TMA Virtual House of Delegates

2020 Transactions
The Texas Medical Association House of Delegates convened virtually Aug. 29 in a prerecorded session, and live at 9 am, Sept. 12, 2020. A small contingent of TMA leaders were present in-person at the TMA Building in Austin, Texas for the Sept. 12 meeting, with all others attending virtually.

Speaker Arlo F. Weltge, MD, and Vice Speaker Bradford W. Holland, MD, presided at each session of the House of Delegates.

During the prerecorded session on Aug. 29, the Rev. Bryan Donahoo, senior pastor at Graceview Baptist Church in Tomball, Texas, gave the invocation.

Board of Trustees Chair Gary W. Floyd, MD, reported on association finances and formally returned responsibility of the House of Delegates function back to the house from the TMA Disaster Board.

Dr. Weltge explained the limited order of business to the house.

Dr. Holland gave an overview of the new online election and voting process.

During the live virtual session Sept. 12, Dr. Weltge again addressed the house to make important announcements regarding the limited business and special circumstances of the meeting.

TMA Executive Vice President and Chief Executive Officer Michael Darrouzet addressed the house.

Chief Teller Tilden L. Childs III, MD, reported a majority of delegates present.

Minutes of the May 2019 meeting were approved.

American Medical Association President Susan R. Bailey, MD, addressed the house.

TMA President Diana L. Fite, MD, addressed the house.

The association’s highest honor, the Distinguished Service Award, was presented to Josie R. Williams, MD. TMA Past President Douglas W. Curran, MD, introduced Dr. Williams.

Special recognition was given to TMA’s past presidents with an honorary slide show presentation.

Special recognition was given to TMA’s 2020 Leadership College graduates with an honorary slide show presentation.

Special recognition was given to acknowledge the passing of Louis J. Goodman, PhD, immediate past executive vice president and CEO of TMA.

The house observed a moment of silence to honor deceased physicians and those who lost their lives to COVID-19.

**CONTESTED ELECTIONS:** On Saturday, Sept. 12, the results of TMA’s contested races were announced, and barring objection the house ratified the results. Voting members of the house were emailed a link to cast their ballot online on Aug. 21. Delegates had until Aug. 28 to cast their votes. A
runoff for the Young Physician position on the TMA Board of Trustees occurred Sept. 4-10. The following members were elected or reelected:

**Trustees** – Three-year term: G. Ray Callas, MD, Beaumont; Gary W. Floyd, MD, Fort Worth; and Kimberly E. Monday, MD, Houston. Young Physician position: M. Brett Cooper, MD, Dallas.

**AMA Alternate Delegates** – Two-year term: Shanna M. Combs, MD, Fort Worth; Eddie L. Patton Jr., MD, Houston; and Yasser F. Zeid, MD, Tyler.

**AWARDS:**

Dr. Holland congratulated the following TMA section award recipients:

**J.T. “Lamar” McNew, MD, Award** – Khoa V. Pham, MD
**Young at Heart Award** – Steven R. Hays, MD
**C. Frank Webber, MD, Award** – Cynthia A. Jumper, MD
**Student Member of the Year Award** – Natasha L. Topolski

The following awards were acknowledged in an honorary slide show presentation:

**Minority Scholarship Awards** – TMA awarded 15 $10,000 scholarships to minority Texas college students entering medical school. Recipients are known as the “Bayardo Scholars” in recognition of the majority support provided by the Texas Medical Association 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. Scholarship award recipients in 2020 were:

Sally Acebo, Sam Houston State University College of Osteopathic Medicine in Huntsville; Abakar Sabir Baraka, UT Health San Antonio Long School of Medicine; Belinda Busogi, McGovern Medical School at UTHealth in Houston; Breanna Chachere, the University of Houston College of Medicine; Briana Cortez, The University of Texas Rio Grande Valley School of Medicine in Harlingen; Michael Goshu, University of the Incarnate Word School of Osteopathic Medicine in San Antonio; Daemar Jones, Texas Tech University Health Sciences Center School of Medicine in Lubbock; Antonio Igbokidi, TCU and UNTHSC School of Medicine in Fort Worth; Andrea McWilliams, Texas Tech University Health Sciences Center Paul L. Foster School of Medicine in El Paso; Ariana Olvera, Baylor College of Medicine in Houston; Heidi Anahi Pargas, Texas A&M University College of Medicine in Bryan/College Station; Ariana Ramirez, University of North Texas Health Science Center Texas College of Osteopathic Medicine in Fort Worth; Veronica Remmert, The University of Texas at Austin Dell Medical School; Alan Villarreal Rizzo, The University of Texas Medical Branch School of Medicine in Galveston; and Jesus Valencia, UT Southwestern Medical School in Dallas.

The **Ernest and Sarah Butler Awards for Excellence in Science Teaching** were awarded to teachers in three categories:

- Overall Winner and Outstanding High School Science Teacher – Adam Unlu, Harmony School of Excellence, Laredo
- Outstanding Middle School Science Teacher – Cynthia Hopkins, Kaffie Middle School, Corpus Christi.
- Outstanding Elementary School Science Teacher – Clara Herrera, Clayton Elementary School, Austin.
ROLL CALL
Sept. 12, 2020
COUNTY MEDICAL SOCIETY DELEGATES AND ALTERNATE DELEGATES:
At-Large No CMS
    Oscar Garza, Pearsall

Bell CMS
    John R. Asbury, Temple; Hongjing Cao, Dallas; Patrick D. Crowley, Temple; A Keith Cryar, Temple; Christa C. DeFries, Temple; Lisa Jennifer Go, Temple; Robert Daniel Greenberg, Temple; James Andrew Hall, Temple; Belur Janakray Patel, Temple; Abirami Subramanian, Temple; Jenny Thomas Jacob, Killeen; Sandra S. Vexler, Temple; Andrew J. Widmer, Belton

Bexar CMS

Big Country CMS
    Jason L. Acevedo, Abilene; Charlotte M. Akor, Abilene; Indira C. Maharaj-Mikiel, Abilene

Brazoria CMS
    Mitesh M. Patel, Lake Jackson; Mammen A. Sam, Pearland

Brazos-Robertson CMS
    Malcolm J. Rude, College Station

Calhoun CMS
    John B. Wright, Port Lavaca

Cameron-Willacy CMS
    Sheila Marie Magoon, Harlingen
Collin-Fannin CMS
Carrie E. De Moor, Frisco; Neha V. Dhudshia, Plano; Marlene Diaz, Plano; Aimee C. Garza, Dallas; Paul Daniel Kivela, Frisco; Sejal S. Mehta, Allen; Sherine E Boyd Reno, Dallas; Brent A. Spencer, Frisco; Amber Van Den Raadt, Southlake

Comal CMS
Emily D. Briggs, New Braunfels; Tyrus Schroeder, New Braunfels

Concho Valley CMS
Bradly Bundrant, Ballinger

Dallas CMS
Drew Wilson Alexander, Dallas; Leyka M. Barbosa, Dallas; Christine Ann Becker, Dallas; Justin M. Bishop, Dallas; Adam C. Carter, Dallas; Vella Victoria Chancellor, Duncanville; Samuel J. Chantilis, Dallas; M. Brett Cooper, Plano; Hina Dave, Dallas; Shashi K. Dharma, Irving; Jeremy Epstein, Carrollton; Walter Francis Evans, Dallas; Juliana M. Fort, Dallas; Raymond L. Fowler, Dallas; Deborah Anne Fuller, Dallas; Angela Fulgham Gardner, Grapevine; John Russell Gilmore, Dallas; Robert D. Gross, Dallas; Robert Ware Haley, Dallas; Madeline Weinstein Harford, Dallas; Sarah Lynn Helfand, Dallas; Eugene Pitts Hunt, Dallas; Zachary S. Jones, Frisco; Seth David Kaplan, Plano; R Elizabeth Kassanoff, Dallas; Rainer Anil Khetan, Dallas; Roger Sunil Khetan, Dallas; Yolanda R. Lawson, Dallas; Benjamin C. Lee, Dallas; C. Turner Lewis, Dallas; David Scott Miller, Dallas; Angela N. Moemeka, Coppell; Marcial Andres Oquendo Rincon, Dallas; Lee Ann Pearse, Dallas; Daniel B. Pearson, Dallas; Shawnta R. Pittman-Hobbs, Desoto; James E. Race, Dallas; Aurelia M. Schmalstieg, Dallas; F. David Schneider, Dallas; John Stuart Scott, Keller; Elizabeth Ruth Seymour, Dallas; Baran Devrim Sumer, Dallas; Robert Eduard Suter, Dallas; Laurie Jayne Sutor, Bedford; Lisa Louise Swanson, Dallas; Bharath Thankavel, Dallas; Anil Kumar Tibrewal, Duncanville; Michael Ian Vengrow, Prosper; Gabriela M. Zandomeni, Heath

Denton CMS
Sathya Priya Bhandari, Flower Mound; Shikha Kaushik Mane, Mckinney; Anil Nanda, Lewisville; Udaya Bhaskar Padakandla, Carrollton

Ector CMS
Olga Ovdyeyenko Dowell, Odessa; Ikemefuna C. Okwuwa, Odessa; Ritchie Rosso, Odessa

El Paso CMS
David Mario Palafox, El Paso

Fort Bend CMS
Cedela Abdulla, Sugar Land; Channon T. Hudgins, Fresno; Jontel Dansby Pierce, Missouri City; Sapna Singh, Sugar Land
Galveston CMS
Aakash H. Gajjar, Houston; Brian D. Masel, Galveston; Bethany E. Powell, Galveston

Gonzales CMS
Humberto J. Rivas, Gonzales

Grayson CMS
Sanobor Kable, Denison; Jonathan Wayne Williams, Sherman

Gregg-Upshur CMS
Craig Kent King, Longview; Robert McKinney Wheeler, Longview

Harris CMS
Audrey E. Ahuero, Houston; Paul M. Allison, Houston; Janette K. Bateman, Pearland; Brian M. Bruel, Houston; Lucy A. Buencamino, Houston; Leanne Burnett, Houston; Sudipta K. Chaudhuri, Houston; Steven M. Croft, Houston; Anh Q. Dang, Houston; Kyle F. Dickson, Bellaire; Rakhi C. Dimino, Houston; Lisa L. Ehrlich, Houston; Angelina Farella, Webster; Lewis E. Foxhall, Houston; Clare N. Gentry, Houston; Bernard M. Gerber, Bellaire; Noel M. Giesecke, Houston; James S. Guo, Houston; Shiva Gupta, Bellaire; Leslie M. Haber, Houston; Steven E. Haber, Houston; Alison J. Haddock, Houston; Shannon B. Hancher-Hodges, Bellaire; Lindsey D. Harris, Houston; Hattie E. Henderson, Houston; Stephen A. Herrmann, Houston; David R. Hoyer, Houston; Terah C. Isaacson, Houston; Nora A. Janjan, Navasota; Laura P. Jimenez-Quintero, The Woodlands; Felicia L. Jordan, Richmond; Yvonne Kew, Houston; Faraz A. Khan, Houston; Karl W. King, Sugar Land; Christine E. Koerner, Houston; Russell W. H. Kridel, Houston; Gus W. Krucke, Houston; Piotr A. Kwater, Houston; Ana L. Leech, Houston; Andrew Li-Yung Hing, Sugar Land; Arthur Lim, Missouri City; Felicity L. Mack, Richmond; Shane M. Magee, Houston; Anna L. C. Mapp, Houston; Robert B. Morrow, Sugar Land; Clifford K. Moy, Houston; Mark L. Nichols, Houston; Rupesh Nigam, Houston; Stacy L. Norrell, Houston; Debra M. Osterman, Cypress; Bradford S. Patt, Houston; Eddie L. Patton, Houston; Kanchan A. Phalak, Houston; Evan G. Pivalizza, Houston; Autumn L. Pruette, Houston; Elizabeth M. Rebello, Houston; Susan N. Rossman, Houston; Manish Rungta, Webster; George D. Santos, Houston; Gary J. Sheppard, Houston; Angela Siler-Fisher, Houston; Mina K. Sinacori, Houston; Michael J. Snyder, Houston; Susanna C. Spence, Missouri City; Charlotte M. Stelly-Seitz, Houston; Angela K. Sturm, Bellaire; Spencer H. Su, Sugar Land; Irvin Sulap, Houston; Rosa A. Tang, Houston; Bao N. To, Houston; Theresa Q. Tran, Houston; Kenneth Y. Tsai, Houston; Dexter G. Turnquest, Houston; Mohammad A. Ursani, The Woodlands; John R. Vanderzyl, Sugar Land; Carlos J. Vital, Houston; Ronald S. Walters, Bellaire; Thomas C. Wiener, Houston; George W. Williams, Bellaire; Wendell H. Williams, Houston; Barbara J. Wilson, Houston; Kevin Scott Winfield, Houston; Alisha Y. Young, Houston; Acsa M. Zavala, Houston

Hidalgo-Starr CMS
Roel E. Cantu, San Juan; Lenore C. DePagter, McAllen; Sandra Esquivel, Weslaco; Alexander John Feigl, Edinburg; Martin Garza, Edinburg; Audrey Lee Jones, Alamo; Chevy Chu Lee, McAllen
**Hutchinson-Hansford CMS**
Wilson H. Landers, Borger

**Jefferson CMS**
Robert Barry Berndt, Beaumont; LeeChuan Andy Chen, Webster; Amy Michelle Townsend, Bridge City

**Kerr-Bandera CMS**
Phillip Eugene Balfanz, Kerrville

**Lubbock CMS**
Thomas A. Bowman, Lubbock; Sandra Dee Dickerson, Lubbock; Juan Francisco Fitz, Wolfforth; Sameer Islam, Lubbock; Kalarickal J. Oommen, Lubbock; Roger Michael Ragain, Lubbock; Eldon Stevens Robinson, Lubbock; Janice Ann Stachowiak, Lubbock; Davor Vugrin, Lubbock; Shiraz A. Yazdani, Lubbock

**McLennan CMS**
Scott E. Blattman, Woodway; William T. McCunniff, Woodway; Russell Scott Warren, Waco; Robert E. Wolf, Waco

**Midland CMS**
James William Huston, Midland; Robert Allen Vogel, Midland

**Nacogdoches-San Augustine CMS**
Gerard Joseph Ventura, Nacogdoches

**Navarro CMS**
Dale Keith Campbell, Corsicana

**Nueces CMS**
Jerry Dean Hunsaker, Corpus Christi; Michael D. McCutchon, Corpus Christi; Jacob J. Moore, Corpus Christi; Mary Dahlen Peterson, Corpus Christi

**Potter-Randall CMS**
Robert Evans Gerald, Amarillo; Evelyn D. Sbar, Amarillo; Neil Roger Veggeberg, Amarillo

**Smith CMS**
Joseph T. Martins, Tyler; William M. McCrady, Tyler; Li-Yu H. Mitchell, Tyler; Evans S. Smith, Tyler; David L. Young, Tyler
Tarrant CMS
Susan K. Blue, Fort Worth; C. Mark Chassay, Fort Worth; Shanna Marie Combs, Fort Worth; Theresa V. Crouch, Arlington; David J. Donahue, Fort Worth; Triwanna L. Fisher-Wikoff, Arlington; Ken C. Hopper, Fort Worth; Nishant B. Jalandhara, Colleyville; R. Larry Marshall, Fort Worth; Gregory J. Phillips, Fort Worth; Stuart C. Pickell, Fort Worth; Robert J. Rogers, Fort Worth; Angela D. Self, Grapevine; Johnathan D. Warminski, Grapevine; Michael E. Wimmer, Fort Worth

Travis CMS
Tony R. Aventa, Austin; Kimberly C. Avila Edwards, Austin; Ira Bell, Austin; Maya B. Bledsoe, Austin; Esther J. Cheung-Phillips, Austin; Elizabeth L. Chmelik, Austin; Scott W. Clitheroe, Austin; Antonia M. Davidson, Austin; Colby C. Evans, Austin; Albert T. Gros, Buda; Katharina Hathaway, Austin; Felix Hull, Austin; Anand Joshi, Austin; Megan K. Kressin, Austin; Jonathan E. MacClements, Austin; Hillary Miller, Austin; Celia B. Neavel, Austin; Graves T. Owen, Austin; Dennis Samuel Pacl, Manor; Tina J. Philip, Round Rock; A. Melinda Rainey, Austin; Dora L. Salazar, Austin; Lynn N. Stewart, Austin; Brian W. Temple, Austin; David N. Tobey, Austin; Zoltan Trizna, Austin; Elizabeth Truong, Austin; Vani S. Vallabhaneni, Austin; Stephanie M. Vertrees, Austin; John F. Villacis, Austin; Belda Zamora, Austin; Guadalupe Zamora, Austin; Jay R. Zdunek, Austin

Victoria-Goliad-Jackson CMS
Caroline Leilani Valdes, Victoria

Walker-Madison-Trinity CMS
Lane Joseph Aiena, Huntsville

Webb-Zapata-Jim Hogg CMS
Luis Manuel Benavides, Laredo; Sunny Wong, Laredo

Wichita CMS
T. David Greer, Henrietta; Bruce Lee Palmer, Wichita Falls; Susan M. Strate, Wichita Falls

Williamson CMS
Maryann Miyun Choi, Georgetown; Susan M. Pike, Georgetown

Young CMS
Donald A. Behr, Graham

EX OFFICIO MEMBERS PRESENT:
President, TMA Officers
Stuart L. Abramson, San Angelo; James R. Eskew, Austin; Roland Adolph Goertz, Waco; Donald Joseph Gordon, Helotes; Gilberto A. Handal, El Paso; Kyle Gregory Krohn, Lufkin; Steven M. Petak, Houston; Vivek U. Rao, Odessa; Edward Wilmar Tuthill, Dallas; Chad White, Hamlin

**Texas Delegate, Texas Delegation to AMA**

Brad G. Butler, Abilene; Gerald R. Callas, Beaumont; William H. Fleming, Houston; Gary W. Floyd, Roanoke; John T. Gill, Dallas; Robert Tau Gunby, Dallas; David Norman Henkes, San Antonio; Asa C. Lockhart, Tyler; Kenneth L. Mattox, Houston; Kevin Hood McKinney, Galveston; Larry E. Reaves, Fort Worth; Leslie Harold Secrest, Dallas; Jayesh B. Shah, San Antonio; Lyle Sheldon Thorstenson, Nacogdoches

**Texas Alternate Delegate, Texas Delegation to AMA**

John T. Carlo, Dallas; Robert Harold Emmick, Austin; John Gerard Flores, Carrollton; Gregory M. Fuller, Keller; Steven Ray Hays, Dallas; Bryan G. Johnson, Frisco; Cynthia Ann Jumper, Lubbock; Jennifer R. Rushton, Austin; Ezequiel Silva, San Antonio; Elizabeth Torres, Sugar Land; Roxanne Marie Tyroch, El Paso; Sherif Z. Zaafran, Houston

**Member, Council on Legislation**

Michael A. Battista, San Antonio; Celeste X. Caballero, Lubbock; Robert K. Cowan, Austin; Victor Hugo Gonzalez, McAllen; Robert E. Jackson, Houston; Thomas J. Kim, Austin; John David Myers, Temple; J. Timothy Parker, Denison; Victor A. Simms, Pearland; Linda M. Siy, Fort Worth; Michelle Babb Tarbox, Lubbock; Gerard A. Troutman, Lubbock; Yasser Fahmy Zeid, Tyler

**Member At-Large, TMA Board of Trustees**

Sue Scher Bornstein, Dallas; Keith A. Bourgeois, Houston; Kimberly E. Monday, Pearland; Richard Wesley Snyder, Dallas; Joseph S. Valenti, Denton

**SPECIALTY SOCIETY DELEGATES AND ALTERNATE DELEGATES PRESENT:**

American College of Cardiology, Texas Chapter: Stanley S. Wang, Austin
Texas Academy of Family Physicians: Troy T. Fiesinger, Sugar Land
Texas Academy of Family Physicians: Li-Yu H. Mitchell, Tyler
Texas Allergy, Asthma, and Immunology Society: Louise H. Bethea, Spring
Texas American College of Physicians: Amanda Kimbrough LaViolette, Austin
Texas American College of Physicians: Andrew J. Widmer, Belton
Texas Assn Obstetricians & Gynecologists: George Sealy Massingill, Fort Worth
Texas Association of Neurological Surgeons: Ramsey R. Ashour, Austin
Texas Association of Otolaryngology: Bradford W. Holland, Waco
Texas Association of Otolaryngology: Jeffrey B. Kahn, Austin
Texas College of Emergency Physicians: Heidi C. Knowles, Forney
Texas Ophthalmological Association: Jack W. Pierce, Austin
Texas Pain Society: C. M. Schade, Mesquite
Texas Pediatric Society: Charleta Guillory, Houston
Texas Pediatric Society: Valerie Borum Smith, Tyler
Texas Radiological Society: Tilden L. Childs, Fort Worth
Texas Society for Gastroenterology & Endoscopy: Pradeep Kumar, Austin
Texas Society of Anesthesiologists: Charles E. Cowles, Pasadena
Texas Society of Anesthesiologists: Stacy L. Norrell, Houston
Texas Society of Pathologists: Allen B. Flack, Wichita Falls
Texas Society of Pathologists: Megan K. Kressin, Austin
Texas Society of Plastic Surgeons: Susan M. Pike, Georgetown
Texas Society of Psychiatric Physicians: Richard L. Noel, Houston

SECTION DELEGATES AND ALTERNATE DELEGATES PRESENT:

Kristian Falcon, Fort Worth, SCMSS, University of North Texas Health Science Center
Anmol Gupta, Houston, SCMSS, Baylor College of Medicine
Neil Gupta, Frisco, SCMSS, Long School of Medicine at UT Health San Antonio
Katherine Grace Holder, Amarillo, SCMSS, Texas Tech University Health Sciences Center
Jessica Killingley, Austin, SCMSS, Dell Medical School at UT Austin
Kireet Koganti, Southlake, SCMSS, Texas A&M University-Medical School
Neelesh C. Mutya, Houston, SCMSS, McGovern Medical School at UT Health Houston
Klarissa A. Saldivar, Laredo, SCMSS, UT Medical Branch
Nathalie Scherer, Fort Worth, SCMSS, TCU and UNTHSC School of Medicine
Whitney Leigh Stuard, Dallas, SCMSS, UT Southwestern Medical Center
Charlie Thai, San Antonio, SCMSS, UIW School of Osteopathic Medicine
Sonia Wadekar, Harlingen, SCMSS, UTRGV School of Medicine
Abdul Majeed Abid, MD, Galveston, SCRFS
Jennifer N. Fan, MD, MPH, Temple, SCRFS
Amanda C. Herrmann, MD, Bellaire, SCRFS
Jerome Jeevarajan, MD, Friendswood, SCRFS
Pruthali Kulkarni, DO, Katy, SCRFS
Matthew Ryan McGlennon, DO, Round Rock, SCRFS
Gates B. Colbert, MD, Richardson, SCYPS
Sara Suzanne Dyrstad, MD, Amarillo, SCYPS
Jennifer G. Liedtke, MD, Sweetwater, SCYPS
Samuel E. Mathis, MD, Galveston, SCYPS
Jacob B. Stetler, DO, Fort Worth, SCYPS

PAST PRESIDENTS PRESENT:
Bohn D. Allen, Arlington; Charles W. Bailey, Austin; Susan Rudd Bailey, Fort Worth; Stephen L. Brotherton, Fort Worth; Carlos Javier Cardenas, Edinburg; Douglas W. Curran, Athens; A. Tomas Garcia, Houston; Austin Irvin King, Abilene; Mark J. Kubala, Beaumont; J. James Rohack, Kemah; Michael E. Speer, Houston; David Vanderpool, Dallas; Josie R. Williams, Paris

Members Present (Quorum: 278)

446 (436 voting + 10 nonvoting)
At an unprecedented live virtual meeting Saturday, Sept. 12, 2020, the Texas Medical Association House of Delegates took action on a variety of initiatives important to the health of all Texans, including adopting policy to address health care disparities specifically related to cancer; laying the foundation for the creation of an LGBTQ Health Section; and setting principles for community-based accountable care organizations (ACOs).

More than 500 people – including 400 voting delegates – participated in Saturday’s meeting, which was conducted live online from the TMA headquarters in Austin.

After 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. The disaster board postponed the 2020 House of Delegates meeting, originally scheduled for May. Due to this cancellation, the disaster board in May acted on behalf of the house to conduct elections for uncontested positions, after postponing contested races.

The house officially convened Aug. 29 in a prerecorded opening session, where the disaster board handed back authority of the house to the TMA speakers and delegates. Ceremonial aspects of the meeting, including the national anthem, pledge of allegiance, and invocation, occurred in the opening session, and the TMA speakers explained the order of business and altered election and voting process for contested races.

TMA leaders then conducted a live, limited final session Sept. 12, focusing on “essential” house business. Many agenda items were tabled until the 2021 annual meeting, scheduled for May 2021 in Austin.

Using technology that allowed for remote voting, delegates overwhelmingly approved recommendations from a combined reference committee focusing on four subject areas: science and public health, financial and organizational affairs, socioeconomics, and medical education and health care quality. The committee, over several weeks, was responsible for collecting written physician testimony, and studying and evaluating more than 100 proposed reports and resolutions on a range of health care topics affecting Texas patients and physicians.

Among the measures delegates adopted were directives for TMA to:

- Tackle racial, ethnic, socioeconomic, and geographic health disparities regarding cancer, and take initial steps to address health care disparities overall;
- Develop policy on electric scooters similar to TMA policy on bicycle helmets, and support measures to reduce speeds and therefore the impact of collisions;
• Create a TMA LGBTQ Health Section (an amendment that allows for the section’s representation in the TMA House of Delegates will need to be approved at the 2021 annual meeting);
• Support principles for community-based ACOs that include engaging local physician leaders in the design of the ACO model; establishing competitive, reasonable, and fair payment rates for physicians; and building and maintaining robust networks;
• Advocate for legislation and regulations to lessen the negative impacts on patients of prior authorization requirements by state-regulated health plans;
• Redouble efforts to reduce the rate of uninsured in Texas during the 2021 legislative session; support elimination of Medicare physician payment cuts because of sequestration; and support increasing funding for Prospective Payment System rural hospitals under Medicare;
• Push for electronic health record (EHR) vendors to be required to deliver a patient’s complete medical record in a format that can be integrated into a new EHR, at no cost to the physician;
• Oppose national proposals to divert Medicare funding for graduate medical education from physicians to training programs for midlevel practitioners;
• Call for a minimum of $1 million in state funding in the 2022-23 state budget to launch a rural training track program; and
• Support federal legislation that would allow physicians to be eligible for interest-free deferment on student loans while they are in residency training.

In addition, retired Paris gastroenterologist and internist Josie R. Williams, MD – a TMA past president – was awarded TMA’s 2020 Distinguished Service Award.

Issues considered by the house, grouped by subject area, are as follows:

Reference Committee on Financial and Organizational Affairs

BOT Report 9 2020. Recommendation that TMA adopt the Online Communications Policy for Texas Medical Association Physician Leaders. **Adopted as amended:**

*This policy provides guidance for the Board of Trustees, Board of Councilors, and all other Texas Medical Association board, council and committee members (“TMA physician leaders”) when participating in online communications. Online communications should be broadly understood for purposes of this policy to include personal blogs, wikis, Twitter, microblogs, message boards, chat rooms, electronic newsletters, online forums, social networking sites, medical practice websites, texts, and any other forms of online communications.*

**Be Conscious of Public Image**

• TMA physician leaders should be aware of the effect their actions may have on their image, as well as the image of TMA and Texas physicians in general. Remember, the information posted or published on online communications may be public information and remains there indefinitely.

• TMA physician leaders who create or maintain their own online communications, including their medical practice websites, that reference their leadership role with TMA should include clear disclaimers that the views expressed by the author on his or her social media site or medical practice website are those of the author’s.

• Sometimes social media content generates press and media attention or legal questions involving TMA. TMA physician leaders should refer these inquiries to the
TMA Division of Communications.

Uphold Confidentiality

TMA physician leaders should not publish, post, or release any TMA information that is considered confidential or not public, such as sensitive company information. Divulging information about TMA’s internal operations and legal matters is prohibited. For additional information, please consult TMA’s confidentiality and disclosure policies before publishing information related to TMA online. If there are questions on what is considered confidential, please check with the TMA vice president and general counsel.

Be Respectful of Others

- TMA physician leaders should be aware that their conduct in online communications may be observed by other Texas physicians, TMA employees, and third parties. TMA physician leaders should use their best judgment and refrain from posting material that is inappropriate or harmful to TMA, TMA’s employees, and TMA’s vendors or suppliers.

- Although not an exclusive list, disrespectful conduct includes posting commentary, content, or images on social media that are defamatory, pornographic, proprietary, harassing, lewd, or libelous, or that create a hostile work environment.

- Any TMA physician leader who personally experiences or witnesses abuse of online communications under this policy should report the situation to TMA’s executive vice president immediately. Pursuant to TMA’s policy, TMA prohibits any form of retaliation for reporting abuse of online communications under this policy.


BOC Report 2 2020. Recommendation that the TMA House of Delegates elect Carlos Hamilton Jr., MD; John D. Oswalt, MD; J. James Rohack, MD; and Nick Nipank Shroff, MD to emeritus membership in TMA. Adopted.

BOC Report 3 2020. Recommendation that the TMA House of Delegates elect Roberto J. Bayardo, MD; Spencer R. Berthelsen, MD; Herbert L. Dupont, MD; and Teodoro A. Saieh, MD to honorary membership in TMA. Adopted.


WIM Report 1 2020. Recommendations that TMA: (1) adopt the section’s operating procedures; and (2) approve the section’s name change from “Women in Medicine Section” to “Women Physicians Section.” Amend the section’s operating procedures to reflect this change, and amend Chapter 3, House of Delegates, Section 3.25, 3.255 Women in Medicine Section, to reflect this change. Adopted.

C-SPH Report 1 2020. Recommendations that TMA: (1) create the Laurance N. Nickey, MD, Lifetime Achievement Award; and (2) the recipient be selected by the Council on Science and Public Health and be awarded every three to five years. Adopted.

C-CB Report 2 2020. Recommendations that TMA: (1) amend Chapter 1, Membership, Section 1.40, Membership in Contiguous Society, and renumber the listing accordingly; (2) amend Chapter 5, Board of Councilors, Section 5.20, Duties, Subsection 5.218, Determine Inactive Societies, and renumber the listing accordingly; (3) amend Chapter 12, County Societies, Sections 12.11, Activity Status of Society, and 12.40, Structure, and renumber the listing accordingly; (4) amend Chapter 1, Membership, Section 1.10, Admission, and renumber the listing accordingly; (5) amend Chapter 5, Board of Councilors, Section 5.40, Duties, and renumber the listing accordingly; and (6) amend Chapter 12, County Societies, Section 12.42, Officers, and renumber the listing accordingly. **Adopted.**

C-CB Report 3 2020. Recommendation that TMA amend the TMA Bylaws Chapter 3, House of Delegates, Section 3.20, Composition, Subsection 3.25, Sections, to establish an LGBTQ Health Section, and renumber the listing accordingly. **Adopted.**

C-CB Report 4 2020. Recommendation that TMA amend the TMA Bylaws Chapter 3, House of Delegates, Section 3.20, Composition, Subsection 3.25, Sections, to establish guidelines governing the establishment and maintenance of sections within the House of Delegates, and renumber the subsection accordingly. **Adopted.**

C-CB Report 5 2020. Recommendation that TMA amend Chapter 10, Committees, Section 10.60, Standing Committees of Boards, Subsection 10.612, Committee on Membership, to expand the Committee on Membership’s section representation, and renumber the subsection accordingly. **Adopted.**


BOT Report 10 2020. Recommendation that TMA not adopt Resolution 106-A-19, Establish a Coalition of Medical Societies to Protect Competition and Sustainability in the Health Insurance Marketplace. **Tabled to 2021.**

BOT Report 12 2020. Recommendations that TMA: (1) pilot a forum for physicians in employed settings, combining virtual communications with in-person programming at TexMed 2021; and (2) approve the evaluation and implementation of priorities and services, with assignment to appropriate councils, committees, and staff units. **Tabled to 2021.**


CM-M Report 2 2020. Recommendations that TMA: (1) create a new telemedicine membership category at one half of TMA full active dues; and (2) if approved, that the TMA Board of Trustees direct the Council on Constitution and Bylaws to recommend the necessary bylaw amendments. **Tabled to 2021.**

Resolution 101 2020. Resolution that: (1) TMA take steps to create a section dedicated to help meet the unique needs of physicians in private practice who reside in this state; and (2) the Texas Delegation to the American Medical Association take a similar resolution to the AMA House of Delegates for consideration. **Tabled to 2021.**

Resolution 102 2020. Resolution that: (1) TMA express its gratitude for the Ambassador Program; and (2) TMA allocate additional resources so the Ambassador Program is able to add at least two new continuing medical education topics each year to its list of presentations that are currently available. **Tabled to 2021.**
Resolution 103 2020. Resolution that the Texas Delegation to our AMA introduce a resolution to the AMA House of Delegates that calls upon AMA to (1) avoid giving general, nonspecific public endorsements of large, omnibus national health care legislation; (2) instead, develop and adopt a more precise endorsement mechanism that can better inform the public of the specific provisions within the proposed legislation, the strength of any underlying evidence, and the AMA position of support or opposition; and (3) maintain an emphasis on the most problematic elements of a bill, present or omitted, that AMA finds to be likely detrimental to the quality or sustainability of our health care system, freedom of choice and practice. **Tabled to 2021.**

Resolution 104 2020. Resolution that: (1) TMA, in its publications, policies, and conferences, shall cease using the term “provider” to describe physicians, substituting “physician,” “resident,” “fellow” or other term that recognizes the education, training, and experience of its members; (2) TMA encourage physicians, its local components, and the media to use the term “physician” instead of “provider” when describing physicians; and (3) TMA refer the process of creating a formal position paper for the use of the term “provider” to the most suited committee or council. **Referred to for action with report back.**

Resolution 105 2020. Resolution that: (1) TMA study the proportionate representation of special interest groups such as LGBTQ+ and underrepresented minorities among active osteopathic and allopathic TMA physician members; and (2) TMA create mechanisms like advisory committees or special interest subcommittees that increase interest and involvement in organized medicine among individuals who fall into special interest group strata on both a state and a county medical society level. **Tabled to 2021.**

Resolution 106 2020. Resolution that: (1) TMA amend policy 9.6.2 Gifts to Physicians from Industry; and (2) TMA inform physician members of appropriate social media marketing practices related to this amendment through the relevant member channels. **Tabled to 2021.**

Resolution 107 2020. Resolution that: (1) TMA advocate for the adoption by health care facilities of policies that protect the rights of immigrants when seeking care, such as designation of private areas of the clinic, and discourage routine collection of patient immigration status information; and (2) TMA support the education of physicians, health care providers, and patients about their rights when seeking medical care, such as their right to refuse to answer questions from immigration agents and to insist that their lawyer be present if they are questioned. **Tabled to 2021.**

Resolution 108 2020. Resolution that: (1) TMA, in collaboration with other medical societies, create and support a permanent, physician-led, independently funded public outreach entity to use multiple media platforms (conventional, online, and social media) to engage the public, share information, promote an educated dialogue, advocate for evidenced-based, incremental, and sustainable health care policy and defend the integrity of the medical profession; and (2) the Texas Delegation to the American Medical Association carry a similar resolution to the AMA House of Delegates which calls upon the AMA to support the aforementioned permanent, physician-led, independently funded public outreach entity. **Tabled to 2021.**

**Reference Committee on Medical Education and Health Care Quality**

C-ME Report 1 2020. Recommendation that policy 185.023 be amended to support TMA advocacy for a minimum of $1 million in state funding in the 2022-23 state budget to allow the state’s Rural Resident Physician Grant Program to become operational. **Adopted.**

C-ME Report 2 2020. Recommendations that: (1) polices 185.005, 200.036, 205.019, and 295.012 be retained; and (2) policy 200.028 be retained as amended. **Adopted.**
C-ME Report 3 2020. Recommendations that: (1) TMA adopt new policy opposing diversion of Medicare funding for graduate medical education to training programs for midlevel practitioners; and (2) the Texas Delegation to the American Medical Association take a resolution to the AMA House of Delegates to adopt policy that opposes the diversion of Medicare funding for graduate medical education from physicians to training programs for advanced practice registered nurses and physician assistants. **Adopted as amended:**

**Opposition to Diversion of Medicare Funding for Graduate Medical Education to Training Programs for Midlevel Practitioners**

The Texas Medical Association (1) strongly opposes reallocating Medicare funding for physician training programs to training programs for advanced practice registered nurses and physician assistants; (2) strongly opposes caps on the funding of graduate medical education programs through Medicare, as mandated by the federal Balanced Budget Amendment of 1997; and (3) vigorously advocates for the Texas congressional delegation to take action to lift the Medicare funding caps for the training of physicians in Texas.

CM-PDHCA Report 1 2020. Recommendation that TMA adopt new policy supporting for interest-free deferment of education loans for residents in training. **Adopted.**

CM-PDHCA Report 2 2020. Recommendations that: (1) polices 205.001 and 205.003 be retained; and (2) policies 205.031 and 205.035 be deleted. **Adopted.**


C-ME Report 4 2020. Recommendation that policy 200.047, Clinical Training Resources for Texas Medical Students, be amended. **Adopted.**

C-ME Report 5 2020. Recommendation that policy 320.007, Town Gown Medical School Funding, be amended. **Adopted.**


**Promoting Education of Sexual Orientation and Gender Identity Health Issues in Academic Health Centers.** To reduce health disparities and enhance access to care for diverse patient populations, TMA supports the integration of education on sexual orientation and gender identity health issues in Texas medical education, graduate medical education, and continuing medical education curricula. This includes support for: discrete evidence-based educational components; and the inclusion of appropriate references throughout the basic science, clinical care, and cultural competency curricula for medical education.


Resolution 201 2020. Resolution that (1) the TMA Council on Socioeconomics, TMA Committee on Health Information Technology, and TMA Council on Medical Education collaboratively study the effects of augmented intelligence (AI) on health care in Texas; and (2) TMA ensure this effort includes guidance on how physicians may be affected and how physicians may prepare for the challenges and the opportunities AI creates. **Tabled to 2021.**
Resolution 202 2020. Resolution that TMA encourage Texas medical schools to implement admissions policies that allow admission of DACA students, for as long as the DACA program is intact. **Tabled to 2021.**

Resolution 203 2020. Resolution that TMA advocate for and support the use of implicit bias training for perinatal physicians in order to improve maternal health outcomes. **Tabled to 2021.**

Resolution 204 2020. Resolution that: (1) TMA recognize and support the need for more geriatricians by providing medical students educational information concerning geriatrics and its opportunities to encourage them to become involved in geriatrics; and (2) TMA support the efforts of medical schools in fostering interest in geriatrics through interest groups and shadowing opportunities. **Tabled to 2021.**

Resolution 205 2020. Resolution that: (1) TMA encourage physicians to use Americans With Disabilities Act material concerning service animals in their inpatient and outpatient settings as a part of their patients’ therapeutic plans; and (2) TMA support the provision of resources in the community to individuals with service animals to inform them how their service animals can be part of a therapeutic plan to better treat their medical needs. **Tabled to 2021.**

Resolution 206 2020. Resolution that: (1) TMA support policy change as it relates to the Texas Medical Board licensure process, such that only current or active mental health conditions need be reported; and (2) TMA support policy and judicial decisions in line with the American Medical Association, such that physicians are not required to disclose previous treatment for mental health conditions but are evaluated solely on performance and current impairment. **Tabled to 2021.**

**Reference Committee on Science and Public Health**

C-SPH Report 2 2020. Recommendations that: (1) polices 55.032, 100.009, and 285.005 be retained; (2) policies 25.010, 95.021, 100.006, 165.006, and 215.020 be retained as amended; and (3) policies 25.002, 25.006, 215.018, and 260.026 be deleted. **Adopted.**

C-SPH Report 4 2020. Recommendations that in lieu of adopting Resolution 304-A-19 that: (1) TMA encourages statewide efforts to increase the general public’s food allergen awareness in all food service establishments, including dissemination of information on the list of major food allergens, the risk of an allergic reaction, methods to prevent cross-contamination in food preparation, and the signs and symptoms associated with anaphylaxis with instructions to call 911; and (2) TMA supports efforts to strengthen food service employee training provided by the Texas Department of State Health Services on food allergy awareness, and to include information on the list of major food allergens, methods to prevent cross-contamination in food preparation, and the signs and symptoms associated with anaphylaxis with instructions to call 911. **Adopted.**

CM-C Report 1 2020. Recommendations that: (1) TMA adopt new policy addressing cancer health disparities; and (2) TMA convene a cross-component workgroup to study and develop policy on disparities in health care. **Adopted.**

CM-C Report 2 2020. Recommendations that: (1) policy 50.009 be retained; (2) policies 50.002, 50.003 280.034, and 315.000 be retained as amended; and (3) policies 50.001 and 50.005 be deleted. **Adopted.**

CM-CAH Report 2 2020. Recommendations that: (1) policies 55.005, 55.016, 55.018, 55.019, 55.035, 135.017, and 260.084 be retained as amended; and (2) policies 55.002 and 260.064 be deleted. **Adopted.**

Adopted.

