COVID-19 tests, bends, and breaks Texas practices as they scramble to stay viable.
Thank you

We are deeply grateful for all you do to keep us safe and healthy.

We are humbled and heartened when we hear about the everyday acts of courage and humanity carried out by Texas physicians. We are proud to support you, and we will continue our work to keep you and your patients safe.
Road to Recovery

COVID-19 has been tough on Texas physicians. For this issue, Texas Medicine spoke to physicians on the ground about their experiences as they make their way back to business as not-so-usual. While some practices are surviving – and trying their best to prepare for future threats – others have not been so lucky. Those experiences align with the Texas Medical Association’s Practice Viability Survey in showing COVID-19 was, and still is, a disruptor unlike any other – challenging the viability of various practice types.

By Joey Berlin and Sean Price

“...we wouldn’t be able to handle a second wave, I don’t think.”
Ricardo Garza, MD, page 21
COVID-19 Isn’t Going Away Soon

If you haven’t noticed, over the past few months this space has been filled by Amy Lynn Sorrel, the magazine’s managing editor.

Amy is one of the most capable journalists I’ve known in 20 years in the business: a skilled editor, a gifted writer, a critical thinker, and her organizational skills make me look like Homer Simpson.

So where have I been, you’ve probably not been wondering?

I’ve been overseeing our daily online COVID-19 coverage, which since March has consisted of more than 300 individual stories, blog posts, videos, and social media graphics.

But because the daily onslaught of news and information has slowed – at least of this writing – I’ve got a few minutes to return to my regularly scheduled editor’s note.

When we first started adding COVID-19 coverage to the magazine, we mostly just republished some of those daily stories. We knew we had to report on it, but we just didn’t have enough information. As the months went by, we dedicated more space and more reporting to the pandemic. By the June issue – which we wrote mostly in pandemic. But where have I been, you’ve probably not been wondering?

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You might’ve come to this realization about the illness as it relates to the practice of medicine.

Hopefully, we’ll find a vaccine or a treatment soon, and COVID-19 won’t dominate health care as it currently does. Until then, we’ll continue to give you as much information as we can.

Because while we’re writing and reporting, you’re on the front lines of the pandemic, caring for patients and putting people’s minds at ease.

Just as Amy stepped up for me during this pandemic, you’re more than capably stepped up for Texas. And that’s worth writing about.

[Signature]
LET’S CONNECT!
Sept. 12, 2020
Noon

TMA Women Physicians Section Virtual Event

Join us for:

- A live discussion with section leadership.
- An engaging keynote talk on leadership and physician resiliency.
- A Q&A session on health care topics affecting women physicians.

To register and stay connected with the TMA Women Physicians Section, visit texmed.org/WPS.
The economic and social burden of untreated hearing loss is astounding. Over 450 million people worldwide (40 million Americans) suffer from disabling hearing loss, and an aging population will cause that number to double by 2050. Hearing loss is a global health epidemic with an annual economic impact of $750 billion.¹

As recently as a decade ago, many health care providers didn’t recognize hearing loss as a significant issue. In fact, many physicians still consider hearing loss to be an expected consequence of normal aging. But that sentiment is rapidly changing. A growing body of epidemiological research has linked hearing loss to significant health problems such as dementia, depression, and increased hospital visits.² In 2017, the Lancet reported that untreated hearing loss is the modifiable risk factor with the strongest association with dementia.³ That link was stronger than exercise, healthy diet, or memory exercises. Additionally, Medicare beneficiaries with hearing loss cost more to manage than their normal-hearing peers.⁴ Despite these alarming statistics, only about 20% of patients who have disabling hearing loss have sought treatment. Reasons for this include: 1) stigma associated with hearing technology; 2) cost (Medicare doesn’t pay for hearing aids); 3) poor understanding of the associated health consequences; and 4) inadequate emphasis placed on hearing loss in the primary care setting.⁴

Combined, these challenges severely limit access to quality hearing health care for millions of Americans (including Texans). Patients are too often forced to seek out hearing treatments themselves. They end up over-paying for hearing aids (in extreme cases up to $10,000) in settings that lack physician oversight and have variable quality.

We can and must do better for our patients
Like many areas of health care, hearing loss is best managed when hearing professionals collaborate closely with physicians. Primary care physicians (PCPs) are uniquely suited to manage hearing loss because 1) patients trust their PCP; 2) PCPs have insight into the overall health and well-being of their patients; and 3) the PCP workforce is large enough to make a meaningful impact. Accountable care organizations, clinically integrated networks, and patient-centered medical homes are perfectly suited to be a positive force in the hearing health of their patients.

Recently, a group of PCPs in North Texas decided to do just that. Tarrant county PCPs are currently using a Food and Drug Administration-approved, iPad-based screener to screen patients who are over the age of 55 and patients with a hearing complaint. This billable test takes two minutes, and it can be self-administered by patients while they wait to see their doctor. Here are some brief insights into some of their innovations:

1. In-office hearing screening:
Hearing assessment has long been part of a comprehensive medical exam. However, many PCPs limited their hearing assessment to a “finger-rub” because affordable hearing screening tools didn’t exist, or the time required to perform the screening was economically prohibitive. Tarrant county physicians are currently using a Food and Drug Administration-approved, iPad-based screener to screen patients who are over the age of 55 and patients with a hearing complaint. This billable test takes two minutes, and it can be self-administered by patients while they wait to see their doctor.

2. Hearing aid purchasing groups:
North Texas physicians created the nation’s first hearing aid purchasing group owned by PCPs (US Hearing Partners or USHP). This purchasing group is able to negotiate with device manufacturers for better pricing, which ultimately benefits patients through cost savings.

Commentary

Hearing Health Care Belongs to Primary Care

by JED GRISEL, MD & GREG FULLER, MD

Greg Fuller, MD

Jed Grisel, MD

1.
3. **Partnerships with trusted hearing clinics**: The expertise and cost involved with dispensing hearing aids are prohibitive for most PCPs. Instead, USHP physicians jointly use a trusted hearing clinic to support their patients. This clinic has physician oversight and stringent quality standards.

4. **Hearing aid leasing**: The average cost for a pair of programmable hearing aids exceeds $4,000. This cost covers the device as well as hours of work with a trained hearing professional to optimize the hearing aid to specifically meet the patient’s needs. Many patients simply cannot afford hearing aids, and insurance plans are slow to provide adequate coverage. To address this cost barrier, USHP offers affordable leasing options. Patients can have fixed, low, monthly payments while always having access to updated, modern hearing aids.

These are only a few of the innovative steps that Texas primary care physicians are taking to bring hearing solutions to their patients. Advances in science, innovation in technology, and changes in health care policy also are transforming the hearing health care landscape. The result is a unique and exciting opportunity for PCPs to promote the health and well-being of their patients.

**REFERENCES**

"Hey Doc! What Does FDA-Approved Treatment Mean?"

**AS COVID-19 RESEARCH CONTINUES** at a rapid pace, your patients may get confused by all the terminology surrounding potential treatments and preventions. Here’s a quick-reference guide of some commonly used Food and Drug Administration (FDA) terms to help you discuss them with patients. Find more information and a downloadable poster at tma.tips/FDAterms.

**FDA-APPROVED**

When the FDA approves a drug, it means the agency has determined, based on substantial evidence, that the drug is effective for its intended use, and that the benefits of the drug outweigh its risks when used according to the product’s approved labeling. As of late June, no drugs met these criteria for treatment or prevention of COVID-19.

**INVESTIGATIONAL TREATMENTS**

Also called “experimental drugs,” these therapies are still being studied in clinical trials to determine whether they can safely and effectively prevent or treat a specific disease or condition.

**EXPANDED ACCESS**

Sometimes called “compassionate use,” expanded access provides patients with a pathway for use of an investigational treatment. For example, as of this writing, expanded access was one way for some seriously ill COVID-19 patients to use convalescent plasma.

**EMERGENCY USE AUTHORIZATION (EUA)**

During a public health emergency like the COVID-19 pandemic, EUAs allow FDA to quickly grant access to early-stage therapies or tests when no approved options are available. FDA has granted EUAs to a handful of possible COVID-19 treatments, and the agency can grant or revoke that status at any time as more data becomes available. For example, on June 15, FDA revoked the EUA it granted on March 28 to use hydroxychloroquine and chloroquine to treat COVID-19 in certain hospitalized patients.

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Source: Food & Drug Administration
By now you probably have a good idea of which activities pose a greater risk catching COVID-19. To help your patients, the Texas Medical Association COVID-19 Task Force and Committee on Infectious Diseases created this chart, which ranks activities based on their risk level. For a printable version to share on your social media accounts or to display in your office, visit tma.tips/RiskChart.
There is no other comprehensive accounting of U.S. health care workers’ deaths. The Centers for Disease Control and Prevention has counted 368 COVID deaths among health care workers, but acknowledges its tally is an undercount.


EXCERPT

Pondering Telemedicine?

Start With These Questions

THE USE OF TELEMEDICINE has risen exponentially, thanks to temporary policy changes and flexibilities in place during the COVID-19 pandemic. If you’re still considering implementing telemedicine, you’ll want to know a few specific details about any vendor you are evaluating, including basic company information, product functionality, training, support and maintenance, and price.

Here are a few questions you should ask prospective vendors:

• How long has the company been in business?
• How long has the product been offered?
• Is the company involved in any litigation?
• What are the technical requirements to use the product?
• How are patient profiles created?
• What devices are compatible with the product?
• What upload and download speeds are necessary for product performance?
• What equipment is necessary for my practice to use the product?
• Does the company have technical support for physicians and patients?
• Is there an ongoing cost for maintenance, support, and upgrades?

Find the Texas Medical Association’s Telemedicine Vendor Evaluation chart, and more, at www.texmed.org/Telemedicine.

“To state the obvious, COVID-19 is now spreading at an unacceptable rate in Texas, and it must be corralled.”

Gov. Greg Abbott at a press conference addressing the rapid spike in COVID-19 cases and hospitalizations in June.
We have a whole suite for maternal health.

Join more than 100,000 medical professionals who get free CME with Texas Health Steps Online Provider Education. Choose from a wide range of courses relevant to your practice, including short tutorials and quick courses on topics like Medicaid guidelines, ethics and mental health—available 24/7. Learn more at TXHealthSteps.com.
In the late 19th and early 20th centuries, industrialization heralded profound changes for American workers: Steam engines replaced animals; machines replaced hand tools. But improved efficiency came at a human cost. Work often was hazardous, especially for railroad workers. Heavy train carriages often caused crushed limbs and lacerations. In a 1907 article in the *Texas State Journal of Medicine*, Houston's R.W. Knox, MD, shared preferred treatment methods for railcar workers injured on the job.

Some cases were deceptive in appearance, he noted. After a limb was run over by a wheel, the skin appeared intact, but the muscles were usually “ground to a pulp.”

Anxious patients hoping to avoid amputation were left disappointed. Surgical incisions confirmed the prognosis, “a hopeless mass of crushed bone and muscle.” The limb would have to be removed.

Other times, patients got lucky. In one case, eyewitnesses reported that a truck ran over a man, and in another case, a man was violently flung in front of a train car. Yet, both men received only minor injuries.

