. ■



As private practice physicians who serve large numbers of Medicaid patients in Tennessee, we wish to express our appreciation to the Tennessee Medical Association [TMA] and the Memphis Medical Society, for their support of our lawsuit seeking relief from an unfair recoupment of funds for services provided to Medicaid patients.

The TMA, Yarnell Beatty, Katie Dageforde Hartig, and others came forward to defend our cause. Special thanks to David King and the law firm of Bass, Berry, and Simms. This summary judgment in favor of the physicians has widespread ramifications for defending our profession against arbitrary restrictions which harm our patients.

The Medicaid recoupment was the result of a statute in the law known as ACA 2010.This statute defined primary care in a way that removed the primary care physician's right to provide point of care services in a community based medical practice. For example, pregnancy tests and urinalysis were defined, under ACA 2010, as a pathology services. Physicians billing for urinalysis and a pregnancy test at the time of the office visit, failed to meet criteria for "primary care" because the urinalysis and pregnancy test codes [pathology] constituted 67% of the billed service codes.

If the statute had prevailed, "primary care" recognition could be granted only to physicians and nurses who limit their billing to office visit codes. For physicians in rural and underserved communities, many patients depend on the office's ability to provide some lab, minor surgery, and imaging services at the point of care. The Patient Centered Medical Home seeks to coordinate care and minimize fragmentation of service. ACA 2010 was supposed to promote this, but this statute did the opposite.

Therefore, we extend special thanks and recognition to the TMA for standing tall in defense of best practices for our patients.

UNITED WE STAND.....

Wm. MacMillan Rodney MD

John Pymm DO

Carla Lyn Boswell MD

Amanda Wood MD

Ike Emereuwaonu MD

Deborah Roquiz MD

John RM Rodney MD

O Lee Berkenstock MD

Rickey Carson MD

Philip Sutherland MD

Tiffany Meador MD

Kelly Arnold MD

Private Practice Chattanooga

Private Practice North Memphis

The Memphis Medical Society

TMA™ Tennessee Medical Association

Ask TMA

Q: I want to allow physician assistants (PA) to start performing X-rays in my office after proper training and establishing written protocols. I have been told a PA could do anything the physician is licensed to do if such service is provided within the usual component of the supervising physician's scope of practice, there is a written protocol in place, and it is within the skill set of the PA. Am I safe to pursue this?

A: No, rules promulgated by the Board of Medical Examiners would likely prohibit a PA from performing x-rays in a physician's office unless the PA received approved training and became certified by the board to perform x-rays.

The Board of Medical Examiners' Rule on Utilization of X-Ray Operators in Physician's Offices contains a section titled Certification Requirement. This section states that:

All persons operating x-ray machines in physicians' offices in Tennessee must possess a certificate issued by the Board pursuant to this Chapter of rules with the exception of the following who are exempted from certification:

(1) Licensed medical doctors

(2) Medical interns, residents and clinical fellows

(3) Students engaged in clinical practice while enrolled in a Board approved radiological education course required to receive radiological certification.

(4) Graduates of a Board approved radiological education course who are awaiting examination but only for a period not to exceed six months from the date that the course was completed. After sitting for the examination this exemption shall continue for a period not to exceed 75 days. At all times while awaiting examination or examination results and until certification is received, graduates shall practice only under supervision as set forth in rule 0880-5-.05 (2)(c).

The rule specifically exempts physicians from the x-ray certification rule requirement but does not specifically exempt PAs. Typically, if a statute has an exemption list, only those on the list are actually exempt. The same would be true for a rule. There is a maxim in law, "expressio unius est exclusio alterius" which is often cited by courts for the proposition that where a statute specifically designates the things upon which it operates, an inference exists that all things omitted were intentionally omitted.

Thus, it can be inferred that the agency promulgating the rule specifically intended that only the licensed healthcare professions such as medical doctors, interns, residents, student, etc. specifically exempted from certification, are exempt from certification to operate x-ray machines in physician offices. It follows then that since PAs were omitted from the x-ray operating certification list, such omission was intentional by the agency which promulgated the rule and that such omission would supersede the authority of a physician supervisor to delegate x-ray operation to a PA.