Joint Report 2 2020. Recommendations that: (1) TMA develop a policy for electronic scooters like TMA Policy 55.021 Bicycle Helmets; (2) TMA support the use of geofencing in cities where electric scooters are used to reduce speeds and therefore the impact of collisions; (3) TMA develop and support policy that prevents the use of electric scooters while under the influence of drugs or alcohol. Such policy should include holding electric scooter users to motor vehicle blood-alcohol-content standards, making e-scooter users eligible for a driving under the influence charge when applicable, and supporting state or city councils implementation of curfew hours by turning off scooters, for example, from midnight to 5 a.m. on weekends, to prevent riding while intoxicated; (4) TMA support the use of brightly colored, neon, or reflective materials on electric scooters to make them more visible to those operating motor vehicles in the vicinity; (5) TMA expand its opposition to the use of electronic handheld devices while operating a motor vehicle to include electric scooters. Electric scooters should build infrastructure compatible with using an electronic map hands-free if that is a consumer need; (6) TMA support regulating only one rider at a time on scooters to ensure riders can hold the handlebars; and (7) TMA support parking fines or impounding when riders block the sidewalk or other pedestrian routes with scooters. Adopted.

C-SPH Report 3 2020. Recommendations that: (1) TMA support and promote the Texas Medical Advisory Board process by increasing physician awareness and TMA member participation on the Medical Advisory Board to ensure adequate representation, and support potentially needed expansion of this important public service to Texas; (2) TMA promote physicians’ awareness of their ability to report their patients to law enforcement or the Department of Public Safety with concerns regarding their patient’s ability to safely drive or possess firearms; and (3) TMA promote a review of the funding of the Medical Advisory Board by the Texas Legislature to assess the potential for expanding the scope of this key public service. Tabled to 2021.

C-SPH Report 5 2020. Recommendations that: (1) TMA monitor and confer with the Texas Department of State Health Services as it convenes the new Food Allergy Ad Hoc Committee, as well as develop and share information for members on the role of this new ad hoc group; (2) TMA members be informed of opportunities to be engaged in, monitor, and contribute to the important work of the standing DSHS Stock Epinephrine Advisory Committee; (3) That TMA members be made aware of entities in their communities that may seek physician support in developing standing orders and providing prescriptions for unassigned auto-injectors in various settings; and (4) TMA develop communications for physicians on the expansion of access to unexpired auto-injectors in various public settings. Tabled to 2021.

Joint Report 3 2020. Recommendations that: (1) TMA support the joint statement by the Centers for Disease Control and Prevention and the Environmental Protection Agency (EPA), which defines bed bugs as a pest of significant public health importance and recognizes that bed bugs are a continuing problem for residents in the state of Texas; (2) TMA encourage the further development of effective and affordable pest treatment options and expanded access to current evidence-based options approved by EPA or other reputable entities; (3) TMA supports better public and physician education on bed bug identification, treatment, and threats to public health; (4) TMA supports additional research on bed bug incidence to the extent that is practical and feasible and in line with methods used for similar public health pests; and (5) TMA encourages municipal efforts to implement measures based on the published integrated pest management approaches and on other evidence-based examples for bed bug treatment practices. Tabled to 2021.

Resolution 301 2020. Resolution that: (1) TMA educate its members on the various aspects of e-cigarette use through ongoing CME and articles in Texas Medicine Today; (2) TMA advocate for legislation that bans the sale of flavored, mint, and menthol tobacco products including both e-cigarette products and
combustible products; (3) TMA advocate against social media companies using influencers to advertise electronic nicotine delivery systems; and (4) TMA advocate against the sale of e-cigarettes and their component products and accoutrements at retail clinics. Tabled to 2021.

Resolution 302 2020. Resolution that: (1) TMA urge the Texas Legislature to make laws to protect physicians from persecution in passing confidential information without personal liability to various governmental agencies; (2) TMA encourage physicians to make inquiry into patients’ well-being a matter of routine medical practice; and (3) TMA urges physician to document instances of alleged abuse or persecution in the patient’s medical records. Tabled to 2021.

Resolution 303 2020. Resolution that TMA study and make active recommendations for a safe harbor in Texas allowing certified entities that have nonfetal tissue and non-whole-organ human tissue waste from a consenting adult patient to use the tissue strictly for research purposes and clinical diagnostics. Tabled to 2021.

Resolution 304 2020. Resolution that: (1) TMA advocate for community physician access to provide medical care in both U.S. Customs and Border Protection and U.S. Immigration and Customs Enforcement immigrant detention facilities; and (2) TMA advocate for the right of community physicians to contact health care providers working in the immigrant detention facilities, in accordance with HIPAA, to ensure continuity of care for patients transferred to other health care facilities or released from custody. Tabled to 2021.

Resolution 305 2020. Resolution that: (1) TMA support integrating validated suicide prevention training programs into the curriculum of preclinical students in Texas medical schools in accordance with Association of American Medical Colleges interpersonal, intrapersonal, and science competences for medical students, and Liaison Committee on Medical Education and Commission on Osteopathic College Accreditation standards; and (2) TMA recognize the importance of studying suicide identification and prevention training programs in order to develop the most efficacious method of training for Texas students. Tabled to 2021.

Resolution 306 2020. Resolution that: (1) TMA support the production and distribution of educational materials regarding the importance of postmortem brain tissue donation for the purposes of medical research and education; (2) TMA encourage the inclusion of additional information and consent options for brain tissue donation for research purposes on appropriate donor documents; (3) TMA encourage all persons to consider consenting to brain and other tissue donation for research purposes; and (4) TMA encourage efforts to develop and improve logistical frameworks for the procurement and transit of postmortem tissue for research and educational purposes. Tabled to 2021.

Resolution 307 2020. Resolution that TMA support the need for local, county, and state governmental entities to decommission existing and not construct new wastewater treatment plants in or near flood plains and waterways. Tabled to 2021.

Resolution 308 2020. Resolution that TMA support the need for local, county, and state governmental entities to commit the necessary resources and responsibility to effectively eliminate recurrent flooding in Texas. Tabled to 2021.

Resolution 309 2020. Resolution that: (1) TMA educate its members, Texas and federal policymakers, and the public on the scientific evidence about the causes and the impact of climate change on the health of Texans, the seriousness of these threats, and nonpartisan evidence-based remedies; (2) TMA advocate for nonpartisan evidence-based remedies for climate change and include in its communications on budgetary priorities the future needs of state preparedness for the effects of climate change on human
health, such as increased ferocity of natural disasters and more frequent infectious disease outbreaks by vector-borne diseases and dangerous new viruses; and (3) the substance of the education and advocacy shall be managed through the established mechanisms of the TMA Council on Science and Public Health and the Council on Legislation. **Tabled to 2021.**

Resolution 310 2020. Resolution that TMA create policy using the following language: The Texas Medical Association supports and will advocate for removing the requirement that a Texas Medicaid beneficiary infected with hepatitis C virus have liver fibrosis before being eligible to receive direct-acting antiviral therapy. **Tabled to 2021.**

Resolution 311 2020. Resolution that: (1) TMA advocate for culturally informed mental health outreach and services to increase utilization by minority youths in schools, including advocating for an increase in the number of minority mental health professionals; (2) TMA advocate for school districts to incorporate best practices to reduce biases including those against minority students facing mental health and behavioral disorders; and (3) TMA advocate for increased data collection of mental health intervention outcomes among minority adolescents. **Tabled to 2021.**

Resolution 312 2020. Resolution that: (1) TMA shall investigate options, identify strategies, and support ongoing efforts to sustain the Texas Cardiac Arrest Registry to Enhance Survival (Texas-CARES) Program in order to collect data on out-of-hospital cardiac arrest (OHCA) incidence, 9-1-1 response, emergency medical services (EMS) treatment, and patient outcomes; (2) TMA work with state, regional, and local EMS organizations, universities, hospitals, public health entities, communities, and the Texas Legislature to support the Texas-CARES registry and quality improvement program in order to maximize survival after OHCA; (3) TMA work to ensure that the state of Texas shall own the data collected by the Texas CARES registry; (4) TMA support adding sudden cardiac arrest as a reportable condition in Texas; and (5) the Texas Delegation to the American Medical Association carry a similar resolution to the AMA House of Delegates for consideration. **Tabled to 2021.**

Resolution 313 2020. Resolution that: (1) TMA advocate for increased funding and capacity for in-patient psychiatric beds throughout Texas with a priority emphasis in areas that lack local access to mental health facilities; (2) TMA policy 215.019 Public Mental Health Care Funding be amended; and (3) TMA policy 55.033 Children’s Mental and Behavioral Health be amended. **Tabled to 2021.**

Resolution 314 2020. Resolution TMA that work with appropriate authorities at the Texas Department of State Health Services in reevaluating the requirement for platelets on site at all facilities providing maternal care with a designation of level of care II through IV and remove this onerous requirement. **Tabled to 2021.**

Resolution 315 2020. Resolution that: (1) TMA oppose U.S. Immigration and Customs Enforcement from operating in hospitals; (2) TMA advocate for state legislation that designates hospitals as sensitive locations where U.S. Immigration and Customs Enforcement cannot operate; and (3) TMA encourage hospitals to publicize their status as sensitive locations to interested parties. **Tabled to 2021.**

Resolution 316 2020. Resolution that: (1) TMA support concurrent prescribing (coprescription) of naloxone (or other opioid antagonists) with prescriptions and refills of opioids in alignment with the Centers for Disease Control and Prevention naloxone coprescription guidelines; (2) TMA support the implementation of an automatic opioid-opioid antagonist coprescription risk index support tool within electronic health record (EHR) management systems; and (3) the TMA Committee on Health Information Technology research and recommend pragmatic implementation of automatic opioid-opioid antagonist coprescription suggestions within HER management systems to EHR vendors. **Tabled to 2021.**
Resolution 317 2020. Resolution that: (1) TMA develop model legislation extending employee lactation accommodation rights to employees of private companies and companies of fewer than 50 staff members; (2) TMA amend policy 140.008; (3) TMA develop model legislation extending employee lactation accommodation rights to employees of private companies and companies of fewer than 50 staff members. Tabled to 2021.

Resolution 318 2020. Resolution that: (1) TMA encourage its members to engage with their local 27 communities and local school boards to develop comprehensive sexual education programs for 28 adolescents that do not teach abstinence as the only effective practice to reduce the risk of unintended 29 pregnancy or sexually transmitted infections; and (2) TMA amend policy 55.016, Sexuality Education. Tabled to 2021.

Resolution 319 2020. Resolution that: (1) TMA adopt new policy to support an opt-out organ, eye, and tissue donation system in Texas; and (2) TMA amend Policy 280.010 Physician Role in Promoting Organ and Tissue Donation and Transplantation. Tabled to 2021.

Resolution 320 2020. Resolution that: (1) TMA encourage implementation of postpartum depression screenings as routine protocol for perinatal and postnatal women in health care settings; and (2) TMA promote education regarding postpartum depression screenings to primary care physicians who are in contact with perinatal and postpartum women. Tabled to 2021.

Resolution 321 2020. Resolution that: (1) TMA adopt and recommend energy conservation guidelines for Texas medical practices; (2) TMA partner with the My Green Doctor initiative and promote its guidelines to physicians and health care providers in Texas; and (3) TMA promote education for green practices for physicians and health care providers in Texas. Tabled to 2021.

Resolution 322 2020. Resolution that: (1) TMA support the use of low titer group O whole blood as the optimal blood product in hemorrhagic shock for use in the prehospital setting; and (2) TMA support the use of low titer group O whole blood as the optimal blood product in hemorrhagic shock for use in the hospital setting. Tabled to 2021.

Resolution 323 2020. Resolution that TMA concur with the scientific consensus that the Earth is undergoing adverse global climate change with anthropologic contributions, and acknowledge that climate change will increasingly affect public health, with disproportionate impacts on vulnerable populations such as the children, elderly, and people of low socioeconomic status. Tabled to 2021.

Resolution 324 2020. Resolution that TMA advocate for mandatory waiting periods following the purchase of firearms to reduce firearm-related injuries and deaths. Tabled to 2021.

Resolution 325 2020. Resolution that: (1) TMA recognize that inadequate patient health literacy is a barrier to effective medical diagnosis and treatment; (2) TMA recommend the adoption of a health literacy policy at all health care institutions that should aim to improve physician and other health care professional communication and educational approaches to patient visits; and (3) TMA encourage the allocation of public and private funds for research on health literacy as well as the development of low-cost community and health system resources focused on improving health literacy. Tabled to 2021.

Resolution 326 2020. Resolution that TMA support collaboration of qualified stakeholders to develop standard practice guidelines for diagnosis and treatment of childhood iron deficiency anemia that empower primary care physicians to exhaust treatment and care options within their scope before issuing subspecialty referrals. Tabled to 2021.
Resolution 327 2020. Resolution that: (1) TMA supports increased funding for long-acting reversible contraceptives and other prescriptive contraceptives for women who do not qualify for services under the Healthy Texas Women Program and Texas Family Planning Program and who do not have reliable access to Title X funded clinics; (2) TMA supports and advocates for the reduction of the age at which a minor can access prescriptive contraceptives, including long acting reversible contraceptives, without parental consent from either a) 18 to 17, to match the Texas age of consent, or b) from 18 to 15, to accommodate the entire age group of adolescents who are at increased risk of teenage pregnancy within the state of Texas; and (3) TMA advocates for the expansion of the Texas “mature minor” doctrine described in TMA Policy 55.004 Adolescent Sexual Activity to include access to contraceptive options, such as prescriptive birth control methods (i.e. oral contraceptives, shots, and intrauterine devices), and sexual health services (i.e. pap smears and treatment for urinary tract infections) without parental consent. Tabled to 2021.

Resolution 328 2020. Resolution that: (1) TMA support lowering the legal age at which a minor can access contraceptives without a guardian or parental consent to at least the age of 17; and (2) TMA continue to support initiatives, programs, and funding that eliminate barriers to adolescents accessing reproductive health care. Tabled to 2021.

Resolution 329 2020. Resolution that: (1) TMA support legislation increasing vaccine availability in immigrant holding facilities; and (2) TMA acknowledge the importance vaccinations for the health of immigrants in holding facilities on the border, which can also directly affect the health of Texas citizens. Referred for action with report back.

Resolution 330 2020. Resolution that: (1) TMA support existing municipal, county, and state programs that allow undocumented immigrants with end-stage renal disease (ESRD) to receive regularly scheduled dialysis; (2) TMA support universal access to nonemergency, regularly scheduled dialysis as a humane and cost-effective standard of care for all individuals with ESRD, regardless of immigration status, for whom dialysis is appropriately indicated; and (3) TMA collaborate with relevant stakeholders to identify and implement ways to achieve regularly scheduled dialysis as a standard of care for all individuals with ESRD in Texas. Tabled to 2021.

Resolution 331 2020. Resolution that TMA amend policy 55.021 Bicycle Helmets to encourage physicians to be informed about the safety of helmet use for elementary school children cyclists, promote awareness, and share with local school health and safety advisory committees evidence-based, best practices regarding helmet safety education for schoolchildren. Referred for action with report back.

Reference Committee on Socioeconomics

BOT Report 11 2020. Recommendations that: (1) TMA adopt Principles for Community-Based Accountable Care Organizations; and (2) TMA actively promote use of a community-based accountable care organization(s) as the foundation of any future Medicaid 1115 waiver. Adopted.

C-HSO Report 2 2020. Recommendations that: (1) policies 85.012, 20.005, and 260.001 be retained; and (2) policy 115.010 be retained as amended. Adopted.


CM-RH Report 1 2020. Recommendations that: (1) TMA reaffirm support for existing TMA policy 190.032 Medicaid Coverage and Reform and redouble its efforts to reduce Texas’ rate of uninsured
during the 2021 legislative session; (2) TMA highly prioritize replenishing funding for the State Physician Education Loan Repayment Program, as 2018-19 budget cuts to this program prevent an estimated 94 physicians from receiving loan repayment funding each year and prevent many underserved communities from benefiting from increased access to physician services; (3) TMA make a high priority adding $1 million to the state budget for 2022-23 to start the Rural Resident Physician Grant Program, HB 1065; (4) TMA support step-down hospital formation by expanding the bed capacity and service requirements used to qualify a hospital for Medicaid and Medicare payments; (5) TMA support elimination of the Medicare physician payment reductions because of sequestration; (6) TMA support elimination of the Medicare critical access hospital 96-hour condition of payment regulation; (7) TMA support expansion of Medicare critical access hospital (CAH) designation requirements, increase funding for CAHs, and/or study why CAH designation doesn’t always save rural hospitals; and (8) TMA support increasing funding for Prospective Payment System rural hospitals under Medicare. **Adopted.**

CM-HIT Report 1 2020. Recommendation that the Texas Delegation to the American Medical Association take a resolution to AMA formally requesting AMA assistance with model contract language and regulatory relief through electronic health record (EHR) vendor certification that ensures EHR vendors are contractually required to deliver the patient’s complete medical record in a discrete, industry-standardized, nonproprietary format that can be imported into the new EHR at no cost to the physicians. **Adopted.**

CM-HIT Report 2 2020. Recommendation that policy 155.009 be retained as amended. **Adopted.**

BOT Report 13 2020. Recommendation that TMA advocate for significant legislative and/or regulatory reforms to lessen (1) the negative impact of state-regulated health plan prior authorization requirements on patients and (2) the burden of state-regulated health plan prior authorization requirements on physician practices. **Adopted.**

C-SE Report 1 2020. Recommendations that: (1) TMA adopt new policy opposing revisions to the federal definition of public charge that prevent legal immigrants or their children from using local, state or national health, nutrition, and housing services, including Medicaid or the Children’s Health Insurance Program; (2) TMA continue to advocate that the new federal rules be rescinded to protect the health of all Texans; and (3) TMA develop resources to help physicians accurately and concisely convey to their patients what the federal rules relating to public charge do and do not say. **Tabled to 2021.**

CM-PPA Report 3 2020. Recommendation that TMA seek legislation that would provide that: (1) should an administrative law judge find that the Texas Medical Board (TMB) failed to meet its burden of proof on charges that served as the basis for a temporary suspension or restriction of a physician’s license, TMB shall overturn and vacate the temporary suspension or restriction as soon as practicable and dismiss the case; (2) the effect of an overturned and vacated temporary suspension or restriction, unless specifically appealed by TMB to district court, shall be that the suspension or restriction never happened and never should have happened; and (3) any mention of charges against a physician related to the temporary suspension or restriction shall be removed from the physician’s TMB profile, any related report to the National Practitioner Data Bank voided, and the case dismissed, unless and until a court of law reverses the administrative law judge’s findings of facts and conclusion of law. **Tabled to 2021.**

Resolution 401 2020. Recommendation that: (1) TMA for legislation requiring commercial insurance carriers to provide accurate information regarding the patient’s cost-sharing liability and the insurance plan’s liability when a medical office or facility provides the diagnosis codes and Current Procedural Terminology codes via phone or the internet; (2) TMA advocate for legislation requiring commercial insurance carriers to provide updated information at the time of insurance eligibility verification regarding factors that may result in the claim being denied (e.g. the insurance carrier is waiting for the primary
policyholder to verify that he or she does not have other health insurance coverage); (3) TMA advocate for legislation requiring commercial insurance carriers to respond to telephone inquiries regarding the patient’s cost-sharing liability by providing accurate information both verbally and via a fax confirmation; (4) TMA advocate for legislation penalizing commercial insurance carriers (via fines and the publication of statistics showing the number of complaints regarding noncompliance by each insurance carrier) for instances where the above information is inaccurate or not provided in a timely manner; and (5) the Texas Delegation to the American Medical Association carry a similar resolution to the AMA House of Delegates. Tabled to 2021.

Resolution 402 2020. Resolution that TMA work with state officials to determine the number of Level I and Level II trauma centers necessary to support communities of various sizes throughout Texas and to provide necessary funding to make Level I and Level II trauma centers viable with adequate funding for all other service lines. Tabled to 2021.

Resolution 403 2020. Resolution that: (1) TMA oppose the imposition of service and use taxes on processes that are not actually part of delivering a medical service; and (2) TMA work with the Texas Comptroller of Public Accounts and state legislators to resolve and clarify that medical billing, including outsourced billing services, is not the adjudication or practice of insurance, and thus should not be subject to insurance-related sales taxes. Tabled to 2021.

Resolution 404 2020. Resolution that: (1) TMA adopt as policy that individual physicians should be paid the contracted rate while awaiting approval of their credentials by a health plan; and (2) TMA advocate for legislation that individual physicians be paid by health plans for their services while they are awaiting formal approval of their credentials. Tabled to 2021.

Resolution 405 2020. Resolution that: (1) TMA adopt as policy that physicians should not be required to refund the contracted rate should credentialing be denied by a health plan; and (2) TMA advocate to amend, by changing “may recover” to “may not cover,” Texas Insurance Code, Title 8, Health Insurance and Other Health Coverages, Subtitle F. Physicians and Health Care Providers, Chapter 1452 Physician and Provider Credentials, Sect. 1452.106 Effect of Failure to Meet Credentialing Requirements, to state that “the managed care plan issuer may not recover from the applicant physician or the physician’s medical group an amount equal to the difference between payments for in-network benefits and out-of-network benefits.” Tabled to 2021.

Resolution 406 2020. Resolution that TMA work with an established and credible human resources or placement firm to develop, implement, and publish a physicians’ salary survey available to TMA members only that takes into account a variety of factors that affect salary including, but not limited to, specialty, demographics, practice type and size, geographic location, and different types of contractual payment arrangements. Tabled to 2021.

Resolution 407 2020. Resolution that TMA adopt policy that payers – insurance companies and managed care companies, including companies managing governmental insurance plans – must compensate physicians for the time physicians and their staff spend on services outside of direct patient care (noncare services) such as authorization and preauthorization for coverage and payment for prescriptions, laboratory tests, radiology tests, procedures, surgeries, hospitalizations, and physician visits, as well gathering, compiling, and submitting medical records and data. Such compensation shall be promptly paid in full by payers to physicians at a level commensurate with the education, training, and expertise of the physician and at a rate comparable to that of the most highly trained professionals. The physician shall bill the payers for time spent by the physician and his or her staff in performing noncare services including, but is not limited to, time spent filling out forms, reviewing the patient’s medical record, gathering patient-related data, making telephone calls (including time spent negotiating “phone trees” and
hold time), documenting in the patient’s medical record, communicating with the patient, altering treatment plans (such as changing medications to comply with formularies), printing, copying, and faxing. Upon receiving such a bill, the payers shall pay the physician promptly, with significant interest penalties assessed for delay in payment. Because noncare services benefit the payers, compensation owed to physicians for these services should not be billable to patients. **Tabled to 2021.**

Resolution 408 2020. Resolution that: (1) TMA create policy that health plans in a binding contract with a physician must apply the same level of benefits concerning patient responsibility (copay, coinsurance) regardless of the contracted physician or provider rendering the service; and (2) TMA take this issue to the state legislature for potential statutory action; and (3) the Texas Delegation to the American Medical Association carry a similar resolution to the AMA House of Delegates for policy development and legislative action. **Tabled to 2021.**

Resolution 409 2020. Resolution that TMA advocate for legislative changes to the Texas Education Code as described in TMA Policy 55.056 requiring that athletic preparticipation physical examinations for school-age children be conducted only by licensed allopathic or osteopathic physicians, or appropriately supervised physician assistants or advanced practice nurses licensed in Texas. **Tabled to 2021.**

Resolution 410 2020. Resolution that: (1) TMA urge physicians to bring their concerns regarding decisions made by physicians working for insurance companies to the attention of the Texas Medical Board and Texas Department of Insurance, as these decisions affect patient outcome, and that TMA create a clearinghouse of all complaints against insurance companies and insurance doctors and aggregate this data; and (2) the Texas Delegation to the American Medical Association take this resolution to the AMA House of Delegates, urge the AMA House of Delegates to adopt similar policy, and urge the AMA Council on Ethical and Judicial Affairs to devise ethical opinions similar to the TMA Board of Councilors’ opinions on medical necessity determination and utilization review. **Tabled to 2021.**

Resolution 411 2020. Resolution that TMA work to limit the use of prior authorizations to only treatments not supported by the medical literature. **Referred for action with report back.**

Resolution 412 2020. Resolution that: (1) TMA urge our legislators to review and make transparent the “fail-first” policy of step-edit therapy and study how it affects patient outcomes; and (2) TMA ask the American Medical Association to review the ethical implication of step-edit therapy and make further recommendations on its use. **Tabled to 2021.**

Resolution 413 2020. Resolution that TMA support limiting the copayments insured patients pay 38 per month for prescribed insulin. **Tabled to 2021.**

Resolution 414 2020. Resolution that TMA will work with relevant stakeholders to support coverage of and payment for postpartum maternal health care for at least 12 months postpartum under the newborn child’s health insurance plan, including Children’s Medicaid and Children’s Health Insurance Program plans for women who are otherwise uninsured or ineligible for Medicaid. **Tabled to 2021.**

Resolution 415 2020. Resolution that: (1) TMA amend the wording of TMA Policy 265.028 to support inclusion of a patient’s biological sex; current gender identity; sexual orientation; preferred gender pronoun(s); preferred name; and clinically relevant, sex-specific anatomy in medical documentation and related forms, including in electronic health records, in a culturally sensitive and voluntary manner; (2) TMA amend the wording for TMA Policy 265.028 to advocate for the incorporation of recommended best practices of LGBTQ+ friendly and gender-neutral medical documentation into electronic health records and other health information technology products at no additional cost to physicians; and (3) TMA, with input from the TMA LGBTQ+ Health Workgroup and appropriate medical and community-
based organizations, promote among our membership these recommendations pertaining to medical
documentation and related forms, including in electronic health records. **Tabled to 2021.**

Resolution 416 2020. Resolution that: (1) TMA recognize that the appropriate forum for medical liability
suits against physicians is the state in which care is rendered; and (2) The Texas Delegation to the AMA
take this resolution with the added language below to AMA: That our AMA recognize that access to care
for patients seen by out-of-state physicians may be diminished when there is uncertainty about the
appropriate legal forum for medical liability claims. **Referral for action with report back.**

Resolution 417 2020. Resolution that: (1) TMA advocate for health insurance companies to adopt cash
based incentive programs like the Medicare Incentives for Prevention of Chronic Disease program to
promote usage of preventive care services; and (2) TMA support further research on health care initiatives
that can increase usage of preventive care services by individuals. **Tabled to 2021.**

Resolution 418 2020. Resolution that: (1) TMA promote awareness and education for physicians,
legislators, and the public on the importance of adequate parental leave, especially paid leave, in ensuring
good maternal and infant health outcomes and promoting the health and well-being of the family; (2)
TMA support federal, state, local, and private parental leave policies that provide adequate time to give
birth, recover, and breastfeed, and allow for parental bonding following the birth or adoption of a child;
(3) TMA support policies that provide at least 12 weeks of paid parental leave following the birth or
adoption of a child; (4) TMA support that paid parental leave policies incorporate funding mechanisms
that do not put an undue burden on solo or small business owners; and (5) TMA evaluate how internal
policies for employees should be updated to provide paid parental leave following the birth or adoption of
a child. **Tabled to 2021.**

Resolution 419 2020. Resolution that: (1) TMA advocate for the inclusion of Medicaid expansion
initiatives on a statewide ballot to allow eligible Texas voters to decide; and (2) TMA encourage a
reopened dialogue on the topic of Medicaid expansion as an avenue to reduce the high rate of uninsured
individuals in Texas. **Referral for action with report back.**

Resolution 420 2020. Resolution that: (1) TMA urge insurance companies to cease and desist from
requiring physicians to spend time – in addition to their extensive professional training – in training in
each companies’ requirements for patient care; (2) TMA urge the Texas Medical Board to condemn such
practice by insurance companies as beyond the companies’ purview of physician training responsibilities;
(3) TMA urge the Texas insurance commissioner to investigate the appropriateness of insurance
companies imposing on physicians the onerous and unnecessary burden of web-based or otherwise
administered training; and (4) TMA urge the Texas Legislature to take adequate measures to prevent
insurance companies from interfering with the education of physicians by engaging in the wasteful
exercise of requiring physicians to train in the companies’ preferences, objectives, and/or goals. **Tabled
to 2021.**

Resolution 421 2020. Resolution that: (1) TMA, in collaboration with other medical societies, create and
support a permanent, physician-led, independently funded “center” for the balanced, nonpartisan study of
health care reform. This entity will maintain and advertise for an online platform to provide a balanced
critique upon the strengths and limitations of general and specific policy proposals, health care reports,
and national health care systems for the benefit of the general public; and (2) the Texas Delegation to the
American Medical Association carry a similar resolution to the AMA House of Delegates, calling upon
AMA to support the aforementioned permanent, physician-led, independently funded center for balanced,
nonpartisan study of health care reform. **Tabled to 2021.**
Resolution 422 2020. Resolution that: (1) TMA educate physicians and disseminate to them information on basic tenets of proper physician oversight and supervision of midlevel practitioners and encourage physicians to bring to the attention of the Texas Medical Board physicians who are not providing supervision as required per the delegation of duties; and (2) the Texas Delegation to the American Medical Association take this resolution to the AMA House of Delegates, urging it to develop national guidelines for proper oversight and collaboration of midlevel practitioners by a physician. **Tabled to 2021.**

Resolution 423 2020. Resolution that: (1) TMA recognize and encourage mobile-first designs within our health care systems IOT (internet of things) vendors; (2) TMA encourage a mobile-first design goal among hospital administrations within their own local scope of health care systems; and (3) TMA be aware of rising trends in patient informational technology and adjust future legislation accordingly with respect to previously written TMA policy and future technological trends. **Tabled to 2021.**

Resolution 424 2020. Resolution that: (1) TMA adopt the American Medical Association policy Value-Based Decision-Making in the Health Care System H-450.938; and (2) TMA adopt policy encouraging physicians to practice value-based decisionmaking, to the best of their ability, as a core tenet of physician professionalism. **Tabled to 2021.**

Resolution 425 2020. Resolution that: (1) TMA support efforts to inform patients of the difference in training requirements between American Board of Plastic Surgery (ABPS) board-certified plastic surgeons and individuals board certified through self-designated medical boards; and (2) TMA reaffirm its commitment to advocate for appropriate scope of practice by discouraging non-ABPS-certified individuals from advertising themselves as board-certified plastic surgeons and performing plastic surgery procedures. **Tabled to 2021.**

Resolution 426 2020. Resolution that: (1) TMA work with state agencies to study the results, regulation, and quality review mechanisms of freestanding birthing centers and at-home birthing services; and (2) TMA determine if additional regulations and public education are needed. **Tabled to 2021.**

Resolution 427 2020. Resolution that: (1) TMA collaborate with the American Medical Association in advocating for the Centers for Medicare & Medicaid Services (CMS) to adjust the secondary hospice enrollment criteria for dementia. Specifically, CMS should incorporate dementia patients who are Functional Assessment Staging Test Stage 6e, who, or their families on their behalf, have chosen not to receive medications or interventions for acute illnesses; and (2) TMA collaborate with AMA in advocating for CMS to expand the coverage and availability of other, novel provisions of care for dementia patients, such as expanding the Medicare Care Choices model that allows palliative services to be provided in the home setting, as a bridge to hospice care. **Tabled to 2021.**
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WHAT TO DO WHEN

MONDAY, July 13

**Handbook for Delegates Posted Online**
View the handbook at www.texmed.org/HOD.

**Online Testimony Opens**
Review items for consideration by the house and submit your written testimony at www.texmed.org/Testimony.

SATURDAY, Aug. 1

**Candidate Materials Posted for Delegate Review**
Review candidate profiles and videos before elections open (website TBA).

**Written Testimony Closes**
Submit your testimony before end of day, Aug. 1. The Special Session Reference Committee will meet in executive session to review testimony and write its report between Aug. 7 and Aug. 24.

FRIDAY, Aug. 7

**Deadline for Reporting Delegates**
County medical societies and sections, please submit your delegate roster to TMA by Aug. 7.

FRIDAY, Aug. 21

**Voting for Elected Offices Opens (12 am)**
Delegates will be emailed a link. Review candidate materials and cast your ballot.

FRIDAY, Aug. 28

**Voting for Elected Offices Closes (11:59 pm)**

SATURDAY, Aug. 29

**TMA House of Delegates Opening Session**
Delegates and alternates, check your email for a link to view a prerecorded opening session.

**Final Reference Committee Report Posted**
A link to the final reference committee report will be emailed to house members and posted online. View the report at www.texmed.org/HOD.

FRIDAY, Sept. 4

**Runoff Election Voting Opens (If Necessary)**

THURSDAY, Sept. 10

**Runoff Election Voting Closes (If Necessary)**

SATURDAY, Sept. 12

**TMA House of Delegates Final Session**
9 am
Check your email for a link to join as either delegate, alternate, or guest.

NOTES

- **Availability of Reference Committee Report:** We will post the final report on the TMA House of Delegates webpage as early as possible.
- **This schedule includes house events ONLY.** For other meetings, please check with your appropriate county society, caucus, section, board, council, and committee staff to determine if and when these meetings will occur.
- **Reminder:** The Handbook for Delegates refers only to items being considered by the house. Reports and resolutions in the handbook and posted on the website are working drafts; they should not be considered as expressing Texas Medical Association views and programs until the house acts on them.
- **Clarification:** ONLY the Recommendation portions of reports and the Resolve portions of resolutions are considered by the House of Delegates; the Whereas portions are informational and explanatory.
Preamble
These House of Delegates Standing Rules – Special Circumstances serve as an operational guide and description for how the Texas Medical Association’s House of Delegates will conduct its elections of candidates in contested races and business at the virtual annual meeting, which concludes Sept. 12, 2020. The TMA Board of Trustees, acting as a disaster board, authorized the speakers to create these special circumstances rules during a disaster board meeting June 28. These rules shall be in effect until the adjournment of the closing session of the virtual house.

Special Circumstances Rules for TMA House of Delegates Contested Elections
1. Nominations for the 2020 TMA House of Delegates contested elections are closed.
2. Candidates for contested elections must submit their candidate materials, including a two-minute campaign video to be posted on the TMA website, by July 31, 2020. This material will be made available to delegates and TMA members (web login) on Aug. 1. No other candidate videos will be posted or allowed to be forwarded.
3. Candidates are limited to one mass communication outside their caucus to all delegates and alternates.
4. Caucuses are strongly encouraged to ensure that any contact with candidates provides equal and fair opportunities to each candidate in a contested race. Further, caucuses are prohibited from soliciting additional interviews or speeches from candidates outside the TMA-sponsored virtual event and online speeches.
5. The deadline is Aug. 7 for caucuses to report to TMA their list of delegates and alternates.
6. Candidates in contested races will be asked to take part in a virtual event to familiarize delegates with candidates. This may be open to concurrent viewing by TMA members and recorded to allow delayed viewing.
7. Voting will occur through a secure and confidential electronic method and will be open for one full week, starting Friday morning, Aug. 21, at 12:00 am. A “Voting for Candidates Is Now Open” email will be sent at 8 am on Aug. 21 to each credentialed delegate to his or her preferred TMA email address. Delegates may cast their vote by clicking on an auto-login link in the email, which will take them to the TMA website where they can review each candidate’s campaign information and cast their ballot securely. Voting will close on Aug. 28 at 11:59 pm. An email will be sent on Aug. 28 to each credentialed delegate announcing the close of voting.
8. In the event of the need for a runoff election, the house will be notified of the runoff in a similar manner. Candidate materials will be available. Runoff candidates and caucuses will be allowed a single additional contact with delegates. Runoff elections would be held after the formal house opening on Sept. 4 and closed by Thursday night, Sept. 10, at 11:59 pm. The chief teller will review election results.
9. Validated results of the election will be provided by the chief teller, who will review the voting process, canvass election results, and report the final confirmed election results during the house session Saturday morning, Sept. 12. The full house will then ratify the results of the virtual elections.

Special Circumstances Rules for TMA House of Delegates Business
1. The default recommendation is that all currently submitted items of business will be tabled to the 2021 house meeting with some specific exceptions.
   a. Business considered at the 2020 house should be limited to essential, urgent, or informational items or reports that could reasonably be adopted by consent.
   b. 2020 business items will be referred to the Special Session Reference Committee and posted online for written testimony. After reference committee consideration of this testimony, a final Special Session Reference Committee report will be submitted and placed on the consent agenda. Consent items may be extracted during the final house session only for a motion to table the item
c. All other submitted items of business will be tabled to the 2021 house meeting with exception of a motion to refer to the board (for consideration or action) with report back at the 2021 house session.

d. Submission of additional items of business will be closed.

2. The speakers, with TMA staff (including specifically the TMA staff assigned to each of the four reference committees), will review all currently submitted items of business and identify items that are considered essential or urgent or reports that could reasonably be adopted by consent. These items may be considered by the House Steering Caucus (made up of TMA caucus and section chairs) and if accepted by the House Steering Caucus be posted for consideration and testimony to the reference committee.

3. Final Session Consideration of Business: After review by the speakers of the Special Session Reference Committee report, the final report will be posted as the order of business two weeks prior to the final session of the house. The final session of the house will allow parliamentary consideration of the reference committee report recommendations. The speakers will be allowed to table (to the 2021 TMA House of Delegates) any final business considered on the house floor that becomes too confusing, complex, or intricate such that it overwhelms the virtual platform during the final session. This decision by the speakers could be overruled by a two-thirds affirmative vote of the house.

4. Extraction of Consent Items from the Reference Committee Report as Order of Business for Final Session: Extractions of consent items from the final reference committee report Order of Business will be limited to either a motion to table the item to the 2021 House of Delegates or a motion to refer to the board (for consideration or action) with report back at the 2021 house session.
SPECIAL SESSION REFERENCE COMMITTEE
September 2020

CHIEF TELLER
Tilden L. Childs, III, MD, Tarrant County Medical Society

SPECIAL SESSION REFERENCE COMMITTEE
David J. Donahue, MD, chair, Tarrant County Medical Society
Christopher Sung Jin Chun, MD, Dallas County Medical Society
Patrick D. Crowley, DO, (Resident), Bell County Medical Society
Arathi A. Shah, MD, Travis County Medical Society
James Guo, MD, Harris County Medical Society
Kireet Koganti (Student), Dallas County Medical Society
David T. Lam, MD, Bexar County Medical Society
Li-Yu H. Mitchell, MD, Smith County Medical Society

House of Delegates Online Testimony – submit testimony on reports and resolutions for reference committee consideration: https://www.texmed.org/testimony. Deadline for submission is August 1.
CONFLICTS OF INTEREST POLICY OF THE TEXAS MEDICAL ASSOCIATION

When acting as representatives of the Texas Medical Association, members shall exercise the utmost good faith in all transactions touching upon their representation. In their dealings with and on behalf of the association, they are held to a strict rule of honesty and fair dealing between themselves and the association.

If a matter involves a member acting as a representative of TMA that in any way could give rise to conflict of interest for that member, then that member must physically withdraw from the situation so as not to participate in any discussion or vote regarding that matter. If that member does not self-identify in such situations, then any member or executive staff member may make known the conflict to the chair of the meeting at the earliest opportunity. If there is any question as to whether a conflict exists, the matter shall be put to a vote of the appropriate component of the association.