Sometimes limbs could be saved. Dr. Knox had more than one patient who had sustained crushed toes after their feet were caught under train wheels. “It would not be good surgery in these cases to attempt a completed amputation,” Dr. Knox wrote, and following a skin grafting operation, flaxseed poultices, and steady application of heat, the patient likely would recover.

**ARTIFACT: WICKER WHEELCHAIR**

The most striking features of this late 19th and early 20th century wheelchair are the wicker backrest and seat. At the time, this was a practical material choice that rendered the chair lightweight and easy to maneuver. The chair also features rear caster wheels and wood armrests and legrests. Its two rubber wheels are attached to metal push rings for self-propelling. But it also has a rear push handle behind the seat.

Paved public walkways and ramps are 20th century phenomena. Earlier, dirt roads and cobblestone streets would have made the wheelchair nearly impossible to use outside of the home. Similarly, this wheelchair, fragile in construction, was used only indoors.
Louis Leichter practices administrative, regulatory, and criminal law with an emphasis on physician representation.

His practice extends to both state and federal entities such as the Texas Medical Board, Drug Enforcement Administration, the OIG and the United States Department of Justice. He routinely represents physicians in hospital credentialing matters and medical staff affiliation disputes (Peer Review) which are integrally related to Texas Medical Board investigations.

He has represented over 5,000 physicians before the Texas Medical Board in matters involving licensing, discipline, and enforcement.

E. G. Morris has over 40 years of experience in a broad range of criminal matters in cases affecting health care practitioners.

He has represented physicians, nurses, pharmacists, psychologists, physical therapists, and other health care professionals facing criminal investigations of fraud, pill mill operations, and recoupment efforts.

Mr. Morris is a Board Certified criminal law specialist.

Our law firm stands ready to assist you in the defense of your medical license and healthcare-related legal concerns.

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Stephanie Stephens received a not-so-welcome gift entering her new job running Medicaid operations for the nation’s second-largest state: A global pandemic.

In that sense, the universe wasn’t easy on Ms. Stephens, the new director of Medicaid and CHIP for the Texas Health and Human Services Commission (HHSC).

“The first several weeks have been a balancing act,” Ms. Stephens said in written responses to questions from Texas Medicine in June, noting that HHSC had to respond to COVID-19 while continuing its usual day-to-day operations and planned improvements.

But at least she had the expertise. Ms. Stephens already had more than a decade of experience within HHSC’s walls when she succeeded Stephanie Muth, who retired on May 1.

Previously HHSC’s deputy Medicaid director, Ms. Stephens has been with HHSC since 2008, when she joined the agency as a policy analyst. Prior to that, she was a health and human services budget analyst at the Texas Legislative Budget Board.

“I feel fortunate to take on this role after serving as deputy director. The path charted by ... Stephanie Muth is a strong guide,” she said.

Her to-do list includes improving HHSC’s oversight and advancing value-based care in the agency’s programs.

“We can’t do these things alone. It takes partnership among all of us – the people who rely on us for services, our health plans, our providers, along with the support we get from the Office of the Governor, Texas legislators, and our federal partners,” Ms. Stephens said.”

The Austin native traces her interest in health care to her college days, when she worked in an intensive treatment program for children with severe attention deficit and hyperactivity disorder combined with other behavioral and developmental disorders.

“I saw how these conditions affected the children’s lives and their families, and the impact of the children receiving effective treatment and services. This experience sparked my interest in health care and my specific skills led me to policy,” she said. “I would not have made it to Medicaid director without the mentorship I received along the way. I’ve worked for a number of state Medicaid directors and have watched and learned from their inspiring yet distinct leadership styles.”

Although she notes state agencies in Texas have responded to plenty of natural disasters and public health emergencies, COVID-19 has required Ms. Stephens and HHSC to create a new rulebook as they go.

“In the beginning, we pulled out past response plans for guidance,” she said, “and quickly recognized this public health emergency is unprecedented.”
She said the agency continually reassessed its response to the pandemic. At the same time, HHSC provided “significant flexibilities” to help patients and practitioners, including covering COVID-19 testing without prior authorization and allowing extensive telemedicine use.

“When the time is right, we will look back on our efforts to identify what we can do better, despite hoping we never encounter anything like this again,” Ms. Stephens said.

The pandemic, and its effect on the Medicaid and CHIP population, is far from the only pressing concern HHSC has faced during Ms. Stephens’ early months on the job. Recent dips in vaccination rates are also on her radar, as is enhancing oversight of Medicaid managed care organizations (MCOs).

“Our team is actively communicating with the Department of State Health Services to develop messaging for members around the importance of check-ups and immunizations,” Ms. Stephens said. “We are exploring opportunities in collaboration with our MCOs and providers on the front lines to develop immunization clinics that are safe and convenient for the Texans we serve. We are also tracking data, as certain immunization measures play a key role for some of our quality programs.”

She also highlighted the importance of collecting input from and providing feedback and timely information to stakeholder organizations like the Texas Medical Association. “It’s the only way we can prioritize our focus for improvement and be more innovative in the Texas Medicaid program,” she said. “In this role, I plan to focus on a more deliberate approach in how we communicate with stakeholders across our various initiatives. We need to be clear and consistent.”

JOEY BERLIN is associate editor for Texas Medicine. You can reach him at (800) 880-1300, ext.1393; (512) 370-1393; or joey.berlin@texmed.org.
T Texas-regulated insurers must continue to pay for telemedicine services, including mental health visits, at the same rate as in-person visits through Sept. 12, the Texas Department of Insurance (TDI) announced in late June.

TDI said it is extending the requirement that was part of an emergency rule that has been in place since March. It was set to expire July 14.

Under the emergency rule, state-regulated health insurers and health maintenance organizations (HMOs) also must:

• Cover telemedicine services using any platform permitted by state law; and
• Not require more documentation for telemedicine services than they require for in-person services.

To make telemedicine available to more patients and their physicians during the emergency declaration period, many state and federal rules and regulations regarding telehealth have been relaxed temporarily. In addition, commercial and government payers have issued waivers and policy changes to help physicians care for as many patients as possible.

Find tools and resources — including a chart of the various changes, waivers, and expiration dates — on the Telemedicine section (www.texmed.org/Telemedicine) of TMA’s COVID-19 Resource Center (www.texmed.org/Coronavirus).

**HOUSE MEETING GOES VIRTUAL; FALL CONFERENCE CANCELED**

**BY AMY SORREL**

Due to the ongoing COVID-19 pandemic, the Texas Medical Association Disaster Board voted to conduct a virtual meeting of the TMA House of Delegates that will culminate in a live virtual session on Saturday, Sept. 12.

The board also voted to cancel the association’s TMA 2020 Fall Conference originally scheduled for Sept. 11-12 in the Austin area.

TMA leaders will run a limited 2020 House of Delegates meeting using virtual technology that will allow delegates to vote remotely in contested elections and take action on essential house business.

“The board made the unprecedented decision to conduct a virtual meeting to protect the health and well-being of delegates and all meeting attendees while respecting the traditions and bylaws of this great organization. We did not make this decision lightly,” House Speaker Arlo F. Weltge, MD, said. “Every attempt will be made to ensure that all delegates and members will be able to contribute to the TMA’s policymaking progress.”

After collecting written testimony and nominations, the house will conduct elections and the reference committees will initiate business over a period of several weeks throughout August and early September. The final live virtual session of the house will take place on Sept. 12, when President Diana L. Fite, MD, will deliver her address, TMA leaders will announce election results, and delegates can consider and vote on reference committee reports and resolutions deemed “essential.”

Find more details, including a timeline of business, at www.texmed.org/HOD.

Because the COVID-19 pandemic was declared a national emergency, the TMA Board of Trustees voted in March to invoke a bylaws provision allowing it to function as a Disaster Board and to assume certain responsibilities of the House of Delegates, TMA’s policymaking body. That included overseeing and conducting elections and installations of TMA officers and other necessary business.

Due to the cancellation of TexMed 2020, TMA’s annual meeting, the Disaster Board in May acted on behalf of the house to conduct elections for uncontested positions, after postponing contested races.

**TEXMED 2020 WAS CANCELED, BUT YOU CAN STILL EARN CME**

Although Texas physicians couldn’t gather for TexMed 2020 in May, some of the educational sessions and presentations that were scheduled for the annual conference are now available free to members in the Texas Medical Association Education Center.

Check out these courses — each worth CME credit — by visiting www.texmed.org/CME.

• **Marijuana and Colorado: A Look at Marijuana and the Opioid Crisis** presented by Kenneth Finn, MD. Bring some clarity to
the misinformation and misunderstanding on the role of cannabinoids in medical conditions.

- Palliative Care vs. Hospice: Seeing the World Through a Different Lens presented by Shawnta Pittman-Hobbs, MD. Understand how to discuss advance care planning with patients to improve outcomes at the end of life.

- Practical Approach to Physical Activity and Exercise in People with Diabetes presented by Renee Enriquez, MD. Learn how exercise and physical activity can prevent or delay certain types of diabetes, improve blood glucose control, and positively affect the cardiovascular health of diabetic patients.

- When Mental Health Goes to College presented by Jessica Moore, MD. This webinar addresses current trends in college mental health, campus suicide, and serving diverse student populations.

Most of TMA’s CME programs are free for TMA members and their practice staff thanks to a generous sponsorship by the Texas Medical Association Insurance Trust.

And mark your calendars for May 14 and 15 for TexMed 2021 at the JW Marriott in Austin.

TEXANS TAKE NEW AMA LEADERSHIP SPOTS
BY STEVE LEVINE

Although Susan Rudd Bailey, MD’s installation as the new American Medical Association president earned most of the attention, four other Texas physicians earned leadership positions during the virtual 2020 annual meeting of the AMA House of Delegates in June. (See “A New Leader for a New Time,” July 2020 Texas Medicine, pages 12-13, www.texmed.org/BaileyAMA.)

As expected, Russell W.H. Kridel, MD, a facial plastic surgeon from Houston, is the new chair of the AMA Board of Trustees. Dr. Kridel, a board member since 2014 and chair-elect of the board last year, said he looks forward to working with Dr. Bailey at the top of the AMA leadership team.

“Sue and I grew up in the Texas Medical Association; we know what’s important to Texas physicians, especially as it relates to practice viability,” he said. “The pandemic has made heroes of physicians on the front lines, but it’s also put their practices at tremendous risk. We have to protect physicians and their practices so we can continue to provide the good care we do to our patients.”

Dr. Kridel said his to-do list includes making sure physicians have adequate personal protective equipment (PPE) and financial support to recover from the COVID-19 pandemic; better payment to cover care for patients who have lost job-based insurance; and decreased paperwork and prior authorization demands from commercial insurers.

Also as expected, Lubbock pulmonologist Cynthia A. Jumper, MD, was unopposed in her bid for reelection to the AMA Council on Medical Service.

“I want to thank the house and the state of Texas for having the confidence in my abilities to serve another four years on the council,” said Dr. Jumper, who also serves on the TMA Board of Trustees. “You each will have my promise to work hard and tirelessly to represent the very fluid field of medical education while living the values of the AMA.”