A PA could, of course, complete the required course and examination to become a certified x-ray operator in addition to being a PA. Because of the inherent safety risks involved in taking x-rays and because of the specific rules on this subject, this is an exception to the general rule that a PA can perform those tasks that are within the supervising physician's normal scope under the physician's supervision.

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Q: A colleague recently told me that if I test positive on a urine drug screen test, my employer has to report me to the licensing board. Is this true?

A: In some situations, yes the employer will have to make a report. In 2017, the Tennessee General Assembly passed a law requiring a licensed healthcare facility or other healthcare employer to report a positive confirmed drug test or a refusal to submit to a drug test of a healthcare practitioner to the appropriate licensing board unless an exemption applies. ***It does not require*** an employer to conduct urine drug testing.

This new law considers a positive drug test as a violation of the licensee's practice act and requires an employer or facility to report to the licensing board when:

1. *The healthcare practitioner refuses to submit to an employer's drug test; or*
2. *Tests positive for any drug on any government or private sector preemployment or employer-ordered confirmed drug test.*

If a licensee produces a lawful prescription, a valid medical reason for using the drug or reports to a substance abuse peer assistance or treatment program, the employer does not have to make a report to the licensing board. Rules detailing the reporting requirements were recently published by the Tennessee Department of Health.

To obtain a full understanding of this requirement, see our Law Guide topic titled **Urine Drug Testing**. Any questions may be directed to *legal@tnmed.org*.

TMA members can "Ask TMA" by emailing **becky.morrissey@tnmed.org** or calling **800.659.1862**. Questions and comments will be answered personally and may appear anonymously in reprint for the benefit of members.

Who is Going to Take Care of Me?

By Karl Misulis, MD, PhD & Christa Stoscheck, PhD

The deficit in physician supply is growing. According to a study published by the AAMC in 2017, the United States will face a shortage of between 40,800 and 104,900 physicians by 2030. Presently, there is little concerted political effort to alleviate this shortage. The AAMC has proposed that this issue be addressed by further expansion of medical school class sizes and residency positions, greater use of midlevel practitioners and better use of technology. But we do not seem to be moving as quickly as needed. This is an issue of patient access to care, care quality and patient safety. In the present political and economic climate, it is not clear that the winds of change favor a rational solution.

The U.S. does not graduate enough physicians. Medical school enrollment has grown, more in osteopathic than allopathic schools, but the numbers have not increased to meet the anticipated demand for physicians. Medical schools also have not met the demands of qualified candidates for spots in a class. There is brisk competition for positions, resulting in many students taking two years or longer after college to gain admission. Of all students who successfully complete their pre-med requirements, only 40% are accepted into U.S. medical schools. There is no doubt that many applicants who are denied admission would make good physicians. Many, although not all, U.S. students who attend foreign medical schools do so because of difficulty with domestic admissions, yet return as fine physicians.

We need to increase the available medical school spots, and while we are at it, we need to make medical education more affordable.

The other principal bottleneck for educating physicians is insufficient slots for graduate medical education. Although there are sufficient spots for most American graduates, there are insufficient spots for those who want to practice in the U.S. coming from foreign medical schools. In the 2018 match, there were more than 8,000 unmatched applicants.

We need more residency spots.

Later entry into medical school and lower acceptance rate might be counterbalanced somewhat by longer careers. We have a paucity of good data, but median retirement age is between 65 and 67 years for physicians, but with 20% still practicing at age 75. However, the number of hours worked and numbers of patient encounters does drop off for physicians in their senior years.