At the discretion of the external entity or TMA component involved, the member who has withdrawn may provide information to the group in the same manner as any person requested by the group.

Adopted by the Board of Trustees Feb. 27, 2004 — Adopted by the House of Delegates May 14, 2004

EXPLANATION OF CONFLICTS OF INTEREST

Definitions (The following is intended to be illustrative rather than exhaustive.)

A. “Interests” — Following are examples of financial and business “interests”:
   1. Sales to or purchases from the association by a board, council, or committee member, either individually or through a company or other entity in which that person has a substantial interest;
   2. Loans to or from the association by a board, council, or committee member directly or through a substantially owned entity; or
   3. Other interests in a related business or profession which might conflict with the policies of the association.

B. “Direct” or “Indirect” — The meaning of “direct” interest is clear enough, but “indirect” has a wide range of meanings. Examples of “indirect” interests are:
   1. A board, council, or committee member owns a substantial share of a company but has put the ownership interest in that person’s spouse’s or another’s name; or
   2. The spouse or another relative owns a company which sells goods or services to the association.

C. “Substantial” — Where the outside interests consist of ownership (direct or indirect) of an entity doing business with the association, a “substantial” conflict means 5 percent or greater ownership of the other business.

Activities That Might Cause Conflict of Interest

Conflict of interest may be considered to exist in those instances where the actions or activities of an individual on behalf of the association also involve (a) the obtaining of an improper personal gain or advantage, (b) an adverse effect on the association’s interests, or (c) the obtaining by a third party of an improper gain or advantage. Conflicts of interest can arise in other instances. While it is impossible to list every circumstance giving rise to a possible conflict of interest, the following will serve as a guide to the types of activities which might cause conflicts and which should be fully reported to the association.

A. Gifts, Gratuities and Entertainment — Direct or indirect acceptance by an individual (including members of that person’s family) of gifts, excessive or unusual entertainment, or other favors from any outside concern which does or is seeking to do business with the association. This does not include the acceptance of items of nominal value which are of such a nature as to indicate that they are merely tokens of respect or friendship and not related to any particular transaction or activity.

B. Investments — Financial Interests
   1. Holding by an individual, directly or indirectly, of a substantial financial interest in any outside concern from which the association secures goods or services (including the service of buying or selling stocks, bonds, or other securities).
   2. Competition with the association by an individual, directly or indirectly, in the purchase or sale of property or property rights or interest.
   3. Representation of the association by an individual in any transaction in which the individual or a member of his family has a substantial financial interest.

C. Inside Information — Disclosure or use of confidential information for the personal profit or advantage of the individual or anyone else.

Conflicts of Interest — Scenario 1

A TMA member serves as a TMA representative in a group that includes physicians and nonphysicians. For the group to meet its ultimate goal, it must choose a vendor of certain services. At the time of the selection process, the TMA member has
a significant financial interest in one of the proposed vendors that is not widely known among the group’s members. The TMA Conflicts of Interest Policy would apply as follows:

The TMA member should withdraw from the meeting so as not to participate in any discussion or vote regarding the selection of a vendor. If the TMA member does not self-identify, then any TMA member or executive staff member may make known to the group’s chair the TMA member’s financial interest in the vendor. If there is any question as to whether a conflict exists, the matter should be put to a vote of the appropriate component of the association.

At the discretion of the council, the member who withdrew from the meeting may provide information to the council the same as any person so requested by the council.

Conflicts of Interest — Scenario 2
A TMA member serves on a TMA council as well as on the board of trustees of his or her state specialty society. The state specialty society has taken a position on a scope of practice issue of high concern to that group of specialists. The TMA council on which the member serves also is considering TMA policy on the same issue for the purpose of making a recommendation to the House of Delegates.

To comply with the Conflicts of Interest Policy, that member should withdraw from the council meeting so as not to participate in any discussion or vote regarding the TMA position on scope of practice with respect to that specialty society position. If the member does not self-identify, then any TMA member or executive staff member may make known to the chair the member’s service on the specialty society board of trustees. If there is any question as to whether a conflict exists, the matter shall be put to a vote by the council. Should the council vote that the member has a conflict of interest on the scope of practice issue, the member should withdraw from the discussion (leave the room) and not vote.

At the discretion of the council, the member who withdrew from the meeting may provide information to the council the same as any person so requested by the council.

Conflicts of Interest — Scenario 3
A TMA member serves on a TMA board, council or committee (hereinafter, “board”) as well as on the board of trustees of an endorsed entity. The TMA board has an agenda item before it that directly affects the endorsed entity (e.g., a proposal for a royalty payment, a proposal regarding underwriting or rate setting by the endorsed entity, or a proposal concerning operations).

To comply with the Conflicts of Interest Policy, that TMA board member should withdraw from the meeting so as not to participate in any discussion or vote regarding the TMA position on any matters directly affecting the endorsed entity. If the TMA board member does not self-identify, then any TMA member or executive staff member may make known to the chair the TMA board member’s service on the board of trustees of the endorsed entity. If there is any question as to whether a conflict exists, the matter shall be put to a vote by the board. Should the board vote that the TMA board member has a conflict of interest on the issue directly affecting the endorsed entity, the TMA board member should withdraw from the discussion (leave the room) and not vote.

At the discretion of the board, the board member who withdrew from the meeting may provide information to the board in the same manner as any person so requested by the board.

Conflicts of Interest — Scenario 4
A TMA member serves on a TMA board, council or committee (hereinafter, “board”) as well as on the board of trustees or in an executive capacity with ABC health insurance company (hereinafter, “ABC”). The TMA board has an agenda item before it which directly affects ABC (e.g., a proposal for a royalty payment by ABC; a proposal regarding payment practices by ABC; or litigation with ABC as a plaintiff, defendant, or as amicus curiae).

To comply with the Conflicts of Interest Policy, that TMA board member should withdraw from the meeting so as not to participate in any discussion or vote regarding the TMA position on any matters directly affecting ABC. If the TMA board member does not self-identify, then any TMA member or executive staff member may make known to the chair the TMA board member’s service on the board of trustees or in an executive capacity with ABC. If there is any question as to whether a conflict exists, the matter shall be put to a vote by the board. Should the board vote that the TMA board member has a conflict of interest on the issue directly affecting ABC, the TMA board member should withdraw from the discussion (leave the room) and not vote.

At the discretion of the board, the board member who withdrew from the meeting may provide information to the board in the same manner as any person so requested by the board.
Texas Medical Association
Officers, Board, Council, Committee Members and Section Officers
September 2020

TMA Officers
Diana L. Fite, MD, President
E. Linda Villarreal, MD, President-Elect
David C. Fleeger, MD, Immediate Past President
Michelle A. Berger, MD, Secretary/Treasurer
Arlo F. Weltge, MD, MPH, Speaker
Bradford W. Holland, MD, Vice Speaker

TMA Board of Trustees
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Richard Wesley Snyder II, MD, Vice Chair
Sue S. Bornstein, MD
Keith A. Bourgeois, MD
Gerald R. Callas, MD
Douglas W. Curran, MD
Cynthia A. Jumper, MD
Jayesh B. Shah, MD
Joseph S. Valenti, MD
Lindsay K. Botsford, MD, YPS Trustee
Kayla A. Riggs, MD, RFS Trustee
Vamsi Potluri, MSS Trustee

TMA Board of Councilors (continued)
Steven R. Hays, MD, Dist. 14
Cindy R. Porter, MD, Dist. 15
Amir Ahmadian, DO, RFS Rep.
Akshat Kumar, MSS Rep.
Jessica Killingly, MSS Alternate Rep.

Texas Delegation to AMA
Delegates
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Michelle A. Berger, MD, Vice Chair
Gary W. Floyd, MD, Vice Chair
Brad G. Butler, MD
Gerald R. Callas, MD
Diana L. Fite, MD
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William H. Fleming, III, MD
John T. Gill, MD
William S. Gilmer, MD
Robert Tau Gunby, Jr., MD
Asa C. Lockhart, MD, MBA
Kenneth L. Mattox, MD
Kevin Hood McKinney, MD
Larry E. Reaves, MD
Leslie Harold Secret, MD
Jayesh B. Shah, MD
Lyle Sheldon Thorstenson, MD
E. Linda Villarreal, MD
Arlo F. Weltge, MD, MPH
Alternate Delegates
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Robert Harold Emmick, Jr., MD
John Gerard Flores, MD
Gregory M. Fuller, MD
Laura Faye Gephart, MD, MBA
Steven Ray Hays, MD
Bryan G. Johnson, MD
Cynthia Ann Jumper, MD, MPH
Faith C. Mason
Theresa Phan, MD
Jennifer R. Rushton, MD
Ezequiel “Zeke” Silva III, MD
Elizabeth Torres, MD
Roxanne Marie Tyroch, MD
Sherif Z. Zaafran, MD
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AMA President
Susan Rudd Bailey, MD
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Olga Ovdveyenko Dowell, MD
Keith Ryan Eppich, MD
Oscar Garza, MD
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Ann C. Hughes-Bass, MD
Nishant B. Jalandhara, MD
January Y. Tsai, MD
Vani Venkatachalam, MD
Maliha Khan, MSS Rep.
Anna Rogalska, MSS Alternate Rep.
Consultant:
George H. Perkins, MD

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- Athira Unnikrishnan, MD  
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  - Lucas Wong, MD

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- Katherine Holder, MSS Alternate Rep.

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Jacob Stetler, DO
Jimmy Widmer, MD

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Ronak Ghiya, MD, Delegate
Hussain Saleem Lalani, MD, Delegate

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Vamsi Potluri, BOT Special Appointee
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Joseph Stanley Gabriel, MD, San Antonio
## HOUSE OF DELEGATES COMPOSITION

**September 2020**

County society delegates ................................................................. 411

**Ex officio-voting positions** ........................................................................ 161
- President .......................................................................................... 1
- President-Elect ............................................................................... 1
- Immediate Past President ............................................................. 1
- Secretary/Treasurer ........................................................................ 1
- Speaker .......................................................................................... 1
- Vice Speaker .................................................................................. 1
- At-large members of the Board of Trustees .................................. 12
- Councilors ...................................................................................... 15
- Texas Delegation to the AMA ....................................................... 33
- Members of the Council on Legislation ........................................ 18
- Chairs of all other councils ............................................................ 8
- International Medical Graduate Section delegate ....................... 1
- Young Physician Section delegates ............................................... 7
- Resident and Fellow Section delegates ........................................ 4
- Medical Student Section delegates .............................................. 13
- Specialty society delegates ........................................................... 24
- Past Presidents .............................................................................. *20

**Ex officio nonvoting positions:**
- TEXPAC Chair ............................................................................... 1
- Delegates emeritus of the Texas Delegation to the AMA ............ 1

**Total voting membership** ..................................................................... *529
- Delegates ......................................................................................... 411
- Voting Ex officio ........................................................................... 161
- Less those holding multiple voting positions ............................ 23

*Past presidents who are active or emeritus members have a vote, but are not included in the Total voting membership to determine a quorum.*
MEMBERS OF THE HOUSE OF DELEGATES AND VICE COUNCILORS
September 2020

KEY

D Delegate
A Alternate Delegate
Ex Ex Officio
D-IMGS Delegate, International Medical Graduate Section
A-IMGS Alternate, International Medical Graduate Section
D-YPS Delegate, Young Physician Section
A-YPS Alternate, Young Physician Section
D-RFS Delegate, Resident and Fellow Section
A-RFS Alternate, Resident and Fellow Section
D-MSS Delegate, Medical Student Section – D-MSS
A-MSS Alternate, Medical Student Section – A-MSS
SSD Specialty Society Delegate – SSD
SSA Specialty Society Alternate – SSA
P Past President – P
EMER Delegate Emeritus of Texas Delegation to AMA
TX Chair, TEXPAC
VC Vice Councilor

SPECIALTY CODES

Code Description
A Allergy
ACA Adult Cardiothoracic Anesthesiology
ADL Pediatric Adolescent Medicine
ADM Addiction Medicine
ADP Addiction Psychiatry
AHF Advanced Heart Failure & Transplant Cardiology
AI Allergy & Immunology
ALI Allergy/Immunology, Clin & Lab Immunology
AM Aerospace Medicine
AMF Family Practice, Adolescent Medicine
AMI Internal Medicine, Adolescent Medicine
AN Anesthesiology
APM Anesthesiology, Pain Medicine
AR Radiology, Abdominal
AS Surgery, Abdominal
ASO Advanced Surgical Oncology
ATP Pathology, Anatomic
BBK Pathology, Blood Bank/Transfusion Med.
BIN Brain Injury Medicine
BIP Brain Injury Medicine
CAP Child Abuse Pediatrics
CBG Genetics, Clinical Biochemical
CCA Anesthesiology, Critical Care Medicine
CCE Critical Care Medicine (Emergency Medicine)
CCG Genetics, Clinical Cytogenetic
CCM Internal Medicine, Critical Care Medicine
CCP Pediatric Critical Care
CCS Surgery, Critical Care
CD Cardiovascular Disease
CFS Surgery, Craniofacial
CG Genetics, Clinical
CHD Adult Congenital Heart Disease
CHN Neurology, Child
CHP Psychiatry, Child & Adolescent
CHS Congenital Cardiac Surgery (Thoracic Surgery)
CIM Clinical Informatics (Preventive Medicine)
CIP Clinical Informatics
CLP Pathology, Clinical
CMG Genetics, Clinical Molecular
CN Neurology, Clinical Neurophysiology
CPP Pediatrics/Psychiatry/Child & Adolescent Psychiatry
CRS Colon & Rectal Surgery
CS Cosmetic Surgery
CTR Cardiothoracic Radiology
D Dermatology
DBP Pediatrics Developmental-Behavioral
DIA Diabetes
DMP Dermatopathology
DR Radiology, Diagnostic
DS Surgery, Dermatologic
EFM Emergency Medicine/Family Medicine
EM Emergency Medicine
EMP Emergency Medicine Pediatrics
EMS Emergency Medical Services
END Endo, Diabetes & Metabolism
ENR Endovascular Surgical Neuroradiology
EP Epidemiology
EPL Epilepsy
ES Endovascular Surgical Neuroradiology
ESM Emergency Medicine, Sports Medicine
ESN Endovascular Surgical Neuroradiology
ETX Emergency Medicine, Medical Toxicology
FM Family Medicine
FMP Family Medicine/Preventive Medicine
FOP Pathology, Forensic
FPG Family Practice, Geriatric Medicine
FPP Psychiatry/Family Medicine
FPR Female Pelvic Medicine & Reconstructive Surgery, OB/Gyn
FPS Plastic Surgery, Facial Plastic
FSM Family Practice, Sports Medicine
GE Gastroenterology
GO Gynecological Oncology
GP General Practice
GPM General Preventive Medicine
GS Surgery, General
GYN Gynecology
HEM Hematology
HEP Hepatology
HMP Pathology, Hematology
HNS Surgery, Head & Neck
HO Hematology/Oncology
HOS Hospitalist
HPA Hospice & Palliative Medicine (Anesthesiology)
HPD Hospice & Palliative Medicine (Radiology)
HPE Hospice & Palliative Medicine (Emergency Medicine)
HPF Hospice & Palliative Medicine (Family Medicine)
HPI Hospice & Palliative Medicine (Internal Medicine)
HPM Hospice & Palliative Medicine
HPN Hospice & Palliative Medicine (Psychiatry & Neurology)
HPO Hospice & Palliative Medicine (Obstetrics & Gynecology)
HPP Hospice & Palliative Medicine (Pediatrics)
HPR Hospice & Palliative Medicine (Physical Medicine & Rehabilitation)
HPS Hospice & Palliative Medicine (Surgery)
HS Surgery, Hand
HOS Orthopedics Hand Surgery
HSP Hand Surgery (Plastic Surgery)
HSS Hand Surgery (Surgery)
IC Cardiology, Interventional
ICE Clinical Cardiac Electrophysiology
ID Infectious Diseases
IEC IM/Emergency Med/Critical Care Med
IFP Internal Medicine/Family Practice
IG Immunology
ILI Internal Med, Clin & Lab Immunology
IM Internal Medicine
IMD Internal Medicine/Dermatology
IMG Internal Medicine, Geriatrics
INM Internal Medicine/Nuclear Medicine
IPM Internal Medicine, Preventative Medicine
ISM Internal Medicine, Sports Medicine
LM Legal Medicine
MBG Medical Biochemical Genetics
MDG Internal Medicine/Medical Genetics
MDM Medical Management
MDP Medical Physics
MEM Internal Medicine, Emergency Medicine
MFM Maternal and Fetal Medicine
MG Medical Genetics
MGG Genetics, Molecular Genetic Pathology
MGP Pathology, Molecular Genetic Pathology
MM Medical Microbiology
MN Internal Medicine/Neurology
MP Internal Med/Psychiatry
MPD Internal Medicine, Pediatrics
MPM Internal Med/Phys Med And Rehabilitation
MSR Radiology, Musculoskeletal
N Neurology
NC Nuclear Cardiology
NDN Psychiatry & Neurology, Neurodevelopmental Disabilities
NDP Pediatrics Neurodevelopmental Disabilities
NEP Nephrology
NM Nuclear Medicine
NMN Neuromuscular Medicine
NMP Neuromuscular Medicine (Physical Medicine & Rehabilitation)
NNM Neurology/Nuclear Medicine
NO Otology/Neurotology
NP Pathology, Neuropathology
NPM Neonatal-Perinatal Medicine
NPR Neurology Physical Medicine and Rehab
NR Radiology, Nuclear
NRN Neurology,Diag Rad,Neuroradiology
NS Neurological Surgery
NSP Pediatric Neurological Surgery
NTR Nutrition
NUP Neuropsychiatry
OAN Obstetric Anesthesiology (Anesthesiology)
OAR Orthopedic, Adult Reconstructive
OBG Obstetrics and Gynecology
OBS Obstetrics
OCC Obstetrics/Gynecology, Critical Care Medicine
OFA Orthopedics, Foot and Ankle
OM Occupational Medicine
OMF Surgery, Oral & Maxillofacial
OMM Osteopathic Manipulative Medicine
OMO Orthopedic, Musculoskeletal Oncology
ON Oncology
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## Alpha Composition of the House of Delegates

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| Alternate: Adela S. Valdez, MD, MBA |
| Collin-Fannin CMS | Delegate: Lucia L. Williams, MD, MPH  
| Delegate: Carrie E. De Moor, MD  
| Delegate: Neha V. Dhudhia, MD  
| Delegate: Marlene Diaz, MD  
| Delegate: Aimee C. Garza, MD  
| Delegate: Sejal S. Mehta, MD  
| Delegate: Priyanka Pahuja, MD  
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| Delegate: Brent A. Spencer, MD  
| Delegate: Amber Van Den Raadt, DO  
| Alternate: Mei Melvin Hu, MD  
| Alternate: Radha Gopal Iyengar, MD  
| Alternate: Fareha Abid Kazi, MD  
| Alternate: Alan David Koenigsberg, MD  
| Alternate: Darren Eric Meyer, MD  
| Alternate: Marian D. Steininger, MD  
| Alternate: Diep Denise Tran, MD  
| Alternate: Daniel Joseph Verret, MD |
| Colorado Basin CMS | Delegate: James Ray Burleson, MD  
| Delegate: Heather H. Vasser, MD  
| Delegate: Tyrus Schroeder, MD  
| Delegate: Judith Lynn Thompson, MD  
| Alternate: Claire Marie Coco, MD  
| Concho Valley CMS | Delegate: Bradly Bundrant, MD, MPH  
| Delegate: Kathleen A. Cubine, DO  
| Delegate: Daniel Joseph Verret, MD  
| Delegate: Jonathan Ray Burleson, MD |
| Dallam-Hartley-Sherman-Moore CMS | Delegate: James Ray Burleson, MD  
| Delegate: Drew Wilson Alexander, MD  
| Delegate: Christine Ann Becker, MD  
| Delegate: Adam C. Carter, MD  
| Delegate: Mark A. Casanova, MD, FAAHPM  
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| Delegate: Angela Fulgham Gardner, MD  
| Delegate: John Russell Gilmore, MD  
| Delegate: Victor Gonzalez, MD |
| Dallas CMS (continued) | Delegate: Robert D. Gross, MD  
| Delegate: Robert Ware Haley, MD  
| Delegate: Madeline Weinstein Harford, MD  
| Delegate: Sarah Lynn Helfand, MD  
| Delegate: Eugene Pitts Hunt, III, MD  
| Delegate: Zachary S. Jones, MD  
| Delegate: Seth David Kaplan, MD  
| Delegate: R Elizabeth Kassanoff, MD  
| Delegate: Rainer Anil Khetan, MD  
| Delegate: Roger Sunil Khetan, MD  
| Delegate: Kevan Wayne Klein, MD  
| Delegate: Yolanda R. Lawson, MD  
| Delegate: Benjamin C. Lee, MD  
| Delegate: C. Turner Lewis, III, MD  
| Delegate: Nathan P. Long, MD  
| Delegate: Dan Ken McCoy, MD  
| Delegate: David Wayne Mercier, MD  
| Delegate: David Scott Miller, MD  
| Delegate: Angela N. Moemeka, MD  
| Delegate: Benjamin R. Morrissey, MD  
| Delegate: Lee Ann Pearse, MD  
| Delegate: Daniel B. Pearson, III, MD  
| Delegate: James E. Race, MD  
| Delegate: Pervaiz Rahman, MD  
| Delegate: Assad Joe Saad, MD  
| Delegate: John Stuart Scott, DO, MHA, FASA  
| Delegate: Elizabeth Ruth Seymour, MD  
| Delegate: Robert Eduard Suter, DO  
| Delegate: Laurie Jayne Sutor, MD  
| Delegate: Lisa Louise Swanson, MD  
| Delegate: Lisa Carole Taylor-Kennedy, MD  
| Delegate: John Morrow Truelson, MD  
| Delegate: Michael Ian Vengrow, MD  
| Delegate: Joe B. Ventimiglia, MD  
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| Alternate: Hina Dave, MD  
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| Alternate: Roy Lynn Rea, MD  
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| Alternate: Tami R. Roberts, MD  
| Alternate: Aurelia M. Schmalstieg, MD  
| Alternate: F. David Schneider, MD, MSPH  
| Alternate: Anjali N. Shah, MD  
| Alternate: Baran Devrim Sumer, MD |
Delegates and Alternates by County Medical Society

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Dallas CMS (continued)

Alternate: Bharath Thankavel, MD
Alternate: Anil Kumar Tibrewal, MD

Denton CMS

Delegate: Sathya Priya Bhandari, MD
Delegate: Shikha Kaushik Mane, MD
Delegate: Anil Nanda, MD
Delegate: Udaya Bhaskar Padakandla, MD
Alternate: Folahan Kolawole Ayoola, MD
Alternate: Hannah G. Moussa, MD

Denton CMS

Delegate: Sathya Priya Bhandari, MD
Delegate: Shikha Kaushik Mane, MD
Delegate: Anil Nanda, MD
Delegate: Udaya Bhaskar Padakandla, MD
Alternate: Folahan Kolawole Ayoola, MD
Alternate: Hannah G. Moussa, MD

Ector CMS

Delegate: Olga Ovdyeyenko Dowell, MD
Delegate: Anjaiah Kodityal, MD
Delegate: Ikemefuna C. Okwuwa, MD
Alternate: Nimat Alam, MD
Alternate: Sara Suzanne Dyrstad, MD
Alternate: Victor H. Gil, MD
Alternate: Ritchie Rosso, Jr., MD

El Paso CMS

Delegate: Ogechika Karl Alozie, MD
Delegate: James Byron Boone, III, MD
Delegate: Jose Manuel De La Rosa, MD
Delegate: Andres S. Enriquez, MD
Delegate: Azalia Veronica Martinez, MD
Delegate: Richard W. McCallum, MD
Delegate: David Mario Palafox, MD
Delegate: Juan Rodrigo Perez, MD
Delegate: Luis Hernando Urrea, II, MD
Alternate: Alison L. Days, MD, MPH
Alternate: Fernando F. Raudales, MD

Ellis CMS

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Erath-Somervell-Comanche CMS

Alternate: Frank Vance Terrell, MD

Fort Bend CMS

Delegate: Cedela Abdulla, MD
Delegate: Jontel Dansby Pierce, MD
Delegate: Sapna Singh, MD
Alternate: Channon T. Hudgins, MD
Alternate: Susan Aleyamma Mathew, MD
Alternate: Shubha P. Shetty, MD

Galveston CMS

Delegate: Aakash H. Gajjar, MD
Delegate: John George Knecht, III, MD
Delegate: Brian D. Masel, MD
Delegate: Bethany E. Powell, MD
Alternate: Thomas Duke Kimbrough, MD
Alternate: Ben G. Rainer, MD
Alternate: Beth M. Teegarden, MD
Alternate: Michele Dieu Thiet, MD

Gonzales CMS

Delegate: Humberto J. Rivas, MD

Grayson CMS

Delegate: Sanober Kable, MD
Delegate: Jonathan Wayne Williams, MD
Alternate: Shannon Williams Hayes, MD
Alternate: Vijay Khetpal, MD
Alternate: Peter A. Selz, MD

Greenbelt CMS

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Gregg-Upshur CMS

Delegate: Craig Kent King, MD

Guadalupe CMS

Delegate: Yu-Jie John Kuo, MD
Alternate: Lori Reese Anderson, MD
Alternate: George Sterling Mannel, MD

Hale-Floyd-Briscoe CMS

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Alternate: Travis G. King, MD

Harris CMS

Delegate: Audrey E. Ahuero, MD
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Delegate: Ronda E. Alexander, MD
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Delegate: Hattie E. Henderson, MD, CMD
Delegate: David R. Hoyer, Jr., MD
Delegate: Terah C. Isaacson, MD
Delegate: Nora A. Janjan, MD, MPSA, MBA
## Delegates and Alternates by County Medical Society

### Harris CMS (continued)

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Delegates and Alternates by County Medical Society
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Rusk CMS
Delegate: Mary Joyce Starling, MD
Alternate: Gordon G. Uretsky, MD

San Patricio-Aransas-Refugio CMS
Delegate: Isabel C. Menendez, MD

Shelby-Sabine CMS
Delegate: Keith Edward Miller, MD

Smith CMS
Delegate: Li-Yu H. Mitchell, MD
Alternate: Brandon M. Ashton, MD
Alternate: Kamran Shahid, MD
Alternate: Evans S. Smith, MD

Tarrant CMS
Delegate: Susan K. Blue, MD
Delegate: Jeffrey Chase, MD
Delegate: C. Mark Chassay, MD
Delegate: Shanna Marie Combs, MD
Delegate: Theresa V. Crouch, MD
Delegate: Miguel De Valdenebro, MD
Delegate: David J. Donahue, MD
Delegate: Michael G. Enger, MD
Delegate: Josephine Rebecca Fowler, MD
Delegate: Ken C. Hopper, MD
Delegate: Cheryl Lynn Hurd, MD
Delegate: Nishant B. Jalandhara, MD
Delegate: Woody V. Kageler, MD
Delegate: R. Larry Marshall, MD
Delegate: Terence Joseph McCarthy, MD
Delegate: Matthew M. Murray, MD
Delegate: Gregory J. Phillips, MD
Delegate: Stuart C. Pickell, MD, FACP, FAAP
Delegate: Ann E. Ranelle, DO
Delegate: Robert J. Rogers, MD
Delegate: Angela D. Self, MD
Delegate: Mark M. Shelton, MD
Delegate: Jason V. Terk, MD
Delegate: Veer D. Vithalani, MD
Delegate: Johnathan D. Warminski, MD
Delegate: Dan A. Willis, MD
Delegate: Michael E. Wimmer, MD

Travis CMS
Delegate: Tony R. Aventa, MD
Delegate: Kimberly C. Avila Edwards, MD
Delegate: Ira Bell, III, MD
Delegate: Maya B. Bledsoe, MD
Delegate: Esther J. Cheung-Phillips, MD
Delegate: Elizabeth L. Chmelik, MD
Delegate: Scott W. Clitheroe, MD
Delegate: Antonia M. Davidson, MD
Delegate: Colby C. Evans, MD
Delegate: Nancy Thorne Foster, MD
Delegate: Vimal T. George, MD
Delegate: Albert T. Gros, MD
Delegate: Juan M. Guerrero, MD
Delegate: Katharina Hathaway, MD
Delegate: Felix Hull, MD
Delegate: Anand Joshi, MD
Delegate: Craig Allen Kuhns, MD
Delegate: Daniel J. Leeman, MD
Delegate: Jonathan E. MacClements, MD
Delegate: Hillary Miller, MD
Delegate: Celia B. Neavel, MD
Delegate: Graves T. Owen, MD
Delegate: Dennis Samuel Pacl, MD
Delegate: A. Melinda Rainey, MD
Delegate: Harris S. Rose, MD
Delegate: Stephanie D. Roth, MD
Delegate: Dora L. Salazar, MD
Delegate: Sarah I. Smiley, DO
Delegate: Lynn N. Stewart, MD
Delegate: Brian W. Temple, MD
Delegate: David N. Tobey, Jr., MD
Delegate: Zoltan Trizna, MD, PhD
Delegate: Vani S. Vallabhaneni, MD
Delegate: Stephanie M. Vertrees, MD
Delegate: John F. Villacis, MD, MSc
Delegate: Belda Zamora, MD
Delegate: Guadalupe Zamora, MD
Delegate: Jay R. Zdunek, DO, MBA
Delegate: Alexander J. Alvarez, MD
Delegate: Maneesh R. Amancharla, MD
Delegate: Sunil C. Kolli, MD
Delegate: Megan K. Kressin, MD
Delegate: Carlos-Nicholas L. Lee, MD
Delegate: Hector A. Miranda-Grajales, MD
Delegate: Maria Claire Monge, MD
Delegate: Michelle C.M. Owens, DO
Delegate: Tina J. Philip, DO
Delegate: Fara Ranjbaran, MD
Delegate: Holli T. Sadler, MD
Delegate: Arathi A. Shah, MD
Delegate: Shaina M. Sheppard, MD
Delegate: F. Douglas Srygley, IV, MD
Delegate: Elizabeth Truong, MD
Delegate: Deepa V. Varshney, MD
Delegate: Christopher D. Vije, MD
Delegate: Sara A. Westgate, MD, PhD
Delegate: J. Stuart Wolf, Jr., MD
Delegate: Jeffrey S. Zalalac, MD
Delegate: Mark B. Randolph, MD

Tri-County CMS
Delegates and Alternates by County Medical Society

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Victoria-Goliad-Jackson CMS
Delegate: George Amechi Osuchukwu, MD
Delegate: Caroline Leilani Valdes, MD
Alternate: Diana M. Mercado-Marmarosh, MD
Alternate: Maria Christina Robles Velasco, MD

Walker-Madison-Trinity CMS
Delegate: Lane Joseph Aiena, MD
Alternate: Gregory C. McKeever, MD

Webb-Zapata-Jim Hogg CMS
Delegate: Luis Manuel Benavides, MD
Delegate: Sunny Wong, MD
Alternate: Eldo Ermenegildo Frezza, MD
Alternate: Marissa R. Gonzalez, MD

Wichita CMS
Delegate: T. David Greer, MD
Delegate: Bruce Lee Palmer, MD
Delegate: Susan M. Strate, MD
Alternate: Jedidiah James Grisel, MD
Alternate: David Sheng Huang, MD
Alternate: Evan C. Meyer, MD

Williamson CMS
Delegate: Maryann Miyun Choi, MD
Delegate: Ami Amar Shah Vira, MD

Young CMS
Delegate: Donald A. Behr, MD
Voting Ex-Officio Members of the House of Delegates
As of Aug. 18, 2020 (multiple voting positions are listed but member only has ONE vote)

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<td>Hidalgo-Starr</td>
<td>Council on Legislation</td>
<td>Member</td>
</tr>
<tr>
<td>E. Linda Villarreal, MD</td>
<td>Hidalgo-Starr</td>
<td>Texas Delegation to AMA</td>
<td>Texas Delegate</td>
</tr>
<tr>
<td>E. Linda Villarreal, MD</td>
<td>Hidalgo-Starr</td>
<td>TMA Officers</td>
<td>President-Elect</td>
</tr>
<tr>
<td>Sonia Wadkar</td>
<td>Hidalgo-Starr</td>
<td>Medical Student Section</td>
<td></td>
</tr>
<tr>
<td>Gerald R. Callas, MD</td>
<td>Jefferson</td>
<td>TMA Board of Trustees</td>
<td>Member At-Large</td>
</tr>
<tr>
<td>Gerald R. Callas, MD</td>
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<td>Texas Delegation to AMA</td>
<td>Texas Delegate</td>
</tr>
<tr>
<td>Mark J. Kubala, MD</td>
<td>Jefferson</td>
<td>Texas Medical Association Past Presidents</td>
<td>Member</td>
</tr>
<tr>
<td>Eman N. Attaya, MD</td>
<td>Lubbock</td>
<td>Council on Health Promotion</td>
<td>Chair</td>
</tr>
<tr>
<td>Eman N. Attaya, MD</td>
<td>Lubbock</td>
<td>Young Physician Section</td>
<td>Delegate</td>
</tr>
<tr>
<td>Celeste X. Caballero, MD</td>
<td>Lubbock</td>
<td>Council on Legislation</td>
<td>Member</td>
</tr>
<tr>
<td>Harry Eugene Hall, MD</td>
<td>Lubbock</td>
<td>TMA Board of Councillors</td>
<td>Councilor</td>
</tr>
<tr>
<td>Katherine Grace Holder</td>
<td>Lubbock</td>
<td>Medical Student Section</td>
<td>Delegate</td>
</tr>
<tr>
<td>Cynthia Ann Jumper, MD, MPH</td>
<td>Lubbock</td>
<td>Texas Delegation to AMA</td>
<td>Texas Alternate Delegate</td>
</tr>
<tr>
<td>Cynthia Ann Jumper, MD, MPH</td>
<td>Lubbock</td>
<td>TMA Board of Trustees</td>
<td>Member At-Large</td>
</tr>
<tr>
<td>Michelle Babb Tarbox, MD</td>
<td>Lubbock</td>
<td>Council on Legislation</td>
<td>Member</td>
</tr>
<tr>
<td>Gerald A. Troutman, MD</td>
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<td>Member</td>
</tr>
<tr>
<td>Roland Adolph Goertz, MBA</td>
<td>McLennan</td>
<td>TMA Board of Councillors</td>
<td>Councilor</td>
</tr>
<tr>
<td>Bradford W. Holland, MD</td>
<td>McLennan</td>
<td>TMA Officers</td>
<td>Vice Speaker</td>
</tr>
<tr>
<td>Lyle Sheldon Thorstenson, MD</td>
<td>Nacogdoches-San Augustine</td>
<td>Texas Delegation to AMA</td>
<td>Texas Delegate</td>
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<tr>
<td>Rodney B. Young, MD</td>
<td>Potter-Randall</td>
<td>Council on Socioeconomics</td>
<td>Chair</td>
</tr>
<tr>
<td>Sheldon Ygnacio Freeberg, MD</td>
<td>Smith</td>
<td>TMA Board of Councillors</td>
<td>Councilor</td>
</tr>
<tr>
<td>Gary E. Gross, MD</td>
<td>Smith</td>
<td>Texas’ Inter-Specialty Society</td>
<td>Delegate</td>
</tr>
<tr>
<td>Asa C. Lockhart, MD, MBA</td>
<td>Smith</td>
<td>Texas Delegation to AMA</td>
<td>Texas Delegate</td>
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<tr>
<td>Yasser Fahmy Zeid, MD</td>
<td>Smith</td>
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<td>Member</td>
</tr>
<tr>
<td>Bohn D. Allen, MD</td>
<td>Tarrant</td>
<td>Texas Medical Association Past Presidents</td>
<td>Member</td>
</tr>
<tr>
<td>Susan Rudd Bailey, MD</td>
<td>Tarrant</td>
<td>Texas Medical Association Past Presidents</td>
<td>Member</td>
</tr>
<tr>
<td>Stephen L. Brotherton, MD</td>
<td>Tarrant</td>
<td>Texas Medical Association Past Presidents</td>
<td>Member</td>
</tr>
<tr>
<td>Tilden L. Childs, III, MD</td>
<td>Tarrant</td>
<td>Texas’ Inter-Specialty Society</td>
<td>Delegate</td>
</tr>
<tr>
<td>Tilden L. Childs, III, MD</td>
<td>Tarrant</td>
<td>Council on Legislation</td>
<td>Member</td>
</tr>
<tr>
<td>Kristian Falcon</td>
<td>Tarrant</td>
<td>Medical Student Section</td>
<td>Delegate</td>
</tr>
<tr>
<td>Gary W. Floyd, MD</td>
<td>Tarrant</td>
<td>TMA Board of Trustees</td>
<td>Member At-Large</td>
</tr>
<tr>
<td>Gary W. Floyd, MD</td>
<td>Tarrant</td>
<td>Texas Delegation to AMA</td>
<td>Texas Delegate</td>
</tr>
<tr>
<td>Gregory M. Fuller, MD</td>
<td>Tarrant</td>
<td>Texas Delegation to AMA</td>
<td>Texas Alternate Delegate</td>
</tr>
<tr>
<td>Heidi C. Knowles, MD</td>
<td>Tarrant</td>
<td>Texas’ Inter-Specialty Society</td>
<td>Delegate</td>
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<tr>
<td>Pruthali Kulkarni, DO</td>
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<td>Resident and Fellow Section</td>
<td>Delegate</td>
</tr>
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<td>George Sealy Massingill, MD</td>
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<td>Texas’ Inter-Specialty Society</td>
<td>Delegate</td>
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<td>Larry E. Reaves, MD</td>
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<td>Texas Delegate</td>
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<td>Nathalie Scherer</td>
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<td>Medical Student Section</td>
<td>Delegate</td>
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<tr>
<td>Linda M. Siy, MD</td>
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<td>Council on Legislation</td>
<td>Member</td>
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<tr>
<td>Ramsey R. Ashour, MD</td>
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<td>Texas’ Inter-Specialty Society</td>
<td>Delegate</td>
</tr>
<tr>
<td>Charles W. Bailey, Jr., MD</td>
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<td>Texas Medical Association Past Presidents</td>
<td>Member</td>
</tr>
<tr>
<td>Michelle A. Berger, MD</td>
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<td>TMA Officers</td>
<td>Secretary-Treasurer</td>
</tr>
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<td>Michelle A. Berger, MD</td>
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<td>Texas Delegation to AMA</td>
<td>Texas Delegate</td>
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<tr>
<td>Robert K. Cowan, MD</td>
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<td>Robert Harold Emmick, Jr., MD</td>
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<td>Texas Alternate Delegate</td>
</tr>
<tr>
<td>James R. Eskew, MD</td>
<td>Travis</td>
<td>TMA Board of Councillors</td>
<td>Councilor</td>
</tr>
<tr>
<td>David C. Fleeger, MD</td>
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<td>Texas Delegation to AMA</td>
<td>Texas Delegate</td>
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<tr>
<td>David C. Fleeger, MD</td>
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<td>Texas Medical Association Past Presidents</td>
<td>Member</td>
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<td>David C. Fleeger, MD</td>
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<td>Immediate Past President</td>
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<tr>
<td>Michael S. Graves, MD</td>
<td>Travis</td>
<td>Texas’ Inter-Specialty Society</td>
<td>Delegate</td>
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<tr>
<td>Yessar Hussain, MD</td>
<td>Travis</td>
<td>Texas’ Inter-Specialty Society</td>
<td>Delegate</td>
</tr>
<tr>
<td>Name</td>
<td>CMS</td>
<td>Committee</td>
<td>Position</td>
</tr>
<tr>
<td>-------------------------------------------</td>
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<tr>
<td>Jeffrey B. Kahn, MD</td>
<td>Travis</td>
<td>Texas’ Inter-Specialty Society</td>
<td>Delegate</td>
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<tr>
<td>Thomas J. Kim, MD, MPH</td>
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<td>Council on Legislation</td>
<td>Member</td>
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<tr>
<td>Pradeep Kumar, MD</td>
<td>Travis</td>
<td>Texas’ Inter-Specialty Society</td>
<td>Delegate</td>
</tr>
<tr>
<td>Amanda Kimbrough LaViolette, MD, MPH</td>
<td>Travis</td>
<td>Texas’ Inter-Specialty Society</td>
<td>Delegate</td>
</tr>
<tr>
<td>Nina Lemieux</td>
<td>Travis</td>
<td>Medical Student Section</td>
<td>Delegate</td>
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<tr>
<td>C. Bruce Malone, III, MD</td>
<td>Travis</td>
<td>Texas Medical Association Past Presidents</td>
<td>Member</td>
</tr>
<tr>
<td>Sandeep G. Mistry, MD</td>
<td>Travis</td>
<td>Texas’ Inter-Specialty Society</td>
<td>Delegate</td>
</tr>
<tr>
<td>Debra A. Patt, MD</td>
<td>Travis</td>
<td>Council on Legislation</td>
<td>Member</td>
</tr>
<tr>
<td>Jack W. Pierce, MD</td>
<td>Travis</td>
<td>Texas’ Inter-Specialty Society</td>
<td>Delegate</td>
</tr>
<tr>
<td>Stanley S. Wang, MD, JD, MPH</td>
<td>Travis</td>
<td>Texas’ Inter-Specialty Society</td>
<td>Delegate</td>
</tr>
<tr>
<td>Kristin A. Wong, MD</td>
<td>Travis</td>
<td>Texas’ Inter-Specialty Society</td>
<td>Delegate</td>
</tr>
<tr>
<td>Allen B. Flack, MD</td>
<td>Wichita</td>
<td>Texas’ Inter-Specialty Society</td>
<td>Delegate</td>
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<tr>
<td>Jedidiah James Grisel, MD</td>
<td>Wichita</td>
<td>TMA Board of Councilors</td>
<td>Councilor</td>
</tr>
<tr>
<td>Ronak D. Ghiya, MD</td>
<td>Williamson</td>
<td>Resident and Fellow Section</td>
<td>Delegate</td>
</tr>
<tr>
<td>Matthew Ryan McGlennon, DO</td>
<td>Williamson</td>
<td>Resident and Fellow Section</td>
<td>Delegate</td>
</tr>
<tr>
<td>Susan M. Pike, MD</td>
<td>Williamson</td>
<td>Texas’ Inter-Specialty Society</td>
<td>Delegate</td>
</tr>
</tbody>
</table>
TMA Balloting Procedures

TMA BYLAWS REFERENCE

7.42  Balloting.

All elections shall be by secret ballot, and a majority of the votes cast shall be necessary to elect. When there are three or more nominees for a single position, the one receiving the least number of votes on each ballot shall be dropped until one of the said nominees receives a majority vote. When there is only one nomination, vote may be by acclamation.