And now two North Texans have seats on the prestigious AMA Council on Ethical and Judicial Affairs. Dallas obstetrician-gynecologist Monique A. Spillman, MD, was elected by her colleagues on the council to serve as the new chair. Meanwhile, Dr. Bailey appointed fellow Fort Worthian Larry Reaves, MD, to a seven-year term on the council.

The council maintains and updates the 169-year-old AMA Code of Medical Ethics, and it promotes adherence to the code’s professional ethical standards.

One Texas physician fell short in his bid to move up the AMA leadership chain. Tyler anesthesiologist Asa Lockhart, MD, did not prevail among a crowded field running for a seat on the AMA board. Dr. Lockhart will continue to serve on the AMA Council on Medical Service.

15 MINORITY MEDICAL STUDENTS AWARDED TMA SCHOLARSHIPS

Fifteen minority students entering Texas medical schools this fall each will receive a $10,000 scholarship from the Texas Medical Association. The students were selected for their academic achievement, commitment to community service, and desire to care for Texas’ increasingly diverse population.

The announcement comes amid Texas’ growing need for physicians and health care workers, as evidenced by the COVID-19 pandemic and the

Newsmakers

Gov. Greg Abbott appointed Brooke Walterscheid as the student regent for the Texas Tech University System Board of Regents for the 2020-21 academic year. The fourth-year medical student at Texas Tech University Health Sciences Center (TTUHSC) School of Medicine served as president of TTUSHC’s Student Government Association in 2018-19. Her one-year term will expire May 31, 2021.
ADVERTORIAL

Apartments Offer a More Reliable Solution

Most physicians deal with a variety of data every day. Some data, like systolic blood pressure readings, are continuous variables that tend to have a normal probability distribution. A certain number of patients will reliably fall within a certain range of blood pressures, and a sufficiently large sample of patients will yield a sample mean predictive of the actual population mean.

![Image of blood pressure monitor](image)

This type of distribution appears often in the natural world and medical disciplines. Outliers, or extreme events, are reliably rare. We would not expect to find a given population in 2020 in which 30 percent of people were taller than seven feet or older than 95 years. Those groups exist on the edges of a thin-tailed normal distribution; we would anticipate no more than a few percentage points of a population to exhibit such variation from the mean.

Other sets of data in the medical world fit less predictable probability distributions. Successful treatment of patients with a certain drug is typically modeled as a binomial distribution — outcomes are dichotomous, and a proportion statistic represents both the success rate and sample mean of the data. Weekly deaths from a given disease in a city would likely fall into a Poisson distribution, which depicts the likelihood of an event occurring over a certain time series.

Investment strategists must also contend with unruly data and strange distributions. The price of stocks and other securities often exhibit fat-tailed distributions — extreme events, hidden by a sample mean that does not predict the actual population mean, have a much higher probability of occurring than they do in a normal distribution. These “black swan” events include the 2001 dot-com bubble, the 2008 financial crisis, and the current COVID-19 pandemic.

Some experts look to commercial real estate to build a portfolio strategy that can mitigate the effects of extreme events. While these events
are inherently difficult to predict, a proper balance of carefully chosen investments can offer a buffer against the damage of a downturn and a quicker recovery when the markets rebound.

One of the biggest reasons real estate investments can have greater resilience against market panics is their inherent illiquidity. Stocks and other securities can be quickly converted to cash; buildings cannot. This feature removes much of the panic selling from real estate, forcing investors to ride out the storm and sheltering the real estate market from the volatility gripping the securities market.

For more information visit RastegarProperty.com

Indeed, even in a typical market, security investments tend to experience more variance over a shorter time series. Investors overleveraged in securities can enjoy higher returns, but they’re also at greater risk for substantial losses. Without strategically selected real assets balancing risk in a portfolio, even moderate negative market shifts can result in considerable losses for an investor.

Among the various classes of commercial real estate, multifamily developments usually offer superior elasticity to other assets like retail outlets and office buildings. Apartment managers work with shorter-term leases and have more ability to adjust rental rates based on market shifts — they can flex rates quickly to retain occupancy and income during a down market, and then regress back to the mean as markets rebound. Apartments also provide shelter to some 65 million Americans (and growing), giving them a considerable reliability advantage over other investment types. Finally, vertically integrated real estate developers can maximize real asset returns by improving management and property value of acquired properties, thus boosting net operating income.

Unfortunately, the extreme events that drive major gains and losses in the market aren’t predictable. They follow strange distributions like incidence of rare disease, not normal distributions like human height. In a world full of this inherent volatility, investment strategies that leverage the advantages of multifamily real estate often have an improved chance of resilience and recovery. Overleveraging in securities or risky business ventures can make an investor critically vulnerable to extreme events; balancing a portfolio with quality real assets can push them back towards the mean.

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opening of two medical schools during the past year.

TMA created the Minority Scholarship Program in 1998 to help diversify the physician workforce to meet the health care needs of Texans. Since the program began, TMA has awarded 148 scholarships totaling $967,500.

The TMA Educational Scholarship, Loan, and Awards Committee chose one recipient entering each Texas medical school from a competitive field of promising future physicians. The scholarship encourages minority students to attend medical school by lessening the financial burden of their postgraduate education, which averages more than $175,000.

This year’s winners are:

- Sally Acebo of Katy, Sam Houston State University College of Osteopathic Medicine, Huntsville
- Kemi Alabi of Fort Worth, University of the Incarnate Word School of Osteopathic Medicine, San Antonio
- Abakar Sabir Baraka of San Antonio, UT Health San Antonio Long School of Medicine, San Antonio
- Belinda Busogi of Frisco, McGovern Medical School at UTHealth, Houston
- Breanna Chachere of Alvin, University of Houston College of Medicine, Houston
- Briana Cortez of El Paso, The University of Texas Rio Grande Valley School of Medicine, Harlingen
- Daemar Jones of Arlington, Texas Tech University Health Sciences Center School of Medicine, Lubbock
- Antonio Igbekidi of Fort Worth, TCU and UNTSHC School of Medicine, Fort Worth
- Andrea McWilliams of El Paso, TGUHSC Paul L. Foster School of Medicine, El Paso
- Ariana Olvera of Donna, Baylor College of Medicine, Houston
- Heidi Anahi Pargas of Laredo, Texas A&M University College of Medicine, Bryan/College Station
- Ariana Ramirez of Madisonville, University of North Texas Health Science Center Texas College of Osteopathic Medicine, Fort Worth
- Veronica Remmert of Round Rock, UT Austin Dell Medical School, Austin
- Alan Villarreaal Rizzo of Brownsville, The University of Texas Medical Branch School of Medicine, Galveston
- Jesus Valencia of San Antonio, UT Southwestern Medical School, Dallas

The TMA Foundation (TMAF), the association’s philanthropic arm, funds the program.

Recipients are known as the “Bayardo Scholars” in recognition of the majority support provided by the TMA Foundation Trust Fund of Roberto J. Bayardo, MD, and the late Agniela (Annie) M. Bayardo of Houston. Other generous gifts from the TMAF Patrick Y. Leung Minority Scholarship Endowment, TMAF donor physicians and their families, H-E-B, and TMA county medical societies also support the scholarships.

**TMA PHYSICIANS HONOR EXCEPTIONAL SCIENCE TEACHERS**

As physicians, epidemiologists, and health care workers lead the fight against a global pandemic, the Texas Medical Association named nine Texas science teachers winners of its 2020 Ernest and Sarah Butler Awards for Excellence in Science Teaching. This marks the 30th anniversary of the awards, designed to motivate teachers to inspire future doctors and scientists.

TMA honors teachers at the elementary, middle, and high school levels for playing an instrumental role in stirring students’ interest and excitement in science, with the hope they’ll enter the medical field. Teachers receive cash prizes, and their schools receive cash resource grants to enhance their science program. Since the awards began in 1990, TMA has
awarded more than $607,000 to 274 exemplary science teachers across Texas.

The 2020 overall winner, Adam Unlu of Harmony School of Excellence in Laredo, receives $5,000 in addition to his first-place prize. Mr. Unlu teaches 11th- and 12th-grade physics where he encourages his students: “Choose to make mistakes, do it often, dive in; don’t raise your hand and ask someone else.”

In the classroom, Mr. Unlu highlights vocabulary words during demonstrations so students have a better understanding of the newly introduced topic. Outside the classroom, he founded a Saturday Engineering Club and secured grants to purchase 3D printers and other materials. The club built a solar-powered car and modified small battery-operated cars to give mobility to children who cannot walk and are too young to operate their wheelchairs.

First place winners receive a $6,000 cash prize; winners’ schools also receive a $2,000 resource grant to enhance science classroom learning.

- Clara Herrera, Clayton Elementary School, Austin
- Cynthia Hopkins, Kaffie Middle School, Corpus Christi
- Adam Unlu, Harmony School of Excellence (high school), Laredo

Second-place winners receive a $4,000 cash prize, and their schools receive a $1,000 resource grant.

- Mark Rogers, Austin Achieve Elementary School, Austin
- Cynthia Duke, Manvel Junior High School, Manvel
- Jamie Holbrook, Saint Mary’s Hall, San Antonio

Rookie awards are given to science teachers with fewer than seven years of teaching experience. They receive a $1,500 cash prize, and their schools receive a $1,000 resource grant.

- Lisa Lim, Anne Sullivan Elementary School, Sugar Land
- Erin Wise, West Memorial Junior High School, Katy
- Sadaf Syed, Lovejoy High School, Lucas

TMA and TMA Foundation physician leaders presented this year’s teacher awards virtually because of social distancing guidelines.

The 2020 TMA Ernest and Sarah Butler Awards for Excellence in Science Teaching are made possible by a grant from the Texas Medical Association Foundation, which is supported through an endowment generously established at the TMA Foundation by Dr. and Mrs. Ernest C. Butler and gifts from physicians and their families.

Deaths

Homer B. Allen Jr., MD, 97; Brownwood; University of Texas Medical Branch School of Medicine, Galveston, 1950; died July 27, 2017.

Charles A. Berry, MD, 96; Houston; University of California San Francisco School of Medicine, San Francisco, 1947; died March 1, 2020.

Veasy C. Buttram Jr., MD, 85; Houston; University of Texas Medical Branch School of Medicine, Galveston, 1960; died April 1, 2020.

Francis O. Davis, MD, 82; Conroe; University of Illinois College of Medicine, Chicago, 1963; died Jan. 7, 2020.

Hector Del Castillo Sr., MD, 95; Houston; National University of Mexico Faculty of Medicine, Mexico City, 1950; died March 31, 2020.

Paul L. Fragua, MD, 69; Brownwood; University of Texas Medical Branch School of Medicine, Galveston, 1972; died May 17, 2013.

Alan J. Garber, MD, 77; Houston; Temple Medical School, Philadelphia, 1968; died April 9, 2020.

Rakesh Gupta, MD, 56; Denton; University of Texas Medical Branch School of Medicine, Galveston, 1986; died April 8, 2020.