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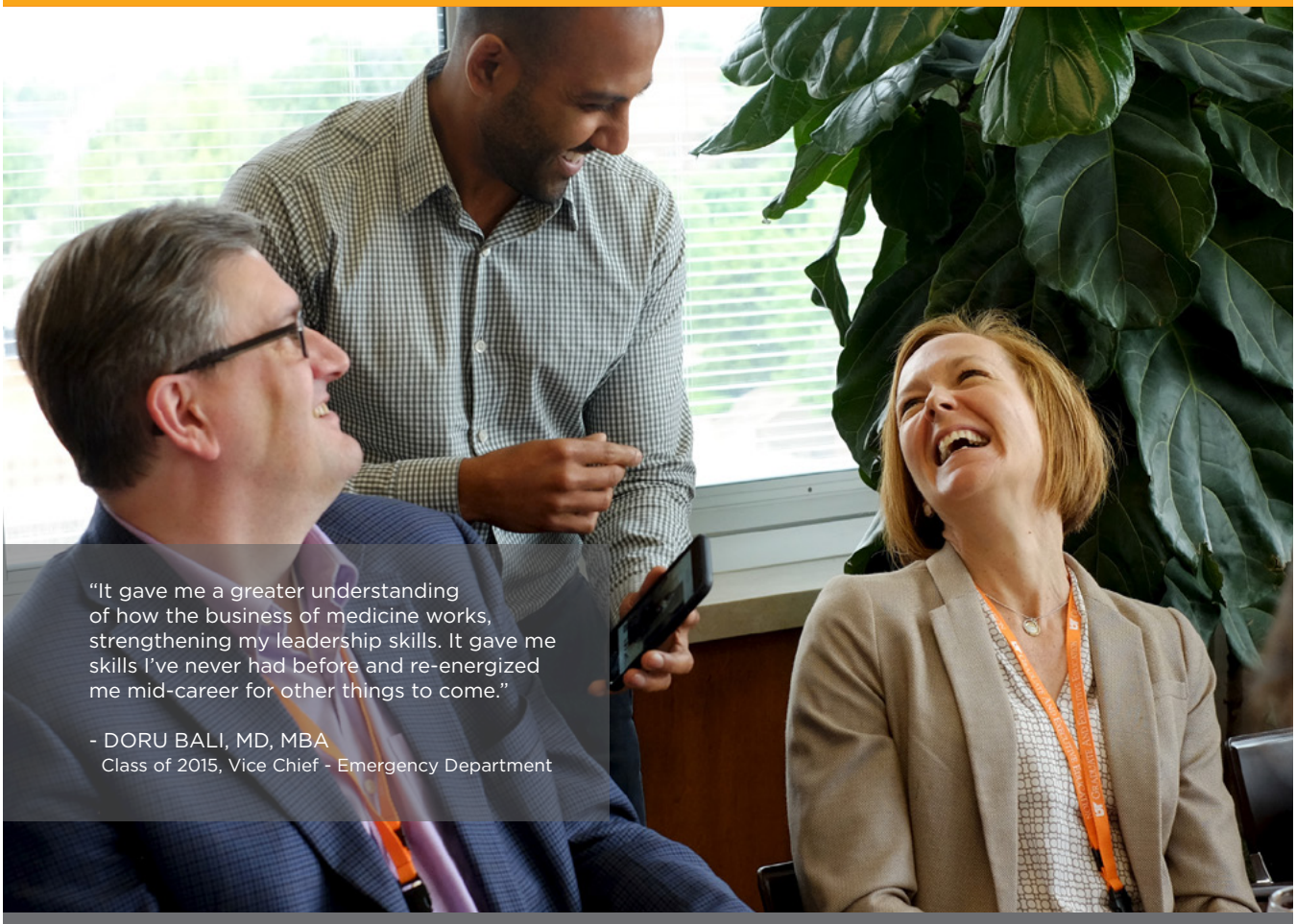

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Some physicians have dropped out of the clinical arena, for a variety of reasons, from long hours, to liability, to regulatory and electronic health record issues.

We need to reduce the burden of regulatory, administrative and documentation requirements to allow physicians to spend more time actually seeing patients. This can be done by having allied healthcare personnel, such as scribes, doing some of this work, designing more efficient technology or by streamlining documentation requirements. Excessive documentation needs to be eliminated. We should return to the days of concise and informative clinical notes. Note-bloat not only results in loss of the patient story, but also results in notes which other providers do not read.

The number of practicing physicians can be augmented by reducing the number of doctors leaving the occupation. As many as one-sixth of primary care physicians leave medicine mid-career. Doctors leave because of burnout, substance abuse, lack of family time, harsh on-call hours and lack of scheduling flexibility. At least some degree of burnout affects between 40% and 60% of all physicians. At the least it can result in poor job satisfaction, at the worst it can contribute to an increased risk of suicide, which is approximately double the rate of the general population. Substance abuse incidence is 50% higher than in the general population.