When (1) two or more vacancies exist, and (2) there are three or more nominees, election procedures are as follows:

7.421  First ballot.

All nominees shall be listed in a randomly determined sequence on a single ballot. Each elector shall have as many votes as there are positions to be filled, and each vote must be cast for a different nominee. No ballot shall be counted if it contains fewer or more than the number of votes to be cast, or if the ballot contains more than one vote for any nominee. Nominees who receive (1) a vote on a majority of the legal ballots cast and (2) the highest majorities shall be elected to the vacancies to be filled.

7.422  Run-off ballot.

The house shall hold a run-off election to fill any vacancy that cannot be filled because of a tie vote.

7.423  Subsequent ballots.

If all vacancies are not filled on the first ballot and three or more positions are still to be elected, the number of nominees on subsequent ballots shall be no more than twice the number of remaining vacancies less one. The nominees on subsequent ballots shall be determined by retaining those who received the greater number of votes on the preceding ballot and eliminating those nominees who received the fewest number of votes on the preceding ballot, except when there is a tie. When two or fewer positions are still to be elected, the number of nominees on subsequent ballots shall be no more than twice the number remaining vacancies, with the nominees determined as indicated in the preceding sentence. On any subsequent ballot, the electors shall cast as many votes as there are positions yet to be elected, and must cast each vote for a different nominee. In any subsequent ballot, if no nominee receives a majority, the nominee receiving the least number of votes shall be dropped. This procedure shall be repeated until all vacancies have been filled.

ONLINE VOTING

Please refer to the TMA House Standing Rules – Special Circumstances, found in the General Information tab of this handbook, to review the process for online voting for the 2020 TMA House of Delegates contested races.
## CONTESTED ELECTIONS
### 2020

### OFFICERS

<table>
<thead>
<tr>
<th>Office</th>
<th>Incumbent</th>
<th>Eligible for Election</th>
<th>Term of Position</th>
<th>Candidates Announced as of April 26</th>
</tr>
</thead>
<tbody>
<tr>
<td>Three Trustees*</td>
<td>G. Ray Callas</td>
<td>Yes</td>
<td>2020-23</td>
<td>G. Ray Callas</td>
</tr>
<tr>
<td></td>
<td>Gary W. Floyd</td>
<td>Yes</td>
<td></td>
<td>Jefferson</td>
</tr>
<tr>
<td>Board of Trustees</td>
<td></td>
<td></td>
<td></td>
<td>John T. Carlo Dallas</td>
</tr>
<tr>
<td>Young Physician Member</td>
<td></td>
<td></td>
<td></td>
<td>Gary W. Floyd Tarrant</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Kimberly E. Monday Harris</td>
</tr>
<tr>
<td></td>
<td>Lindsay K. Botsford</td>
<td>No</td>
<td>2020-2022</td>
<td>M. Brett Cooper Dallas</td>
</tr>
<tr>
<td></td>
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<td></td>
<td>Joseph Maxwell Hendrix Dallas</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Melanie M. Vettimattam Tarrant</td>
</tr>
</tbody>
</table>

*Trustee positions are “at large,” not slotted. TMA Bylaws provide that all nominees for trustee will be listed on a single ballot. At-large trustees serve three-year terms.

## CONTESTED AMA DELEGATION ELECTIONS
### 2020

### ALTERNATE DELEGATES

<table>
<thead>
<tr>
<th>Alternate Delegates</th>
<th>Incumbent</th>
<th>Eligible for Reelection</th>
<th>Term (2 Years) Jan. 1-Dec. 31</th>
<th>Candidates Announced as of April 26</th>
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</thead>
<tbody>
<tr>
<td>1-3</td>
<td>Laura Faye Gephart*</td>
<td>–</td>
<td>2021-22</td>
<td>Shanna Combs</td>
</tr>
<tr>
<td></td>
<td>Vacant</td>
<td></td>
<td></td>
<td>Eddie L. Patton Jr.</td>
</tr>
<tr>
<td></td>
<td>Vacant</td>
<td></td>
<td></td>
<td>Jim Walton</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Yasser Zeid</td>
</tr>
</tbody>
</table>

Delegates and alternate delegates serve two-year terms, Jan. 1, 2021-Dec. 31, 2022.

*Dr. Gephart is moving out of state; this position will be vacant at TMA 2020 Annual Session.
Disclosure of Affiliations and Statement of Compliance with the
Conflicts of Interest Policy of the Texas Medical Association

The Conflicts of Interest Policy of the Texas Medical Association requires each member of the
Board of Trustees, each member of an association council, the executive vice president, the chief
operating officer, and staff vice presidents to disclose annually his or her affiliations and to
execute a statement confirming that, to his or her knowledge, the member or staff member has
complied with the conflicts of interest policy.

**Mere membership in professional or civic organizations does not require disclosure.**

Disclosure of affiliations by these individuals is intended to assist the Texas Medical Association
in resolving conflicts of interest. Such affiliations do not necessarily mean that a conflict of
interest exists or that the affiliation would unduly influence the board, council, or staff member.

TMA House of Delegates’ action also requires that a listing of the affiliations of candidates for
the Board of Trustees (at-large trustee or any office that includes an ex officio seat on the Board
of Trustees, i.e., president, president-elect, secretary/treasurer, and speaker and vice speaker of
the House of Delegates) be reported to the House of Delegates in the *Handbook for Delegates*.

A listing of the affiliations of all members of the Board of Trustees, the executive vice president,
the chief operating officer, and staff vice presidents will be distributed to all members of the
Board of Trustees at each meeting. A listing of the affiliations of all members of an association
council will be distributed to all members of that council at each meeting. A listing of the
affiliations of all members of the Board of Trustees also will be reported to the House of
Delegates in the *Handbook for Delegates* and on the TMA Web site, where access is limited to
members only.

Affiliations and changes in affiliations will be self-reported annually at the time of the TMA
Winter Conference.

The following terms used in this statement have the following meanings:

“**TMA**” means Texas Medical Association, TEXPAC, and “Related Entities” listed in
Attachment A.

“**Material financial interest**” means:
A. a financial ownership interest of 35% or more, or
B. a financial ownership interest which contributes materially (5% or more) to your
   income, or
C. a position as proprietor, director, managing partner, or key employee, or
D. any ordinary income, honorarium, or gift (other than dividends from stock)
   compensation exceeding $1,000 per year in excess of actual expenses.

“**Immediate family member**” shall mean spouse, parent, siblings and their spouses,
children or grandchildren.
Disclosure of Affiliations

Please complete each question to the best of your knowledge. You may list your answers directly on this form or you may provide your answers on a separate sheet of paper. If you attach your CV, please indicate on this form to which questions your CV responds, and please answer all questions not addressed by your CV.

1. Do you or an immediate family member hold or plan to hold a material financial interest in any business which furnishes goods or services, or is seeking to furnish goods or services, to TMA or to any member of the TMA Board of Trustees, TMA Executive Vice President, or TMA Chief Operating Officer?

   No: _____

   Yes: _____

   If yes, please list the name of each business, the type of goods or services involved, and what classification of material financial interest. Indicate the type of material financial interest by using A, B, C, or D as listed in the definitions of material financial interest shown at the bottom of the first page.

   __________________________________________

   __________________________________________

2. Did you or your immediate family receive any grant or other assistance (including the provision of goods, services, or use of facilities, regardless of amount) from TMA?

   No: _____

   Yes: _____

3. Do you or any immediate family member hold or plan to hold a material financial interest in any health care business, health insurance company, or health care facility, including a private medical practice?

   No: _____

   Yes: _____

   If yes, please list the name of each business or facility, provide a brief description of the type of business or facility, and what classification of material financial interest. Indicate the type of material financial interest by using A, B, C, or D as listed in the definitions of material financial interest shown at the bottom of page 1.

   __________________________________________

   __________________________________________
4. Are you or any immediate family member, or do you or any immediate family member anticipate becoming within the next 12 months, a trustee, director, officer, council or committee member, employee, or consultant of any health care organization, health insurance company, or health-related professional society?

No: _____

Yes: _____

If yes, please list the name of each organization, position held, and term of position. If the organization is not a nationally known organization, please provide a brief description of the organization.

__________________________________________________________________________

__________________________________________________________________________

5. Do you hold, or do you anticipate holding within the next 12 months, any paid faculty appointments?

No: _____

Yes: _____

If yes, please list the name of each institution, position held, and term of appointment.

__________________________________________________________________________

__________________________________________________________________________

6. Are you involved in, or do you anticipate becoming involved in, public representation and advocacy, including lobbying, on behalf of any organization?

No: _____

Yes: _____

If yes, please list the name of each organization and describe the nature of the activities in which you are or will be involved.

__________________________________________________________________________

__________________________________________________________________________
7. Are you or any immediate family member involved in any other organizational relationship, activity, or interest which may raise a conflict of interest or impair your objectivity on TMA policies or issues?

No: _____

Yes: _____

If yes, please describe each organizational relationship, activity, or interest.

________________________________________________________________________

________________________________________________________________________

Statement of Compliance with the Conflicts of Interest Policy

I understand that I am expected to conform with the Conflicts of Interest Policy of the Texas Medical Association. To my knowledge and belief, I am in compliance with the Conflicts of Interest Policy and have disclosed my affiliations. I understand that I have a continuing responsibility to comply with the Conflicts of Interest Policy of the Texas Medical Association, and I will promptly disclose any affiliations required to be disclosed under the policy.

Printed name: __________________________________________________________________

Date: _______________ Signature: __________________________________________________________________
RELATED ENTITIES

Two non-profit corporations for which the TMA Board of Trustees serves as the Board of Trustees.

- **TEXAS MEDICAL ASSOCIATION LIBRARY dba TMA KNOWLEDGE CENTER**
  - Ervin E. and Gertrude K. Baden Trust (Baden fund)

- **TEXAS MEDICAL ASSOCIATION SPECIAL FUNDS FOUNDATION**
  - Durham Endowment
  - Durham Student Loan Fund
  - Harriet Cunningham Memorial Graduate Fellowship in Medical Writing
  - Medical Student Loan Fund
  - Harris County Medical Society Alliance Scholarship Fund
  - Overton Annual Lectureship
  - Young Physician Section Rural Student Scholarship Fund
  - TMA Minority Scholarship Program
  - Krishna Memorial Scholarship
  - Patricia Lee Palmer, MD, Memorial Resident Loan Fund
  - Harold Smitson Medical Education Fund
  - directed public health and educational program funds
  - History of Medicine fund
  - Texas Medical Association Alliance Student Loan Fund

Two for-profit corporations for which members of the TMA Board of Trustees serve on the Board of Trustees.

- **TMA PRACTICE EDGE, LLC**
  The TMA Board of Trustees designates four of the seven Board of Managers members, two primary care physicians, a board member, and the TMA CEO.

- **TMA PRACTICE MANAGEMENT HOLDINGS, LLC**
  The TMA Board of Trustees selects three managers by virtue of their office-holder positions in TMA: TMA President, TMA Secretary/Treasurer, and the TMA CEO (Oversees TMASS and National PSO).

**TMA SPECIALTY SERVICES, LLC**
Governance has seven slots appointed by the Managers of Practice Management Holdings, LLC. TMA CEO is chair. The majority of managers are current or former board members.

One unincorporated nonprofit association for which the TMA Board of Trustees is denominated as the Board of Trustees.

- **THE PHYSICIANS BENEVOLENT FUND**

Three trusts for which members of the TMA Board of Trustees serve as Trustees.

- **ANNIE LEE THOMPSON LIBRARY TRUST FUND**

- **DR. S. E. THOMPSON SCHOLARSHIP FUND**
  Trustees of the Dr. S. E. Thompson Scholarship Fund, in addition to the members of the TMA Board of Trustees, include “Dean of the Medical Department of the University of Texas,” now assumed to be Executive Vice Chancellor, Health Affairs, UT System, a position currently held by Kenneth I. Shine, MD.

- **MAY OWEN IRREVOCABLE TRUST**
G. Ray Callas, MD, FASA, served his country in the U.S. Navy as a submariner during Operation Desert Storm. He then graduated from Texas A&M University, earned his medical degree from The University of Texas Medical Branch School of Medicine in Galveston (UTMB), and completed his anesthesiology residency at UTMB. Dr. Callas is a member of the Texas Medical Association’s (TMA) Board of Trustees and has served as a member of the TMA House of Delegates since 2004. In the past, he proudly served as chair of both the TMA Council on Legislation and the Council on Constitution and Bylaws. Committed to TEXPAC, Dr. Callas served on the TEXPAC Board of Directors and TEXPAC Candidate Evaluation Committee. He first joined TMA in 1996, while attending medical school, and is a graduate of the inaugural class of the TMA Leadership College. Dr. Callas also serves as chairman of the Texas Medical Liability Trust Board of Directors, chair of the governor-appointed Jefferson and Orange County Board of Pilot Commissioners, and as a commissioner on the Texas Department of Licensing and Regulation. In his community, Dr. Callas is advisory director of the Beaumont Chamber of Commerce.

He is a board-certified diplomat of the American Board of Anesthesiology. Dr. Callas has practiced medicine with Anesthesia Associates – one of the oldest incorporated and independent anesthesia groups in Texas – since 2004, currently serving as the chair of its Board of Directors. He serves multiple hospitals and surgical center facilitates in Jefferson County and Beaumont. Dr. Callas is relentless in his efforts to protect physicians and their patients through his work with Jefferson County Medical Society (JCMS), the Texas Society of Anesthesiologists (TSA), the American Society of Anesthesiologists, TMA, the American Medical Association (AMA), and the Beaumont community.

Dr. Callas has been involved in JCMS since 2005, serving as president in 2010, and is a current member of its Board of Directors. He serves on the TSA’s Board of Directors, where he is immediate past president. At TSA, he is actively involved in the Administrative Affairs, Governmental Affairs Committees Liaison for Legal and Legislative Services, and Nominating Committees, as well as serving on the TSAPAC Board.

**Personal Statement:** “I passionately believe that physicians must advocate actively for their patients, something I’ve done as chair of the Council on Legislation and as president of the Texas Society of Anesthesiologists in the halls of the Texas Capitol and the U.S. Capitol. I want to promote
professionalism in medicine and continue the work we started to boost TMA’s public image to our patients, elected officials, and legislators. I want to work for you to oversee and guide the association as an at-large-member of the Board of Trustees. Whether representing TMA, AMA, my county society, my specialty society, my practice, or my hospital – I speak out on behalf of the medical profession and for our patients. At a time when outside forces are trying to tear us apart, we Texas physicians need a strong and united TMA more than ever.”

PROFILE
Name: G. Ray Callas, MD, FASA
Specialty: Anesthesiology
Medical School (with year graduated):
The University of Texas Medical Branch at Galveston School of Medicine (UTMB), 2000
Residency Program: Anesthesiology UTMB
Board Certification(s): American Board of Anesthesiology
Primary Residence: Beaumont, Texas
Practice Type/Employment Status: Private practice full-time anesthesiologist/board member, 100%
Primary Practice/Employment Location: Anesthesia Associates, Beaumont, Texas
Do you expect to maintain your current employment status and location through your term in office? Yes
Does your current employment situation(s) require you to work outside of Texas? No
Including the past five years, list all other organizations from which you have received payment, reimbursement, or financial consideration for consulting, advisory, or leadership responsibilities exceeding $1,000 per year in excess of actual expenses:
Texas Medical Liability Trust
Baxter Healthcare
Cadance Pharmaceuticals
Blue Cross and Blue Shield of Texas Physicians’ Advisory Committee
Have you been convicted of a felony or is your medical license restricted? Please explain. No
What TMA positions have you held?
Current
• Member, Board of Trustees
• Patron member, TEXPAC
• Delegate, House of Delegates
• Delegate, Texas Delegation to the AMA
Past
• Chair, Council on Legislation
• Chair, Council Constitution and Bylaws
• Member, Interspecialty Society Committee
• Member, Balance Billing Task Force
• District chair, TEXPAC
• Member, TMA Foundation Board
• Member, Task Force on Physician Services Organization
• Mentor, TMA Leadership College (Graduate 2011)
• Member and Chair, TMA Council on Constitution and Bylaws
• Member, TMA of the Future
• Chair, Small Districts Caucus
• Alternate Delegate, House of Delegates
• Member, TEXPAC Candidate Evaluation Committee and TEXPAC Board of Directors

DISCLOSURE OF AFFILIATIONS
Anesthesia Associates
Texas Medical Liability Trust
Mallinckrodt Pharmaceuticals
Blue Cross Blue Shield of Texas
John T. Carlo, MD

The Dallas County Medical Society (DCMS) is pleased to nominate an outstanding and selfless leader in John T. Carlo, MD, MS, for election to the TMA Board of Trustees.

Dr. Carlo has broad experience as a clinician, health care executive, and public health champion. He is currently chief executive officer for Prism Health North Texas and president of AIDS Arms Physicians, Inc., the largest nonprofit, community-based HIV/AIDS health care service organization in North Texas. The organization provides primary care and HIV treatment for more than 13,000 patients, many who lack health insurance and need additional resources such as housing, transportation, and psychosocial services.

Dr. Carlo was previously the medical director for Dallas County Health and Human Services and appointed health authority from 2006-10. As a community public health advocate, Dr. Carlo has helped to strengthen the community’s response to numerous public health threats, including the H1N1 pandemic, West Nile Virus, and recent large-scale hurricane shelter responses.

Dr. Carlo is past president (2017) and chair of the Board (2018) of DCMS, the second largest medical society in the United States. Since 2007 he has chaired the DCMS Emergency Response Committee, which was a critical resource during the 2014 Ebola crisis in Dallas. For this effort he was awarded the Texas Medical Association (TMA) Presidential Award. Dr. Carlo currently serves on the TMA Council on Legislation and previously served as chair for both the Council on Science and Public Health and the Council on Socioeconomics. In 2017 he was elected by the American Medical Association’s House of Delegates to the AMA Council on Science and Public Health.

Dr. Carlo is recognized as a thought leader and national expert on public health, serving in the U.S. Department of Homeland Security’s and Federal Emergency Management Agency’s National Education Training Program. In this role, he advises local and state elected officials regarding issues on emerging infectious diseases and public health responses to disasters. Dr. Carlo is an active member of the AIDS United Public Policy Committee and the American Heart Association Texas Advocacy Committee.

Dr. Carlo received his medical degree from UT Southwestern Medical School in Dallas and did his residency in general surgery at Baylor University Medical Center. He received his master’s and bachelor’s degrees in biomedical engineering from Tulane University. He enjoys running long distances and living in East Dallas, Texas.
Candidate Profile
John T. Carlo, MD
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**Personal Statement:** “I would serve in order to help achieve the TMA vision to improve the health of all Texans at a critical time when our health care system is at an important crossroad. We must continue to advocate for our patients and our communities through the power of our collective voice fostered by the Texas Medical Association. At this critical time, we will lead with our creative ideas and innovation, as well as inspire everyone to reach towards a future that improves Texans’ health, increases access, remains physician-led, and is cost-efficient.”

**PROFILE**
Name: John T. Carlo, MD, MS
Specialty: Public Health
Medical School and Post Graduate Education: UT Southwestern Medical School, 1996-2000
Residency Program: General Surgery, Baylor University Medical Center, Dallas, TX
Primary Residence (City, State): Dallas, TX
What is your current practice status?
   Administrative: government, health plan, or health-related, but no direct patient care 100%
Primary Employer and Employment Location (city, state): Prism Health North Texas, Dallas, TX
Do you expect to maintain your current employment status and location through your term in office? Yes
Does your current employment situation(s) require you to work outside of Texas? If yes, what is the nature of that work and how many days each month do you work outside of Texas. No
Including the past five years, list all other organizations from which you have received payment, reimbursement, or financial consideration for consulting, advisory, or leadership responsibilities exceeding $1,000 per year in excess of actual expenses.
   Federal Emergency Management Agency (FEMA) funded Mobile Education Programs hosted by the Naval Postgraduate School and Creek Technologies.
Have you been convicted of a felony or is your medical license restricted? Please explain. No
What TMA positions have you held?
  **Current**
  • LGBTQ Health Workgroup, 2019-present
  • Council on Legislation, 2018-present
  • Alternate Delegate, Texas Delegation to the American Medical Association, 2015-present
  • American Medical Association’s Council on Science and Public Health, 2017-present
  • Texas Public Health Coalition, 2016-20; chair, 2018-20
  **Past**
  • Council on Science and Public Health, 2008-14; chair, 2013-14
  • TMA representative, Texas Commission for Environmental Quality’s Study of the Methods for Disposing of Unused Pharmaceuticals, 2009-10
  • Council on Socioeconomics, 2014-2018; chair, 2016-18
  • Be Wise – Immunize℠ Physician Advisory Panel, 2017-19
  • TMA-THA Task Force on Medicaid Physician Payment Reform, 2017-18
  • Workgroup on Firearm Safety, 2018-19

**DISCLOSURE OF AFFILIATIONS**
American Medical Association, Council on Science and Public Health, 2017-25
AIDS United, Public Policy Committee Representative, Advocates for federal funding under the Ryan White Program.
Tarrant County Medical Society (TCMS) is proud to nominate one of their proven leaders, Gary W. Floyd, MD, to continue as a member of the TMA Board of Trustees. Dr. Floyd received his medical degree from The University of Texas Medical Branch School of Medicine in Galveston in 1976. He completed his pediatric residency at Oklahoma Children’s Memorial Hospital. He has practiced pediatrics for more than 35 years in various capacities including private general pediatric practice, academic pediatrics, pediatric emergency and urgent care medicine, and administrative medicine as chief medical officer. He is board-certified by the American Board of Pediatrics and is a fellow of the American Academy of Pediatrics (AAP).

Experienced leaders will be important to guide our TMA with leadership transitions over the next months to years. Currently Dr. Floyd serves as chair of the TMA Board of Trustees, chair of the board’s Investment Committee, and vice chair of our Texas Delegation to the American Medical Association (AMA), where he serves on the Council on Legislation. He is a member of the TEXPAC Patron Club and the AMPAC Capitol Club. Previously he has served on the TMA Council on Constitution and Bylaws; the Select Committee on Medicaid, CHIP, and the Uninsured; and served on and chaired the TMA Council on Legislation.

Dr. Floyd is a recognized leader at the local, state, and national levels of government, as well as his specialty society and medical associations. He is a past president of the Tarrant County Medical Society, the Texas Pediatric Society (TPS), and the Texas Chapter of the AAP. In Tarrant County he serves as chair of the MedStar Ambulance System’s Emergency Physicians Advisory Board. Nationally, Dr. Floyd serves as AAP District VII (Arkansas, Louisiana, Mississippi, Oklahoma, Texas) chair and a member of the AAP Board of Directors as well as a member of the AMA Council on Legislation.

He has frequently testified before Texas House and Senate committees and visited with congressional leaders in Washington, D.C., concerning health care issues dealing with safe management and treatment of patients, issues that impact the viability of medical practice, and protection of physician’s clinical autonomy and independent medical judgment. He has been a strong voice for TMA policies before legislators for many years. His commitment to improving patient care, attempting to reduce regulatory burdens, and serving his colleagues in numerous leadership positions within TCMS, TMA, AMA, TPS, and AAP is a testament to his dedication to patients, colleagues, and our profession.
Personal Statement: “I have always been a passionate advocate for physicians and our patients concerning various health care issues. I believe the House of Delegates is the heartbeat of our TMA, and the members of the Board of Trustees serve to carry out the will of the house, oversee the governance and preserve the financial integrity of the organization. I would be honored to continue to represent you on the Board of Trustees, and I look forward to continuing to serve with each of you in our TMA House.”

PROFILE
Name: Gary W. Floyd, MD, FAAP
Specialty: Pediatrics
Medical School (with year graduated): The University of Texas Medical Branch School of Medicine, 1972-76
Residency Program: Pediatrics at Children’s Hospital of Oklahoma, The University of Oklahoma Health Science Center, 1976-79
Board Certifications: American Board of Pediatrics – Lifetime Certificate, 1983
Primary Residence: Keller, Texas
Practice Type/Employment Status: Academic – Self-employed consultant in government affairs and select pediatric primary and urgent care locum coverage
Primary Practice/Employment Location: Self-employed, Keller, Texas
Do you expect to maintain your current employment status and location through your term in office? Yes
Does your current employment situation require you to work outside of Texas? No
Including the past five years, list all other organizations from which you have received payment, reimbursement, or financial consideration for consulting, advisory, or leadership responsibilities exceeding $1,000 per year in excess of actual expenses:
• American Academy of Pediatrics
• TMA PracticeEdge Board of Trustees
• Texas Medical Foundation (TMF) Health Quality Institute Board of Trustees
Have you been convicted of a felony or is your medical license restricted? No
What TMA positions have you held?
• Tarrant County Medical Society alternate delegate to TMA, 1996-97; delegate, 1998-present
• Reference Committee on Socioeconomics in 1999, 2000 (chair), 2003
• Member, TMA Council on Constitution and Bylaws, 2002-06
• Member, TMA Council on Legislation, 2006-12; chair, 2011-12; consultant, 2012-16
• Chair, Ad Hoc Committee on Retail Health Clinics, 2008-09
• TEXPAC, District 9 chair, 2006-14; vice chair, 2005-06
• Select Committee on Medicaid, CHIP, and the Uninsured, 2007-14
• Delegation to AMA, alternate delegate, 2006-16; delegate, 2016-present; vice chair, 2016-present
• AMA Reference Committee B (Legislation), 2011, 2014; AMA Reference Committee F, 2015-17; AMA Council on Legislation, 2017-present
• Board of Trustees, 2014-present; Executive Committee, 2016-present; chair, Investment Committee, 2016-present; vice chair, 2019-2020; chair, 2020-present
• TMA PracticeEdge Board of Trustees, 2016-present

DISCLOSURE OF AFFILIATIONS
• American Academy of Pediatrics (AAP) District VII (AR, LA, MS, OK, TX) chair
• Member, AAP Board of Directors, January 2020-present
• TMA PracticeEdge Board of Trustees, 2016-present
• TMF Health Quality Institute Board of Trustees, 2015-present; chair 2019-present
• American Medical Association Council on Legislation, 2017-present
The Harris County Medical Society (HCMS) is proud to nominate Kimberly Monday, MD, as a candidate for the Texas Medical Association Board of Trustees.

Dr. Monday is board certified in neurology, clinical neurophysiology, and sleep medicine and is the co-founder of the Houston Neurological Institute.

Through her strong commitment to advocacy she has charted a career path that typifies what it means to be a physician leader. Only seven years after starting her practice she was elected president of her HCMS local branch society. She went on to win election to the HCMS Board of Medical Legislation, which she chaired in 2009. Two years later she was elected to the HCMS Executive Board and was elected president of the society in 2015.

An active member of TMA since 1997, Dr. Monday has served on the TMA Council on Socioeconomics and currently on the TMA Council on Legislation and the Prior Authorization Task Force.

In her effort to understand and positively affect the changing health care environment, Dr. Monday also accepted leadership positions outside of organized medicine. She chaired the bioethics and clinical ethics committees of three different Houston hospitals. She also currently serves on Memorial Hermann Physician Network Board of Directors.

Her leadership extends also to the community at large. Dr. Monday currently serves as the vice chair of the Harris Health Care System Board of Trustees.

Dr. Monday’s work has broadened her understanding of the issues that affect physicians and patients to include the context of the entire health care system. She can draw on her personal experience with the burdens placed upon physicians by bureaucrats. Her knowledge of the myriad socioeconomic and legislative topics with which she has worked over the last 15 years also gives her an understanding of the problems of both urban and rural physicians. But Dr. Monday also brings a deep understanding of the workings of hospitals – from large systems to small community hospitals. Finally, she can relate all these issues in the context of the medical safety net provided by a county hospital district that cares for the indigent.

Dr. Monday is ideally suited for the TMA Board of Trustees. She has immersed herself in the issues that are critically important to physicians and has demonstrated a commitment to lead that will serve TMA well.
**Personal Statement:** “Physicians are at a crossroads in our profession. We must decide if we are going to lead in health care or if we are going to succumb to those who value revenue over patient care. Every day we are taken advantage of by those whose only concern is the bottom line and then we are blamed for all the problems in health care. That must end. We owe it to ourselves and our patients to regain the status as the leaders of health care. As a member of the TMA Board of Trustees, I pledge to work toward that goal every day. I ask for your support.”

**PROFILE**
Name: Kimberly Monday, MD  
Specialty: Neurology  
Medical School (with year graduated):  
- Baylor College of Medicine, 1992  
- Baylor College of Medicine Transitional Internship, 1993  
- Baylor College of Medicine Neurology Residency and Chief Residency, 1996  
- Emory School of Medicine Clinical Neuropysiology Fellowship, 1997  
Residency Program: Baylor College of Medicine Department of Adult Neurology  
Board Certifications: American Board of Psychiatry and Neurology: Adult Neurology, Clinical Neuropsychology, Sleep Medicine  
Primary Residence: Houston, Texas  
Practice Type/Employment Status: Academic –  
- Direct Patient Care: large group practice (over 20 members), 50%  
- Academic, 50%  
Primary Practice/Employment Location: McGovern Medical School at UTHealth, Houston  
Do you expect to maintain your current employment status and location through your term in office? Yes  
Does your current employment situation require you to work outside of Texas? No  
Including the past five years, list all other organizations from which you have received payment, reimbursement, or financial consideration for consulting, advisory, or leadership responsibilities exceeding $1,000 per year in excess of actual expenses:  
- Memorial Hermann Hospital System  
Have you been convicted of a felony or is your medical license restricted? No  
What TMA positions have you held?  
**Current**  
- Council on Legislation, 2018-present  
- Prior Authorization Task Force, 2019-present  
- Delegate, 2004-05; 2010-present  
**Past**  
- Council on Socioeconomics, 2014-18  
- Medical Education Workgroup, Maintenance of Certification Reform, 2016-17  
- Task Force on Behavioral Health, 2014-16  
- Chair, TEXPAC District 11, 2015  
- Committee on Continuing Medical Education, 2009-12  

**DISCLOSURE OF AFFILIATIONS**  
Houston Neurological Institute: Single Specialty Group Medical Practice  
Class A Share Owner CHI Patient’s Medical Center Pasadena Texas  
Harris County Hospital District  
Neuroscience Service Line Medical Director Memorial Hermann Health Care System  
Memorial Hermann Physician Network  
Vice Chair Clinical Operations, Department of Neurology, UT McGovern Medical School Houston  
Texas Neurological Society
The Dallas County Medical Society (DCMS) is proud to nominate M. Brett Cooper, MD, for the Texas Medical Association Board of Trustees, young physician member.

Dr. Cooper has been a member of TMA since starting fellowship in 2015 and since that time, he has continued to further his involvement with the organization. Recognizing the need to advocate for policy that supports the health and well-being of the adolescent patients he sees; Dr. Cooper joined the Committee on Child and Adolescent Health as an RFS representative. This position led to opportunities to promote awareness of HIV PrEP through a CME session at TexMed 2017.

Upon moving to Dallas to start his faculty position, he became involved in DCMS, serving first as an alternate delegate to the HOD and now as a delegate. Dr. Cooper was honored to join the LGBTQ Health Workgroup in 2018, leading to a first of its kind CME session on LGBTQ Health at TexMed 2019, as well as a Texas Medicine cover story on the health care disparities faced by this population. He recently was asked to join the Ad Hoc Committee on Employed Physicians, working to find ways that TMA can best meet the needs of those members employed by a hospital/health system or in academic medicine.

Dr. Cooper is a 2019 graduate of the TMA Leadership College, joining the ranks of other young physicians who play a crucial role in ensuring that this organization continues to be an effective advocate for the both the practice of medicine and for the health and well-being of the patients whom we serve. His participation in the Leadership College has prepared him well to be an effective member of the Board of Trustees.

In addition to his work at TMA, Dr. Cooper also serves as the advocacy chair for the TX Regional Chapter of the Society for Adolescent Health and Medicine. This position allows him to coordinate with advocacy groups across the state on behalf of physicians and patients.

Personal Statement: “As one of the most regulated professions, medicine is constantly under attack from those wishing to control our profession and the way in which we practice. It is imperative for physicians to be advocates for ourselves and our patients in order to maintain the sanctity of the physician-patient relationship. As an adolescent medicine physician, I see this on a daily basis, and I will continue to fight to maintain this relationship. In addition, as an academic physician, I believe that I can be an effective voice on the Board to help TMA maintain relevance to an ever-changing dynamic of physician practice settings.”
Candidate Profile  
M. Brett Cooper, MD  
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PROFILE
Name: M. Brett Cooper, MD 
Specialty: Pediatrics-Adolescent Medicine 
Medical School and Post Graduate Education:  
Residency Program:  
Residency, University of Toledo, General Pediatrics, 2015  
Fellowship, Baylor College of Medicine, Adolescent Medicine, 2018 
Board Certifications:  
Board Certified, General Pediatrics, the American Board of Pediatrics (ABP)  
Board Eligible, Adolescent Medicine, ABP 
Primary Residence (City, State): Plano, Texas  
What is your current practice status? Academic (direct patient care and teaching), 100%. 
Primary Employer and Employment Location (city, state): 
Employed by UT Southwestern Medical Center, Dallas, Texas. 
Do you expect to maintain your current employment status and location through your term in office? Yes 
Does your current employment situation(s) require you to work outside of Texas? If yes, what is the nature of that work and how many days each month do you work outside of Texas. No 
Including the past five years, list all other organizations from which you have received payment, reimbursement, or financial consideration for consulting, advisory, or leadership responsibilities exceeding $1,000 per year in excess of actual expenses. N/A 
Have you been convicted of a felony or is your medical license restricted? Please explain. No 
What TMA positions have you held? 
Current 
• Member, Ad Hoc LGBTQ Workgroup, 2018-present  
• Committee on Child and Adolescent Health, 2018-present  
• Member, Ad Hoc Committee on Employed Physicians, 2019-present  
• Delegate, Dallas County Medical Society, 2019-present  
• Committee on Membership, Dallas County Medical Society, 2020-present  
• YPS Delegate to the AMA, 2020-present  
Past  
• TMA Leadership College, Class of 2019  
• RFS Member, Committee on Child and Adolescent Health, 2015-18  
• Alternate Delegate, Dallas County Medical Society, 2018-19

DISCLOSURE OF AFFILIATIONS 
Assistant Professor of Pediatrics, UT Southwestern Medical School. Current contract runs through Aug. 31, 2020 and is renewed annually.
Joseph M. Hendrix, MD

Joseph M. Hendrix, MD, promotes a healthy society, empowering the achievement of full potential by actively educating students, medical professionals, and others. Dr. Hendrix currently serves as an assistant professor, teaching medical, graduate, and postgraduate students as part of the UT Southwestern (UTSW) Texas Health Resources Institute for Exercise and Environmental Medicine. At UTSW, he utilizes superior organizational, interpersonal, analytical, and time management skills to provide hands-on learning opportunities for medical students and residents – while communicating with colleagues and students in ways that inspire critical thinking and engagement.

Dr. Hendrix balances the supervision of many graduate student rotations on a monthly basis, while also providing rotation supervision and interactive learning opportunities for medical students in both research and clinical settings. Dr. Hendrix also invests in the professional development of several graduate student trainees each semester by providing medical direction, teaching, and supervision of residents, interns, and fellows in the perioperative environment, maximizing learning opportunities to help each become an excellent doctor optimally prepared to serve the needs of patients and society. Dr. Hendrix believes in the benefits of mentorship and works diligently to instruct and guide several postgraduate medical students each semester through didactic and small group teaching in clinical and research settings. He has served as an invited lecturer at the national, regional, and local level. He has provided many beneficial lectures as an invited participant in various UTSW lecture settings.

Dr. Hendrix’s dedication to serving others through medicine has compelled him to serve on several leadership and advisory committees. In 2016, Dr. Hendrix took on the responsibility of co-chairing the UTSW Endoscopy Lab Committee, ensuring that the lab continues to strive for the highest standards of clinical excellence, while developing new knowledge to serve the needs of patients in the community. Dr. Hendrix has continued to distinguish himself in his field, and in 2018 began serving as a case review expert for the Texas Medical Board in the areas of anesthesiology and pain medicine. He also serves as an ad hoc reviewer for the International Anesthesia Research Society. He consistently leads by example and embodies UTSW’s core values of working with excellence and shared purpose. He is a member of several professional organizations, including the American Academy of Pain Medicine, where he serves as a member of the Ethics Council Committee; the Association of American Medical Colleges Committee on
Educational Affairs; the Institute for Healthcare Improvement; and the Society for Education in Anesthesia, among others.

Outside the field of medicine, Dr. Hendrix supports or is a member of several organizations focused on building meaningful relationships and connections that foster greater social inclusion and well-being, including Dallas Multifaith Outreach, the Texas Women’s Foundation, and the Jewish Federation of Greater Dallas. His record of exceptional clinical ability, excellent teaching, and noteworthy accomplishments in both clinical research and service to the medical community makes him an ideal candidate for the Young Physician TMA Board Member to the TMA Board of Trustees.