Todd H. Overton, MD, 82; Amarillo; University of Arizona College of Medicine, Tucson, Ariz., 1971; died Jan. 23, 2020.

Joe L. Sanders, MD, 81; San Antonio; UT Southwestern Medical School, Dallas, 1964; died Jan. 31, 2020.

Bobby L. Stafford, MD, 82; Amarillo; UT Southwestern Medical School, Dallas, 1965; died Feb. 19, 2020.

William L. Winters Jr., MD, 94; Houston; Northwestern University Feinberg School of Medicine, Chicago, 1953; died March 13, 2020.
VETERAN LOBBYIST DAN FINCH TO LEAD TMA ADVOCACY TEAM

Dan Finch, a trusted advocate for Texas physicians for nearly 40 years, is the Texas Medical Association’s new vice president for advocacy, TMA Executive Vice President and Chief Executive Officer Michael J. Darrouzet announced in June.

“Dan brings tremendous knowledge, outstanding relationships on both sides of the aisle in Austin and in Washington, and an intuitive understanding of Texas physicians’ needs and concerns,” Mr. Darrouzet said. “He provides the stability our physicians require at this critical juncture in Texas health care, economics, and politics.”

Mr. Finch has served as TMA director of legislative affairs since 2006, which followed a 24-year run in a similar position at the Harris County Medical Society – the nation’s largest county medical society. Since earning his journalism degree at the University of North Carolina at Chapel Hill in 1975, Mr. Finch has spent nearly all of his professional career in organized medicine. He worked for the North Carolina Medical Society and the American Medical Association before moving to Houston in 1982.

“A doctor long ago told me if we do what’s right for patients, we’ll do what’s right for physicians, and that’s always been my guiding light,” he said.

Moving forward, Mr. Finch said “making sure folks who need access to care get access to care” is the biggest challenge for his team and Texas physicians in working with the U.S. Congress and the Texas Legislature. The downturn in the economy increases patients’ need for safety net medical services, while it also places a nearly unprecedented drain on the Texas treasury.

“Medicaid and the Children’s Health Insurance Program are counter-cyclical with the economy,” he said. “We have to apply creative solutions to make sure we don’t just drive up costs by sending patients to the emergency room.”

Mr. Finch said he is particularly concerned about preserving hospitals and physicians’ practices in rural Texas. “It is an ongoing and continuous challenge to maintain small rural hospitals and, in turn, the physicians and nurses and everyone who works in those hospitals,” he said.

Mr. Finch praised his predecessor for putting together an excellent public affairs team that has remained intact and risen to the multiple challenges the COVID-19 pandemic has presented.

“TMA is blessed with a really talented squad,” he said. “They’ve worked together for a decade or more and contribute a wealth of experience in health policy and working with the legislature. I can’t imagine working with a more talented and dedicated group.”

Dan Finch
Case Management for Children and Pregnant Women

Ongoing support for high-risk pregnancies.

When your patients with Medicaid have medical needs that might affect their health care, refer them to case management services.

Case managers help your OB patients navigate the health system by coordinating access to care related to their health conditions.

To refer your patient, call Texas Health Steps at 1-877-847-8377 (1-877-THSteps) or visit https://hhs.texas.gov/case-management-provider

Case Management for Children and Pregnant Women is a Texas Medicaid benefit for eligible patients. It serves children birth through age 20 with a health condition or health risk and women of any age who have a high-risk pregnancy.
As June began, Ricardo Garza, MD, was still walking the tightrope: standing, but unable to withstand another gust of wind. COVID-19 swept away about 35% of the San Antonio solo cardiologist’s practice revenue, and that was just what he could calculate as he waited for insurers to process straggling claims. But he had returned to in-office operations without any layoffs.

He anticipated that by August, his revenues would return to pre-pandemic levels. But that hope carried a caveat of which he and many other Texas physicians had to be mindful. “Any sort of setback, anything that would scare the populace, the patients, from coming back will be very harmful, will be very disruptive,” Dr. Garza said. “At that point, if we were to have a second wave ... and patients were not to come to the office, we would then probably have to furlough some staff members. We wouldn’t be able to handle a second wave, I don’t think.”

And yet, as this story went to press in late June, a second wave seemed plausible. On June 25 Gov. Greg Abbott reinstated an executive order restricting non-emergent, elective procedures in hospitals, albeit more...
limited than the first one issued in March. The move came as Texas began experiencing a tremendous spike in new COVID-19 cases and hospitalizations weeks after the state reopened its businesses.

While some practices are surviving – and trying their best to prepare for future threats – others weren’t so lucky.

On-the-ground experiences align with the Texas Medical Association’s Practice Viability Survey in showing COVID-19 was, and still is, a disruptor unlike any other – challenging or torpedoing the viability of various practice types. (See “How Has COVID-19 Affected Your Practice?” pages 26-27.)

**Pushed to the edge**

Thirty-seven years after he opened his first office in the East Texas town of Athens, ophthalmologist Bob Nettune, MD, simply didn’t have a way to reopen those doors. His son, also an ophthalmologist, did, but his path was rocky and the future still uncertain.

Dr. Nettune had entered 2020 planning to retire in about two years, capping a professional journey in which medicine was his second career; he was originally a corporate attorney. Dr. Nettune split his time between his original office and others in nearby Kaufman and Cedar Creek Lake.

“My office manager was turning 65 in two years, and we were going to walk out the door together,” Dr. Nettune said. “She was going to retire at 65, and then I was going to retire just short of 80.”

When the pandemic began, Dr. Nettune started by closing his offices for two weeks. That turned into three. And then more.

“I kept thinking, well, maybe if I’m real careful and I wear my N95 mask all the time in the clinic, that I would be able to get back in and see patients,” he said.

He waited for a clear message that the virus threat was dissipating – a sign that as an ophthalmologist and surgeon, an “in your face” physician, he wouldn’t be at such high risk. Like the rest of the world, he kept waiting.

“Then combine that with, if I go ahead and operate on any of these folks, I have to give them a 90-day global period that I have to provide continued service in addition to the surgery. That would obligate me to be in practice for another three months in this unknown period. That was too much,” he said. “I just couldn’t take the chance of subjecting myself to the risk.

“I think we ended up giving [it] about six weeks,” he said. “We just kept waiting and waiting, and clarity didn’t come with this disease. So I finally had to say – really tough decision – I said we’d better close it down.”

Meanwhile, Dr. Nettune’s son, a cornea and cataract specialist in Dallas and Plano, was surviving but hurting. Greg Nettune, MD, told *Texas Medicine* his seven-physician practice, Cornea Associates of Texas, lost the vast majority of its monthly revenue and furloughed staff before it obtained funds from the federal government’s Paycheck Protection Program (PPP). Those funds and cash reserves helped Cornea Associates push through and rehire all of its staff.

“Ophthalmologists have really high overhead, probably have some of the highest overhead of any specialty, partly because of the space and equipment we need and the microscopes and lasers and things that are just very expensive,” Dr. Greg Nettune said. “At 50% volume, we’re still not actually making money yet, so we really need
to be right around 70% to be a viable business. Hopefully, we can keep it going.

“I’m worried a little bit. I don’t see how we’re ever going to go back to that pre-COVID volume, just because of social distancing. You can’t have the same amount of patients coming through the office.”

The telemedicine life raft
TMA’s Practice Viability Survey found most Texas physicians saw their salaries and work hours slashed as a result of the pandemic. (See “How Has COVID-19 Affected Your Practice?” pages 26-27.)

One of those physicians was Dallas gynecological surgeon Wesley Anne Brady, MD. Her practice revenue fell by more than 90% during the roughly six-week period when elective procedures were banned under Gov. Greg Abbott’s first executive order in March. Dr. Brady stopped paying herself during those six weeks, but by June, her solo practice had bounced back. Fortunately, Governor Abbott’s second executive order did not affect outpatient surgery centers, where she does a lot of her procedures.

“Over the last six weeks, I’ve been saving every penny. So I’ll be able to keep the office open, I hope, and keep my employees employed, and just do the best I can,” she said after the new order.

Telemedicine consultations kept the practice from hitting rock bottom. That and $64,000 from the PPP were godsend. The outpatient center where Dr. Brady performs most of her surgeries reopened in May. Patients were ready and willing to come back in for elective procedures, and she immediately enjoyed one of her busiest months. She told Texas Medicine in early June that month was already booked, as was July.

“The unknown was scary,” Dr. Brady said. “But I knew that we would get through it – just buckle down, work together. There’s nothing we could really do about it except follow the rules and be flexible, go with the flow. My staff was wonderful. They were real understanding, and when they were at home, we updated the website and did lots of projects that we didn’t have time to do when we were so busy at the office.”

Telemedicine also became a life raft for Dr. Garza, as it did for countless other doctors. (See “The Tele-Future Is Now,” July 2020 Texas Medicine, pages 15-19, www.texmed.org/TelemedFuture.)

During the first period of restrictions on medical care, he couldn’t order imaging procedures, which he says make up about 25% of a cardiologist’s revenue. But virtual visits allowed him to see essentially the same number of patients as he normally does. He made it through that restricted period without laying off any of his four medical assistants.

“Probably the greatest adjustment we made – truly critical – was the understanding that in-person visitation was going to be impossible,” he said. “And there are ongoing care issues with patients. Blood pressure adjustments, laboratory tests come back, and adjustments in their cholesterol medicines: These are the routine, day-to-day things that all ... cardiologists who see patients have to manage. Not to mention symptomology: ‘I’m a little short of breath, my blood pressure’s high.’ Those things persist despite the patient’s inability to come into the office structure. Telemedicine became our only real means of continuing the care.”

However, Dr. Garza says the second
wave of restrictions will affect cardiology patients who schedule elective procedures at the hospital through his office, such as diagnostic cardiac catheterizations.

“That’s a whole lot of admissions from a cardiologist’s perspective,” he said. “The other issue is we get into the circumstance where patients become obviously ... apprehensive about leaving their environment. And even though ... stress testing, as an example, was not precluded, we could still do stress testing to evaluate patients, but patients themselves are just apprehensive about coming. They will put off doing some of that routine evaluation testing.”

For independent practices, he said, “this is the moment to sink or swim. And the only swimming I see available, the only life raft, is going to be more telemedicine. I think we have to go all-in; this is the way we’re going to maintain connection to our patients so we can continue their care plans and adjust their medications and adjust their care.”

Telemedicine also provided a buffer while pediatricians like Michael Bornstein, MD, waited for U.S. government funding to materialize; the initial $50 billion allocated under the federal CARES Act went only to practitioners who took Medicare patients. Dr. Bornstein, who runs an independent all-pediatrics practice in Richmond near Houston, told Texas Medicine he’d lost about 70% of his practice revenue at the start of the pandemic; that figure “improved” to 50% by June.

Dr. Bornstein said his survival methods included shutting down one of his three offices; dividing his large waiting room into “sick” and “well” sides; advertising those precautions to his patients and reminding them to come in for well visits; and receiving two small-business loans, including PPP funds.

“My plan is to never lay anybody off and for everything to go back to normal. What my big hope is, is that No. 1, I don’t ruin everything I’ve built over the last 27 years,” he said. “I can empty out my retirement funds and empty out all my savings and just work until I’m 80. I hope that doesn’t happen. But I’m optimistic that it comes to an end, that people start coming in to do well checkups, because this is the well-checkup time of the year.”