Work-life balance pushes some physicians out of the profession. An astounding 71% of physicians say they are unhappy with their work-life balance. This is no surprise since most doctors average nearly 60 work-hours per week, many putting in as many as 80 hours.

We should be more cognizant of the stressors and lifestyle concerns. Perhaps we should not wait for intervention until some sentinel event occurs. We should see if we can redesign our practices to allow flexibility in practice to meet individual needs.

Occupational projections for medical scientists are no better than for clinicians. Career openings for medical scientists are projected to expand, according to the Bureau of Labor Statistics. However, these are generally poorly paid, considering that qualified candidates have a medical science Ph.D. and/or M.D.

The outlook for university medical scientists is clouded by funding concerns. The 2018 federal budget includes a 17% reduction in NIH spending. Data shows a reduction in funded grant applications especially for young scientists. The new federal tax code gives smaller deductions for drug company research so pharmaceutical research funding is also declining.

Then there is the difficulty of academic advancement which results in attrition of junior faculty. Harvard Medical School data from 2017 shows that only 25% of faculty are at the Associate Professor or Professor rank. Between academic and industrial reductions in research, young scientists start to look elsewhere to make a living.

According to a study published by the AAMC in 2017, the United States will face a shortage of between 40,800 and 104,900 physicians by 2030.

If we want to be at the forefront of progress in medical frontiers, we must fund research and promote young investigators adequately.

How do we solve the physician supply problem?

For clinical medicine, we need to grow medical schools and residency positions as long as we continue to have a projected deficit in available physicians.

Midlevel providers, such as nurse practitioners, need to be used appropriately and more extensively. Rather than considering midlevel providers as competitors, we should work with them as teammates.

For medical scientists, we should have better funding for early-career research particularly, and enhanced opportunities for academic advancement.

How do we reduce the cost of healthcare in America?

The focus of this essay is on workforce rather than finances, but these arenas are tightly bound together. We cannot solve the workforce problem without a prudent investment in the future and without restructuring of how the monies are spent. A meaningful reduction in cost of healthcare will only occur when we have adequate value structure to our healthcare system. Quality and efficiency should become significant determinants of compensation. We will never get away from a significant production component if we expect providers to see an expected patient volume, but the incentive to see more, and perhaps too many, should be reduced and the incentive to give better care should be greater.

Will we ever achieve our goals? We will have to. Our nation cannot perpetuate the high cost of healthcare, and we are not getting our money's worth. We will need to become more efficient, more cost-effective and deliver better care.

The solutions to these problems are not simple nor are they inexpensive. However, if we want the United States to be at the forefront of medical science and to increase the quality of care for its citizens, we must make the necessary investments.

As healthcare providers, we need to participate in designing the solutions. If we do not, economic pressures and governmental forces will force legislated solutions, and we will not like the end result. ■

PRESIDENT'S COMMENTS

(Continued from page 5)

The data validates our ongoing efforts to self-regulate prescribing and reduce initial opioid dosage and supply. We've worked hard to change the culture within the medical community.

Of course, TMA members rightfully expect our President to lead in more than one area. We've had an outstanding year in the General Assembly, 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 worked hard to modify the governor's bill on opioid prescribing and dispensing to assure no patients were inadvertently harmed in the process. TMA also negotiated that PAs would not be able to practice independently; read more in this issue about what led to that bill being withdrawn.

We continue to make gains in membership and train doctors to lead team-based healthcare delivery teams. And the organization is on firm financial footing, thanks in part to a successful building move in Nashville and responsible management by our Board and staff.

I'm proud of what we've accomplished in such a short time. I've also come to realize through all these efforts just how much work still needs to be done on Tennessee's number one public health crisis.

The world expects us to police ourselves, yet we cannot get the data we need to identify who is overprescribing in our state. The aforementioned report shows that Tennesseans filled 6,709,154 opioid prescriptions in 2017. That's still too much. If we find ways to better leverage the Controlled Substance Monitoring Database to compare ourselves to each other, 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. All levels of government and insurance companies will continue to apply pressure to NOT prescribe opioids for chronic pain in an attempt to prevent patients from becoming 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 pledge to stay involved and carry the torch for doctors on the opioid epidemic. Our work is far from finished and, aside from my pediatric patients and families, I've never been more passionate or inspired about anything in my professional life.