PROFILE
Name: Joseph Maxwell Hendrix, MD
Specialty: Anesthesiology
Medical School and Post Graduate Education (with years):
   University of Michigan Medical School, 2002-06
Residency Program:
   UT Southwestern Medical Center, Anesthesiology
Board Certification(s): Anesthesiology, Pain Medicine, Transesophageal Echocardiography
Primary Residence (City, State): Irving, Texas
What is your current practice status? Check all that apply and provide percentages:
   Direct Patient Care: large group practice (over 20 members) 80%
   Academic 10%
   Research (non-clinical) 10%
Primary Employer and Employment Location (city, state):
   University of Texas Southwestern Medical School, Dallas, Texas
Do you expect to maintain your current employment status and location through your term in office? Yes
Does your current employment situation(s) require you to work outside of Texas? If yes, what is the nature of that work and how many days each month do you work outside of Texas. No
Including the past five years, list all other organizations from which you have received payment, reimbursement, or financial consideration for consulting, advisory, or leadership responsibilities exceeding $1,000 per year in excess of actual expenses.
   Texas Medical Board
Have you been convicted of a felony or is your medical license restricted? Please explain. No
What TMA positions have you held?
Current
   • TMA Leadership College, 2019-20

DISCLOSURE OF AFFILIATIONS
Texas Society of Anesthesiologists House of Delegates, alternate delegate
UT Southwestern Medical School, assistant professor, 2012-present
The Tarrant County Medical Society (TCMS) is honored to endorse the candidacy of Melanie Vettimattam, MD, for Young Physician Section board member to the Texas Medical Association Board of Trustees.

Dr. Vettimattam has practiced in a large group practice for the last two years. In that time, she built a practice, discovered the nuances of coding, and learned how to manage her staff – none of which were taught in medical training. As the Young Physician Section board member, she intends to help other young physicians tackle these same issues.

In the beginning of her career, Dr. Vettimattam felt helpless to a tangled web of corporate policies. She took the opportunity to join the Best Practices Committee in her organization, which broadcasted best practices for all providers. After just one year, her dedication was recognized when she was asked to chair the committee. Since becoming committee chair, she has had input on corporate policies and been empowered to highlight some of these issues to corporate leadership. As the Young Physician Section board member, she is excited to help shape policies to benefit her peers.

She also believes it is vitally important to become involved in the local community. As a volunteer at Mission Arlington (a local free clinic), she discovered numerous local financial resources available which she was then able to bring to her practice to assist her patients. Being a “young physician” is no excuse for ignorance of these policies. Being involved in the local community and networking with peers creates sharper professionals with a higher standard of patient care.

Network opportunities are also a great way to discuss ongoing struggles that each physician faces. Being involved in health care policy at the national and state level is becoming more and more important. Health care policies impact the daily workload of physicians and are increasing the administrative burdens for young physicians. Dr. Vettimattam would like to provide more opportunities for young physicians to network with each other – to learn, coordinate, and teach each other.

**Personal Statement:** “As a young physician, I know how bewildering and terrifying the practice of medicine can be. It is overwhelming to try and practice good medicine, meet metrics, build a solid practice, and make connections with fellow physicians. Being part of the young physicians committee has helped me to navigate some of these obstacles. If you vote for me as Young Physician Section representative, I will do my best to forge relationships between fellow physicians, help ensure comraderies, and bring to the forefront some challenges facing new physicians in an ever-changing health care environment.”
PROFILE
Name: Melanie Vettimattam, MD
Specialty: Family Medicine
Medical School and Post Graduate Education (with years):
   McGovern School of Medicine at UTHealth, 2010-14
Residency Program:
   Augusta University (formerly Medical College of Georgia), Family Medicine, 2014-17
Board Certification(s): American Board of Family Medicine
Primary Residence (City, State): Fort Worth, Texas
What is your current practice status? Check all that apply and provide percentages:
Direct Patient Care: large group practice (over 20 members) 100%
Primary Employer and Employment Location (city, state): USMD, Bedford, TX
Do you expect to maintain your current employment status and location through your term in office? Yes
Does your current employment situation(s) require you to work outside of Texas? If yes, what is the
nature of that work and how many days each month do you work outside of Texas. No
Including the past five years, list all other organizations from which you have received payment,
reimbursement, or financial consideration for consulting, advisory, or leadership responsibilities
exceeding $1,000 per year in excess of actual expenses.
   None
Have you been convicted of a felony or is your medical license restricted? Please explain. No
What TMA positions have you held?
Current
   • Member, Young Physicians Section
   • Member, Women in Medicine Section

DISCLOSURE OF AFFILIATIONS
Texas A&M College of Medicine, affiliated faculty member, 2020-22
AMA Alternate Delegate
(Vote for three)

Shanna M. Combs, MD

Tarrant County Medical Society (TCMS) is proud to nominate one of their leaders, Shanna M. Combs, MD, as an alternate delegate to the American Medical Association. Dr. Combs has been active in organized medicine since medical school. She attended the University of New Mexico School of Medicine in Albuquerque, N.M. During her time in medical school she became involved with the New Mexico Medical Society and with mentorship from local physicians, Dr. Combs became a delegate to the American Medical Association. After medical school, Dr. Combs completed her residency at John Peter Smith Hospital in Fort Worth.

Dr. Combs practices in Fort Worth as an obstetrician/gynecologist. She initially became involved with the Texas Medical Association (TMA) as a member and eventually chair of the Committee of Reproductive, Women’s, and Perinatal Health. She has continued her work with TMA as a member of the Committee on Membership as well as the LGBTQ Health Work Group.

Dr. Combs has become increasingly involved at the local level with TCMS. She has contributed to Women in Medicine, Young Physician, and Medical Student events for county members. In 2018, she was elected to be the treasurer/secretary and now serves as the vice president of TCMS. She has also contributed to Project Access Tarrant County as a volunteer physician as well as recruited other local physicians to the program. She is an active participant in the Board of Advisors as well as the Board of Directors for TCMS.

Dr. Combs is a medical educator and has been an assistant professor at the Texas College of Osteopathic Medicine since graduation from residency. She has also been actively involved in the development of the new TCU and UNTHSC School of Medicine and is now the Obstetrics and Gynecology Clerkship Director for the new school. She is actively involved with the Texas Association of Obstetricians and Gynecologists as well as with District XI (Texas) of the American College of Obstetricians and Gynecologists, where she now serves as the Medical Student Advisor. She is always working with medical students and residents to help them see the importance of involvement in organized medicine as a contribution to their profession.

Dr. Combs has contributed to work at the national and state level on maternal health, women’s health, mental health, LGBTQ health, as well as the importance of physician autonomy. She will be an asset to the TMA delegation to the American Medical Association.
**Personal Statement:** “I have always been a passionate advocate for my patients through my work at the regional, state, and national level. Our state has faced a maternal health crisis. Through my work at TMA as well as with the ACOG and TAOG, I have worked to make Texas a safer place for women to give birth and for their children to have a healthy mother. Through continued advocacy with the American Medical Association, I hope to continue to be a powerful voice for my patients and fellow physicians.”

**PROFILE**

Name: Shanna M. Combs, MD, FACOG  
Specialty: Obstetrics and Gynecology  
Medical School and Post Graduate Education (with years):  
- University of New Mexico School of Medicine, 2004-08  
Residency Programs:  
- John Peter Smith Hospital, Fort Worth, Texas, 2008-12  
Board Certification(s):  
- American Board of Obstetrics and Gynecology  
Primary Residence (City, State): Fort Worth, Texas  
What is your current practice status? Check all that apply and provide percentages:  
- Direct Patient Care: large group practice (over 20 members), 60%  
- Academic, 30%  
- Other; please describe: TexasAIM physician champion at JPS Hospital, 10%  
Primary Employer and Employment Location (city, state): Acclaim Physician Group, Fort Worth, Texas  
Do you expect to maintain your current employment status and location through your term in office? Yes  
Does your current employment situation(s) require you to work outside of Texas? If yes, what is the nature of that work and how many days each month do you work outside of Texas. No  
Including the past five years, list all other organizations from which you have received payment, reimbursement, or financial consideration for consulting, advisory, or leadership responsibilities exceeding $1,000 per year in excess of actual expenses.  
- ACOG Maternal Levels of Care Site Surveyor  
Have you been convicted of a felony or is your medical license restricted? Please explain. No  
What TMA positions have you held?  
**Current**  
- Vice President, Tarrant County Medical Society, 2020  
- Delegate, Tarrant County Medical Society, 2017-present  
- Member, Committee on Membership, 2018-present  
- Consultant, Committee on Reproductive, Women's and Perinatal Health, 2018-present  
- Member, Workgroup on LGBTQ Health, 2017-present  
**Past**  
- Secretary/Treasurer, Tarrant County Medical Society, 2019  
- TMA Leadership College, 2017-18  
- Chair, Committee on Reproductive, Women's, and Perinatal Health, 2016-18  
- Vice chair, Committee on Maternal and Perinatal Health, 2014-16  
- Member, Committee on Reproductive, Women’s, and Perinatal Health, 2013-18
The Harris County Medical Society (HCMS) is honored to nominate Eddie Patton Jr., MD, MBA, as a candidate for alternate delegate to the American Medical Association.

Dr. Patton is a board-certified neurologist with additional training and expertise in neuro muscular disorders. He received his medical degree from Wayne State University and completed his residency and a fellowship at Baylor College of Medicine. He then went on to obtain an MBA from the Jones School of Business at Rice University. He has been a private practicing neurologist in Houston since 2011.

Dr. Patton has a firm grasp on the importance of public policy and how it affects the practice of medicine. He chose to be a physician leader from the beginning. At the same time as he began his practice in 2011, he ran for, and won, an officer position in his HCMS branch organization, ultimately serving as branch president in 2014-15. He is a 2014 graduate of the TMA Leadership College and a 2016 graduate of the American Academy of Neurology’s (AAN) Emerging Leaders Forum.

Dr. Patton is well-versed in the intricacies and issues of state and federal government. He is currently a member of the HCMS Board of Medical Legislation and in 2018 was appointed by Gov. Greg Abbott to the Texas Council on Alzheimer’s Disease and Related Disorders. He was elected in 2019 to serve as vice chair of this council. From 2015-18, he has chaired the Federal Advocacy Work Group of the AAN. As chair, Dr. Patton is responsible for aiding in the creation and execution of the federal advocacy agenda for the AAN. He has been a part of lobbying campaigns on numerous occasions both federally with Neurology on the Hill, sponsored by the AAN, and here in Texas through TMA’s First Tuesdays at the Capitol.

If elected, Texas physicians will be well represented by an established leader with wide ranging public policy experience and with the youthful exuberance to be a leader in the AMA for years to come.

*Personal Statement:* “There is no doubt that public policy decisions made in Washington, D.C., exert tremendous influence on our practices and on the lives of our patients. Conversely, Texas physicians have a proud history of exerting as much influence as we can back on the policy-making process. I believe the AMA would benefit from that spirit of Texas advocacy. It is time that MD’s take a more prominent position in guiding changes in health care. My education and experiences give me a unique view of all aspects of
health care policy including the impact on physicians, patients, and the economy. I want to see the AMA take a more forceful role in health care policy development and implementation in Washington just like TMA has done so effectively in Texas. And I want to be a part of the Texas delegation that leads the AMA to the position of influence it should hold.”

PROFILE
Name: Eddie L. Patton Jr., MD, MBA
Specialty:
Medical School and Post Graduate Education (with years):
  - Wayne State University School of Medicine, Doctor of Medicine, 2005
  - Rice University Jones School of Business, Master of Business Administration, 2018
  - Alabama State University, Master of Science, 2001
Residency Programs:
  - Baylor College of Medicine, 2006-09
  - Neuromuscular Fellowship, Baylor College of Medicine, 2009-11
Board Certification(s): American Board of Psychiatry and Neurology
Primary Residence (City, State): Sugar Land, Texas
What is your current practice status? Check all that apply and provide percentages:
  - Direct Patient Care: large group practice (over 20 members), 100%
Primary Employer and Employment Location (city, state):
  - University of Texas Department of Neurosciences, Houston, Texas
Do you expect to maintain your current employment status and location through your term in office? Yes
Does your current employment situation(s) require you to work outside of Texas? If yes, what is the nature of that work and how many days each month do you work outside of Texas? No
Including the past five years, list all other organizations from which you have received payment, reimbursement, or financial consideration for consulting, advisory, or leadership responsibilities exceeding $1,000 per year in excess of actual expenses.
  - Alexion – Speakers Bureau
  - Biogen – Speakers Bureau
Have you been convicted of a felony or is your medical license restricted? Please explain. No
What TMA positions have you held?
  - TMA Leadership College, class of 2014
  - Socioeconomics Reference Committee
  - HCMS Delegation to TMA
  - Young Physician Representative to AMA
The Dallas County Medical Society is pleased to announce the candidacy of James (Jim) W. Walton, DO, MBA, FACP, for election as an alternate delegate to the American Medical Association.

Dr. Walton is an experienced and innovative physician leader. He has been chief executive officer for Genesis Physicians Group since 2013, providing executive leadership to more than 1,700 physician and allied health members in a North Texas independent practice association (IPA). Through Genesis, Dr. Walton also established an innovative Accountable Care Organization (ACO), contracting with commercial, Medicare Advantage, Medicaid, and the Centers for Medicare & Medicaid Services for value-based care. Prior to Genesis, Dr. Walton served at Baylor Health Care System from 1996-2013 in senior positions such as vice president of Community Health Improvement, vice president and chief health equity officer, and vice president of Network Performance/Baylor Quality Alliance.

Dr. Walton has been a strong leader in organized medicine. He is a past president (2015) and chair of the Board (2016) of the Dallas County Medical Society (DCMS), the second largest medical society in the United States. From 2000-12, Dr. Walton volunteered countless hours as medical director for Project Access Dallas, a project sponsored by DCMS. Project Access improved health care access for the Dallas working poor through the coordination of a county-wide network of hospital, professional, and social service volunteers. Dr. Walton currently serves as co-chair of the DCMS Socioeconomics Committee and was chair of the Community Service Committee from 2006-13. Dr. Walton contributes his time to the Visiting Nursing Association as a member of the Board of Directors and volunteer. Finally, Dr. Walton was member of the District 3 Dallas County Commissioner Health Advisory Committee (2006-11) and member of the University of Texas at Dallas Healthcare Executive Council (2016-present). He currently teaches health care management as undergraduate adjunct faculty at UT Dallas’ Jindal School of Management.

Dr. Walton is a subject matter expert in value-based care models and health equity. He has published extensively on health care quality, financing, and reducing disparities through effective community health programs. He has been recognized for his health economics work in D Magazine, Modern Healthcare, and The Dallas Business Journal.

Dr. Walton received his Doctor of Osteopathic Medicine from the University of North Texas Health Science Center and completed his residency in internal medicine at Methodist Hospital of Dallas. He received his master’s in business administration from the University of Michigan.
Candidate Profile
Jim Walton, DO
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Personal Statement: “To represent TMA at the American Medical Association provides me the opportunity to bring my diverse medical practice and health care administrative experiences together as the Texas delegation advocates for patients and physicians in the current and future policy developments. As health care policy has taken center stage in our national dialogue, there will be important opportunities to advance the physician’s voice and our collective narrative around the practice of medicine in Texas.”

PROFILE
Name: James (Jim) Walton, DO, MBA, FACP
Specialty: Internal Medicine
Medical School and Post Graduate Education (with years):
   University of North Texas Health Science Center at Fort Worth, Texas College of Osteopathic Medicine, 1978-82
Residency Program: Miami Valley Hospital (PSY1 & PGY2); Methodist Hospital of Dallas (PGY3)
Board Certification(s): American Board of Internal Medicine
Primary Residence (City, State): Dallas, Texas
What is your current practice status?
   Administrative: government, health plan, or health-related, but no direct patient care 100%
Primary Employer and Employment Location (city, state): Genesis Physicians Group, Dallas, TX
Do you expect to maintain your current employment status and location through your term in office? Yes
Does your current employment situation(s) require you to work outside of Texas? If yes, what is the nature of that work and how many days each month do you work outside of Texas. No
Including the past five years, list all other organizations from which you have received payment, reimbursement, or financial consideration for consulting, advisory, or leadership responsibilities exceeding $1,000 per year in excess of actual expenses.
   Innovista Health Solutions
   The University of Texas at Dallas
   Aetna, Inc.
Have you been convicted of a felony or is your medical license restricted? Please explain. No
What TMA positions have you held?
   Current
   • Member, 1990-present
   • Dallas County Medical Society delegate to TMA
   • Member, Select Committee on Medicaid, CHIP, and the Uninsured
   • Member, Workgroup on Value-Based Payment Initiatives
   Past
   • Member, Council of Socioeconomics
   • Member, Patient-Physician Advocacy Committee
AMA Alternate Delegate
(Vote for three)

Yasser Zeid, MD

Gregg-Upshur and Smith County Medical Societies and the Lone Star Caucus are proud and honored to nominate Yasser Zeid, MD, for the position of alternate delegate to the American Medical Association. Dr. Zeid has been an active member of organized medicine and the Texas Medical Association for more than 22 years. He is a dedicated leader with extensive knowledge in private practice management, especially in a rural setting, and patient access issues, especially for Medicaid recipients and the underinsured, as well as legislative issues including tort reform and scope of practice.

Dr. Zeid has been in private practice in East Texas for more than 22 years. It has been a challenge and has required a thorough understanding of the health care delivery system in order to survive acquisition by surrounding hospitals and larger groups – yet continue to provide quality care to his patients. Dr. Zeid is proud to be still practicing medicine in a private setting. Dr. Zeid is dual-boarded in obstetrics/gynecology and female pelvic medicine and reconstructive surgery (FPMRS).

Dr. Zeid joined TMA in 1997 and became involved shortly before Proposition 12 in 2001-02. Since then he has been a member of the Ad Hoc Committee on Medicaid and the Uninsured and a member, and later chair, of the Committee on Maternal and Prenatal Health. He was also a member of the Council on Public Health prior to being appointed to the Council on Legislation. He has also been involved in TEXPAC, a Patron member, member of the TEXPAC board, Chair of SD#1, and a member of the Candidate Evaluation Committee. He served multiple terms as the president of the Rusk County Medical Society and the Gregg-Upshur County Medical Society. He recently moved his main office from Longview to Tyler and plans to transition to the Smith County Medical Society after TexMed. Dr. Zeid was appointed by Gov. Greg Abbott to serve on the Statewide Health Coordinating Council.

Personal Statement: “I believe serving as an AMA Alternate Delegate would provide a platform not only to understand the ever-changing climate of health care but also would allow me to bring to the AMA the challenges that Texas physicians face in rural East Texas and help influence the national dialogue in a way that would benefit Texas patients and physicians under the leadership of TMA.”
PROFILE
Name: Yasser Zeid, MD
Specialty: Obstetrics and Gynecology, Female Pelvic Medicine and Reconstructive Surgery
Medical School and Post Graduate Education (with years):
   Ain Shams University, Cairo Egypt, 1988
Residency Programs:
   St. Luke’s Hospital, Bethlehem, PA transitional year residency, 1993
   The Brooklyn Hospital Center, Brooklyn, NY Obstetrics and Gynecology, 1997
Board Certification(s):
   American Board of Obstetrics and Gynecology, 2000
   Female Pelvic Medicine and Reconstructive Surgery, 2016
Primary Residence (City, State): Tyler, Texas
What is your current practice status? Check all that apply and provide percentages:
   Direct Patient Care: solo, small group, or shared overhead, 90%
   Administrative: government, health plan, or health-related, but no direct patient care, 10%
Primary Employer and Employment Location (city, state): Zeid Medical Group
Do you expect to maintain your current employment status and location through your term in office? Yes
Does your current employment situation(s) require you to work outside of Texas? If yes, what is the nature of that work and how many days each month do you work outside of Texas. No
Including the past five years, list all other organizations from which you have received payment, reimbursement, or financial consideration for consulting, advisory, or leadership responsibilities exceeding $1,000 per year in excess of actual expenses. None
Have you been convicted of a felony or is your medical license restricted? Please explain. No
What TMA positions have you held?
Current
   • Delegate, Gregg-Upshur County Medical Society, 2006-14 and 2016-present
   • Member, Ad Hoc Committee on Medicaid and the Uninsured, 2008-present
   • Member, Council on Legislation, 2017-present
   • Member, Taskforce on Prior Authorization, 2019-present
   • Member, board member, Candidate Evaluation Committee member and SD #1 chair, TEXPAC, 2005-present
Past
   • Delegate, Rusk County Medical Society, 2005
   • President, Rusk County Medical Society
   • President, Gregg-Upshur County Medical Society, 2012-13 and 2018
   • Member and Chair, Committee on Maternal and Perinatal Health, Member 2006-12, Chair 2010-12
   • Member, Council on Science and Public Health, 2012-17
   • Member, Task Force to Reduce Administrative Hassle with Managed Care and Medicaid as Mandated by SB 1150, 2014-15
2019 AUDIT TRAIL

Action Items Adopted or Referred by the
Texas Medical Association House of Delegates

Awards/nominations, amendments to the Constitution and Bylaws, and policy review recommendations are not included.

FROM REFERENCE COMMITTEE ON FINANCIAL AND ORGANIZATIONAL AFFAIRS:

Board of Councilors Report 6 – Sunset Policy Review: That: (1) policies 245.010, Physician Discrimination, 160.019, Temporary Texas License for Medical Opinion and Testimony, and 160.012, Antitrust Laws, be retained; (2) policies 195.029, Registry for Advance Directives, and 105.017, Privacy of Medical Records, be deleted; and (3) policy 165.004, Government Competency Checks, be retained as amended. Adopted.

REFERRED TO: Add to TMA Policy Compendium

STATUS: (1) Policies 245.010, 160.019, and 160.012 reaffirmed in TMA Policy Compendium; (2) policies 195.029 and 105.017 deleted from TMA Policy Compendium; and (3) policy 165.004 amended in TMA Policy Compendium.

Board of Trustees Report 14 – Inactive County Medical Societies: That TMA: (1) define an active county medical society as one that provides the following annually: (a) a list of the reporting year’s elected officers and delegates with their terms of office; (b) a list of the reporting year’s meetings with attendance noted; (c) confirmation of the county medical society annual membership dues rate; and (d) evidence of filing county medical society annual federal nonprofit tax returns, such as IRS Form 990; (2) allow county medical societies with 50 or fewer members to reduce the number of required officers to three: president, president-elect, and secretary/treasurer; and (3) refer Board of Trustees Report 14-A-19 to the Council on Constitution and Bylaws for recommended bylaws amendments to implement recommendations 1 and 2. Adopted.

REFERRED TO: Council on Constitution and Bylaws


REFERRED TO: Add to TMA Policy Compendium

STATUS: Policies 105.018 and 160.018 reaffirmed in TMA Policy Compendium.


REFERRED TO: Council on Constitution and Bylaws

STATUS: Updated TMA Bylaws to reflect amendments adopted by the house.
Committee on Physician Health and Wellness Report 1 – Policy Review and Amendment to Committee Charge: That: (1) Policy 95.014, Drug Screening of Physicians, be deleted; and (2) TMA Bylaws Section 10.621, Committee on Physician Health and Wellness be amended. Adopted.

REFERRED TO: (1) Add to TMA Policy Compendium and (2) Council on Constitution and Bylaws

STATUS: (1) Policy 95.014 deleted from TMA Policy Compendium; (2) Updated TMA Bylaws to reflect amendments adopted by the house.


REFERRED TO: Add to TMA Policy Compendium

STATUS: Policy 265.019 reaffirmed in TMA Policy Compendium.


REFERRED TO: Add to TMA Policy Compendium

STATUS: Policy 245.009 reaffirmed in TMA Policy Compendium.

Council on Practice Management Services Report 1 – Patient-Centered Medical Responsibilities (Resolution 101-A-18): That the Texas Medical Association (1) support a patient-centered medical record checkup campaign encouraging individuals to ensure they have an up-to-date medical record summary that is accessible in a disaster; and (2) applaud House Concurrent Resolution No. 143, designating May 1 as Texans Medical Record Checkup Day, adopted by the 86th Texas House of Representative. Adopted as amended.

REFERRED TO: (1) TMA Communications Division and Council on Health Promotion (2) No action needed for item 2

STATUS: (1) TMA Communications wrote and distributed a news release to media outlets statewide in late-April, promoting Texans Medical Record Checkup Day (May 1) and the need for patients to understand how they can obtain their medical record summaries via their physicians’ online portal. TMA also will solicit a physician author for a Me And My Doctor blog post to educate the public about this issue. TMA Communications also ran an infographic in the April Texas Medicine magazine and in Texas Medicine Today, informing physicians about this issue and the importance of patients understanding this process. (2) No action needed for item 2.

Council on Practice Management Services Report 3 – Establish a Standing Committee on Health Information Technology: That: (1) TMA establish a standing Committee on Health Information Technology, and (2) TMA Bylaws Chapter 10, Committees, Section 10.52 be amended to include a new section for the Council on Practice Management Services, with a new subsection, 10.521, Committee on Health Information Technology to read as follows, and the remainder of the chapter be renumbered accordingly. Adopted.

REFERRED TO: Council on Constitution and Bylaws and TMA President
STATUS: (1) Standing Committee on Health Information Technology has been appointed. (2) Updated TMA Bylaws to reflect amendments adopted by the house.

Council on Socioeconomics Report 4 – Establishing a Standing Committee on Medicaid, CHIP, and the Uninsured: That: (1) the select committee on Medicaid, CHIP, and the Uninsured be made a standing committee called the Committee on Medicaid, CHIP, and the Uninsured, reporting to the Council on Socioeconomics; (2) the number of members of the committee be set at 15 to allow broad representation to address the programs and activities of the committee; and (3) That TMA Bylaws Chapter 10, Committees, Section 10.53 be amended to include a new subsection, 10.531, Committee on Medicaid, CHIP, and the Uninsured, and to renumber the remainder of the chapter accordingly. Referred.

REFERRED TO: Board of Trustees

STATUS: Discussion continues about how to structure the committee.

Council on Science and Public Health Report 6 – Task Force on Behavioral Health: That: (1) The Task Force on Behavioral Health be designated a subcommittee of the Council on Science and Public Health, renaming the task force as the Subcommittee on Behavioral Health; and (2) TMA amend the charge of the council in the TMA Bylaws Section 9.808. Adopted.

REFERRED TO: (1) Council on Science and Public Health and (2) Council on Constitution and Bylaws

STATUS: (1) The Subcommittee on Behavioral Health has been designated as a subcommittee of the Council on Science and Public Health. The subcommittee had their first meeting at Winter Conference 2020 and continues to work on its assigned charges by the Council on Science and Public Health. (2) Updated TMA Bylaws to reflect amendments adopted by the house.

Texas Delegation to the AMA Report 3 – Texas Delegation Operating Procedures Changes: That the TMA House of Delegates approve an amendment to the Texas Delegation’s Operating Procedures, 5.0 Delegate Review Committee. Adopted.

REFERRED TO: Texas Delegation to the AMA

STATUS: Texas Delegation Operating Procedures updated.

Resolution 101-A-19 – Saturday-Sunday Meeting Schedule for the Texas Medical Association (Lone Star Caucus): That: (1) All meetings of TMA be moved to a Saturday-Sunday format from the current Friday-Saturday format; and (2) this resolution be referred to the Board of Trustees to study the feasibility and economic impact on physicians and the association and report back to the House of Delegates in 2020. Referred.

REFERRED TO: Board of Trustees

Resolution 102-A-19 – Written Testimony at TMA Reference Committees (Lone Star Caucus): That the Texas Medical Association House of Delegates reference committees may receive testimony prior to the meeting of the House of Delegates for resolutions and recommendations assigned to the reference committees from any member of the Texas Medical Association. The speakers of the House of Delegates shall determine an appropriate process to receive, compile, and make available this testimony. Adopted as amended.

REFERRED TO: Speakers, HOD Staff, Council on Constitution and Bylaws and TMA Technology Department

STATUS: TMA members may submit written testimony on resolutions and reports for the House of Delegates virtual annual meeting through the TMA website. These submissions will be posted online for all members to read prior to Annual Session, and reference committee members will be notified of each submission. See SPKR Report 2 2020 in Handbook.

Resolution 103-A-19 – Gratitude for Continuing Medical Education Courses (Lone Star Caucus): That the TMA House of Delegates express its gratitude for the continuing medical education courses offered to TMA members courtesy of TMA Insurance Trust. Adopted.

REFERRED TO: No action needed for Resolution 103-A-19

STATUS: No action needed for Resolution 103-A-19

Resolution 104-A-19 – Alternate Delegates May Address the House of Delegates (Lone Star Caucus): That alternate delegates to the TMA House of Delegates be allowed to address the house on matters pending before the House of Delegates without being credentialed as a delegate and that under these circumstances may suggest but cannot make any changes to the content of any resolution or recommendation being considered by the House of Delegates. Referred for action.

REFERRED TO: Board of Trustees

STATUS: The board approved that Resolution 104-A-19 not be adopted, and that the speakers develop language regarding rights and privileges for delegates and alternate delegates for inclusion in the TMA House of Delegates Standing Rules for adoption by the house at the 2020 meeting. See SPKR Report 2 2020 in Handbook.

Resolution 105-A-19 – Pharmacies Practicing Medicine (Harris County Medical Society): That (1) the Texas Medical Association work with the state legislature to pass a law declaring that pharmacies in Texas may not require physicians to disclose any patient medical records information as a condition for filling a prescription; (2) TMA work with the Texas Medical Board and the Texas State Board of Pharmacy to prevent pharmacists from engaging in conduct that is defined as “the practice of medicine,” including, but not limited to, alteration of medication, dosage, duration, frequency, or quantity of a prescription while in the execution of their duties; and (3) that pharmacists may not rely on corporate policy as justification to usurp the orders of a physician lawfully acting under the Texas Medical Practice Act. Adopted as amended.

REFERRED TO: Add to TMA Policy Compendium. Council on Legislation and Office of the General Counsel

STATUS: 30.039 Pharmacists Practicing Medicine added to TMA Policy Compendium.
Resolution 106-A-19 – Establish a Coalition of Medical Societies to Protect Competition and Sustainability in the Health Insurance Marketplace (Harris County Medical Society):
That (1) TMA, in collaboration with other state and specialty medical societies, create and provide support for a permanent coalition that, through political advocacy and public outreach, advocates for incremental health care reform that preserves patient choice, physician autonomy, competition in the health insurance marketplace, and sustainability within the health care system; (2) TMA, in collaboration with other medical societies, search out and provide support for a distinct entity whose purpose is to study the current health care system and compare it to other systems as a means to develop and support model state and national legislation that is responsible, incremental, and sustainable; (3) TMA, in collaboration with other medical societies, search out and provide support for a distinct entity whose function is to educate the public on issues pertinent to potential health care legislation. This entity will promote greater public awareness of the benefits of competition in health care and the health insurance marketplace; and (4) the Texas Delegation to the American Medical Association carry this resolution to the AMA House of Delegates. Referred for study and report back.

REFERRED TO: Board of Trustees


Resolution 107-A-19 – Physician Dispensing of Prescriptions (Harris County Medical Society):
That physicians licensed by the Texas Medical Board (TMB) be allowed to prescribe, dispense, and sell prescriptions, over-the-counter medications, and medical devices to patients in Texas with regulation only by TMB. Referred for study and report back.

REFERRED TO: Council on Legislation


Resolution 108-A-19 – Initial Assessment and Treatment Recommendation by Specialists (Young Physician Section):
That TMA recognize that the best practice of patient care dictates that it is the responsibility of the physician to develop the diagnosis and treatment in the evaluation of a patient, while it is recognized under limited circumstances that an initial evaluation may be conducted by a nurse practitioner or physician assistant. Referred for study and report back.

REFERRED TO: Council on Health Care Quality and Interspecialty Society Committee


Resolution 109-A-19 – Licensure Status on TMA Membership Applications (Tarrant County Medical Society):
That a county medical society board of censors’ examination of an applicant be limited only to the applicant’s licensure status with the TMB; the membership application be updated to reflect the examination of only the applicant’s licensure status (when applicable); and TMA bylaws be amended accordingly. Referred for study and report back.

REFERRED TO: Board of Councilors

Resolution 110-A-19 – Blue Cross and Blue Shield of Texas Charitable Requirements as a Not-for-Profit Corporation (Texas Academy of Family Physicians): That the Texas Medical Association (1) express its disappointment to Blue Cross Blue Shield of Texas on its decision to contract with a foreign-based, multinational health care firm to open 10 primary care medical centers in Dallas and Houston; (2) conduct a comprehensive study of these market developments, with appropriate stakeholders, to develop a data-driven strategy to include any public policy options that assure fair business practices and enforceable protections from predatory behavior and adverse patient consequences, and that empowers physicians to compete and thrive in Texas’ health care markets. Adopted as amended.

REFERRED TO: (1) TMA President and (2) Council on Socioeconomics

STATUS: (1) Dr. Fleeger sent letter to Blue Cross Blue Shield of Texas. (2) The board approved a recommendation asking that the TMA Council on Socioeconomics convene a group of leadership on how best to pursue a proposal for an economic study to include representatives from the Board of Trustees, Council on Legislation, Council on Socioeconomics, Council on Practice Management Services, Dallas County Medical Society, and Harris County Medical Society. If a determination is made to move forward, representatives from the impacted specialty societies (TAFP, ACP Texas, TSP, and TRS) should be included in the study. Conducting a comprehensive study requires hiring a consulting firm as TMA does not have the internal resources. Due to additional internal staffing constraints a budget request will be submitted soon but is delayed.

Resolution 111-A-19 – Opposing Legislation that Mandates Physician Discrimination (Travis County Medical Society, Texas Pediatric Society, and Texas Chapter of the American Academy of Pediatrics): That TMA support removal of "opposite sex" as a requirement for affirmative defense to prosecution within the Texas Penal Code and that TMA oppose legislation or regulation that mandates physicians and other health professionals discriminate against or limit access to health care for a specific patient population. Adopted.

REFERRED TO: Council on Legislation, add to TMA Policy Compendium, and Communications Staff

STATUS: 60.010 Opposing Legislation that Mandates Physician Discrimination added to TMA Policy Compendium. The September 2019 issue of Texas Medicine magazine included an article titled, “Following an Unethical Law,” regarding Section 21.11 of the Texas Penal Code. The article called for the removal of the “opposite sex” language in the law as a defense against prosecution under the Texas Penal Code.

Resolution 112-A-19 – Equal Pay for Equal Work (Dallas County Medical Society): That (1) the Texas Medical Association adopt policy to oppose discrimination in physician compensation and promote the principle of equal pay for equal work; (2) TMA create: (a) implicit bias training for all physicians and (b) an education campaign to unify TMA around improving conditions for women physicians; (3) TMA policy containing references to “sex” or “gender” reflect proper usage of the words. The AMA Journal of Ethics suggests “sex” be used when referencing the biological differences between males and females and “gender” be used when referencing the complex psychosocial self-perceptions, attitudes, and expectations people have about members of both sexes; (4) TMA establish a Women in Medicine Section whose purpose is to: (a) strengthen engagement and representation of female physicians in organized medicine through the development of relevant policy, programming, and services, and (b) closely monitor gender equity in
medicine; and (5) TMA Bylaws, Chapter 3, House of Delegates, Section 3.25, Sections, be amended as follows: 3.25 Women in Medicine Section: The House of Delegates shall have a section named the Women in Medicine Section. Any TMA physician member may become a member of the section, and female physicians who are TMA members are members of the section automatically. The section shall have the authority to elect one voting delegate to serve in the House of Delegates. The section shall elect an alternate delegate who may serve as provided in 3.32. The section will be directed by an elected governing council and governed by operating procedures approved by the House of Delegates. The operating procedures shall provide the purposes, organization, and procedures of the Women in Medicine Section.


REFERRED TO:

(1) and (3) Add to TMA Policy Compendium; (2)(a) Council on Practice Management Services; (2)(b) Council on Health Promotion and Women in Medicine Section; (4) Board of Trustees; and (5) Council on Constitution and Bylaws

STATUS:

(1) 245.023 Equal Pay for Equal Work added to TMA Policy Compendium.

(2) A cross-divisional team comprised of TMA staff from the following departments met and performed extensive market research to identify existing implicit bias training programs and resources: Communications, Human Resources, Medical Education, Membership Development, Practice Management Education, and Public Health. The team organized a matrix detailing each programs’ overview, objectives, and available CME. Staff will continue to research programs and identify which program(s) can assist physicians in satisfying implicit bias training needs and requirements. The newly formed Women Physicians Section has identified physicians to work alongside members of the Council on Health Promotion to develop “an education campaign to unify TMA around improving conditions for women physicians.” (3) 60.011 References to Sex and Gender in TMA Policy added to TMA Policy Compendium. (4) The Women in Medicine inaugural meeting was held during the 2019 TMA Fall Conference. The section will monitor gender equity in medicine. (5) TMA Bylaws, Chapter 3, House of Delegates, Section 3.25 Sections, has been amended to include the Women in Medicine Section and charge. See WIM Report 1 2020 in Handbook.

FROM REFERENCE COMMITTEE ON MEDICAL EDUCATION AND HEALTH CARE QUALITY:

President Report 2-A-19 – Improving the Quality Payment Program and Preserving Patient Access: That: (1) TMA strongly advocate for Congress to make participation in the Merit-Based Incentive Payment System and alternative payment models under the Quality Payment Program completely voluntary; (2) TMA strongly advocate for Congress to eliminate budget neutrality in the Merit-Based Incentive Payment System and finance incentive payments with supplemental funds that do not come from Medicare Part B payment cuts to physicians and other clinicians; (3) TMA call on the Centers for Medicare & Medicaid Services to provide a transparent, accurate, and complete Quality Payment Program Experience Report on an annual basis so the association can analyze the data to advocate for additional exemptions, flexibilities, and reductions in reporting burdens, administrative hassles, and costs; (4) TMA establish formal policy that the Centers for Medicare & Medicaid Services increase the low-volume threshold for the 2020 Quality Payment Program and future years of the program for all physicians but continue to offer them the opportunity to opt in or voluntarily report; (5) TMA establish formal policy that the Centers for Medicare & Medicaid Services preserve patient access by exempting small practices (1-15 clinicians) from required participation in the Merit-Based Incentive Payment System but continue to offer them the opportunity to opt in or voluntarily report; and (6) the Texas Delegation to the American Medical Association ask the AMA House of Delegates to adopt similar policy and calls to action. Adopted.
REFERED TO: (1) (2) and (3) Council on Health Care Quality; (4) and (5) Add to TMA Policy Compendium; and (6) Texas Delegation to the AMA

STATUS: (1)-(3) The Council on Health Care Quality submitted a formal comment letter to the Centers for Medicare & Medicaid Services with recommendations to improve the Quality Payment Program (QPP) and its Merit-Based Incentive Payment System (MIPS) and Alternative Payment Model tracks. (6) The Texas Delegation submitted a resolution to the 2019 Annual Session of the AMA House of Delegates with similar recommendations. However, because two QPP resolutions by other state medical associations were referred for study and report back at the 2019 Interim Session of the AMA House of Delegates, TMA’s QPP resolution was referred for study as well. At the 2019 Interim Session, the AMA Board of Trustees presented a comprehensive report on the QPP, but TMA found the recommendation to be inadequate. The report was ultimately referred back to the AMA Board of Trustees for further consideration, with new recommendations likely to come in June 2020. (4) and (5) 195.038 Improving the Quality Payment Program and Preserving Patient Access added to TMA Policy Compendium.


REFERED TO: Add to TMA Policy Compendium

STATUS: Policy 205.030 reaffirmed in TMA Policy Compendium.


REFERED TO: Add to TMA Policy Compendium

STATUS: Policies 185.018 and 200.031 reaffirmed in TMA Policy Compendium.

Council on Medical Education Report 2-A-19 – Support of Expanded Eligibility for Inpatient Medicaid GME Funding to Teaching Hospitals: That TMA adopt new policy: (1) TMA supports expansion of the eligibility for the state’s inpatient Medicaid graduate medical education (GME) supplemental payments to include additional types of teaching hospitals. These monies can play a critical role in incentivizing hospitals to maintain and expand existing residency programs, as well as develop new programs. TMA recognizes that this growth is needed to maintain an adequate GME capacity that will accommodate the growing number of medical school graduates. (2) TMA supports the specific use of the additional Medicaid GME payments for the support of GME programs. TMA supports the proposed Medicaid GME expansion initiatives developed by the Texas Health and Human Services Commission, including: extending eligibility for the inpatient Medicaid GME supplemental payments to teaching hospitals owned and managed by non-state governmental entities, such as cities or counties; extending eligibility of teaching hospitals owned and managed by non-governmental organizations, such as private hospitals; and updating the inpatient Medicaid GME add-on payments to teaching hospitals based on current costs. Adopted.