Survival tactics
Like most physicians and business owners, Dallas pulmonologist Michelle Chesnut, MD, wasn’t fully prepared for the pandemic. Yet, in a sense, she’d been preparing for it all along.

Dr. Chesnut told Texas Medicine she and her practice partner of 12 years gave themselves a leg up on COVID-19 practice survival because they run a “lean” operation with almost exclusively outpatient work and very little hospital-based activity. With an extremely vulnerable population of patients with underlying pulmonary conditions, Dr. Chesnut quickly decided in mid-March to go to telehealth visits exclusively and jumped to collect a loan during the first round of PPP funding.

“I was talking to the bank at 10 at night on a Friday night when that PPP program opened, trying to get all of our stuff through as quickly as possible,” she said, “because we knew the money was going to run out very, very quickly, which it obviously did.”

Even those quick and proactive steps didn’t shield the practice’s bottom line. Dr. Chesnut says in March her practice experienced a 25%-30% drop in revenue; in April, those figures plummeted to roughly 75%. Multiple factors contributed to that drop, she says, including patients being intimidated by telemedicine and restrictive requirements on its use until commercial and government insurers temporarily loosened them.

“Our older patients didn’t even have devices that they can do telehealth on. ... Some patients just said, ‘It’s OK, I’m just going to reschedule and I’ll see y’all after all this is over.’ Because I think a lot of patients at that time thought, ‘This is going to be
a month, and then it’s going to blow over, and I’ll just reschedule my appointment.’ Obviously, we know now that’s not true,” she said.

“And like most practices, what we do is not just the evaluation and management code; it’s not just the office visit. We have a full pulmonary function lab in our office, and pulmonary function testing is something that is separately billed for from the office visit. When we went to telehealth, all of that billing immediately went to zero.”

Fortunately, the practice weathered the losses without laying off or furloughing any staff and returned to in-person visits in early June.

“That’s more worrisome.”

Similarly, internist John Flores, MD, says his Little Elm Medical Clinic’s abrupt transition to all-telemedicine was easier than it would’ve been otherwise because of low overhead costs. The two-physician practice near Dallas owns its building, and its mortgage payments are lower than many rent payments would be. It also outsources many of the business aspects of the practice to firms that handle human resources, marketing, and information technology. Those services charge Little Elm a percentage “pretty reasonable compared to what I used to pay for billing alone,” Dr. Flores said.

“My original patients, I’m seeing their children. Babies that I helped deliver, now I have working for me. I don’t want to lay people off. But that ... has to be the first thing I would do, as I would say it’s the most money. It doesn’t make sense (to do anything else); I can’t not order cotton balls, but that’s cheap anyway. It’s really the salaries that eat up most of the money, and vaccines. And I have to have vaccines. I can’t have people coming in and go, ‘Well, I can’t give you any vaccines, because I couldn’t afford them.”

Dr. Bob Nettune, forced to shutter just shy of four decades after he began, struggles to come up with solutions for doctors to brace for another pandemic or anything like it: “Boy, I don’t know how you prepare for something like this.”

But Dr. Chesnut sounds a note of optimism, saying while COVID-19 couldn’t have been anticipated, it forced her office to get creative.

“I don’t think we ever felt like we were going to have to throw in the towel and it was going to be impossible. I guess if it went on forever and ever and ever,” she said. “But I think we could see that there was a way that we were going to be able to get back into the office safely and bring patients back into the office.”

A broader concern will be COVID-19’s impact on physician practice in light of this year’s overall economic realities. On June 8, the National Bureau of Economic Research officially declared that the U.S. had been in a recession since February.

Dr. Flores, immediate past chair of TMA’s Council on Socioeconomics, said in June that the next six months are a concern for him.

“When the recession hit back in ’07, ’08, ’09, it really caused a lot of people to lose their job, lose their insurance, and basically not be able to afford to take care of their chronic conditions. And we already saw a huge drop in the number of ... those patients coming in to take care of themselves – their diabetes, their blood pressure, their cholesterol – because some were concerned about being exposed,” he said.

“At the same time, we didn’t want to expose them, because we really didn’t know what was going to happen with the COVID.

“Now, I’m more concerned about [whether] what happened 13 years ago would happen again in the next six months. Because really, long-term, that’s more worrisome.”
COVID-19 has been tough on Texas physicians. To assess just how tough, the Texas Medical Association in May surveyed 1,548 physicians across various specialties and practice sizes. About 30% said their offices had laid off or furloughed workers, and a majority saw their work hours, salaries, and patient volume drop.

Setbacks like these could cause the number of independent Texas physicians to decline, which could exacerbate already unhealthy trends in medicine, says Dan Finch, TMA vice president of advocacy. They include: subsequent higher costs for patients as independent physicians flee to work at traditionally more-expensive hospitals and large medical groups; increased shortages in rural and inner-city areas, where the lack of physicians already is most acute; and entrusting patient care services currently done by physicians or under physician supervision to nonphysician providers working beyond their education and training.

See the full survey report at www.texmed.org/Surveys. For more information and practice resources, visit TMA's Practice Viability resource page at www.texmed.org/PracticeViability.

How Has COVID-19 Affected Your Practice? by SEAN PRICE

### Practice Impact

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<th></th>
<th>Physicians</th>
<th>OB/Gyn</th>
<th>Surgical Specialties</th>
<th>Indirect Patient Access/Care</th>
<th>Nonsurgical Specialties</th>
<th>Pediatrics</th>
<th>Primary Care</th>
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<td>62%</td>
<td>77%</td>
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<td>58%</td>
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See the full survey report at www.texmed.org/Surveys. For more information and practice resources, visit TMA’s Practice Viability resource page at www.texmed.org/PracticeViability.
### Cash Flow Concerns

- Applied for a Small Business Administration loan: **64%**
- Reduced physician compensation or reduced benefits: **63%**
- Accepted Health and Human Services stimulus funds: **45%**
- Drew from personal funds: **43%**
- Applied for other types of financial assistance (e.g., line of credit, grant, loan deferment): **33%**
- Laid off or furloughed staff: **30%**
- Received accelerated/advance payment: **16%**
- Closed or sold practice: **2%**

### Telemedicine Payment Parity

Percentage of physicians paid at the same rate as in-person visits

<table>
<thead>
<tr>
<th>Payer Type</th>
<th>All the Time</th>
<th>Some of the Time</th>
<th>None of the Time</th>
<th><em>I don't bill for it</em></th>
<th><strong>I don't know</strong></th>
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</thead>
<tbody>
<tr>
<td>Medicare</td>
<td>18%</td>
<td>13%</td>
<td>6%</td>
<td>22%</td>
<td>61%</td>
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<tr>
<td>State-regulated commercial payers</td>
<td>13%</td>
<td>26%</td>
<td>6%</td>
<td>17%</td>
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<tr>
<td>Medicare Advantage</td>
<td>11%</td>
<td>14%</td>
<td>6%</td>
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<tr>
<td>Medicaid</td>
<td>8%</td>
<td>9%</td>
<td>8%</td>
<td>28%</td>
<td>47%</td>
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<tr>
<td>ERISA plans (employer-sponsored)</td>
<td>6%</td>
<td>19%</td>
<td>7%</td>
<td>18%</td>
<td>51%</td>
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</tbody>
</table>

*Note: Due to rounding, percentages may not add up to 100%.

*There were multiple reasons for a physician to choose “I do not bill for telemedicine,” including not using telemedicine at all or not using it with a specific payer.

**Physicians were more likely to select “I don’t know” when asked about payment parity for any type of payer. This may be due to the fact multiple changes have been made by various payers. Often these changes were not with the same effective dates.*
IN TEXAS, COVID-19 outbreaks have been especially pronounced in three types of facilities: nursing homes, jails or prisons, and meatpacking plants. The Amarillo area has plenty of all three.

But it was the meatpacking plants that drew national attention to Amarillo’s COVID-19 problems. The city, which straddles Potter and Randall counties, has numerous plants that employ 12,000 to 15,000 people. In early April, Amarillo’s two hospitals began filling up with COVID-19 patients who worked at a plant in neighboring Moore County. Two weeks later, workers from a plant in Potter County flooded in.

So many workers became sick at U.S. meatpacking plants that consumers rushed to buy meat amid fears the plants would close and cause shortages. In April, President Donald Trump declared meatpacking plants “critical infrastructure” to keep them from shutting down.

Concerns over the loss of meatpacking also prompted Gov. Greg Abbott in May to send in surge response teams made up of members from the Texas Army National Guard and the Texas Military Department, coordinated by the Texas Department of State Health Services and the Texas Division of Emergency Management.

Meatpacking operations create almost perfect conditions for spreading COVID-19, says Rodney Young, MD, chair of family medicine at the Texas Tech University Health Sciences Center (TTUSHC) School of Medicine in Amarillo. Workers typically stand close together on a production line, and they share a locker room to change into and out of work clothes.

“A packing plant is a dream come true for a virus,” he said.

Despite growing numbers of sick and absentee workers, some of these plants initially resisted the idea of improving the social distancing of employees on their production lines, says infectious disease specialist Scott Milton, MD, the public health authority for Potter and Randall counties as well as the city of Amarillo. He is also...
associate professor of internal medicine at TTUHSC in Amarillo. “A lot of the people we talked to were not receptive to us asking to slow down their plants because it’s a huge economic issue,” he said. “And we understood that.”

Other plants started making changes even before health officials showed up, Dr. Milton says. They spaced out workers, provided masks and eye shields, and put plastic dividers between workers in some places.

Pandemic in the Panhandle
In the spring of 2020, Potter County had one of the highest rates of COVID-19 cases and deaths in the state – far outstripping the rates in more populous counties like Harris and Dallas.

The governor’s surge response teams tested people and helped identify COVID-19 hotspots, says Gerard Troutman, MD. He’s an Amarillo emergency physician who helped oversee the testing operations, ensuring teams used appropriate personal protective equipment and administered tests properly. He is also medical director for Amarillo and Lubbock Emergency Medical Services, head of the Panhandle region’s Texas Emergency Medical Task Force, and a member of the Texas Medical Association’s Council on Legislation.

“As you can imagine when you start testing thousands of people, coordination becomes a big issue,” he said. “How do we gather all that stuff and get it from point A to point B to be tested? Who’s going to [process the tests]? Where do those results go?”

The testing itself went quickly. The teams tested about 3,500 people in four days, Dr. Milton says.

But getting the results back proved slow. Many of the testing centers were either overwhelmed with requests or still coping with how to get up and running, Dr. Troutman says.

As a result, many people had to wait up to two weeks to get results back. “There were folks [who had been tested] who were anxious for several days, wanting to know the results,” Dr. Milton said. “The testing was delayed at first, but it’s gotten better as time went on [and] as the capacity increased.”

Despite those headaches, testing was helpful in isolating disease hotspots, he adds. “We knew that there was a problem [with COVID-19 spreading]. The question is how much of a problem and how much control did we have in trying to mitigate that.”