I hope all of you will join me in staying the course. ■

FOR THE RECORD

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FOR THE RECORD

In Memoriam

Bailey Fred Allred, MD | age 90
Died February 2, 2018. Graduate of University of Tennessee College of Medicine. TMA Direct member.

William Landess Bourland, MD | age 71
Died April 4, 2018. Graduate of University of Tennessee College of Medicine. Memphis Medical Society Member.

Edward Buonocore, MD | age 86
Died February 15, 2018. Graduate of State University of New York College of Medicine. Knoxville Academy of Medicine member.

John Edgar Campbell Jr, MD | age 94
Died January 23, 2018. Graduate of University of Tennessee College of Medicine. Knoxville Academy of Medicine member.

James B. Cox, MD | age 94
Died February 26, 2018. Graduate of Jefferson Medical College. Knoxville Academy of Medicine member.

William F. Fleet, Jr., MD | age 84
Died March 22, 2018. Graduate of Vanderbilt University School of Medicine. Nashville Academy of Medicine member.

Robert G. Howard, MD | age 87
Died October 27, 2017. Graduate of University of Louisville School of Medicine. Roane-Anderson County Medical Society member.

Herman Jacob Kaplan, MD | age 92
Died December 31, 2017. Graduate of Vanderbilt University School of Medicine. Nashville Academy of Medicine member.

Cecil Harry Kimball, MD | age 99
Died February 20, 2018. Graduate of University of Vermont College of Medicine. Bradley County Medical Society member.

William M. Leppert, MD | age 63
Died April 8, 2018. Graduate of University of Tennessee College of Medicine. Memphis Medical Society member.

Thomas A. Lincoln, MD | age 92
Died May 28, 2017. Graduate of University of Minnesota Medical School. Knoxville Academy of Medicine member.

James Brown Millis, MD | age 87
Died January 24, 2018. Graduate of University of Tennessee College of Medicine. Nashville Academy of Medicine member.

Edwin A. Meeks, Sr., MD | age 92
Died March 17, 2018. Washington-Unicoi-Johnson County Medical Society member. Vanderbilt University School of Medicine graduate.

Marion R. Moore, MD | age 85
Died September 27, 2009. Graduate of University of Tennessee College of Medicine. Memphis Medical Society member.

Kenneth L. Raulston, Jr., MD | age 79
Died February 14, 2018. Graduate of University of Tennessee College of Medicine. Knoxville Academy of Medicine member.

Julian Matthew Richardson | age 26
Died March 7, 2018. University of Tennessee Health Science Center student. Memphis Medical Society member.

Kenneth L. Sears, MD | age 62
Died January 25, 2018. Graduate of University of Cincinnati College of Medicine. Nashville Academy of Medicine member.

Charles Ray Smith, MD | age 88
Died November 8, 2017. Graduate of University of Tennessee College of Medicine. Nashville Academy of Medicine member.

Kenneth E. Shoemaker, MD | age 82
Died November 10, 2003. Graduate of University of Tennessee College of Medicine. Bradley County Medical Society member.

Norman LeMaster Sims, MD | age 86
Died February 19, 2018. Graduate of University of Tennessee College of Medicine. Nashville Academy of Medicine member.

Iris Snider Slowey, MD | age 74
Died February 9, 2018. Graduate of University of Tennessee College of Medicine. Dormant Medical Society Member (formerly McMinn County Medical Society).

Walter W. Wheelhouse, MD | age 68
Died March 8, 2018. Graduate of Vanderbilt University School of Medicine. Upper Cumberland Medical Society member.

Volker Gert Winkler, MD | age 65
Died February 20, 2018. Graduate of University of Western Ontario Medical School. Consolidated Medical Assembly of West Tennessee member.

Burgin Henry Wood, MD | age 94
Died January 4, 2018. Graduate of University of Tennessee College of Medicine. TMA Direct Member.

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