REFERED TO: Council on Medical Education and add to TMA Policy Compendium

STATUS: 200.056 Support of Expanded Eligibility for Inpatient Medicaid GME Funding to Teaching Hospitals added to TMA Policy Compendium.
TMA sent letters in 2019 supporting the administrative rules drafted by HHSC to extend Medicaid GME eligibility to non-state government and private teaching hospitals and tracked the progress in implementing the new rules. TMA also supported state legislation in the 2019 State Legislative Session for updating the inpatient Medicaid GME add-on payments to teaching hospitals based on current costs.

**Council on Medical Education Report 3-A-19 – Fixing the Inequity in Medicare GME Funding for Texas Teaching Hospitals Compared to Other States:** That TMA adopt new policy: TMA supports equity in the “hospital-specific per resident base year cost amount” used by the Centers for Medicare & Medicaid Services to determine Medicare GME funding for teaching hospitals in Texas. Achieving equity in Medicare GME payments is particularly important to states with high population growth rates, such as Texas, to further enable expansion of the state’s GME capacity to meet the state’s growing demand for physicians’ services. This payment equity is needed for teaching hospitals that have Medicare GME funding caps as well as new teaching hospitals that are in their Medicare GME cap-building phase. TMA urges the AMA to act on AMA Policy D-305.973(c) to make the Medicare direct medical education per resident figure more equitable across teaching hospitals while ensuring adequate funding of all residency programs. **Adopted.**

**REFERRED TO:** Council on Medical Education and add to TMA Policy Compendium

**STATUS:** 200.057 Inequity in Medicare GME Funding for Texas Teaching Hospitals added to TMA Policy Compendium. A letter was sent to AMA to urge action on AMA Policy D-305.973(c).

**Council on Medical Education Report 4-A-19 – Study of Projected Need for More Medical Schools in Texas:** That TMA adopt new policy: TMA recognizes that medical schools require extraordinary resources to meet national accreditation standards and to maintain educational excellence. With the increasing number of medical schools under development in Texas, it is in the best interest of the state for a comprehensive study to be done on the projected need for additional medical schools. The study should be commissioned by the Texas Higher Education Coordinating Board, similar to this agency’s work in 2002, which evaluated the projected need the people of Texas have for physicians’ services and the need for opportunities in the state to become a physician. TMA supports the coordinating board’s use of the study in evaluating future proposals for the establishment of new medical schools in the state. **Adopted.**

**REFERRED TO:** Council on Medical Education and add to TMA Policy Compendium

**STATUS:** 200.058 Projected Need for More Medical Schools in Texas added to TMA Policy Compendium. A letter was sent to the Texas Higher Education Coordinating Board asking for consideration to be given toward conducting an updated study of the projected need for more medical schools in the state.

**Council on Medical Education Report 5-A-19 – Medical Students in Natural Disaster/Emergency Situations and Related Liability Coverage (Resolution 108-A-18):** That Policy 200.055, Maximizing Participation of Medical Students in Natural Disaster and Emergency Situations, be amended. **Adopted.**

**REFERRED TO:** Add to TMA Policy Compendium

**STATUS:** Policy 200.055 amended in TMA Policy Compendium.

**REFERRED TO:** Add to TMA Policy Compendium

**STATUS:** (1) 200.059 Maximizing Match Rates for Candidates to U.S. Residency Programs added to TMA Policy Compendium; and (2) Policy 30.036 amended in TMA Policy Compendium. TMA surveyed Texas medical schools to identify the number of fourth-year medical students in 2019 who did not match to a residency position and to track outcomes for students who did not match in 2018. Statewide summaries were provided to the medical schools.

Council on Health Service Organizations Report 1-A-19 – Supportive Palliative Care Policy: That TMA develop policy to advocate for legislation that defines “supportive palliative care” as a distinct and different term from “hospice palliative care” under Texas Health and Safety Code Chapter 142. **Adopted.**

**REFERRED TO:** Council on Legislation and add to TMA Policy Compendium

**STATUS:** 85.018 Supportive Palliative Care added to TMA Policy Compendium.


**REFERRED TO:** Add to TMA Policy Compendium

**STATUS:** 265.029 Identification Bracelets for Patients with Hearing Loss added to TMA Policy Compendium.


**REFERRED TO:** Add to TMA Policy Compendium

**STATUS:** Policies 20.008 and 20.007 reaffirmed in TMA Policy Compendium.

Committee on Physician Distribution and Health Care Access Report 1-A-19 – Improving Access to Care in Medically Underserved Areas through Project ECHO and the Child Psychiatry Access Project Model: That: (1) TMA adopt new policy on Improving Access to Care Through Project ECHO and Promoting Awareness of Potential Benefits of the Child Psychiatry Access Project Model for Texas; and (2) the Texas Delegation to the AMA be directed to advocate for promoting awareness and greater implementation of the Project ECHO and Child Psychiatry Access Project models among both academic health centers and community-based primary care physicians; work with stakeholders to identify and mitigate barriers to broader implementation of the models in the US; monitor whether payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in Project ECHO programs and if confirmed, promote awareness among physicians; support broadband connectivity in all rural areas; and encourage the U.S. Department of Health
and Human Services to publish its findings on the potential benefits of the Project ECHO model, as required by the federal ECHO Act of December 2016 (P.L. 114-270, 114th Congress) at the national level. ** Adopted. **

** REFERRED TO:** (1) Add to TMA Policy Compendium and (2) Texas Delegation to the AMA

** STATUS:** (1) 290.010 Improving Access to Care in Rural and Medically Underserved Areas added to TMA Policy Compendium.

TMA met with leadership of Texas academic health centers to promote the expansion of Project ECHO in the state and to monitor the implementation of the Child Psychiatry Access Network (CPAN). TMA also advocated in favor of state legislation to establish the CPAN which was successful.

(2) A resolution to the AMA was adopted in 2019 that sought new policy to promote awareness and participation in Project ECHO. The AMA Academic Physicians Section then held an informational session on Project ECHO at the 2019 Interim Meeting.

** Resolution 201-A-19 – Alternative Maintenance of Certification (MOC) Pathways to Comply with Antitrust Rulings (Harris County Medical Society): ** That any facility or medical staff in Texas that has complied with Texas law in requiring maintenance of certification (MOC) must accept proof of MOC from one of multiple recertifying entities. **Reaffirmed TMA Policy 175.021 in lieu of adoption of Resolution 201. **

** REFERRED TO:** Add to TMA Policy Compendium

** STATUS:** 175.021 Maintenance of Certification Requirement reaffirmed in TMA Policy Compendium.

** Resolution 202-A-19 – Clarification of Physician Protection from Maintenance of Certification (MOC) in Facility Bylaws (Harris County Medical Society): ** That: (1) unless statutorily exempted, every facility in Texas must conduct a vote (over a timeframe of two to four weeks) of the entire medical staff, regardless of medical staff appointment category, prior to including or allowing to remain in the medical staff bylaws any requirement of MOC; (2) regardless of the existence of any system-wide medical staff bylaws, MOC requirements and voting shall be facility-specific, with each facility providing proof of receipt of a notice to each physician when the facility plans to conduct such a vote; and (3) this vote must ignore any wishes of the facility system, administration, or medical staff representatives and under no circumstances should there be any reprisals against any physician by the facility system, administration, or medical staff representatives over any activity involving matters pertaining to MOC. ** Adopted. **

** REFERRED TO:** Council on Legislation and add to TMA Policy Compendium

** STATUS:** 175.027 Physician Protection from Maintenance of Certification in Facility Bylaws added to TMA Policy Compendium.

** Resolution 203-A-19 – Restrictions to Requirements of Maintenance of Certification (MOC) (Harris County Medical Society): ** That the Texas Medical Association oppose mandatory maintenance of certification. **Adopted as amended. **

** REFERRED TO:** Add to TMA Policy Compendium

** STATUS:** 175.028 Requirements of Maintenance of Certification added to TMA Policy Compendium
Resolution 205-A-19 – Eliminating Professional and Colloquial Use of the Term “Mental Retardation” by Physicians in a Clinical Setting (Medical Student Section): That (1) the Texas Medical Association recommend physicians adopt the term “intellectual disability” instead of “mental retardation”; and (2) the Texas Delegation carry this, or a similar resolution, to the American Medical Association that the term “mental retardation” be replaced with more widely accepted terminology by all United States physicians in a clinical setting. Adopted as amended.

REFERRED TO: (1) Division of Communications and add to TMA Policy Compendium and (2) Texas Delegation to the AMA

STATUS: (1) 90.003 Intellectual Disability added to TMA Policy Compendium; Three Texas Medicine Today stories and a Blogged Arteries post have been published on this subject: https://www.texmed.org/Template.aspx?id=50695
https://www.texmed.org/Template.aspx?id=50789
https://www.texmed.org/Template.aspx?id=50933
https://www.texmed.org/Template.aspx?id=51062
(2) AMA Resolution 024-A-19 was adopted. Policy H-70.912: RESOLVED, That our American Medical Association recommend that physicians adopt the term “intellectual disability” instead of “mental retardation” in clinical settings.

Resolution 206-A-19 – Consideration for Care of Individuals with Autism Spectrum Disorder (ASD) (Medical Student Section): That the Texas Medical Association (1) support the provision of resources in the community to individuals with autism and to their families in order to provide a more comprehensive spectrum of primary and preventative care to individuals with autism; and (2) encourage physicians to promote existing resources in order to better accommodate patients with ASD in rural or underserved communities. Adopted as amended.

REFERRED TO: Council on Health Promotion, Committee on Medical Home and Primary Care, Committee on Rural Health, and add to TMA Policy Compendium

STATUS: 260.111 Autism Spectrum Disorder added to TMA Policy Compendium. TMA staff completed the following activities to promote resources developed by the Committee on Medical Home and Primary Care and the Committee on Rural Health.

• Created a page on the TMA website with resources for physicians to easily access and share with patients and their families (www.texmed.org/Autism);
• Created a campaign to educate TMA members about the webpage and how it can be utilized to benefit their patients and their families; and
• Published a story, “Addressing Autism: Giving Physicians Tools,” in the December 2019 issue of Texas Medicine, featuring physician experts who work with patients with autism spectrum disorder. (www.texmed.org/AddressingAutism/)

Resolution 209-A-19 – Promoting Health Insurance and Health Policy Education Prior to Residency (Medical Student Section): That the Texas Medical Association support and promote the availability of educational resources for medical students on the business of medicine and health policy. Adopted as amended.
REFERRED TO: Add to TMA Policy Compendium and Medical Student Section, Resident and Fellow Section.

STATUS: 200.056 Business of Medicine Education for Medical Students added to TMA Policy Compendium. TMA has multiple resources of educational materials on insurance and health policy. These materials are currently available and free to members. In order to make this information more readily accessible, the information can all be found on the student page of the TMA website. Additionally, TMA hosts a lecture series for TMA student chapters which provides live presentations on their individual campuses. Educational topics include Managed Care/HMO/PPO, Medical Economics, the Importance of Politics in Medical Careers, and many more. Efforts to promote these resources are ongoing and include informational items in TMA-Medical Student Section business meeting packets and on PowerPoint slides projected during business meetings, reminders in chapter update emails, and in the student version of TMA’s daily newsletter, Texas Medicine Today.

Resolution 210-A-19 – Recommendation for Hemorrhage Control Training of Health Care Professionals (Medical Student Section): That the Texas Medical Association (1) support initiatives that promote training in hemorrhage control, such as Stop the Bleed®; and (2) support the inclusion of hemorrhage control supplies in first aid kits in public spaces. Adopted as amended.

REFERRED TO: (1) Committee on Emergency Medical Services and Trauma and (2) Add to TMA Policy Compendium

STATUS: (1) The Committee on Emergency Medical Services and Trauma has worked with the Texas College of Emergency Physicians to support medical students promoting hemorrhage control training, including collaborating with TMA communications to educate physicians and the public about the 2019 Stop the Bleed campaign. Forthcoming initiatives also include a story in the April Texas Medicine about the initiative and working with medical student leaders of Lone Star Survivors, a local hemorrhage control training program, to submit a blog article for Me and My Doctor in order to increase public knowledge of training opportunities. The committee will continue to work on this ongoing initiative. (2) 100.031 Hemorrhage Control Supplies in First Aid Kits added to TMA Policy Compendium. HB 496 passed in the 2019 Texas Legislature, supporting hemorrhage control supplies in public schools. The Committee on Emergency Medical Services and Trauma is working to support the implementation efforts of Representative Gervin-Hawkins, the author of the bill, and the Texas Education Agency. Texas Medicine ran a story regarding Resolution 210 in April 2020 regarding both components of the charge for outreach purposes.

Resolution 211-A-19 – The Integration of LGBTQ Health Topics Into Medical Education (Medical Student Section): That TMA: (1) support the integration of LGBTQ health care topics into undergraduate and graduate medical education; and (2) work with the appropriate parties to develop best practices for the integration of LGBTQ health care education into undergraduate and graduate medical education as well as CME. Referred with a report back.

REFERRED TO: Council on Medical Education and Council on Science and Public Health
Resolution 212-A-19 – Improve Physician-Hospital Relations (Harris County Medical Society): That the Texas Medical Association (1) study ways to protect the relationship of physicians and their patients after inpatient hospital referrals and report back to the TMA House of Delegates at its annual 2020 meeting; and (2) study ways to improve the representation of all practice types of physicians through hospital medical staff bylaws to include the business associate agreement, if any. Adopted as amended.

REFERRED TO: Council on Health Service Organizations

Resolution 213-A-19 – Complying with Value-Based Care Quality Measures for Medication Adherence (Elizabeth Torres, MD): That TMA work with payers to identify standard methodologies that address quality measure requirements for medication adherence in response to marketplace influences beyond the physician/providers control. Adopted.

REFERRED TO: Council on Health Care Quality and Council on Socioeconomics

FROM REFERENCE COMMITTEE ON SCIENCE AND PUBLIC HEALTH:


REFERRED TO: Add to TMA Policy Compendium

STATUS: Policy 260.062 deleted from TMA Policy Compendium.


REFERRED TO: Add to TMA Policy Compendium

STATUS: Policy 325.009 deleted from TMA Policy Compendium.
Committee on Emergency Medical Services and Trauma Report 2-A-19 – Appropriate Physician Oversight of EMS Medical Practices (Resolution 302-A-18): That new TMA policy, the Texas Medical Association will advocate for the Texas emergency medical service (EMS) systems to provide adequate funding for physicians to play an active role in the provision of Medical Direction and Oversight. This includes adequate support staff to accomplish this goal with the level of involvement necessary to perform the duties required by the Texas Medical Board (TMB) and Department of State Health Services (DSHS); thus facilitating safe oversight and management of EMS medical practices, be adopted in lieu of Resolution 302-A-18. Adopted.

REFERRED TO: Council on Legislation and add to TMA Policy Compendium

STATUS: 100.032 Appropriate Physician Oversight of Emergency Medical Service Medical Practices added to TMA Policy Compendium.

Committee on Emergency Medical Services and Trauma Report 3-A-19 – Sunset Policy Review: That Policy 100.013, Trauma Funding, be retained and Policy 205.029, Hurricane Ike and The University of Texas Medical Branch, be deleted. Adopted.

REFERRED TO: Add to TMA Policy Compendium

STATUS: Policy 100.013 reaffirmed and policy 205.029 deleted from TMA Policy Compendium.


REFERRED TO: Add to TMA Policy Compendium

STATUS: Policy 260.081 deleted from TMA Policy Compendium

Council on Practice Management Services Report 2-A-19 – Improving Health Technology Products to Address the Issues of Sex and Gender: That the Texas Delegation to the AMA introduce a resolution to the AMA House of Delegates asking AMA to adopt the following: (1) Research the problems related to the handling of sex and gender within health information technology (HIT) products and how to best work with vendors so their HIT products treat patients equally and appropriately, regardless of sexual or gender identity; and (2) Advocate for the incorporation of recommended best practices into electronic health records and other HIT products at no additional cost to physicians, and investigate the use of personal health records to reduce physician burden in maintaining accurate patient information instead of having to query everyone regarding sexual orientation and gender identity at each encounter. Adopted.

REFERRED TO: Texas Delegation to the AMA

STATUS: AMA Resolution 242-A-19 was adopted. Policy H-315.967: RESOLVED, That our American Medical Association research the problems related to the handling of sex and gender within health information technology (HIT) products and how to best work with vendors so their HIT products treat patients equally and appropriately, regardless of sexual or gender identity; and be it further RESOLVED, That our AMA investigate the use of personal health records to reduce physician burden in maintaining accurate patient information instead of having to query each patient regarding sexual orientation and gender identity at each encounter; and be it further RESOLVED, That our AMA advocate for the incorporation of
recommended best practices into electronic health records and other HIT products at no additional cost to physicians.

Council on Science and Public Health Report 1-A-19 – Extreme Risk Protection Orders and Gun Violence (Resolution 314-A-18) – That (1) TMA Policy 260.015, Firearms, be amended to read: The Texas Medical Association recognizes gun violence as a public health issue requiring the promotion of evidence-based strategies in Texas. Medical professional organizations should speak out about the prevention of firearm-related injuries and deaths, and TMA calls on physicians to support: (a) The primary prevention of firearm morbidity and mortality through educating Texans about firearm safety and the potential hazards of firearm ownership, recognizing that physicians have an unencumbered right to inquire of and inform patients and their families about the risks of firearms and in particular the risk to children; (b) Promotion of the Texas Hunter Education and certification program developed by the Texas Department of Parks and Wildlife; (c) Providing anticipatory guidance in the clinical setting on the dangers of firearm ownership in an informational, nonjudgmental manner, encouraging firearm owners to adhere to best practices for reducing the risk of accidental or intentional injuries or deaths by ensuring firearms are not accessible to children, adolescents; or people with mental, behavioral, or substance use disorders; (d) Strict enforcement of federal and state gun control laws and mandated penalties for crimes committed with a firearm, including illegal possession; (e) The use of trigger locks (such as can be provided by www.projectchildsafe.org) and locked gun cabinets to help prevent unintentional discharge; and (f) Unfettered study of issues involving firearms and public health and safety, and Texas’ participation in national surveillance studies on violence in the United States, ensuring the state has timely, accurate data on firearm-related mortality and morbidity to guide Texas’ public health prevention activities (Res. 28S, p 176, A-93; Substitute CPH Rep. 3-A-08; amended CSPH Rep. 5-A-18); (2) That the Task Force on Behavioral Health develop information for physicians on the prevention and assessment of suicide risk and promote awareness of mental health first-aid training for physicians and office staff, and of state statute on the sharing of information on patients at risk; (3) That TMA advocate for a protective order process to allow for the implementation of risk-based protective orders to address those reported to be at high risk of violence to others or self-harm; (4) Policy 325.002, Family Violence, be amended to read: The Texas Medical Association believes that physicians should be aware of the resources available in their community such as information provided by the Texas Family Violence Council and information on family protective orders developed by the Office of the Attorney General to inform and support victims of domestic violence. Physicians should make this information available in their waiting rooms or have their office staff provide it. The association should provide physicians with information on the symptoms of domestic violence and abuse, and physicians should record information on domestic violence in the patient’s medical file (CPH, p 129, A-92; amended CPH Rep. 3-A-10). Adopted as amended.

REFERRED TO: (1) and (4) Add to TMA Policy Compendium; (2) Council on Science and Public Health; (3) Council on Legislation; and (1)-(4) Council on Health Promotion

STATUS: (1) Policy 260.015 amended in TMA Policy Compendium; (4) Policy 325.002 amended in TMA Policy Compendium. (2) The Subcommittee on Behavioral Health, formerly the Task Force on Behavioral Health, convened during Winter Conference 2020 to begin its work on this charge. The subcommittee planned to present a TMA Distinguished Speaker Series presentation scheduled for April 23, 2020 on suicide prevention and will feature Drs. Neavel, Dr. Kim, and Dr. Roaten as panelists, along with a carefully vetted youth with lived experience of suicidality. This event was cancelled due to COVID-19, but is being targeted for a reschedule in early September. (1) – (4) Texas Medicine Today story outlining this entire new policy published Aug. 13, 2019, in the aftermath of the El Paso mass shooting.

REFERRED TO: Add to TMA Policy Compendium

STATUS: Policy 265.018 amended in TMA Policy Compendium.


REFERRED TO: (1) Resolution 313-A-18 was not adopted; (2) and (3) Add to TMA Policy Compendium

STATUS: (2) 260.112 Parental Education on Prevention of Firearm Accidents in Children added to TMA Policy Compendium; (3) Policy 245.021 reaffirmed in TMA Policy Compendium.

Council on Science and Public Health Report 4-A-19 – Early Childhood Adversity and Health: That (1) the Texas Medical Association identify adverse childhood experiences (ACEs) as a public health issue and advance TMA activities to increase awareness and understanding of ACEs among TMA members and the public, and ensure physicians have information on resources for screening patients, payment for care, and local resources and services for their patients; (2) TMA, in coordination with other state entities, convene a summit with physicians and other health professionals, community leaders, and representatives of public health and high risk populations to identify priorities for addressing ACEs. This includes identifying barriers physicians face in screening and caring for children and adults, gaps in services and resources in public programs and communities, evidence-based programming, access to data for assessment, and understanding the unique needs of specific populations; and (3) TMA advocate for public health initiatives and activities that provide effective support and care for children and adults exposed to trauma. Adopted as amended.

REFERRED TO: (1) and (3) Add to TMA Policy Compendium; (2) Council on Science and Public Health

STATUS: (1) and (3) 55.062 Early Childhood Adversity and Health added to TMA Policy Compendium (2) Council on Science and Public Health and the Subcommittee on Behavioral Health planned on collaborating with University of Texas Systems Pediatric Brain Health Summit, originally scheduled for March 23-24, 2020, to engage TMA physicians in a
specialized breakout session with keynote expert in ACEs Dr. Jack P. Shonkonff, from Harvard T.H. Chan School of Public Health. This event was postponed due to COVID-19.


REFERRED TO:  Add to TMA Policy Compendium

STATUS:  (1) Policies 260.019 and 260.022 reaffirmed in TMA Policy Compendium; (2) Policies 95.031, 95.032, 100.017, 260.051, 260.041, 260.059, and 260.082 deleted from TMA Policy Compendium; and (3) Policies 95.023, 260.003, 260.080, 260.083, 280.035, and 260.103 amended in TMA Policy Compendium.

Resolution 301-A-19 – Distribution and Display of Human Trafficking Aid Information in Public Places (Lone Star Caucus, Lubbock County Medical Society): That: (1) TMA adopt as policy that readily visible signs, notices, posters, placards, or other readily available educational materials providing information about reporting human trafficking activities or providing assistance to victims and survivors be permitted in local clinics, emergency departments, or other medical settings; (2) TMA, through its website or internet presence, provide downloadable materials displaying the National Human Trafficking Hotline number to aid in displaying such information in local clinics, emergency departments, or other medical settings and advocate that other recognized medical professional organizations do the same; (3) TMA urge both state and federal governments to make changes in laws to advocate the broad posting of the National Human Trafficking Hotline number in areas such as local clinics, emergency departments, and other medical settings; and (4) our Texas Delegation to the American Medical Association take this resolution to the AMA House of Delegates for consideration. Adopted.

REFERRED TO:  (1) Add to TMA Policy Compendium; (3) and (4) Texas Delegation to the AMA; and (1)-(3) Council on Science and Public Health

STATUS:  (1) 260.113 Distribution and Display of Human Trafficking Aid Information in Public Places added to TMA Policy Compendium. (1)-(4) TMA Human Trafficking webpage created: https://www.texmed.org/humantrafficking/. This webpage includes the latest resources and downloadable materials on human trafficking for practices and clinics; training and education resources for health professionals; and links to CME courses to recognize, screen, and take appropriate action to combat human trafficking.

(3) In November 2019, a small group of TMA member physicians, with the backing of the council, provided feedback on a draft Texas Health and Human Services Commission (HHSC) training that is currently under development on human trafficking. The training produced by HHSC will be offered to all physicians in Texas to fulfill the new statewide CME
requirements of HB 2059 by 9/1/2020. The physician workgroup and the council has been working with TMA advocacy to prepare for making amendments to state policy regarding HB 2059 and the unprecedented requirement that the human trafficking CME must go through HHSC for approval. (3) and (4) AMA Resolution 023 was adopted. Policy H-440.814: RESOLVED, That our American Medical Association adopt as policy that readily visible signs, notices, posters, placards, and other readily available educational materials providing information about reporting human trafficking activities or providing assistance to victims and survivors be permitted in local clinics, emergency departments, or other medical settings; and be it further RESOLVED, That our AMA, through its website or internet presence, provide downloadable materials displaying the National Human Trafficking Hotline number to aid in displaying such information in local clinics, emergency departments, or other medical settings and advocate that other recognized medical professional organizations do the same; and be it further RESOLVED, That our AMA urge the federal government to make changes in laws to advocate for the broad posting of the National Human Trafficking Hotline number in areas such as local clinics, emergency departments, and other medical settings

Resolution 302-A-19 – Statement of Personhood Measures (Dallas County Medical Society): That the Texas Medical Association, regarding any personhood measure, advocate and inform on proposed public policy measures related to reproductive health based on evidence-based medicine, which promotes the safety and effective treatment of patients, and preserves access to comprehensive reproductive care including assisted reproductive services. Adopted as amended.

REFERRED TO: Committee on Reproductive, Women’s, & Perinatal Health

STATUS: This resolution provides guidance to the council and will be used to shape any future TMA comment needed if and when the topic of reproductive health is raised in public policy debate or discussion. The council will monitor future personhood measures to advocate and inform on proposed public policy measures related to reproductive health based on evidence-based medicine, which promotes the safety and effective treatment of patients, and preserves access to comprehensive reproductive care including assisted reproductive services.

Resolution 303-A-19 – Improving Medical Clearance Policies for Traumatic Brain Injury Patients (Dallas County Medical Society): That: (1) TMA reaffirm its policy stating that it strongly supports current national and Texas gun law and regulations relating to medical need and public safety, and advocates for legislation that more strongly implements these laws due to public health concerns; (2) TMA advocate for amending Texas law to clearly include prohibiting symptomatic TBI patients from obtaining or retaining a license to carry a firearm until medical clearance; (3) TMA create policy, advocate for, and support legislation that expands to all people the medical clearance requirements and firearm purchasing restrictions in Texas’ license-to-carry law; (4) TMA advocate for legislation that would promote and emphasize the need and importance of physician reporting of all patients who have prohibitive conditions, including symptomatic TBI patients, to the Texas Medical Advisory Board; (5) TMA advocate for expansion of and investment into the Medical Advisory Board so it is better known by physicians, easier to use, and explicit regarding the medical conditions that may require reporting to it; (6) TMA advocate for legislation that expands the Medical Advisory Board’s oversight of possibly impaired individuals with gun licenses to all possibly impaired gun owners; and (7) that the Texas Delegation to the AMA carry any newly adopted policy related to TBI and access to firearms to AMA. Referred for study.
Resolution 304-A-19 – Requirement for Food Allergy Posters and Employee Training in Food Establishments (Harris County Medical Society, Louise H. Bethea, MD, Texas Allergy, Asthma & Immunology Society): That TMA: (1) provide advocacy support to the Texas Allergy, Asthma & Immunology Society’s efforts as the society seeks the passage of legislation mandating, not just recommending, that all food service establishments display a poster related to food allergen awareness in an area of the establishment accessible primarily to its employees. This poster must include the risk of an allergic reaction, a list of the major food allergens, methods to prevent cross-contamination in food preparation, and signs and symptoms associated with anaphylaxis with instructions to call 911; and (2) advocate for a mandate that food service employees be required, on a biennial basis, to be trained in food allergy awareness with information on which foods – milk, eggs, wheat, soy, shellfish, fish, peanuts, and tree nuts – cause the most reactions; trained in the prevention of cross-contamination in food preparation; and trained in the signs and symptoms associated with anaphylaxis with instructions to call 911. The training programs can be completed online or in class form and should be certified by a nationally recognized organization and approved by the Texas Department of Health and Human Services. Referred for study with report back.

Resolution 305-A-19 – Allow the Possession and Administration of an Epinephrine Auto-Injector in Certain Entities (Harris County Medical Society, Louise H. Bethea, MD, Texas Allergy, Asthma & Immunology Society): That: (1) epinephrine auto-injectors be allowed to be placed in public places in areas accessible as determined by the entity. Those entities include amusement parks, camps, institutions of higher education, food service establishments, sports venues, concerts, state government entities, retail facilities, churches, synagogues, youth centers, and any other entity the Texas Executive Commissioner, by rule, designates as an entity that would benefit from the possession and administration of epinephrine auto-injectors; (2) an employee or volunteer with these entities be trained on an annual basis by an approved source to administer an epinephrine auto-injector to a person reasonably believed to be experiencing anaphylaxis on the premises of the entity; (3) policies relating to epinephrine auto-injectors be established by the Texas Executive Commission; and (4) a trained person who in good faith initiates treatment using an epinephrine auto-injector under the rules established by the state be immune from civil or criminal liability, as will the entity or business and those associated with the prescribing, dispensing, and administration of the epinephrine auto-injectors. Referred.

Resolution 306-A-19 – Opposition to Limiting the Physician’s Role in the End-of-Life Process (Harris County Medical Society): That the Texas Medical Association oppose any efforts to limit the physician’s compassionate and ethical role in the end-of-life process. Adopted as amended.

Referred to:
Council on Science and Public Health, Office of the General Counsel, and Council on Legislation

Status:

Referred to:
Council on Legislation and Council on Science and Public Health

Status:

Referred to:
Council on Legislation and Council on Science and Public Health

Status:

Status:
85.019 Physician’s Role in End-of-Life Process added to TMA Policy Compendium.
That: (1) TMA consider bed bugs as a public health issue; (2) the resolution be referred to the appropriate TMA council, committee, or body to seek a mechanism for the collection, study, and public reporting of data on the impact of bed bugs on the public health of Texans; (3) the resolution be referred to the appropriate TMA council, committee, or body to collaborate with the Texas Association of City and County Health Officials to develop guidelines for local health authorities using an Integrated Pest Management approach to bed bugs; (4) TMA in collaboration with the Texas Department of State Health Services support regulatory changes that encourage the reporting, treatment, and study of bed bugs in state-supported living centers; (5) TMA seek legislation to address the public health issue of bed bugs in Texas, most especially when affecting vulnerable populations or inhabitants of multifamily dwelling units (MDUs); and (6) the Texas Delegation carry this resolution, or a similar one, to the American Medical Association to develop public health recommendations and seek regulatory or legislative action for this growing national public health issue, especially in regard to the collection, study, and public reporting of data on the impact of bed bugs; the effect of bed bug infestations on MDUs; and the U.S. Department of Housing and Urban Development’s role in bed bug management. Referred for study.

REFERRED TO: Council on Science and Public Health


Resolution 308-A-19 – Regulation of Electric Scooters (Bexar County Medical Society): That TMA: (1) work with the Texas Department of Public Safety (DPS) to have electric scooters regulated as bicycles and require operators to follow traffic laws as bicycle operators; (2) work with DPS to place an age restriction on electric scooter operators to limit the use of these scooters by children too young to understand traffic laws and to allow only one operator per scooter; and (3) work with DPS to require the use of helmets when operating electric scooters and to add safety features so that car drivers can see them. Referred for study.

REFERRED TO: Council on Science and Public Health and Committee on Emergency Medical Services and Trauma


Resolution 309-A-19 – Factoring Adolescent Sleep Patterns into Middle and High School Start Times (Medical Student Section): That TMA encourage physicians to be informed on the biologic sleep needs of adolescents, promote awareness of this need to the community, and communicate with local school health advisory committees to share evidence-based, best practices regarding health promotion, including the benefits of later school start times for adolescents. Adopted.

REFERRED TO: Council on Health Promotion and add to TMA Policy Compendium

STATUS: 55.061 Adolescent Sleep Patterns and School Start Times added to TMA Policy Compendium.

TMA communications has placed multiple blog posts on the public-facing “Me And My Doctor” blog about adolescents’ need for adequate sleep. At least one such TMA post refers to (and links to) the American Academy of Pediatrics’ recommendation regarding later school start times. The TMA Committee on Child and Adolescent Health also is aware of the issue of adolescents’ sleep needs, including the benefits of later school start times.
Local districts have jurisdiction over such decisions, and many Texas school districts already adjust class schedules per these recommendations.


REFERRED TO: Add to TMA Policy Compendium


Resolution 311-A-19 – Identifying Trauma and Mental Health Susceptibilities in Schools (Medical Student Section): That TMA advocate for school-based systems of mental health care that provide an integrated system of educator training, referral to treatment, and clear access to providers. Adopted.

REFERRED TO: Add to TMA Policy Compendium

STATUS: 215.023 Identifying Trauma and Mental Health Susceptibilities in Schools added to TMA Policy Compendium.

Resolution 312-A-19 – Opposition to Increasing Work Requirements for the Supplemental Nutrition Assistance Program (SNAP) (Medical Student Section): That the Texas Medical Association recognizes the importance of the benefits of the Supplemental Nutrition Assistance Program (SNAP) to support the nutrition and health of many Texans and will caution state leadership when work requirements compromise the health benefits provided through participation in SNAP. Adopted as amended.

REFERRED TO: Add to TMA Policy Compendium

STATUS: 260.114 Work Requirements for the Supplemental Nutrition Assistance Program added to TMA Policy Compendium.

Resolution 313-A-19 – Physicians Counseling Patients About the Risks of Direct-to-Consumer Genetic Testing (Medical Student Section): That the Texas Medical Association support establishing policies that promote educating the public about potential risks and benefits created by direct-to-consumer genetic testing. Adopted as amended.

REFERRED TO: Council on Legislation and add to TMA Policy Compendium

STATUS: 105.020 Physicians Counseling Patients About the Risks of Direct-to-Consumer Genetic Testing added to TMA Policy Compendium.

Resolution 315-A-19 – Notification of Generic Drug Manufacturing Changes (Harris County Medical Society): That (1) the Texas Medical Association work with Texas legislators to ensure that each patient is expressly notified at the time of dispensing by the pharmacy or pharmacy benefit manager of a change in the manufacturer of his or her generic medication; and (2) the Texas Delegation to the American Medical Association present a similar resolution to the AMA House of Delegates for consideration. Adopted as amended.

REFERRED TO: (1) Council on Legislation and (2) Texas Delegation to the AMA

STATUS: (2) AMA Policy H-115.974 was reaffirmed in lieu of AMA Resolution 130-A-19.
Resolution 316-A-19 – Determinants of Health (Harris County Medical Society): That the Texas Medical Association (1) educate physicians about the social determinants of health for the purpose of assisting physicians to better understand their impact on patient health outcomes and wellbeing; (2) educate state and federal policy makers, business leaders, and governmental and commercial payors about the influence of social determinants of health on overall health care quality and health care costs; (3) collaborate with innovative public and private partnerships to address social determinants of health and advocate for their adoption by state policy makers; and (4) advocate that governmental and commercial payors modify existing performance and quality programs reflect the higher expected health care utilization and cost of population at greater risk of exposure to social determinants of health and appropriately risk adjust physician compensation to reflect these higher costs. Adopted as amended.

REFERRED TO: Add to TMA Policy Compendium and Council on Health Care Quality and Council on Socioeconomics

STATUS: 265.030 Social Determinants of Health added to TMA Policy Compendium. TMA has undertaken numerous initiatives related to Social Determinants of Health (SDOH), including: 1) offered continuing medical education on SDOH at the general session at Fall Conference 2019 to educate physicians on their impact on health outcomes; 2) partnered with The Physicians Foundation and The Health Initiatives to conduct a study on SDOH; 3) advocated that the Quality Payment Program (QPP) by the Centers for Medicare & Medicaid Services adopt new policies to implement risk adjustment methodologies related to SDOH and account for social risk factors in Medicare payment; 4) advocated that Texas Medicaid pursue a federal waiver to broadly implement SDOH initiatives within the Medicaid program, including payment for physicians and health systems that implement strategies to address SDOH; 5) actively participated in an SDOH Learning Collaborative convened by a large health foundation, Texas Medicaid, and Medicaid managed care plans; and 6) met with commercial health plan representatives to discuss how plans use SDOH data in their value-based payment initiatives. Additionally, TMA has testified before multiple state legislative and interim hearings on the need to better address SDOHs as part of Texas’ efforts to improve health outcomes while lowering health care costs. Over the next year, advocacy and education relating to SDOH will remain a high priority.

FROM REFERENCE COMMITTEE ON SOCIOECONOMICS:

Committee on Rural Health Report 1-A-19 – Expand Availability of Broadband Internet Access to Rural Texas: That TMA advocate for the expeditious expansion of broadband connectivity to all rural areas of Texas. Adopted.

REFERRED TO: Add to TMA Policy Compendium

STATUS: 275.006 Broadband Internet Access to Rural Texas added to TMA Policy Compendium.

REFERRED TO: Add to TMA Policy Compendium

STATUS: Policy 100.016 reaffirmed in TMA Policy Compendium.

Council on Socioeconomics Report 1-A-19 – Health Plan Claim Auditing Programs: That: (1) TMA policy 65.008 be amended; and (2) the Texas Delegation take a resolution to the AMA House of Delegates at its 2019 Annual Meeting asking for adoption of this policy and advocacy. Adopted.

REFERRED TO: (1) Add to TMA Policy Compendium and (2) Texas Delegation to the AMA

STATUS: (1) Policy 65.008 amended in TMA Policy Compendium (2) The Texas Delegation introduced Resolution 716 at the June 2019 AMA House of Delegates annual meeting. Existing AMA policy was reaffirmed in lieu of the resolution.


REFERRED TO: Add to TMA Policy Compendium

STATUS: (1) Policies 40.005, 55.055, 130.019, 145.025, 145.026, 145.027, 160.017, 190.029, 235.029, 325.008, and 335.014 reaffirmed in TMA Policy Compendium; and (2) Policies 120.010 and 180.033 amended in TMA Policy Compendium.

Resolution 401-A-19 – Participation in Government Programs When Receiving Payment for Uncompensated Care (Lone Star Caucus): That: (1) all Texas health care facilities receiving federal or state funds for uncompensated care must also accept Medicare, Medicaid, TRICARE, CHIP, and federally subsidized health insurance via the Affordable Care Act from patients covered by these forms of insurance; and (2) some of the funds for uncompensated care now going to the hospitals in Texas be transferred to another part of the Texas Medicaid program and used to increase the payment rate for physicians who provide Medicaid services. Adopted.

REFERRED TO: Council on Socioeconomics

STATUS: (1) The Council on Socioeconomics is partnering with legislative staff to provide ongoing advocacy. (2) The Select Committee on Medicaid has signed on to a letter with other groups to advocate amending and extending the 1115 waiver. They also advocated for physicians being paid commercial rates.

Resolution 402-A-19 – Prescription Monitoring Program Integration Into Electronic Medical Records (Lone Star Caucus): That the Texas Medical Association (1) advocate for prescription monitoring program integration into electronic medical records, at no cost to the physician, providing patient-specific information whenever a physician attempts to prescribe a controlled substance; and (2) advocate for the integration of the
PMP into Texas-based public health information exchanges (currently five), at no cost to the exchanges, so that physicians have one stop for obtaining patient’s health information. **Adopted as amended.**

**REFERRED TO:** Committee on Health Information Technology and add to TMA Policy Compendium

**STATUS:** 95.046 Prescription Monitoring Program Integration Into Electronic Medical Records added to TMA Policy Compendium. Section 82 of the Supplemental Budget Bill passed by the 86th (2019) Texas Legislature immediately appropriated $6 million to the Board of Pharmacy to (1) update the Prescription Monitoring Program (PMP) to the NarxCare platform; and (2) Purchase the user licenses for Appriss (Texas’ PMP) for all prescribers and pharmacists. Most EHRs now have integrated the PMP into the physician’s workflow so that patient-specific information is available when a physician launches a prescription. This comes at no cost to the physician. Additionally, health information exchanges can access and deliver PMP information to physicians at no additional cost to the physician or the HIE.