Pressure from public opinion and Governor Abbott’s office helped persuade some meatpacking companies to change their procedures, Dr. Milton says. Amarillo’s spring outbreak peaked in the first week of May. Hospitals were crowded, but they weren’t yet overwhelmed.

“We weren’t out of [hospital] beds, but we were worried that we may be if [COVID-19] were to surge anymore,” he said.

Fortunately, that never happened. Meatpacking plants, nursing homes, jails, and prisons improved their safety efforts, and testing became more available, Dr. Milton says.

The path forward
Governor Abbott’s office did not return phone calls from Texas Medicine seeking comment about the use of surge response teams. In late May, he said at a press conference in Amarillo that in the event of another similar wave of COVID-19 outbreaks, the state was prepared to “send in these surge response teams that will be able to tamp down any flare up, using the model we have seen in Amarillo,” the Texas Tribune reported.

The spring outbreak had the unintended consequence of providing certain populations – like big groups of meatpackers – with some level of community-acquired immunity from COVID-19, though it’s still unclear how much immunity, Dr. Young says. That and the new precautions in place should make further outbreaks among those groups less likely in the near future.

But mass viral spread in churches, schools, and other places where people gather seem inevitable, Dr. Young says. Many in the Panhandle still have a “frontier” attitude, and the “idea of wearing a mask to hide from some virus just doesn’t sit well with them,” he said.

That’s worrisome because Amarillo’s two hospitals serve as the medical hub for a huge chunk of territory, which includes the Texas Panhandle as well as parts of New Mexico, Colorado, Kansas, and Oklahoma.

However, with the regional hotspots under control, Amarillo’s medical professionals now have the same goal as other Texas cities – making sure the community spread of COVID-19 doesn’t overwhelm local resources.

“There’s one of two paths forward,” Dr. Young said. “We’ll either have enough exposures that we start to get more natural immunity within the population. Or, we’ll get a vaccine and immunize broadly. I presume it will be a combination of those two things, but we still aren’t sure just how long it will take to reach those broader levels of immunity, or how long they will last.”

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As most of the nation quickly found out once coronavirus took hold, staying home nearly around the clock can be disconnecting, disheartening, and tough on the psyche.

But some people’s objections to self-quarantine go well beyond, “But it’s going to be so boring.”

Wendy Chung, MD, chief epidemiologist for the Dallas County Department of Health and Human Services, says the department has heard understandable concerns and poignant stories from patients.

“Oftentimes, the resistance to quarantine and isolation has to do with very real social needs: A fear of losing their job, not being able to pay the rent, or not having a place to stay where they can safely self-isolate. That’s what we encounter,” she said.

Umair Shah, MD, executive director of Harris County Public Health, says his department runs into similar cases. The good news, he says, is that so far it hasn’t been often.

As the state ramps up “contact tracing” as a key part of Gov. Greg Abbott’s plan to stop the spread of COVID-19 and return Texas to economic normalcy, some health officials say physicians can help those for whom quarantine and isolation are a challenge.

“What we are really doing is we’re talking to somebody who may be on a bus, their second bus for the day. And out of the blue ... we’re telling them, ‘Hey, you tested positive.’ Or in the situation of a contact, we may be saying, ‘Hey, you may have been exposed to somebody who was positive.’ And that person may have just lost a job,” Dr. Shah said.

To help with quarantine concerns, Dr. Chung says mechanisms for physicians to more easily refer patients and their families to social support resources would be ideal.

Unmet needs

Contact tracing involves identifying people at high risk of getting COVID-19 because of their contact with an infected person; notifying those people of their exposure; and, as they quarantine, monitoring them daily for symptoms for 14 days since their last exposure. (See “Texas Health Trace,” page 33.)

Once a tracer contacts someone who has tested positive for the virus or is suspected of having it, the tracer may make a referral for medical treatment or testing. Tracers also ask the person about their close contacts and then reach out to those people.

A “close contact,” as defined by the Centers for Disease Control and Prevention, is someone who was within 6 feet of the person for at least 15 minutes within at least two days of a positive test or the onset of illness.

According to Dr. Chung, some patients or their close contacts have res-
ervations about quarantine and isolation. Some may fear that when they get out of quarantine, their job will be in someone else's hands. Others may have a family member who requires their care – either in their home or elsewhere.

Contact tracers keep tabs on those contacts with texts and calls throughout their 14-day isolation period. But Dr. Chung says important questions remain.

“What [happens] next to the person you are calling who may not have a way to get food delivered?” she asked. “What [happens] next to the COVID-19 patient or contact who has a one-bedroom residence and has a mother undergoing chemotherapy, and has no alternative to safely self-quarantine? They can't move out, and neither can the mother.”

Dr. Chung says the need for social services and housing options to support people in those situations is “enormous.”

Physicians who diagnose or treat those contacts could be a referral source for those resources. Dr. Chung envisions a resource center to which physicians can direct those patients.

“Patients have often been referred to call 2-1-1,” Dr. Chung said, referring to the state’s regional and local call centers that inform callers about resources that include help for mental health, disabilities, and assistance if they can’t pay bills. “But 2-1-1 can become overloaded with calls, and in some cases what is really needed is a good case manager or a social worker.”

“A very important connection”
The Texas Department of State Health Services (DSHS) told Texas Medicine in a statement that through its contract tracing and case investigation interviews, the department asks people about needs they foresee having in isolation.

“If they indicate a need, someone from the public health region in which they are located will follow up with them to find out what their needs are and then connect them to community resources to help, such as access to food, medication, mental health (care) and other kinds of assistance,” DSHS said.

The department added that its social services division in each public health region provides follow-up support for contacts.

“To help with this effort, we’re in the process of hiring staff, all of which have backgrounds in either public health, social services, or case management. Lastly, DSHS has also contracted with multiple hotels across the state for those who don’t have a safe place to isolate or have some other extenuating circumstances,” the agency said, adding that it planned to make this resource available in early July.

In mid-May, as part of an announcement of the state’s containment plan for a COVID-19 outbreak in Amarillo, Governor Abbott announced that area hotels were available to those who couldn’t otherwise isolate. Austin city leaders also made hotel rooms available early in the pandemic.

For more information on the state’s contact tracing efforts, visit tma.tips/dshstracing.

Across the state, Dr. Shah says, local health departments are doing their part to connect patients to social services. But those connections “are always very difficult because every individual has an individual circumstance that’s very unique,” he said. “In other words, one size does not fit all.

“I’m glad to hear what DSHS is saying. I will say that there are opportunities to do a better job with that. That is obviously a very important connection that must happen.”

Umair Shah, MD

Texas Health Trace

The Texas Department of State Health Services has developed an online system, Texas Health Trace, for Texans who test positive for COVID-19, have symptoms of the disease, or believe they’ve been exposed to someone who tested positive. The system includes information on how and where to get tested; what to do if you test positive; and how to obtain food and other necessities if you must self-isolate.

Texas Health Trace, which requires a valid email address for registration and use, is available at tma.tips/texashealthtrace. For more information on the state’s contact tracing efforts, visit tma.tips/dshstracing.

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MEDICAL SCHOOLS typically have predictable schedules. The timing of lectures, clerkships, exams, and even extracurricular activities tend to follow in the same grooves year after year. Students can reliably block out even minor events months ahead of time and be confident they'll take place.

All that changed with COVID-19. Since March, when the pandemic began closing down schools, businesses, and other institutions across the state, figuring out what comes next in medical school has been anything but predictable, says Swetha Maddipudi, a third-year medical student at UT Health San Antonio Long School of Medicine.

"Every day is a new day, and the plan you had the previous day [for school] is completely different," she said.

For students' safety, schools shut down in-person classes and clinical clerkships in March and conducted the rest of the spring semester online. At press time in June, schools planned to return to in-person classes by the late summer or early fall.

But all that could change as well because of the unpredictable impact of COVID-19, says Beth Nelson, MD, associate dean of undergraduate medical education at The University of Texas at Austin Dell Medical School. Spikes in infection rates could prompt a city or region to shut down, causing hundreds of medical students to recalibrate once again.

“If we could have had a clear plan – 100% certain – moving forward, I think [the students] would have been able to adjust,” she said. “But for months, it’s been, ‘This is our best guess, this is our best hope. If everything goes well, we’ll be doing it this way.’ You don’t feel like you have confidence in the timeline.”

While schools were able to adapt classrooms and clinical clerkships – however imperfectly – to virtual formats, medical school benchmark testing temporarily ground to a halt. Prometric, the testing service that administers the biggest medical school exam – the United States Medical Licensing Examination, or USMLE – canceled all testing dates starting March 17 to revamp its procedures for social distancing.

When the company reopened testing in May, not only was there a backlog, there were fewer seats for each test because of distancing requirements. As a result, students scheduled testing dates only to see them canceled, sometimes abruptly.

“Some of my friends and peers had their exam spots cancelled just days before their exam, and some were canceled the night before,” Ms. Maddipudi said.

Cancellations added to an already pressure-filled medical school experience, says Deborah Conway, MD, interim vice dean for undergraduate medical education and professor of...
obstetrics and gynecology at the Long School of Medicine.

Residency program officials frequently use USMLE test scores to help determine which students get admitted to their programs, she says. (See “Changing the USMLE,” page 36.) Students typically set aside four to eight weeks to study carefully for Step 1 and Step 2 of the USMLE because their careers depend on it.

“So [USMLE tests] were already incredibly stressful events for medical students on a really tight timeline,” she said.

The cumulative effect of all this uncertainty is that today’s medical students are facing pressures that older physicians never faced in medical school, says Robert Carpenter, MD, a bariatric surgeon, clinical associate professor, and head of wellness at Texas A&M University College of Medicine.

This unprecedented situation may lead to some positive long-term changes – like easing the psychological pressures students face, he says. But it’s clearly taking a toll right now.

“You’re going through all the stress that’s normal and natural for a medical student. Oh, and, by the way, you’re doing that in what realistically is a recession ... overlaid by the worst pandemic in a century,” Dr. Carpenter said.

Chasing the USMLE

Medical students aren’t the only ones caught up in the testing chaos, Dr. Nelson says. Many college students applying to get into medical school have been unable to take the Medical College Admission Test, or MCAT. As a result, medical schools in many states have opted to drop the MCAT as a requirement, though Texas schools were still mulling that decision in June.

However, the USMLE is the major area of concern. In May, Prometric opened up testing on a limited basis in 10 Texas cities, according to its website. But with cancellations still frequent, students played a risky game of cat-and-mouse as the test’s availability seemed to shift from city to city, Dr. Carpenter says.

For instance, a Texas A&M student might plan to take a test in Austin, find out it’s canceled, and then have to shift to Lubbock at the last minute.

“How do I get, as a medical student with [a lot of time demands], safely from here to Lubbock, take the test, and come back without being exposed [to COVID-19]?” Dr. Carpenter asked.

Ms. Maddipudi checked the Prometric website daily for updates and tried to figure out which city would work for her.

“We were putting in a lot of brain-power each day to anticipate what might happen with our testing spots,” she said. “We had to decide if we should pre-emptively reschedule our tests to a later date that might be safe from cancellations or continue to hope that our testing spot would be safe.”

After six cancellations or reschedules, Prometric expanded testing availability in June, according to the company’s website. After that, the situation began to stabilize, Ms. Maddipudi says, and she was able to schedule a test in San Antonio for early June.

“There came a point where I just wanted to take the test and get it over with,” she said. “I cared less about my performance and more about clearing this hurdle so I could move on to my clinical years.”

Ms. Maddipudi had planned to spend eight focused weeks studying for Step 1. Instead, it took her a hectic 14 weeks, she says. And while the test was over for her, about two-thirds of her fellow third-year students at Long School of Medicine still waited to take Step 1.

Healthy changes

At the start of the pandemic, U.S. medical schools and teaching hospitals withdrew medical students from clinical clerkships at medical centers for their own safety and to preserve the personal protective equipment (PPE) that was in short supply for clinicians.

For many students, this was a psychological blow because they wanted to help fight the pandemic, Dr. Carpenter says. But it also was a professional blow because without clerkships – or with truncated ones – stu-
Changing the USMLE

ALL PHYSICIANS ARE FAMILIAR with the United States Medical Licensing Examination, or USMLE, the three-step examination for medical licensure in the U.S. However, they may not know about recent changes to the test prompted by COVID-19 and other concerns.

• Step 1 is a one-day test taken at the end of the second year of medical school. It measures knowledge of basic sciences. Residency programs have relied heavily on Step 1 scores to screen candidates. However, the test will become pass-fail in 2022, which is part of a nationwide effort to deemphasize it as a residency screening tool in favor of more accurate measures to determine if candidates are a good fit.
• Step 2 is a two-day test taken by fourth-year students that has two parts. Clinical Knowledge, or CK, tests students on clinical sciences like internal medicine, surgery, and gynecology. Clinical Skills, or CS, requires students to examine and diagnose actors posing as patients. To avoid spreading COVID-19, USMLE has suspended Step 2 CS until 2021.
• No changes are planned for Step 3, a two-day test taken after the first year of residency.

Each day at the hospital and spent the evening studying for the exam, which they would take at the end of the eight weeks.

But COVID-19 forced the school to cut down the clerkship’s hospital time to four weeks. So students spent the first four weeks studying, took the test, and then did their four weeks in the hospital, he says.

The new schedule had a lot of benefits, Mr. Mithani says. For instance, it allowed him to help more patients while he was in the hospital because he wasn’t worried about studying in the evening. Typically, two or three students might achieve honor status in a rotation, and in this case at least eight did.

At the same time, he and other students were able to relax in the evening after working all day in the hospital, which helped with their peace of mind.

“It’s kind of an intensified study time and intensified hospital time,” he said. “They’ve just divided it up better.”

Already, medical students and physicians are prone to burnout and psychological stress. (See “Battling Burnout,” April 2018 Texas Medicine, pages 10-13, www.texmed.org/BattlingBurnout.) Medical schools should use the changes caused by COVID-19 to reassess how they’re operating, especially if those changes ease the load on students, Dr. Carpenter says.

“We don’t have to continue to perpetuate the cycle of physician education being a point of extreme strain or psychological isolation,” he said. “We can change that dialogue.”

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Use Patient-Centered Techniques When Discussing PMP Data

Pain can be a sensitive topic for both patients and physicians. Building trust through effective communication is paramount to ensuring better health outcomes. If you notice a potential concern after checking your patient’s profile in the Texas Prescription Monitoring Program (PMP), here are some evidence-based practices to help guide your conversation:

**ASK OPEN-ENDED QUESTIONS**
Stating the facts about PMP data and asking open-ended questions without judgment leads to more productive conversations. Try asking:

- “Your patient profile shows that you have the same prescription from multiple prescribers. Can you tell me more about that?”
- “I want to check in about how you are managing your pain. Your prescription history shows some early refills of medications, so I want to know how you’re feeling about your treatment plan.”

**USE ACTIVE LISTENING & THE TEACH-BACK METHOD**
By using statements that reflect your patients’ own words and asking them to repeat back key information, you can ensure they understand medication instructions and risks. Summarize by asking:

- “What I hear you saying is ...”
- “Ok, let’s go over our treatment plan together ...”
- “We went over a lot of information, so I like to make sure we’re on the same page. Pretend for a minute I’m the patient and you’re the doctor — can you repeat back to me what the dosage instructions are for this medication?”

**AVOID STIGMATIZING LANGUAGE**
Stigmatizing words erode your patients’ trust and ultimately affect the care they receive. Studies demonstrate that patient-centered language can help reduce stigma and improve treatment.

<table>
<thead>
<tr>
<th>Stigmatizing</th>
<th>Supportive</th>
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<tr>
<td>Drug abuse</td>
<td>Drug or medication misuse</td>
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<tr>
<td>Drug addict</td>
<td>A person with substance use disorder</td>
</tr>
<tr>
<td>Clean/Dirty (referring to drug test results)</td>
<td>Negative/Positive/Substance-free</td>
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For more tips on conversations with patients about the PMP and safe and effective alleviation of pain, visit the free, downloadable Prescriber Toolkit at txpmp.org/resources.

*Sign on before you sign off.*
UNDER TEXAS LAW, physicians treating COVID-19 patients in a volunteer capacity have potential defenses against lawsuits that might arise from that care.

But for non-volunteer physicians on the COVID battlefield—often working in harrowing, overloaded settings, high on patient count and low on equipment—the same liability shields don’t exist. And with a resurgence in COVID-19 cases and hospitalizations taking hold in June, the Texas Medical Association continued its pandemic-long push to extend liability protections to all frontline physicians, volunteer or not.

In early April, TMA, the Texas Hospital Association (THA), Texas Health Care Association, and other groups urged Gov. Greg Abbott to issue an executive order temporarily limiting liability for all health care workers on the front lines of the COVID-19 crisis. The letter asked the governor to extend existing liability protections for volunteers to all physicians, health care practitioners, and facilities.

“In some situations, they are facing shortages of life-saving equipment while trying to render care to a patient population that exceeds their capacity,” the joint letter noted. “In other situations, to fill personnel shortages, they are being asked to provide health care services that, while within the scope of their licenses or other authorizations, are outside of their facility’s historical credentialing policies or

Pandemic Poses Legal Pitfalls

TMA seeks better liability shields for all physicians during COVID-19

by JOEY BERLIN
outside their chosen specialty practice.”
Governor Abbott has so far not issued an executive order, but he has requested federal liability protections, which, at press time in June, Congress was weighing as part of the next COVID-19 relief package.

State volunteer protections
Texas law provides certain civil liability protections for physicians acting in a volunteer, uncompensated capacity in response to events like COVID-19, according to a recently updated TMA white paper. (See “Volunteer Liability Protections: A Rundown,” below.) Among those:

• State law provides immunity from civil liability for volunteers whose acts occur “in giving care, assistance, or advice in response to a man-made or natural disaster,” unless their conduct is reckless or they engage in “intentional, willful, or wanton misconduct.” That immunity applies only if the person’s volunteer help comes at the request of a local, state, or federal agency, or certain charitable organizations that provide services to mitigate the effects of a disaster.
• 2019 legislation enacted in response to Hurricane Harvey limits volunteer physicians’ liability while helping out during a man-made or natural disaster without requiring a request for help.
• The state’s “Good Samaritan” law is meant to incentivize physician volunteers to respond to medical emergencies. It limits volunteers’ liability for providing emergency care that results in injury if the care was provided in good faith. However, the Good Samaritan law doesn’t protect willful or wanton misconduct, or a person who administers emergency care but caused the emergency to begin with.
• Texas’ Charitable Immunity and Liability Act (CILA) limits liability for volunteer health care workers of certain charities in the case of death, damage, or injury to a patient. Volunteers looking for immunity under CILA must demonstrate four requirements to invoke the law. Those include showing that they were acting within the course and scope of their duties or functions within the organization.

“Note that, while these protections exist, these laws do not prevent the physician from being sued. Instead, these are affirmative defenses a physician may raise and must prove to defeat a medical professional liability claim,” TMA’s white paper explains. “Thus, it is still highly recommended that a physician (active or retired) carry liability insurance to help offset costs that may be needed to successfully defend a lawsuit.”

Volunteer Liability Protections: A Rundown

VOLUNTEER PHYSICIANS can play an immensely valuable role in combating the pandemic, and a Texas Medical Association white paper details the protections state law may give retired physicians and others lending their uncompensated time to the fight. Find it at tma.tips/volunteeliability.

TMA’s Office of the General Counsel also notes that current volunteer protections may not be broad enough to apply to all volunteer physician services during a disaster declaration.

The need for more
At the federal level, Congress in late March granted limited civil liability shields for volunteers as part of the CARES Act. According to the American Medical Association, those protections override state laws that are inconsistent with CARES, but state laws that offer greater protection take precedence.

Non-volunteer physicians, however, remain relatively unprotected. TMA’s April 3 letter asked Governor Abbott for help, noting that attorneys already were advertising COVID-19 litigation.

Paid physicians, other health care workers, and facilities “are facing a surge of incoming patients, that may or may not be infected with a virus that they may or may not be equipped to handle,” the letter said. “They are running low on personal protective equipment necessary to protect themselves, but they are still there. They are having to delay care for non-COVID-19 conditions to divert most efforts to combat the virus. They are being reassigned from their specialty areas to
other areas of care where they may not have the most updated training. And now they are being threatened with litigation. This threat risks deterring our physicians and health care providers from providing needed, urgent patient care.”

For example, TMA is concerned about potential physician liability for care delays as the result of government orders related to the pandemic.

End-of-life care presents one scenario in which wide liability protections could help physicians rest easy while doing their jobs to the best of their ability, says Robert Fine, MD, clinical director of Baylor Scott & White’s Office of Clinical Ethics and Palliative Care.

“Unfortunately, we don’t have as airtight of liability protection as we would like, and it is in particular around the [do-not-resuscitate] part of limiting life-sustaining treatment,” Dr. Fine said.

A backup plan
If broader protections don’t come, Texas health care organizations have a plan for how to proceed if patient load exceeds care capacity.

In a March 29 letter TMA, THA, and other organizations asked Governor Abbott to endorse the use of mass critical care guidelines developed by the Texas health care community over the past decade. As explained in the guidelines, they establish a protocol “to allocate scarce health care resources (intensive care services, including ventilators) to those who are most likely to benefit medically during a pandemic respiratory crisis or other emergency situation that has the potential to overwhelm available intensive care resources.”

The guidelines are based on tighter control of resources; giving priority to patients “for whom treatment most likely would be lifesaving and whose functional outcome most likely would improve with treatment”; and, in a state of emergency, the governor having the authority to supersede laws or regulations that might conflict with the guidelines.

To read the guidelines for adult and pediatric care, visit tma.tips/massccguidelines.

TMA’s letter also asked Governor Abbott to “suspend any license reviews, criminal penalties, and civil damages for following mass critical care guidelines.”

“Physicians and providers need to know they will not be subjected to civil/criminal/regulatory review when operating under mass critical care guidelines whose purpose is to save lives while avoiding discrimination,” the letter said.