**Resolution 403-A-19 – Prior Authorization Approval (Lone Star Caucus):** That (1) the criteria for prior approval for patient referrals, tests, surgeries, procedures, and medications be available to all physicians at the time of the request for such action; (2) the types of patient referrals, tests, surgeries, procedures, and medications that typically require prior authorization be kept to a minimum, and such criteria be available to the physician and staff in a transparent manner; and (3) prior approval for patient referrals, tests, surgeries, procedures and medications be handled in a timely fashion, appropriate to facilitate treatment of the illness for which the test or intervention is being sought. **Adopted as amended.**

**REFERRED TO:** Council on Socioeconomics and add to TMA Policy Compendium

**STATUS:** 235.040 Prior Authorization Approval added to TMA Policy Compendium. (1), (2), and (3) The Council on Socioeconomics (CSE) is partnering with legislative staff to provide ongoing advocacy. The House Select Committee is analyzing changes to Medicaid. The Payment Advocacy department continues to do messaging to payers about prior authorization burdens during carrier meetings.

**Resolution 404-A-19 – Medicare Part B Coverage of Vaccines (El Paso County Medical Society):** That the Texas Medical Association advocate for the Centers for Medicare & Medicaid Services and other payers to include the zoster virus vaccine, hepatitis A vaccine, meningitis vaccine, and all future vaccines recommended by the Centers for Disease Control and Prevention Advisory Committee on Immunization Practices and administration of these vaccines in both CMS and payer fee schedules. **Adopted as amended.**

**REFERRED TO:** Council on Socioeconomics and add to TMA Policy Compendium

**STATUS:** 135.026 Medicare Part B Coverage of Vaccines added to TMA Policy Compendium. TMA’s medical economics division sent a letter to CMS regarding payment for vaccines.

**Resolution 405-A-19 – Lower Drug Costs (Lone Star Caucus):** That TMA advocate reducing the higher cost of medications by supporting negotiation of drug prices for Medicare and Medicaid. **Adopted.**

**REFERRED TO:** Council on Socioeconomics and add to TMA Policy Compendium
STATUS: 195.039 Lower Drug Costs added to TMA Policy Compendium. Texas currently negotiates pharmacy rebates for Medicaid. TMA monitors Medicaid’s rebate program and will advocate for lower drug costs as the need arises. The council is engaged in ongoing Medicare advocacy when the opportunity arises.

Resolution 407-A-19 – Compensation to Physicians for Activities Other than Direct Patient Care
(Harris County Medical Society): That the Texas Medical Association form a task force including members of Council on Legislation, Council on Socioeconomics, Council on Healthcare Quality and interested county medical societies to strategically prepare solutions for advocacy that address and mitigate the burden of prior authorization and that the task force bring a report back to the House of Delegates in 2020. **Adopted as amended.**

REFERRED TO: Board of Trustees


Resolution 408-A-19 – Managing Patient-Physician Relations Within Medicare Advantage Plans
(Harris County Medical Society): That (1) the Texas Medical Association adopt a policy that Medicare Advantage plans allow a primary care physician (PCP) to remove patients from his or her patient panel if the PCP has proven that he or she has been unable to establish a patient-physician relationship, despite repeated attempts; (2) the physician’s Healthcare Effectiveness Data and Information Set (HEDIS) and other quality scores and ratings not be affected by those patients with whom the physician has been unable to establish a relationship, despite multiple documented attempts; and (3) the Texas Delegation to the American Medical Association take this resolution to the AMA House of Delegates. **Adopted as amended.**

REFERRED TO: (1) and (2) Add to TMA Policy Compendium and (3) Texas Delegation to the AMA

STATUS: (1) and (2) 195.040 Patient-Physician Relations within Medicare Advantage Plans added to Policy Compendium, (3) the Texas Delegation introduced Resolution 715 at the June 2019 AMA House of Delegates annual meeting. Existing AMA policy was reaffirmed in lieu of the resolution.

Resolution 409-A-19 – Update Practice Expense Component of Relative Value Units (Harris County Medical Society): That the Texas Delegation to the American Medical Association submit a resolution to the AMA House of Delegates at the 2019 Annual Meeting requesting that the AMA pursue efforts to update resource-based relative value unit practice expense methodology so that it accurately reflects current physician practice costs, with report back at the AMA House of Delegates 2019 Interim Meeting. **Adopted.**

REFERRED TO: Texas Delegation to the AMA

STATUS: The Texas Delegation introduced Resolution 131 at the June 2019 AMA House of Delegates annual meeting. The resolution was referred for decision to the AMA Board of Trustees with a report back at the AMA House of Delegates 2019 Interim Meeting. The AMA board voted that in lieu of Resolution 131 the AMA conduct a pilot study to determine the best mechanism for gathering physician practice expense data, including the feasibility of fielding a new physician practice expense survey, and work with the Centers for Medicare & Medicaid Services to update the resource-based relative value practice expense methodology. Anticipation of the pilot
program is expected in 2020, and the AMA Health Policy Unit would be the lead on the pilot.

Resolution 410-A-19 – Laboratory Benefit Managers (Texas Society of Pathologists and Travis County Medical Society): That: (1) TMA support efforts to reduce laboratory benefit management policies that result in delays in patient care, reduced patient access, or increased patient costs without clinical justification; and (2) support any policies regarding laboratory benefit management arrangements that preclude any potential conflict of interest in programs adopted by health insurance payers to provide laboratory benefit management, including prohibition on the use of any laboratory benefit management entity financially affiliated with a clinical laboratory. Adopted.

REFERRED TO: Council on Socioeconomics and add to TMA Policy Compendium

STATUS: 155.012 Laboratory Benefit Managers added to TMA Policy Compendium. The council is working with legislative affairs to ensure that previous successes in preventing laboratory benefit managers from reducing access, delaying care, increasing cost and engaging in conflict of interest are not eroded. The council continues to work with specialty groups as additional advocacy opportunities arise.

Resolution 411-A-19 – Data Migration Responsibilities of Electronic Health Record Vendors in Client Contract Termination (Medical Student Section): That (1) the Texas Medical Association work with the American Medical Association and other state medical societies to develop model contract and business associate agreement (BAA) language that ensures electronic health record (EHR) vendors are required to deliver the patient’s complete medical record in a discrete, industry-recognized, nonproprietary format that can be imported into the new EHR at no cost to the physicians; and (2) our TMA seek legislative and/or regulatory relief to require that physicians have access to their former EHR data while transitioning EHRs to ensure continuity of patient care, limit gaps in information exchange, and ensure physician ownership of data. Adopted as amended.

REFERRED TO: Committee on Health Information Technology and Office of the General Counsel


Resolution 412-A-19 – Medical Necessity Tax Exemption for Feminine Hygiene Products (Medical Student Section): That: (1) TMA recognize feminine hygiene products as basic and essential health care necessities; and (2) TMA support the removal of the Texas sales tax on feminine hygiene products. Adopted.

REFERRED TO: Add to TMA Policy Compendium

STATUS: 330.016 Tax Exemption for Feminine Hygiene Products added to TMA Policy Compendium.

Resolution 413-A-19 – The Benefits of Importation of International Pharmaceutical Medications (Medical Student Section): That the Texas Delegation to the American Medical Association ask the AMA to study the implications of prescription drugs importation for personal use and wholesale purchase across our southern and northern borders. Adopted as amended.

REFERRED TO: Texas Delegation to the AMA
The Texas Delegation introduced Resolution 129 at the June 2019 AMA House of Delegates annual meeting. The resolution was combined with another similar resolution (115). The final decision of the AMA House of Delegates was to reaffirm existing AMA policies D-100.983 and D-100.985 and adopt new policy:

AMA supports the personal importation of prescription drugs only if: a) patient safety can be assured; b) product quality, authenticity, and integrity can be assured; c) prescription drug products are subject to reliable, “electronic” track and trace technology; and d) prescription drug products are obtained directly from a licensed foreign pharmacy, located in a country that has statutory and/or regulatory standards for the approval and sale of prescription drugs that are comparable to the standards in the United States.

Resolution 414-A-19 – Studying Financial Barriers of Rural Hospitals (Medical Student Section): That the Texas Medical Association collaborate with other qualified organizations to identify root causes of rural hospital closures and the impact on communities with a report back to the House of Delegates in 2020. Adopted as amended.

REFERRED TO: Committee on Rural Health


Resolution 415-A-19 – Improving Buprenorphine Access for Opioid Substance Use Disorder Treatment (Medical Student Section): That the Texas Medical Association (1) support state efforts to increase the reimbursement rate of buprenorphine to better reflect its actual cost and medication-assisted treatment overhead costs to physicians; and (2) support the elimination of preauthorization requirements for insured patients with opioid use disorders seeking buprenorphine treatment. Adopted as amended.

REFERRED TO: Council on Legislation and add to TMA Policy Compendium

STATUS: 235.014 Buprenorphine Access for Opioid Substance Use Disorder Treatment added to TMA Policy Compendium.

Resolution 416-A-19 – Revising the Texas Department of Insurance Division of Workers’ Compensation Designated Doctor Training and Education Process (Bexar County Medical Society): That TMA work with the Texas Department of Insurance Division of Workers’ Compensation: (1) through the regulatory process to ensure that the TDI-DWC examination being given has questions that are accurate and have been validated; (2) to eliminate the requirement for physicians to repeat the course and exam process every two years; and (3) to develop less costly methods of obtaining and maintaining the appropriate level of education requirement to ensure that the Designated Doctors are using the Guides to the Evaluation of Permanent Impairment, 4th edition accurately and that injured workers are being evaluated fairly. Adopted.

REFERRED TO: Council on Socioeconomics

STATUS: The Council on Socioeconomics is partnering with legislative staff to provide ongoing advocacy.
TEXAS MEDICAL ASSOCIATION
2020 HOUSE OF DELEGATES ANNUAL SESSION

OPENING SESSION
Saturday, August 29, 2020
(The speakers may take items out of order.)

1. Call to Order
   Arlo F. Weltge, MD, Speaker
   Bradford Holland, MD, Vice Speaker

2. National Anthem/ Pledge of Allegiance
   Arlo F. Weltge, MD, Speaker

3. Invocation
   Reverend Bryan Donahoo, Graceview Baptist Church, Tomball

4. Hand Off TMA Disaster Board and Annual Association Finances Report
   Gary Floyd, MD, Chair

5. Order of Business Explanation
   Arlo F. Weltge, MD, Speaker

6. Election and Voting Overview
   Bradford Holland, MD, Vice Speaker
1. Call to Order
   Arlo F. Weltge, MD, Speaker
   Bradford Holland, MD, Vice Speaker

2. Introductions
   Arlo F. Weltge, MD, Speaker
   Michael Darrouzet, Executive Vice President/CEO

3. Report of Credentials
   Tilden Childs, MD, Chief Teller

4. Announcements
   Arlo F. Weltge, MD, Speaker

5. Approval of May 17-18, 2019 Minutes
   Arlo F. Weltge, MD, Speaker

6. AMA President Address
   Sue Bailey, MD, AMA President

7. TMA President Address
   Diana Fite, MD, TMA President

8. Distinguished Service Award
   Introduction: Douglas Curran, MD, Past TMA President
   Josie Williams, MD, Past TMA President

9. Recognition of Section Award Recipients
   Bradford Holland, MD, Vice Speaker

10. Moment of Silence
    Bradford Holland, MD, Vice Speaker

11. Opportunity for Extractions
    Arlo F. Weltge, MD, Speaker

12. Election Results
    Tilden Childs, MD, Chief Teller

13. Projection of What Has Been Extracted
    Bradford Holland, MD, Vice Speaker

14. Final Session Reference Committee Report
    Financial and Organizational Affairs
    Arlo F. Weltge, MD, Speaker
    Science and Public Health
Medical Education and Health Care Quality
Socioeconomics
Bradford Holland, MD, Vice Speaker

15. Adjourn
Arlo F. Weltge, MD, Speaker
Bradford Holland, MD, Vice Speaker
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES
ORDER OF BUSINESS
2020 Virtual Annual House
September 12, 2020

Type of Business Key:
Financial and Organizational Affairs = FOA
Medical Education and Health Care Quality = MEHCQ
Science and Public Health = SPH
Socioeconomics = SOCIO
Tabled to 2021 = TABLE

REPORTS:

2. Reports of Speakers
   1. Written Testimony at Texas Medical Association Reference Committees, Resolution 102-A-19
   2. House Standing Rules

3. Reports of Board of Trustees
   1. 2019-20 Board Officers and Committees
   2. Disclosure of Affiliations
   3. TMAIT, TMFHQI, and TMLT
   4. Medical Student and Resident Physician Loan Funds
   5. Minority Scholarship Program
   6. TMA Leadership College
   7. Pending Lawsuits Involving Texas Medical Association and Audit Trail
   9. Online Communications Policy for TMA Physician Leaders
   10. Establish a Coalition of Medical Societies to Protect Competition and Sustainability in the Health Insurance Marketplace, Resolution 106-A-19
   11. Principles for Community-Based Accountable Care Organizations
   12. Physicians in Employed Settings
   13. Compensation to Physicians for Activities Other Than Direct Patient Care
   15. Investments
   16. TMA Disaster Board of Trustees Actions on Behalf of TMA House of Delegates

4. Report of Executive Vice President

5. Report of Interspecialty Society Committee
   1. Sunset Policy Review

6. Report of Committee on Membership
   1. Membership Development
   2. New Telemedicine TMA Dues Category

7. Reports of Board of Councilors
   1. Distinguished Service Award – Josie R. Williams, MD
   2. Emeritus Nominations
   3. Honorary Nominations
   5. County Medical Societies Constitution and Bylaws
8. Reports of Committee on Physician Health and Wellness
   1. Committee on Physician Health and Wellness Update
   2. Sunset Policy Review

9. Reports of Texas Delegation to the AMA
   1. AMA House of Delegates Meetings in 2019
   2. AMA Membership, Representation, and Delegation Leadership

10. Report of International Medical Graduate Section
    1. International Medical Graduate Section Update

11. Report of Medical Student Section
    1. Medical Student Section Update

12. Report of Resident and Fellow Section
    1. Resident and Fellow Section Update

13. Report of Young Physician Section
    1. Young Physician Section Update

14. Report of Women in Medicine Section
    1. Women in Medicine Operating Procedures Changes

15. Reports of Council on Constitution and Bylaws
    1. Amendments to Constitution, Article V. House of Delegates
    2. Amendments to Bylaws Regarding Inactive and Small County Medical Societies
    3. Amendment to Bylaws and Constitution Establishing an LGBTQ Health Section
    4. Amendment to Bylaws Governing Sections
    5. Amendment to Bylaws Expanding Committee on Membership Section Representation

16. Reports of Council on Health Care Quality
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REPORT OF SPEAKERS

SPKR Report 1 2020

Subject: Written Testimony at Texas Medical Association Reference Committees, Resolution 102-A-19

Presented by: Arlo Weltge, MD, Speaker and Bradford Holland, MD, Vice Speaker

DISCUSSION. Resolution 102-A-19 was adopted as amended at TexMed 2019 as follows:

That the Texas Medical Association House of Delegates reference committees may receive testimony prior to the meeting of the House of Delegates for resolutions and recommendations assigned to the reference committees from any member of the Texas Medical Association. The speakers of the House of Delegates shall determine an appropriate process to receive, compile, and make available this testimony.

The resolution was referred to the speakers, House of Delegates staff, Council on Constitution and Bylaws, and TMA technology staff to be developed into policy.

TMA staff met to develop an initial course of action and to discuss the best way to implement a system that would allow written testimony to be submitted for consideration by the TMA House of Delegates. Discussion focused on creation of a website with the ability for physicians to log in or to fill out pertinent information that identifies the individual providing written testimony along with any conflicts of interest. After testimony is received, it would be reviewed to ensure there is no slander, libel, or antitrust or HIPAA violation. The testimony would then be made available in a public folder for easy access.

On Aug. 27, 2019, the speakers and TMA staff met by conference call to discuss the matter further. During this call, the following was discussed:

- Review of all testimony by TMA legal staff prior to publication/dissemination;
- Making the testimony available to the general membership and reference committee members;
- Allowing additional information and supporting documents, such as a .pdf file, to be uploaded;
- Limiting the amount of written testimony to align with the two-minute rule for oral testimony;
- Setting a deadline for written testimony (to allow for the review, compilation, and posting of all testimony prior to the meeting); and
- Allowing either written or oral testimony but not both so that written testimony would be used only in lieu of an individual not being able to be present at the meeting.

During the winter House of Delegates caucus chair meeting, TMA staff Grant McInnes and John Dorman presented the proposed system to the caucus chairs and heard their comments and concerns. The feedback heard was:

- Add a question mark icon with an explanation of what “speaking on behalf of” means.
- Add an explanation of what constitutes a conflict of interest, with examples.
- On the home page, post legal terminology to explain the review of submissions and the basis for a possible rejection of the written testimony.
- Enable the website to generate a one-page summary print-out of submissions for each reference committee, listing submissions broken down into yea, nay, and supportive information testimony.
- Limit the maximum number of submissions per member for each item to three documents no more than five megabytes in size each.
1. **Collection**

- Physician identifies via login on web application on House of Delegates portal
- Submits information (info, behalf, favor/against)
- Submits testimony
- Attaches supporting documents if desired

2. **Review**

- Submission received
- Staff review
- Legal review
- Optional chair review
- Acceptance

3. **Dissemination**

- Testimony formatted for posting
- Testimony posted on house portal
- Submissions summarized for Ref Com hearing
- Process complete

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1. **Collection**

Physicians will be required to log in to the texmed.org website before submitting written testimony. This will allow TMA to match the submission with the physician’s record in the TMA system. This is important so submissions cannot be anonymous or spoofed.

Once authenticated, a physician will complete a form and submit his or her written testimony. An email will be sent to the physician and a TMA staff person notifying them of a new submission.

2. **Staff Review**

Upon notification of written testimony, TMA staff will log in to the refcom.texmed.org website, which is used to manage reference committees and agenda items and provide real-time updates of reference committee meetings at TexMed. Submissions are scanned first to make sure the documents are free from potential viruses and worms. They will then be reviewed by TMA legal counsel to make sure no submission contains slander, libel, or antitrust or HIPAA violations.
3. Dissemination

Once the submission is approved, it will be formatted and placed on the House of Delegates portal for all TMA members to access. Each submission will include the name of the submitter and purpose of submission with any stated conflict of interest.

The acceptance of written testimony will close 14 days before the start of each year’s TexMed. This will give staff ample time to review documents and prepare them for reference committee members to review before the start of reference committees.

Testimony submitted after the 14-day window can be sent to a shell email address (refcom@texmed.org) monitored by House of Delegates staff. When a submission arrives, it will be reviewed (as noted above) and an effort will be made to disseminate it to the reference committee members, but it will not be posted on the website and not be available to all TMA members. There is no guarantee that any submission sent after the 14-day window will be seen by any reference committee members. The reference committee chair will inform the reference committee session during the open hearing at the House of Delegates meeting about all testimony and materials received ahead of time and specifically clarify any additional items that have been received after the 14-day deadline that will be part of the consideration for each agenda item.

Written testimony submission will be implemented under the newly proposed standing rules for House of Delegates (see Speakers Report 2 2020).
At the 2020 TMA Winter Conference, the TMA speakers and caucus chairs discussed the implementation of house standing rules for future TMA House of Delegates meetings. The adoption of standing rules would help codify many of the house’s traditions that are not covered by TMA’s Constitution and Bylaws or the American Institute of Parliamentarians Standard Code of Parliamentary Procedure.

According to TMA Bylaws:

3.73 Standing Rules. The House of Delegates shall have the authority to establish standing rules. The house shall be guided in its actions by its standing rules and this Constitution and Bylaws. In all instances not covered by this Constitution and Bylaws or its own standing rules, the American Institute of Parliamentarians Standard Code of Parliamentary Procedure shall govern.

Consensus was reached at the Winter Conference caucus chair meeting that the speakers would introduce a basic framework of house standing rules with essential operating procedures defined, allowing for the addition of rules through subsequent amendments. One rule to be included in the initial house standing rules was the allowance for submission of reference committee testimony prior to the house meeting, as adopted by Resolution 102-A-19 at TexMed 2019.

Resolution 102-A-19 was adopted as amended:

That the Texas Medical Association House of Delegates reference committees may receive testimony prior to the meeting of the House of Delegates for resolutions and recommendations assigned to the reference committees from any member of the Texas Medical Association. The speakers of the House of Delegates shall determine an appropriate process to receive, compile, and make available this testimony.

Additionally, at TexMed 2019, Resolution 104-A-19 was referred to the Board of Trustees for action. Resolution 104-A-19 states:

Alternate Delegates May Address the House of Delegates (Lone Star Caucus): That alternate delegates to the TMA House of Delegates be allowed to address the house on matters pending before the House of Delegates without being credentialed as a delegate and that under these circumstances may suggest but cannot make any changes to the content of any resolution or recommendation being considered by the House of Delegates.

At the 2019 TMA Fall Conference, the board voted not to adopt Resolution 104-A-19. Since the TMA Bylaws do not prohibit alternate delegates from addressing the TMA House of Delegates, the Board of Trustees directed the speakers instead to include in the house standing rules language regarding rights and privileges for delegates and alternate delegates, for adoption by the house at the 2020 meeting, without making formal policy and thus changes to the TMA Bylaws.
To comply with the Board of Trustee’s action on Resolution 104-A-19, the speakers have developed the attached TMA House of Delegates Standing Rules. These rules cover those issues not addressed by the TMA Bylaws, including the issue of submission of testimony prior to the house meeting (Resolution 102-A-19) and the issue of alternate delegates addressing the House of Delegates (Resolution 104-A-19).

At its June 28, 2020 meeting, the TMA Board of Trustees, acting on behalf of the TMA House of Delegates as a disaster board, adopted these TMA House Standing Rules and referred them to the Council on Constitution and Bylaws and the TMA speakers for further recommendations with a report back at TexMed 2021. The board approved also that the speakers will work with the Council on Constitution and Bylaws to evaluate formalizing a House of Delegates “advisory body” composed of caucus chairs and representatives to help facilitate house function and report back at TexMed 2021.
Texas Medical Association
House of Delegates Standing Rules

Preamble
These House of Delegates Standing Rules serve as an operational guide and description for how the Texas Medical Association’s House of Delegates conducts its business at the annual meeting and throughout the year in accordance with the Texas Medical Association’s Constitution and Bylaws, the American Institute of Parliamentarians Standard Code of Parliamentary Procedure, and standing tradition. The TMA House of Delegates will adopt these standing rules at the opening of each yearly session, and these rules shall be in effect until revoked.

Alternate Delegates Addressing the House of Delegates
Alternate delegates may address the house by approaching the alternate delegate microphone and waiting to be called upon by the speaker. Recognition of alternate delegates is at the discretion of the speaker. Alternate delegates may neither make motions, nor alter the business of the house, nor vote.

Amendments to House Standing Rules
These rules shall be amended by a majority vote using the formal house resolution process outlined in TMA’s Constitution and Bylaws and become effective immediately upon adoption.

Overruling the Speaker of the House
The speaker of the house can be overruled by a two-thirds vote.

Suspension of the House Standing Rules
Suspension of these house standing rules requires a two-thirds vote.

Written Testimony
The acceptance of written testimony for reference committees will close 14 days before the start of each year’s TexMed.

  Collection: Physicians will be required to log in at texmed.org to submit written testimony through a dedicated form submission page.

  Staff Review: Once written testimony is received, TMA staff will review each submission for potential viruses/worms or other cyber attacks. Submissions will then be reviewed by TMA legal counsel to make sure no submission contains slander, libel, or antitrust or HIPAA violations.

  Dissemination: Once the submission is approved, it will be formatted and placed on the House of Delegates portal for all TMA members to access.

Testimony submitted after the 14-day window can be sent to a shell email address (refcom@texmed.org) monitored by House of Delegates staff. Such submissions will be disseminated to the reference committee members but will not be available to all TMA members since these submissions will not have time to undergo review. There is no guarantee that any submission sent after the 14-day window will be seen by any reference committee members. The reference committee chair will inform the session about any additional submissions that will be considered as part of the consideration of each agenda item.
Subject: 2019-20 Board Officers and Committees

Presented by: E. Linda Villarreal, Chair

Texas Medical Association Bylaws provide that the board shall organize by electing a chair, a vice chair, and a secretary, and that the chair shall appoint committees as needed. In May 2019, the board elected E. Linda Villarreal, MD, as chair; Gary W. Floyd, MD, as vice chair; and Richard W. Snyder, MD, as secretary. Keith A. Bourgeois, MD, and G. Ray Callas, MD, were elected to fill the at-large positions on the board’s executive committee. Ex officio members of the board’s executive committee are the chair, vice chair, and secretary of the board, and the president of the association, David C. Fleeger, MD. The board also welcomed Kayla A. Riggs, MD, as the resident member for 2019-20, and Ankita V. Brahmaroutu as the medical student member for 2019-20.

Board committees for 2019-20 are:

- Investments (Dr. Floyd, chair; Michelle A. Berger, MD; Dr. Bourgeois; Dr. Callas; Douglas W. Curran, MD; Dr. Fleeger; Dr. Snyder; Dr. Villarreal as board chair liaison; and TMA Foundation liaison Craig Norman, RPh);
- Educational Scholarship and Loan (Sue S. Bornstein, MD, chair; Cynthia A Jumper, MD; Jayesh B. Shah, MD; Joseph S. Valenti, MD; Arlo F. Weltge, MD; Dr. Riggs; Ms. Brahmaroutu; Dr. Villarreal as board chair liaison; Dr. S.E. Thompson Scholarship Fund Trustee Raymond S. Greenberg, MD; Medical Student Section (MSS) representative Jordan McKinney; MSS alternate representative Joseph Camarano; and TMA Alliance representatives Pam Abernathy and James P. Davis); and
- Finance (Dr. Berger, chair; Lindsay K. Botsford, MD; Diana L. Fite, MD; Dr. Snyder; Dr. Shah; Dr. Valenti; Dr. Jumper, and Bradford W. Holland, MD).

Drs. Fite, Villarreal, Bourgeois, Callas, Floyd, Weltge, and Fleeger represent the board on the TMA/Texas Osteopathic Medical Association/TMF Health Quality Institute Liaison Committee. Drs. Bornstein, Callas, Curran, Bourgeois, Fite, Fleeger, Shah, and Valenti represent the board on the TMA/Texas Medical Liability Trust Liaison Committee.

Nancy Foster, MD, chairs the board’s Committee on Physicians Benevolent Fund. Committee members are Sue Bailey; Vickie Blumhagen; Beverly Ozanne; Raymond C. Jess, MD; Muriel Mendell; Ann Morales; George Peterkin III, MD; and Shirley Sanders. Dr. Villarreal is the board’s liaison to the committee.

J. Marvin Smith III, MD, chairs the board’s History of Medicine Committee. Members are Joel S. Dunnington, MD; Mark J. Kubala, MD; Steve L. Steffensen II, MD; Mellick Sykes, MD; Margaret Vugrin, MSLS, AHIP; and J. Patrick Walker, MD. J.J. Waller, MD, serves as the TMA Alliance representative, Kelley Eileen Grant as the MSS representative, and Brooke Denise Walterscheid as the MSS alternate representative.

The TMA board also appoints the Texas Medicine Editorial Board. Chelsea I. Clinton, MD, chairs the board. Members are Jeff Apple, MD; Eman Attaya, MD; Seemal Desai, MD; Troy Fiesinger, MD; Christopher Garrison, MD; Roger Khetan, MD; Gary Ventolini, MD; and Alexis Wiesenthal, MD. Vastal
Patel, MD, serves as the Resident and Fellow Section representative and Pranati Pillutla as the MSS representative.
In May 2006, the House of Delegates adopted Board of Trustees Report 18-A-06 as amended to read as follows:

that (1) any candidate for at-large trustee or any office that includes an ex officio seat on the Board of Trustees (president, president-elect, secretary/treasurer, and speaker and vice speaker of the House of Delegates) provide full disclosure of affiliations on a form developed by the speaker of the House of Delegates for that purpose; (2) all members of the Board of Trustees (at-large trustees and officers) provide full disclosure of affiliations each year at the time of the Winter Conference, and that full disclosure be reported to the House of Delegates in the Handbook for Delegates, on the TMA Web site, and by any other method deemed appropriate by the Board of Trustees; and (3) when a health insurance company or HMO requests recommendations for appointment to a physician advisory committee or any other component, the TMA president shall recommend for appointment individuals who best represent TMA’s position, and the names of those individuals recommended by TMA and subsequently appointed by the health insurance company or HMO will be reported to the House of Delegates for information at its next meeting.

At its January 2011 meeting, the Board of Trustees amended the disclosure form to require that those who answer “yes” to the following questions must indicate the type of material financial interest using the letters, A, B, C, or D from the list below:

Do you or an immediate family member hold or plan to hold a material financial interest in any business which furnishes goods or services, or is seeking to furnish goods or services, to TMA or to any member of the TMA Board of Trustees, TMA Executive Vice President, or TMA Chief Operating Officer?

Do you or any immediate family member hold or plan to hold a material financial interest in any health care business, health insurance company, or health care facility, including a private medical practice?

The types of material financial interest to disclose are:

A. a financial ownership interest of 35 percent or more, or
B. a financial ownership interest which contributes materially (5 percent or more) to your income, or
C. a position as proprietor, director, managing partner, or key employee, or
D. any ordinary income, honorarium, or gift (other than dividends from stock) compensation exceeding $1,000 per year in excess of actual expenses.

Attached is a list of affiliations disclosed by all members of the Board of Trustees.
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   Cynthia A. Jumper, MD

The University of Texas Medical School at Houston
   Arlo F. Weltge, MD

TIMEO2 Healing Concepts, LLP
   Jayesh B. Shah, MD

VaxCare
   Douglas W. Curran, MD (D)

Waco Otolaryngology, PC
   Bradford W. Holland, MD (C)

Wound Care Alliance
   Jayesh B. Shah, MD

BY MEMBER:

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Bailey Square Surgery Center  
Northwest Surgery Center  

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PathAdvantage Associated  
Texas Medical Home Initiative  

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Texas Medical Liability Trust (D)  

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Harris County Democratic Party  
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Anesthesia Associates (D)  
Beaumont Chamber of Commerce  
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Jefferson and Orange County Board of Pilot Commissioners  
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Mallinckrodt Pharmaceuticals (D)  
Texas Department of Licensure and Regulations  
Texas Medical Liability Trust (D)  
Texas Society of Anesthesiologists (C and D)  

Douglas W. Curran, MD  
American Academy of Family Physicians  
Blue Cross and Blue Shield of Texas (D)  
Lakeland Medical Associates (C)  
Texas Academy of Family Physicians  
VaxCare (D)  

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Tarrant County Emergency Physicians Advisory Board
Texas Medical Association PracticeEdge, LLC (C and D)
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Texas Pediatric Society

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Baylor University, Department of Communication Sciences and Disorders
Extraco Banks, Community Board of Directors
Fishpond Surgery Center (D)
Texas Association of Otolaryngology
Waco Otolaryngology, PC (C)

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American Board of Medical Specialties
American College of Physicians, Texas Chapter
American Medical Association
Employees Retirement System of Texas
Medical Care Advisory Committee, Texas Medicaid
Texas Tech University Health Sciences Center-Lubbock

Jayesh B. Shah, MD
American College of Hyperbaric Medicine
Mission Trail Baptist Hospital/Tenet
South Texas Wound Associates, PA
TIMEO2 Healing Concepts, LLP
Wound Care Alliance

Richard W. Snyder, MD
American College of Cardiology, Texas Chapter
Blue Cross and Blue Shield of Texas (D)
Cardiovascular Provider Resources, Inc.
HeartPlace, PA
Southwestern Medical Foundation
Specialty Physician Assurance Company
Texas Medical Association Specialty Services, LLC

Joseph S. Valenti, MD
Caring for Women, PA
Lone Star Alliance
Physicians Foundation
Texas Medical Liability Trust

E. Linda Villarreal, MD
Blue Cross and Blue Shield of Texas (D)
Memorial Medical Clinic

Arlo F. Weltge, MD
American College of Emergency Physicians
American Medical Response
Houston Community College
The University of Texas Medical School at Houston
REPORT OF BOARD OF TRUSTEES

BOT Report 3 2020

Subject: TMAIT, TMFHQI, and TMLT

Presented by: Gary W. Floyd, MD, Chair

Texas Medical Association Insurance Trust Board of Trustees

The TMA Board of Trustees has responsibility to appoint four members of the TMA Insurance Trust (TMAIT) Board of Trustees. In accordance with TMA Insurance Trust’s Amended Agreement and Declaration of Trust, the fifth appointed position is held by the executive vice president of TMA without any term limitation. The TMA board also fills the position reserved for a member of the Young Physician Section. The TMA board offers nominations for the remaining three positions, which are elected by policyholders through the proxy mechanism. Current TMAIT officers are Wendy Parnell, MD, of Dallas (board chair) and Richard Noel, MD, of Houston (secretary). The term of Russ Juno, MD (immediate past chair), expires in September 2020. Dr. Noel will cast the proxy vote to elect Lan Le, DO, of Fort Worth to fill the open position.

TMF Health Quality Institute Board of Trustees

The TMF Health Quality Institute (TMFHQI) Board of Trustees comprises physicians, nonphysicians, and consumer (Medicare) beneficiary representatives. The TMFHQI Board of Trustees has up to 15 members, including at least one doctor of allopathic medicine, one doctor of osteopathic medicine, and two consumer representatives. The board may not be composed of a majority of physicians or any other type of practitioner or profession but will include no less than two physicians at all times.

In 2020, no physician terms are expiring.

The TMA Board of Trustees maintains active liaison with the TMF Health Quality Institute Board of Trustees through its TMA/TMF Liaison Committee.

Texas Medical Liability Trust Governing Board

The Texas Medical Liability Trust (TMLT) Governing Board annually makes nominations to the TMLT board. These nominations are, in turn, submitted to and approved by the TMA House of Delegates. TMLT policyholders also can nominate other eligible candidates. These nominations are reported to the House of Delegates.

Beginning with elections in 2007, places on the TMLT board are staggered so that only a portion are up for election each year. Each term is for three years, and board members may be reelected for two additional three-year terms for a maximum of nine years of service on the board. The following places are up for election in 2020:
Place 1: Mark S. Gonzales, MD, will fulfill his term and board tenure at the end of 2020. The TMLT Governing Board recommends nominating Herb Singh, MD, urology, Austin, for a three-year term beginning in 2021.

Place 2: Russell Krienke, MD, will fulfill his second term at the end of 2020. The TMLT Governing Board recommends that Russell Krienke, MD, be reelected for an additional three-year term beginning in 2021.

Place 3: Pamela D. Holder, MD, will fulfill her term and board tenure at the end of 2020. The TMLT Governing Board recommends nominating Lindsey Harris, MD, ophthalmology, Houston, for a three-year term beginning in 2021.

On Aug. 16, 2020, the TMA Board of Trustees, acting as the TMA Disaster Board, approved Drs. Herb Singh, Russell Krienke, and Lindsey Harris, nominees of the TMLT Governing Board, to be placed before TMLT policyholders for election.
Subject: Medical Student and Resident Physician Loan Funds

Presented by: E. Linda Villarreal, MD, Chair

Overview
The medical student and resident physician loan program originated in 1952 with trust donations set up in endowed funds at TMA. Members of the TMA Board of Trustees serve as trustees or as members of the boards of trustees for six loan funds:

- Dr. S. E. Thompson Scholarship Fund;
- May Owen Irrevocable Trust;
- Texas Medical Association Alliance Student Loan Fund (TMA Special Funds Foundation);
- Durham Student Loan Fund (TMA Special Funds Foundation);
- Medical Student Loan Fund (TMA Special Funds Foundation); and
- Patricia Lee Palmer, MD, Memorial Resident Loan Fund (TMA Special Funds Foundation).

The current interest rate of these loans is fixed at 4.4% (with the 0.4% used for a group life policy, as required by the trust documents).

Medical Student Loans
Five student loan funds are available to medical students: Dr. S. E. Thompson Scholarship Fund, May Owen Irrevocable Trust, Texas Medical Association Alliance Student Loan Fund, Durham Student Loan Fund, and Medical Student Loan Fund. From July 1 through Dec. 31, 2019, 99 loans totaling $486,300 were disbursed from the five funds, and additional applications remain in process.

Resident Physician Loans
The Dr. S.E. Thompson Scholarship Fund and the Patricia Lee Palmer, MD, Memorial Resident Loan Fund offer loans to resident physicians. Four resident loans totaling $21,000 were disbursed from July 1 through Dec. 31, 2019.

2020-21 Allocation
In January 2020, the board approved allocations for the 2020-21 school year (June 1-May 31) totaling $845,000, including $38,000 for residents. The loan allocations to the 15 medical schools are based on availability of funds and the history of each school’s utilization.
Subject: Minority Scholarship Program

Presented by: E. Linda Villarreal, MD, Chair

Since 1998, The TMA Minority Scholarship Program has given 149 scholarships to underrepresented minority medical students in Texas for a total of $977,500. Thirteen Texas medical schools have received an award. As of Jan. 24, 2020, the TMA Foundation has collected $23,500 in cash and pledges for the 2020 scholarships. All shortfalls will be covered by 2016 donations received from two private donors: Robert J. Bayardo, MD, and Patrick Leung, MD.

The 2020 program will award fifteen (15) $10,000 scholarships to students matriculating at:

- Baylor College of Medicine,
- Sam Houston State College of Osteopathic Medicine (new 2020),
- Texas A&M Health Science Center College of Medicine,
- TCU and UNTHSC School of Medicine (new 2019),
- Texas Tech University Health Sciences Center School of Medicine,
- Texas Tech University Health Sciences Center-El Paso Paul L. Foster School of Medicine (new 2013),
- The University of Texas at Austin-Dell Medical School (new 2016),
- The University of Texas Health Science Center at Houston-John P. and Kathrine G. McGovern Medical School,
- The University of Texas Health Science Center at San Antonio–Joe R. & Teresa Lozano Long School of Medicine,
- The University of Texas Medical Branch at Galveston School of Medicine,
- The University of Texas Rio Grande Valley School of Medicine (new 2016),
- The University of Texas Southwestern Medical School,
- University of Houston College of Medicine (new 2020),
- University of North Texas Health Science Center at Fort Worth-Texas College of Osteopathic Medicine, and
- University of the Incarnate Word School of Osteopathic Medicine (new 2017).

The TMA Office of Trust Fund Administration must have received candidate applications by Feb. 21, 2020. The BOT’s Educational Scholarship and Loan Committee members review qualified applications and make the selection of winners. Scholarship recipients are notified in April and are required to attend the presentation luncheon at TEXMED 2020 on May 1 in Fort Worth.

Although the U.S. Supreme Court ruling in 2003 allows race to be used in admissions and financial aid processes of academic institutions (subject to certain criteria), the current renewed scrutiny of race-based admissions policies by the Trump administration may act as deterrent to any schools currently using or considering using such a policy. This leaves the TMA scholarship program as one of the few available in the state for underrepresented minority students (as defined by the Association of American Medical Colleges) seeking a career in medicine. TMA’s selected recipients must also express interest in practicing in underserved areas and must demonstrate both community service and leadership. Title VI restrictions generally do not prohibit an organization that is not a recipient of Federal financial assistance from directly giving scholarships or other forms of financial aid to students based on their race or national origin.
Subject: TMA Leadership College

Presented by: E. Linda Villarreal, MD, Chair

Funded by a grant from The Physicians Foundation, the Texas Medical Association Leadership College (TMALC) was launched in 2010 as part of TMA’s effort to ensure strong and sustainable physician leadership within organized medicine.

This successful program, now in its tenth year, boasts 184 alumni. Additionally, 166 graduates are currently serving in TMA leadership via councils, committees, and sections with others representing their county and specialty societies. These physicians serve as thought leaders who can close the divide among clinicians and health care policymakers and serve as trusted leaders in their local communities.

Participants must be active TMA physician members in the first eight years of practice. There is no tuition charge for scholars, but scholars are responsible for their own travel expenses.

This year, TMA will be launching a second cohort known as the Lifelong Leadership cohort. The Lifelong Leadership cohort will mirror the curriculum of the original program, but tailor the content to those whose age or years in practice make them ineligible to participate in the existing Young Physician cohort. Participation will be application- and fee-based, with tuition fees offsetting increased overhead costs without negatively impacting existing programs. The substance of the Lifelong Leadership curriculum will address leadership concerns likely to surface later in a physician’s career: strategic planning and fiduciary responsibility, ethical decision-making, physician burnout, human resource management, and mentorship, among others.