Dr. Fine, who helped develop the guidelines, explains: “The whole point of the guidelines, which they say upfront, is to save as many lives as possible. That means giving priority to treat those that have the best chance of benefiting from the treatment. … We’re not in that horrible place yet. We don’t know if we’ll get there, but we need to be prepared.”

JOEY BERLIN is associate editor for Texas Medicine. You can reach him at (800) 880-1300, ext. 1393; (512) 370-1393; or joey.berlin@texmed.org.

Legal articles in Texas Medicine are intended to help physicians understand the law by providing legal information on selected topics. These articles are published with the understanding that TMA is not engaged in providing legal advice. When dealing with specific legal matters, readers should seek assistance from their attorneys.
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**Sign on before you sign off.**
E&M Coding About to Change

Physicians should benefit from less documentation under revised Medicare rules

by SEAN PRICE

First, the bad news: Physicians need to take some serious time between now and Jan 1, 2021, to study changes that are coming to Medicare outpatient evaluation and management (E&M) codes – changes most private insurers likely will follow.

The revisions – which affect office or other outpatient visit codes and prolonged services codes – will affect physicians in every specialty. (For details visit tma.tips/AMAEMChanges.)

“When you’re working on an outpatient basis, you’re using those codes about 99.5% of the time. They’re the mainstay of the office visit codes,” says Karl Krohn, MD, a Lufkin internal medicine specialist who has been closely following the revamp conducted by the Centers for Medicare & Medicaid (CMS) and the American Medical Association (AMA).

Now the good news: The changes should reduce the amount of documentation needed with each patient, says Dr. Krohn, whose practice consists of more than 80% Medicare patients.

“I think it will go over fairly well once people get used to it,” he said. But he added: “It’s definitely going to change workflows.”

Texas Medical Association experts say the revisions are meant to encourage physicians to spend more quality time with their patients and stress less about administrative burdens.

While the updated rules will affect how practices get paid for patient care, they do not alter how much physicians get paid, nor does TMA expect the changes to interfere with patient care, says Carra Benson, manager of practice management and reimbursement services at TMA. Instead, they should improve physician efficiency by reducing unnecessary paperwork.

“I see this as a positive change,” she said.

However, CMS has yet to explain the framework for the documentation physicians will have to provide. The new E&M guidelines were created in part to reduce audits of physician records, and such ambiguity could undermine the effort to reach that goal, Ms. Benson adds.

Out with the old

Medicare payments for outpatient visits are based on the complexity of treatment, which physicians rank from 1 to 5, with Level 5 patients requiring the most complex care.

In 2018, CMS proposed a plan to reduce documentation on outpatient visits that would have collapsed those levels from five to three and modified the resulting payments. TMA, AMA, and other medical organizations vehemently opposed the plan because it would have led to physicians doing more work for less money while needlessly forcing patients to come in for extra visits. (See “Buying Time: Medicine’s Warnings Prompt CMS to Delay Dramatic Coding and Payment Changes,” January 2019 Texas Medicine, pages 36-39, www.texmed.org/CodingChanges.)

“That was a disaster in the making,” Dr. Krohn said.

CMS agreed to delay those changes and instead accepted AMA’s recommendation for a work group made up of physicians, payers, and health care professionals, among others, to draw
practice management

up an alternative plan. CMS adopted the work group’s new guidelines in 2019, and they will take effect in January.

Medicare has two sets of guidelines on E&M coding, one written in 1995 and another in 1997. Physicians can choose which one they prefer to follow.

The January revisions update both sets, but they especially revise some of the 1997 guidelines physicians have found difficult to follow, Ms. Benson says.

Under the old system, for both sets of guidelines, physicians document the level of complexity by providing information in three categories: patient history, physical exam, and medical decisionmaking. For each of those three categories, physicians are expected to provide greater amounts of documentation as the complexity level rises.

This documentation has been especially difficult for physicians under the 1997 guidelines. For instance, a lower level of complexity might require a physician to show in the physical exam category that the heart, lungs, and abdomen were checked, Dr. Krohn says. For the next level of complexity, the physician would have to show that the eyes, ears, throat, and extremities were checked as well, and that a neurological examination had been done.

For billing purposes, what counted was the actual number of exam elements, or “bullet points,” that have been checked off, not whether they have anything to do with the patient’s condition, he says.

“We’re talking [the sheer number of] items – so much in the history, so much in the physical exam, so much in the medical decisionmaking,” he said. “And it really doesn’t matter what they are as long as you include them. And of course, as you go up to the higher levels, you have to put more in. So, you’re basically just adding things in to get to the higher level of coding. That may make it easier for the coders to review a chart, but it really doesn’t add much to medical care.”

Medical judgment, time matter
The new system simplifies this in three ways, Ms. Benson says.

First, the history and physical exam are no longer counted in determining the level of service, although they still should be documented to indicate the care provided. Second, physicians no longer need to document specific bullet points. Third, the physician now can base the E&M level on either the amount of time they spend with the patient or on their medical decisionmaking.

“Instead of having this multitude of [bullet points] to determine the level of the evaluation and management code, it’s been condensed to two options,” Ms. Benson explained.

For instance, physicians who spend a lot of time with a patient may opt to bill based on time.

On the day of a visit, physicians frequently review information before a patient arrives or after they’ve left. Often this is routine lab work or something similar that takes a few moments. But if the physician spots something that requires deeper attention, these matters can take a lot of time when no patient is present, Dr. Krohn says.

“That’s the first time that [CMS has] acknowledged that not all of our work has to be done when we’re sitting in the exam room,” he said.

The new guidelines also get rid of the requirement that 50% of a physician’s time must be spent counseling a patient, Dr. Krohn says.

“Sometimes you’ll spend 45 minutes in the exam room with the patient trying to get the story out of them so you can figure out what’s going on,” he said. “And that’s not counseling, that’s doing your history and physical. Some patients are simply not good descriptors of their own symptomology.”

A physician who chooses to document based on medical decisionmaking will have more freedom to determine how much documentation is needed, Dr. Krohn adds.

“It leaves the amount that you document up to the discretion of the physician, which I think is appropriate,” he said. “There are some people who document a lot, and there are some people who don’t.”

However, physicians are still waiting for CMS to fully define the baseline requirements for that documentation. Further clarification may come before the beginning of 2021, Ms. Benson says.

“The term [CMS has] applied to it is ‘medically appropriate,’ and they have not defined medically appropriate,” she said. “As we get closer [to Jan. 1], there will be more guidance.”

TMA Resources

FIND OUT MORE about the E&M coding changes due to take effect Jan. 1 by listening to TMA’s new 2021 E&M Changes: What’s to Come webinar at tma.tips/Emchanges. Like most CME programs in the TMA Education Center, this webinar is free to TMA members compliments of the Texas Medical Association Insurance Trust.

SEAN PRICE is a reporter for Texas Medicine. You can reach him at (800) 880-1300, ext. 1392; (512) 370-1392; or sean.price@texmed.org.
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Talk to Patients About: What Is ImmTrac2? Why Do I Need It?

by SEAN PRICE

A typical U.S.-born baby gets a hepatitis B vaccine within 12 hours of birth, receives dozens more throughout childhood and young adulthood, and then winds up in old age with shots that include flu and shingles. Keeping track of all those vaccines over a lifetime is not easy. People move, change physicians, and lose records.

ImmTrac2, Texas’ revised immunization registry, is designed to help people keep their vaccine records in order. Texas residents who sign up can have their immunization records stored for free, allowing physicians, schools, and other authorized people to see which shots a person has received and which ones they’ve missed.

ImmTrac2 follows recommendations from the U.S. Centers for Disease Control and Prevention’s Advisory Council on Immunization Practices. The registry, which replaced an older system by the same name in 2017, got another upgrade this year that allows it to interconnect better with electronic health records, according to the Texas Department of State Health Services (DSHS).

“We know that immunization schedules have become more complex over time, and the types of [medical] providers who are giving immunizations also have become increasingly varied. So having one place to store immunization data is important for the health of Texans,” said Jennifer Shuford, MD. She is the infectious disease medical officer at DSHS, which runs ImmTrac2.

Reducing the hassle of record-keeping prevents children from being either under- or over-immunized, Dr. Shuford adds. ImmTrac2 also stores patient information on antiviral immunizations and medications that are associated with disaster events.

“Right now, we are in a public health disaster [with COVID-19], and the state is allocating an antiviral – remdesivir” to certain institutions and patients, she said. “We’re working with hospitals around the state to make sure that information gets into our registry.”

You can direct your patients to immtrac.dshs.texas.gov for more information.

There is a lot of misinformation about vaccines, so each month Texas Medicine highlights common concerns that patients raise about immunizations. The material is designed to help you talk to your patients and help them understand the benefits of vaccines. Find printable infographics and helpful videos for your patients at www.texmed.org/TalktoPatients.
Medical Mysteries: Solved

by NANCY SEMIN, PhD • photographs by SARAH SUDHOFF

In the April 2020 edition of Texas Medicine, we featured six photographs of medical artifacts from the Texas Medical Association archive and we asked for your help to identify them. Over 30 sleuthing physicians responded, and we give them all a hearty shout out of thanks! We published Part 1 of the answers in the July issue. Here’s Part 2.

One physician suggested the collection of instruments in Photograph D was used for tooth extractions, but the overwhelming responses lead us to believe these are periosteal elevators and Doyen elevators used for rib resection.

Photograph E is a collection of Gellhorn vaginal pessaries. They do look suspiciously like anal dilators, but their circumferential base tells us otherwise. Pessaries are used when a diagnosis of uterine prolapse has been made, and are still used, but today they are made of silicone. These aluminum pessaries likely date to the mid-20th century.

Most perplexing is the object in Photograph F. Only a few physicians hazarded a guess as to what it might be. It may be a generator used to power a suction pump or a device that administers an electrical shock. More likely, it was donated as an incomplete set and without the rest of the parts, its exact purpose may never be known.
When connections are few, health problems can be many.

Having the right resources can help.

Ongoing feelings of loneliness and social isolation can be dangerous to your patients and significantly impact their health. In fact, these patients have a 64 percent greater chance of developing clinical dementia.* That’s why Humana works with physicians and community organizations to develop tools and resources that can help you more easily identify and address loneliness or social isolation in your patients.

To access UCLA’s simple screen for loneliness, or to find community resources that can help your patient, visit PopulationHealth.Humana.com/#toolkits and download the loneliness and social isolation toolkit.

Physicians are essential to Texas.

Insurance is essential to physicians.

In times like these, we are forced to reset our priorities. What seemed important before the pandemic has now moved to the back burner. Basic necessities can no longer be taken for granted. Protecting your life, health and income are now essential priorities that should not be delayed.

If you think your insurance is not providing enough protection, now is the time to review your policies. The advisors at TMA Insurance Trust can review your current plans and help you get the coverage to better protect what is essential in your life.

Contact us for a no obligation consultation toll-free at 1-800-880-8181, Monday to Friday, 7:30 am to 5:30 pm. Or visit us online at tmait.org. It will be our honor to serve the physicians of Texas who are working hard to keep all Texans healthy.