Now Accepting Applications for 2020

Applications for the 2020-21 program are due by August 14, 2020. Visit www.texmed.org/leadership for more information and to access the online application. For questions, contact Melanie Harrison at melanie.harrison@texmed.org, or call (800) 880-1300, ext. 1443.

Congratulations Class of 2020!

Twenty-eight scholars will graduate during a luncheon ceremony held at TexMed 2020 on Saturday, May

Class of 2020 Curriculum

Live Session Topics
- Acts of Leadership
- Emotional Intelligence
- Personal Leadership
- Team Interaction and Development
- Conflict Management
- Personal Branding
- Using Social Media as a Thought Leader
- Legislative Process
- Advocacy in Action
- Media Training
- Physician Burnout
- Online Reputation Management
- Forging Productive Professional Relationships
- Communication Styles

Self-Study: Scholar Project
Scholars select from a comprehensive menu of project suggestions or create a project of their own that complements lessons/topics discussed.
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<tr>
<th>Scholar</th>
<th>Specialty</th>
<th>Practice Location</th>
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<tr>
<td>Philip Balfanz, MD</td>
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<td>Kerrville</td>
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<td>Lisa Caplan, MD</td>
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<td>Bellaire</td>
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<td>Marawan El Tayeb, MD</td>
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<td>Semhar Ghebremichael, MD</td>
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<td>Shiva Gupta, MD</td>
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<td>Joseph Hendrix, MD</td>
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<td>Stephen Herrmann, MD</td>
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<td>Dakeya Jordan, DO</td>
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<td>Carla Laos, MD</td>
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<td>Michael MacKelvie, DO</td>
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<td>Samuel Mathis, MD</td>
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<td>Erin Moody, MD</td>
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<td>Marcial Oquendo, MD</td>
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<td>Ravi Pingali, MD</td>
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<td>Melodi Reese-Holley, MD</td>
<td>OBG</td>
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<td>Katherine Rinard, MD</td>
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<td>Mary Ann Rodriguez, MD</td>
<td>IM</td>
<td>Austin</td>
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<td>Irvin Sulapras, MD</td>
<td>FSM</td>
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<td>Beth Teegarden, MD</td>
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<td>Chandana Thatikonda, MD</td>
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<td>Jenny Thomas Jacob, MD</td>
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<td>Sara Woodward Dyrstad, MD</td>
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<td>Odessa</td>
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At each of its meetings, the Board of Trustees reviews an audit trail of pending lawsuits involving the association. The following is an updated report, prepared in January, by the Office of the General Counsel.

A. LITIGATION AS PLAINTIFF

TMA v. Texas Board of Chiropractic Examiners and Texas Chiropractic Association
(Regarding scope of practice, specifically pertaining to vestibular-ocular-nystagmus [VON] testing)

On Jan. 6, 2010, the Texas Board of Chiropractic Examiners (TBCE) proposed an amendment to 22 Texas Administrative Code §75.17(c)(3), concerning Scope of Practice, to add a new subparagraph (C) to describe training required for doctors of chiropractic to perform VON testing.

The Texas Chiropractic Act defines the practice of chiropractic as using “objective or subjective means to analyze, examine, or evaluate the biomechanical condition of the spine and musculoskeletal system of the human body,” or performing “nonsurgical, nonincisive procedures, including adjustment and manipulation, to improve the subluxation complex or the biomechanics of the musculoskeletal system.” The performance of VON testing does not, in any way, fall within the scope of practice as defined in Texas Occupations Code §201.002(b), and therefore exceeds the rulemaking authority of the board.

VON testing is a purely diagnostic neurological test intended to diagnose a problem of the brain, inner ears, or eyes. It includes tests of vestibular function that are designed to evaluate the inner ear (vestibular apparatus) and the neural connections between the inner ear and the parts of the brain that control eye movement. Symptoms that would prompt VON testing are dizziness, imbalance, and vertigo. These symptoms must be diagnosed rapidly as they may be caused by something as benign as a viral infection of the inner ear or something as ominous as a brain tumor or an impending brainstem stroke.

Ears and eyes are not part of the spine and musculoskeletal system of the human body. Furthermore, disorders affecting the biomechanical condition of the spine and musculoskeletal system of the human body do not cause vestibular system pathology. As VON testing does not fall within the statutory scope of practice of chiropractic, TMA contends that the board’s adopted rule exceeds the practice of chiropractic as defined by law, and impermissibly attempts to permit chiropractors to practice medicine without a license issued by the Texas Medical Board.

TMA submitted comments containing its strong objections to the proposed rule. TBCE withdrew those proposed rules, based on the comments it had received. In its place, the board proposed a revised amendment to §75.17(c)(3)(C), with an increased requirement that, in order to administer this test, a licensee must have received a diploma in chiropractic neurology and successfully completed an additional 150-hour post-graduate specialty course in vestibular rehabilitation. In the preamble to the proposed rule, TBCE wrote the following interesting statement, pertaining to diagnosis: “A vestibular and oculomotor functional assessment can provide a neurologically trained doctor of chiropractic
with a baseline for treatment of a patient as well as the information necessary for a differential
diagnosis and development of a plan for treatment.”

TMA again submitted its strong objections in a comment letter on July 19, 2010. TBCE held a rule
hearing pertaining to the rule on Aug. 6, 2010. At that rule hearing, Sara Austin, MD, neurologist,
tested on behalf of TMA. TBCE voted to adopt the rule, with no debate. The final rule has been
formally adopted.

Incidentally, at that TBCE hearing, the TBCE president stated that any discussion pertaining to scope
of practice should be sent to one member through email, and not to all the board members, in order to
avoid the “open meetings” rule. In light of that statement, on Aug. 25, 2010, TMA sent TBCE a
public records request under the authority of Texas Government Code §552.021 for copies of all
policy statements or interpretations of the law or rules that have been adopted, published, or issued by
the Texas Board of Chiropractic Examiners, or emails or other writings relating to scope of practice
for chiropractors. TBCE produced some documents and withheld others, seeking an attorney general
opinion pertaining to the documents withheld. TMA prepared a response letter to the attorney general,
and the attorney general has ruled in TMA’s favor. TBCE has since produced the documents it sought
to withhold, which contain some information that is quite contrary to TBCE’s position and very
favorable to TMA’s position.

TMA’s main concern is with the vestibular testing rule adopted by TBCE, as VON testing should not
be performed by chiropractors, regardless of any additional chiropractic education or training they
may obtain pertaining to the test. TMA believes the proposed rule §75.17(c)(3) exceeds the
rulemaking authority of the board and is unconstitutional pursuant to Article XVI, section 31 of the
Texas Constitution.

The TMA Board of Trustees authorized TMA to proceed with a lawsuit. David Bragg was retained to
file the suit. The lawsuit was filed on Jan. 31, 2011.

The case was assigned to the 353rd Judicial District Court of Travis County, Texas. The judge was
Rhonda Hurley. Both parties designated their testifying expert. All depositions of expert witnesses
were taken. TBCE experts that were deposed include Frederick Carrick (“chiropractic neurologist”)
and Dr. Brandon Brock (“chiropractic neurologist”). TMA presented Bridgett Wallace and Dr.
Richard Kemper for deposition, and both did an excellent job testifying.

The parties filed cross motions for summary judgment, and the court held a hearing on the motions on
Dec. 5, 2011. The court’s order essentially granted TMA all relief it sought in the lawsuit, and on
TBCE filed its reply brief on Aug. 27, 2012. On Sept. 11, 2012, the court denied oral arguments and
set the case for submission on briefs on Oct. 2, 2012.

On Nov. 21, 2012, the Court of Appeals issued its opinion reversing the trial court’s ruling, which
had granted TMA’s motion for summary judgment. The appellate court also remanded the case back
to the trial court to determine what VON testing is. According to the appellate court, questions of fact
existed regarding whether VON testing is solely a medical test, and whether the test can be used for
chiropractic purposes. In summary, the appellate court reversed on a technicality – a motion for
summary judgment is a purely legal (not factual) finding, and because the appellate court felt there
are factual issues to decide (what is VON), it determined that the motion for summary judgment
ruling was improper.

On remand, TMA filed its first amended original petition on Sept. 13, 2013. In it, TMA added the
following arguments for the court’s determination: the rules improperly define “musculoskeletal
system” to include nerves, and also define that term with a functional context (“that move the body and maintain its form”), which implies that anything that affects movement of the body or maintenance of its form would be included in the musculoskeletal system; the rules improperly authorize certain chiropractors to perform “technologically instrumented vestibular-ocular-nystagmus” testing, which is unrelated to the biomechanical condition of the musculoskeletal system or the spine; and the rule improperly defines “subluxation complex” as a “neuromusculoskeletal condition,” which exceeds the scope of authority conferred on chiropractors by the Chiropractic Act. TMA also amended discovery responses to TBCE’s request for disclosure to reflect the new issues contested in the first amended original petition.

TBCE filed a brief in support of a plea to the jurisdiction on Feb. 28, 2014, with respect to the issue of whether it is within the scope of practice for chiropractors to make a medical diagnosis. After hearing arguments, the court denied the plea, and interlocutory appeal immediately followed on April 3, 2014. On Dec. 8, 2014, the Third Court of Appeals court affirmed denial of the plea, and on Feb. 23, 2015, the Third Court of Appeals overruled TBCE’s motion for panel rehearing and/or en banc rehearing. After petitioning for review with the Supreme Court of Texas, the petition was denied.

On June 16, 2016, TBCE filed a motion for partial summary judgment relating to the diagnosis issue, which the court denied. Accordingly, the case proceeded to trial on Aug. 2-3, 2016. TMA argued that as VON testing reveals nothing about the biomechanical condition of the spine or musculoskeletal system, it is not included in the definition of chiropractic. Since the legislature included only the musculoskeletal system and spine in the definition of chiropractic, TMA argued, the VON testing rule exceeds the scope of chiropractic. TBCE claimed that problems with the vestibular system can affect the musculoskeletal system and therefore are within the purview of chiropractic. As directed by Judge Hurley, written closing arguments were filed by all parties on Aug. 13, 2016.

On Oct. 19, 2016, Judge Hurley issued a final judgment declaring:

- The authorization for chiropractors to perform “technological instrumented vestibular-ocular-nystagmus” exceeds the scope of chiropractic and is therefore void;
- The definition of “musculoskeletal system” to include “nerves” exceeds the scope of chiropractic and is therefore void;
- The definition of “subluxation complex” as a “neuromusculoskeletal condition” exceeds the scope of chiropractic and is therefore void; and
- The use of the term “diagnosis” as used by TBCE in its Scope of Practice Rule exceeds the scope of chiropractic and is therefore void.

On Oct. 25, 2016, TBCE asked the court to file findings and fact and conclusions of law. These were drafted by TMA’s outside counsel, David Bragg, and signed by Judge Hurley. TBCE requested additional findings of fact and conclusions of law. On Dec. 6, 2016, TMA filed its response to TBCE’s request for additional findings of fact and conclusions of law and made its own request for the same. On Dec. 7, 2016, Judge Hurley signed supplemental findings of fact and conclusions of law.

In January 2017, TBCE filed an appeal with the Third Court of Appeals. In its appeal, TBCE argued three main points:

1. Nerves are associated with subluxation complexes and are an integral part of chiropractic treatment, and correction of biomechanical problems affect nerves, which means the rule’s references to “nerves” or “neuro” are consistent with the statutory scope of chiropractic.
2. TMA did not prove that the VON testing provision is invalid because TMA did not demonstrate that VON testing was intended to be used exclusively to diagnose disease of the brain, ear, or eye,
whereas TBCE contends it offered uncontradicted evidence that VON testing is useful in chiropractic evidence.

3. The term “diagnosis” in the challenged rule was within the statutory scope of chiropractic practice, and the issue has already been decided and may not be relitigated.

TMA filed its brief in response to TBCE’s brief on Sept. 11, 2017. The case was heard before the appellate court on Feb. 28, 2018.

On Nov. 21, 2018, the Third Court of Appeals issued a memorandum opinion (Justice C. Bourland) affirming the trial court’s judgment in part and reversing in part:

1. The Third Court overruled TBCE’s first point on appeal. The fact that nerves are affected by disorders in or treatment of the musculoskeletal system does not mean the nervous system or the nerves themselves fall within the scope of chiropractic. The statute contains a limitation to evaluation of the “biomechanical condition of the spine and musculoskeletal system,” citing §201.002(b).
2. The Third Court noted that although VON testing may be a useful tool to chiropractors, the evidence establishes that VON testing helps in the diagnosis of vestibular issues and that such disorders do not fall within the ambit of chiropractic.
3. Finally, the Third Court noted that effective Sep. 1, 2017, Tex. Occ. Code §201.002 was amended to provide that a person practices chiropractic if he or she, among other things, “uses objective or subjective means to diagnose, analyze, examine, or evaluate the biomechanical condition of the spine and musculoskeletal system of the human body.” Thus, because the term “diagnose” is expressly included in the Occupations Code itself, it is valid to include it in rule (although limited to the biomechanical condition of the spine and musculoskeletal system).

On Dec. 31, 2018, TCBE filed a motion for en banc reconsideration on points 1 and 2 contending that the Third Court did not apply the proper de novo review in the statutory interpretation case and instead applied a sufficient evidence analysis. TCBE further argued that VON testing is within the scope of chiropractic treatment as it helps chiropractors rule out other nonvestibular signs of dizziness and refer to other providers. Finally, TCBE challenges TMA’s standing to file suit in this particular cause under the Administrative Procedures Act. On or about Dec. 28, 2018, TCBE filed a petition for review to the Supreme Court of Texas with briefing filed on Feb. 27, 2019. On Jan. 10, 2019, the court denied TCBE’s motion for en banc reconsideration. TMA filed its response to the petition for review on March 26, 2019.

The court requested additional briefing as to whether it should grant the petition for review. On Aug. 21, 2019, TCBE filed its brief, and TMA filed its response on Sept. 25, 2019. As of January 2020, the court has not issued a decision.

B. LITIGATION AS DEFENDANT

No pending litigation at this time.

C. AMICUS CURIAE BRIEFS

1. Gomez v. Memorial Hermann
   (Regarding whether the Supreme Court of Texas should grant the petition for writ of mandamus to produce records from a medical peer review proceeding)

   This case was brought by Miguel Gomez, MD, a heart surgeon, against Memorial Hermann Hospital System (MH) and Michael Macris, MD, and Keith Alexander (CEO of MH) in their
Dr. Gomez seeks documents that purport to measure his quality and efficiency as compared with other doctors in the MH system. Allegedly, these were improperly compiled by another cardiovascular surgeon (Dr. Macris) and spread using MH’s wholly owned nonprofit health corporation (MHMD) to other physicians who likely would refer patients to Dr. Gomez, and the rumor mill at MH. This allegedly was done after MH learned Dr. Gomez had applied for privileges at a competing facility being constructed a few miles from MH’s Memorial City facility. After Dr. Gomez refused to accept a proposed monitoring of his practice without the benefit of peer review by the hospital medical staff’s peer review committee, attempts to restrict Dr. Gomez’s privileges through the MH Memorial City’s medical staff peer review committee failed. Subsequently, the defendants started an alleged rumor mill in an attempt to affect Dr. Gomez’s referrals adversely, thereby affecting patient choice. Some evidence of this, including the testimony of former MH executives now employed with another health care system, is in the case record.

The TMA Patient-Physician Advocacy Committee (PPAC) reviewed numerous briefs and other documents authored by both sides of the case and spent several hours with presenters from each side at its meeting held May 1, 2014, in conjunction with TexMed 2014. Since that time, the Supreme Court of Texas has asked for briefing from Dr. Gomez on the issue of whether the court should accept the case.

Defendants, MH, Dr. Macris, and Mr. Alexander are seeking a writ of mandamus from the Supreme Court of Texas, which would order the trial court to withdraw its order mandating the discovery of certain medical peer review records. The defendants seeking the writ have already filed briefs with the court, arguing that the court should take the case, grant oral argument, and reverse the trial court’s determination that certain documents relevant to the allegation of anticompetitive conduct are discoverable and must be disclosed to the plaintiff. The trial court’s order came after the trial court judge reviewed the documents in camera and made a judgment on each document’s relevance to the allegation of anticompetitive conduct.

Some of the stipulated medical peer review documents were determined to be related to the alleged anticompetitive conduct by the defendants. Under the anticompetitive exception to peer review protection provided by the Texas Occupations Code, discovery of documents is permitted if the peer review records and proceedings requested are relevant to an anticompetitive action or to a federal civil rights proceeding.

The trial court determined that the Texas Occupation Code’s peer review provisions applied, rather than the medical committee protections found in the Texas Health and Safety Code. This determination was based upon the reasoning that the more specific statute controlled. TMA drafted the original peer review bill and supported the resulting medical peer review language, which was passed in 1987 to adopt the protections in the federal Health Care Quality Improvement Act of 1986 and to shore up the Texas peer review protections that had been eroded by the Texas appellate courts. The Texas Hospital Association also supported the bill. The 1987 Texas law protections prohibiting discovery of peer review minutes and proceedings had two exceptions: an anticompetitive action and a civil rights proceeding. These provisions remain unchanged today.

At the meeting of the PPAC, both sides requested that TMA file a brief in support of their respective positions. The defendants argued that the anticompetitive action exception did not fit this case because it did not reach the threshold of an antitrust action, as only one physician was...
allegedly discriminated against. The market for patients to choose a heart surgeon allegedly was not affected. Also, the defendants argued that the Texas Health and Safety Code medical committee provision keeping medical committee records and proceedings confidential should apply. Neither an anticompetitive nor a civil rights exception is included in that medical committee provision.

On June 19, 2014, TMA filed an amicus curiae brief in the case. TMA’s brief argued that plain language of the statute provides an exception to the confidentiality and privilege associated with peer review when a judge makes a preliminary finding that a proceeding or record of a medical peer review committee is relevant to an anticompetitive, not antitrust, action.

TMA’s brief also argued that the legislative history of, and public policy behind, this exception indicates that the facts alleged in this case are precisely those meant to be addressed by this statute. The record reflects that the trial judge in this case made the required preliminary finding and ordered production of some of the proceedings and records of the medical peer review committees involved, as required by the statute. The record also indicates that the judge was presented evidence outside of the contested peer review records and proceedings, which provided an extra check to the potential overuse of the exception. Therefore, there is no need to exercise court’s jurisdiction in this case and grant the petition.

On June 27, 2014, the court requested briefing on the merits. MH’s brief was filed on Aug. 27, 2014. Dr. Gomez’s brief was filed on Oct. 27, 2014. MH’s reply brief was filed on Nov. 26, 2014

Oral arguments were made on Feb. 25, 2015. TMA was in attendance. Dr. Gomez filed a post-submission brief on Mar. 10, 2015. MH filed a response to that brief on Mar. 20, 2015.

On May 26, 2015, the court issued an opinion. The court adopted the logic TMA put forward in its amicus brief and held that the anticompetitive action exception is broader than an antitrust claim such that an individual physician can pursue a claim against a hospital.

Interestingly, the court went on to discuss how confidentiality would work if a committee was both a “medical committee” and a “medical peer review committee”: “records and proceedings of a dual medical committee and medical peer review committee do not enjoy any greater confidentiality under §161.032(a) than they do under §160.007(b).” Therefore, doctors in future lawsuits of this nature will have the benefit of the broader anticompetitive action claim no matter which peer review confidentiality section the hospital claims applies.

A jury trial in the case was held from Mar. 17, 2017, through Mar. 27, 2017. The jury deliberated for two days and delivered its verdict on Mar. 29, 2017. The jury found that MH defamed Dr. Gomez and awarded Dr. Gomez $6.4 million, including $1 million in punitive damages. In May 2017, the state district court judge, who presided over the trial, affirmed the jury verdict by entering an order in Dr. Gomez’s favor that awarded more than $6 million in damages. A notice of appeal was filed on Aug. 10, 2017. A post-judgment mediation was unsuccessful.

After appeal to the First Court of Appeals, TMA submitted its amicus brief on October 23, 2018. In the brief, TMA noted practical concerns on health care facilities abusing qualified privilege to engage in anticompetitive and retaliatory behavior against physicians. TMA further pointed out to the appellate court that MH’s defamatory statements are not privileged or subject to any qualified privilege. Finally, the brief reiterated the point that the jury found evidence of actual malice, which defeats any privilege defense. The parties presented oral argument on Oct. 30, 2018.
After oral argument and all briefs were submitted, the First Court of Appeals issued its opinion on Aug. 15, 2019, in favor of Dr. Gomez, upholding the trial court’s judgment and finding no reversible error. On Dec. 2, 2019, MH filed a petition for review with the Texas Supreme Court.

2. **Noel Dean v. Darshan Phatak, MD**

(Regarding whether a physician who met the standard of care, but later changed his autopsy finding, can be held liable for the earlier finding)

This is a civil rights case against a physician practicing as a medical examiner in Harris County. Darshan Phatak, MD, is employed as an assistant medical examiner with the Harris County Institute of Forensic Sciences, which contracts to provide autopsy services in Harris County. Dr. Phatak performed the autopsy of a certain deceased woman and determined the cause of death to be “homicide” by gunshot wound. Following this determination, the deceased’s husband was arrested and tried for murder. The accused’s murder trial ended in a hung jury. After the trial, the chief deputy medical examiner, in reevaluating the evidence, performed an additional test in relation to the decedent and the gun wound – a gun-to-wound examination – and as a result, the medical examiner’s office changed the cause of death determination in the autopsy report from “homicide” to “undetermined.” Because of this change, the prosecutor dropped the charges, and the accused filed a civil rights suit in federal court against, among others, Dr. Phatak in his individual capacity.

The basis for the lawsuit is that, pursuant to the fourth, sixth, and 14th amendments to the U.S. Constitution, the accused had a right to be free from an intentionally falsified autopsy report, and the accused is asserting just that: that Dr. Phatak intentionally falsified the autopsy report. This assertion is based on the alleged fact that Dr. Phatak allowed a detective to influence the autopsy determination; that he failed to fully consider that the deceased had suicidal thoughts; and that he failed to perform a gun-to-wound comparison. Dr. Phatak has maintained he did not conspire with detectives to falsify the report and has also maintained that nothing in his examination was extraordinary or unusual – he claims he followed protocol.

The federal district court has refused to recognize the defense of qualified immunity to which Dr. Phatak, a governmental employee, should be entitled. In an order on a motion for summary judgment, the court found that, viewed in the light most favorable to the plaintiff, a reasonable juror could conclude that a “reasonable medical examiner would have understood that intentional fabrication of evidence violated a defendant’s right to be free of a wrongful prosecution that caused his pretrial arrest and other deprivations of liberty.” The trouble is that the court’s articulation of the clearly established right – to be free from intentional fabrication of evidence – is far too broad and thus interferes with Dr. Phatak’s right to exercise his medical judgment. It is undisputed that Dr. Phatak followed the protocols of the medical examiner office. The fact that Dr. Phatak relied on reasonable medical judgment and medical standards offered no protection, according to the court. Essentially, the court imposed a higher “standard of care” with its holding.

TMA gathered the support of the American Medical Association, the National Association of Medical Examiners, the College of American Pathologists, and the Texas Society of Pathologists, and filed a joint amicus brief to the U.S. Fifth Circuit Court of Appeals. The brief discussed the importance of medical examiners and that, because of their important function, they should not be held to a higher standard of care than what is ordinarily required of physicians.

On Dec. 6, 2017, the Fifth Circuit held oral arguments. On Dec. 20, 2018, the Fifth Circuit issued a decision vacating the district court’s denial of qualified immunity based on a procedural technicality.
Specifically, the Fifth Circuit determined that the district court’s order and analysis cites
allegations in the pleadings (written statements) but did not reference actual “evidence” in the
record. Without identification of summary judgment evidence, the Fifth Circuit determined it
could not make a reasoned decision to affirm or deny qualified immunity. Accordingly, the Fifth
Circuit remanded the case to the district court to reconsider the motion and instructed the district
court to specifically reference summary judgment evidence in its order. As of January 2020, no
new decisions have been issued by the district court or the Fifth Circuit.

3. Ruben Aleman, MD v. Texas Medical Board
(Regarding the Texas Medical Board’s sanction authority)

On Feb. 26, 2019, TMA filed an amicus brief with the Texas Supreme Court in support of Ruben
Aleman, MD, urging reversal of a trial court order affirming the Texas Medical Board’s (TMB’s)
assessment of an administrative penalty in the amount of $3,000 for Dr. Aleman’s alleged
violation of the Texas Medical Practice Act.

Specifically, TMB alleged Dr. Aleman failed to comply with Texas Health and Safety Code
§193.005(h), which requires an attending physician for a deceased person completing medical
certification on a death certificate to submit information and attest to its validity electronically
using the Texas Electronic Death Registry (TEDR). On July 29, 2011, a mortician presented Dr.
Aleman with a physical, paper certificate of death for a deceased patient and requested that Dr.
Aleman sign the medical certification portion of the certificate. Dr. Aleman signed the paper
certificate with a pen. By signing the paper certificate of death with a pen, Dr. Aleman was
unable to sign the certificate of death electronically using the TEDR. The board initiated a formal
complaint with the State Office of Administrative Hearings (SOAH) against Dr. Aleman for
allegedly violating the Medical Practice Act by purportedly failing to comply with §193.005(h) of
the Health and Safety Code’s requirement that the death certificate be signed electronically.

In response, Dr. Aleman argued that:

1. Failure to submit the electronic signature was not “unprofessional conduct” as intended under
the Medical Practice Act;
2. The alleged violation of Health & Safety Code §193.005(h) is not related to the practice of
medicine for the purpose of TMB’s enforcement jurisdiction but just an unrelated
administrative violation;
3. The sanctions the board imposed were excessive and arbitrary; and were assessed in
retaliation for Dr. Aleman not accepting an agreed order relating to the alleged violation, and
4. SOAH lacked jurisdiction over the formal complaint because of the board’s failure to comply
with a certain statutory notice requirement.

The trial court affirmed TMB’s order, except to the extent that the board’s order waived a
statutory notice requirement (the trial court held the failure to meet the requirement was
procedural and not jurisdictional). On May 18, 2016, Dr. Aleman appealed to the Texas Third
Court of Appeals, which affirmed the trial court’s judgment. On May 15, 2017, Dr. Aleman filed
a petition for review with the Texas Supreme Court. Oral arguments were heard on Jan. 22, 2019.

TMA filed an amicus brief on Feb. 26, 2019, focusing on whether TMB abused its disciplinary
powers by imposing sanctions higher than the lower-end sanctions applicable to first-time
violators and in excess of the standard sanctions mandated by the board’s own rules. Specifically,
the board’s rules, 22 Tex. Admin. Code, §190.14, state:
The standard sanctions outlined in paragraph (9) of this section provide a range from “Low Sanction” to “High Sanction” based upon any aggravating or mitigating factors that are found to apply in a particular case. The board may impose more restrictive sanctions when there are multiple violations … or … any aggravating …factors. … The minimum sanctions … are applicable to first time violators. …The following standard sanctions shall apply to violations of the Act.

The following shows the low- and high-end sanctions for failure to electronically sign a death certificate:

<table>
<thead>
<tr>
<th>Sanctions</th>
<th>Low</th>
<th>High</th>
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<tr>
<td>Failure to electronically sign a death certificate under Health and Safety Code Chapter 193</td>
<td>Remedial plan: 4 hours of ethics/risk management; $500 administration fee</td>
<td>Agreed order: 8 hours of risk management; 4-8 hours of medical ethics; $2,000 administrative penalty; take the JP exam</td>
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Instead of issuing a low-end sanction, which is “applicable” to first-time violators, TMB issued the following sanctions: (1) pay a $3,000 administrative penalty; (2) take and pass the Medical Jurisprudence Exam; (3) complete 16 hours of continuing education (with at least eight hours each in the areas of ethics and risk management); and (4) distribute copies of the board’s final order to health care entities where Dr. Aleman has privileges. Notably, this is higher than the maximum sanctions identified for this type of alleged violation – no aggravating factors were identified in the board’s final order or SOAH’s findings of fact and conclusions of law. During oral argument, TMB argued that the low-end sanction was only applicable to informal settlement discussions; however, this is not what the plain language of §190.14 states.

On May 24, 2019, the Supreme Court of Texas issued its opinion affirming the court of appeals’ judgment in part, reversing it in part, and rendering judgment vacating the sanctions imposed against Dr. Aleman. Justice Lehrmann delivered the majority opinion while Justices Blacklock and Brown concurred, and Justice Boyd filed a dissenting opinion (which would have affirmed the TMB disciplinary decision). Specifically, the majority held that a physician’s act of completing the medical certification for a death certificate manually rather than by using the approved electronic process does not constitute a “prohibited practice” under §164.052 of the Medical Practice Act, and §164.051 in turn does not authorize the board to take disciplinary action against a person for such conduct. In other words, requiring electronic certification may address inefficiencies in the process, but it in no way addresses fraud or deception, according the Supreme Court. In reversing the sanctions order, the Supreme Court noted that it failed to see how disciplining a physician for failing to comply with the electronic certification requirement comports with the express policy behind the Medical Practices Act “to protect the public interest” by “regulat[ing] the granting of [the] privilege [of practicing medicine] and its subsequent use and control.” (Tex. Occ. Code §151.003).

4. **Evelyn Kelly, Individually and on Behalf of the Estate of David Christopher Dunn, v. Houston Methodist Hospital**

(Regarding necessity and constitutionality of the Texas Advance Directives Act)

On Oct. 12, 2015, Aditya Uppalapati, MD, admitted David Christopher Dunn to Houston Methodist with diagnoses of, among other things, end-stage liver disease, the presence of a malignant pancreatic neoplasm with suspected metastasis to the liver, complications of gastric outlet obstruction secondary to his pancreatic mass, hepatic encephalopathy, acute renal failure, sepsis, acute respiratory failure, multi-organ failure, and gastrointestinal bleed.
Shortly after Mr. Dunn’s admission, Dr. Uppalapati advised his family that his condition was irreversible and progressively terminal. Mr. Dunn’s treating physicians concluded he was suffering from the treatment necessary to sustain his life, and with no expectation for improvement, life-sustaining treatment was medically inappropriate for him. As a result, Mr. Dunn’s attending physicians and patient care team recommended to his divorced parents that aggressive treatment measures be withdrawn and that only palliative or comfort care be provided. The parents disagreed on the recommendation and plan, and since Mr. Dunn did not have an advance directive in place, was not married, and had no children, his parents became his surrogate decisionmakers.

On Oct. 28, 2015, the matter was referred to the Houston Methodist Biomedical Ethics Committee for consultation, in accordance with the procedures specified by Health & Safety Code §66.046. Over the next days, hospital representatives exhausted efforts to transfer Mr. Dunn to another facility. Testimony demonstrated that Houston Methodist representatives contacted 66 separate facilities requesting transfer. Potential transfer facilities were provided with the patient’s demographic information and recent clinical information so a transfer determination could be made. All 66 facilities declined the transfer.

On Nov. 20, 2015, attorneys purportedly acting on behalf of Mr. Dunn filed a state court suit in Harris County District Court seeking injunctive relief (despite the fact that Mr. Dunn had been determined mentally incapacitated since his admission to the hospital). It should be noted that former State Sen. Joe Nixon, one of the primary sponsors of 2003’s House Bill 4 (relating to professional liability insurance reform), was representing the plaintiff. In the filing, counsel sought a temporary restraining order preserving the status quo of the life-sustaining treatment being provided to Mr. Dunn while an alternative facility could be located. Additionally, the filing sought a declaration that Houston Methodist’s implementation of §166.046 (the statute regarding procedure if not effectuating a directive or treatment decision) violated the due process rights afforded to Mr. Dunn by the both the Texas and the United States constitutions. On the same day and without the necessity of a hearing, Houston Methodist voluntarily agreed to a temporary restraining order preserving the status quo by continuing life-sustaining treatment to Mr. Dunn, and extending the statutory 10-day period by an additional 14 days in order to continue efforts to locate a transfer facility.

The temporary injunction hearing was scheduled for Dec. 3, 2015. Prior to the temporary injunction hearing, Houston Methodist formally appeared in the matter. In its pleading, Houston Methodist requested an abatement of the matter, which necessarily acted as a prolonged extension of Houston Methodist’s agreed provision of life-sustaining treatment, while guardianship issues of an incapacitated Mr. Dunn, the current plaintiff, could be resolved through the probate court system. The court agreed with the assessment of Mr. Dunn’s incapacity and executed an order of abatement, the form of which was agreed to by counsel for all parties. Notably, in the order of abatement, Houston Methodist voluntarily agreed to preserve the status quo by continuing all life-sustaining treatment.

On Dec. 23, 2015, Mr. Dunn succumbed to his terminal illnesses and passed away. It is undisputed that from the day of his admission until the time of his death, Houston Methodist provided continuous life-sustaining treatment to Mr. Dunn. In fact, following his death, Mr. Dunn’s mother wrote, “We would like to express our deepest gratitude to the nurses who have cared for Chris and for Methodist Hospital for continuing life sustaining treatment of Chris until his natural death.”
On Jan. 8, 2016, the court lifted the stay and allowed substitution of the parties as Mr. Dunn had passed (allowing Ms. Kelly, Mr. Dunn’s mother, to substitute as the plaintiff). The suit continued and alleged that the statute failed to provide adequate constitutional protections for her son in the process that culminated in the determination by the hospital ethics committee that life-sustaining treatment was medically inappropriate. Specifically, the plaintiff alleges that §166.046 violates procedural due process by (1) failing to provide the patient or the patient’s decisionmaker an opportunity to be heard, (2) failing to provide a reasonable opportunity to prepare for a hearing, (3) failing to provide reasonable notice of the reasons why removal of life-sustaining treatment is to occur, and (4) failure to utilize an impartial tribunal to make the decision to withdraw life-sustaining treatment. The plaintiff also argues that §166.046 violates substantive due process in that it deprives an individual of rights protected under the U.S. Constitution. Among these rights, according to the plaintiff, is the right of the individual to make his or her own life-related medical decisions.

TMA filed an amicus brief in the trial court that provided background information regarding the Texas Advance Directives Act and explained why medical futility laws are necessary to maintain the integrity of the medical profession. The trial court ruled on summary judgment against plaintiff with a conclusion that it lacked jurisdiction over Mr. Dunn’s claims due to his death. On Nov. 7, 2017, the plaintiff appealed to the Court of Appeals in Houston (First District). The court set oral argument for March 19, 2019.

On March 5, 2019, TMA joined in the filing of an amicus brief with the Texas Alliance for Patient Access, Texas Alliance for Life, Texas Catholic Conference of Bishops, Texas Baptist Christian Life Commission, Texans for Life Coalition, Coalition of Texans with Disabilities, Texas Hospital Association, Texas Osteopathic Medical Association, and LeadingAge Texas. The brief, submitted by Wallace Jefferson (former chief justice of the Texas Supreme Court), reiterates the points in the trial court brief, among other that: (1) §166.046 is constitutional; (2) dispute resolution laws are necessary to maintain the integrity of the medical profession; (3) a private physician’s treatment decision does not constitute state action; (4) the medical-futility procedure only rarely contradicts a patient’s wish for further intervention; and (5) while §166.046 gives attending physicians a safe harbor, it does not mandate a specific course of action.

On March 29, 2019, the Court of Appeals issued its decision affirming the trial court’s order dismissing the claims for lack of subject-matter jurisdiction by concluding the case was moot. Justice Julie Countiss wrote that “no action inconsistent with Dunn’s alleged desires regarding his medical treatment was ever taken and he was not actually deprived of any constitutionally-protected right” when Houston Methodist invoked the law. Moreover, because Mr. Dunn had succumbed to his terminal condition, there could no longer be a “risk of mistake or unjustified deprivation of life.”

On June 14, 2019, the plaintiff filed a petition for review with the Texas Supreme Court. The court denied the plaintiff’s Petition on Oct. 4, 2019, and then denied the plaintiff’s motion for rehearing on Dec. 16, 2019.

5. The Pinkerton Law Firm, PLLC v. University Cancer Center, Inc.
(Regarding whether a physician’s debt collection action against a law firm falls under the Texas Citizens Participation Act)

Mark D’Andrea, MD, is a radiation oncologist who practices in Harris County and has privileges at many facilities, including the University Cancer Center (UCC). In connection with a 2010 benzene-exposure lawsuit against BP, the Pinkerton Law Firm entered into a letter of protection (LOP) agreement with UCC to provide certain health care services at UCC for the law firm’s
clients related to the benzene exposure. An LOP is a letter sent to a medical professional by a personal injury lawyer representing a person injured in an incident, such as an auto accident, work injury, or fall. An LOP guarantees payment for medical treatment from a future lawsuit settlement or verdict award.

Pinkerton entered a LOP with UCC to provide health care services for the firm’s clients who had allegedly been exposed to the cancer-causing agent “benzene” during a massive release of toxic chemicals at a BP refinery outside of Houston. The law firm agreed to pay a $40 fee to UCC per client referred for its services and entered into a global LOP for each client for the cost of the services provided. In return, the firm would use the medical records from UCC to support its case against BP.

Ultimately, the suit with BP settled. Pinkerton, however, did not honor the LOP with UCC. In August 2018, UCC filed a lawsuit against the firm for failure to honor the LOP, asserting claims for breach of contract and quantum meruit.

Pinkerton filed a motion to dismiss UCC’s claims under the Texas Citizen’s Participation Act (TCPA), which is an anti-SLAPP statute – “SLAPP” is an acronym for “strategic lawsuit against public participation.” The TCPA provides a mechanism for early dismissal of lawsuits based on a party’s exercise of the right to free speech, right of association, and right to petition the government. The purpose of the TCPA, like other anti-SLAPP statutes, is to honor first amendment constitutional protections, including the right to petition, the right to association, and the right of free speech, while also protecting the rights of a person to file a meritorious lawsuit. If the TCPA applies (which the firm argues it does), the plaintiff must meet a higher evidentiary threshold to avoid dismissal of his case.

In its motion to dismiss, Pinkerton argued several reasons why the TCPA should apply to UCC’s claims. First, the law firm argued that the LOP involved its right to petition. Specifically, Pinkerton claimed the LOP “pertains to” a judicial proceeding, i.e., the firm’s participation in litigating the BP case. Second, Pinkerton claimed that UCC’s case relates to the firm’s exercise of free speech. Free speech in the context of a TCPA motion to dismiss has been defined to mean “a communication made in connection with a matter of public concern.” A “matter of public concern” has been defined as an “issue related to” a “health and safety concern,” “economic well-being,” or a “service in the marketplace.” Pinkerton argued that UCC’s breach of contract and quantum meruit claims against it – claims that relate to the provision of health care services – relate to matters of public concern, including “health and safety concerns,” “economic well-being” concerns, and “services in the marketplace.”

UCC responded to Pinkerton’s motion to dismiss. Regarding the TCPA claim, UCC argued this is a debt collection matter, which falls within the commercial dispute exemption of the TCPA. Neither UCC providing services under the LOP, nor UCC’s lawsuit, involved protected speech by Pinkerton intended to reach the firm’s clients – instead, it was just a commercial transaction between the parties.

Ultimately, the trial court agreed with UCC, dismissing the law firm’s motion to dismiss. The firm appealed the trial court’s decision.

On June 3, 2019, TMA filed its amicus brief in support of UCC. There has been substantial criticism on the unfair expansion of the TCPA to matters that were not intended to be the subjects of a TCPA motion to dismiss. TMA urged that this case is another example where someone is arguing to improperly expand the TCPA. This would leave physicians vulnerable financially when they accept LOPs from attorneys and provide health care services. Specifically, TMA
argued that a debt-collection action is not “based” on a “communication” as defined in the TCPA and that the business dispute falls under the commercial speech exemption from the TCPA.

On Aug. 9, 2019, the court informed the parties that it would not hear oral argument, and the case would be submitted before a panel consisting of Justice Lloyd, Justice Goodman, and Justice Landau on Sept. 17, 2019. On Jan. 9, 2020, the Court of Appeals issued a decision in favor of UCC, affirming the lower court decision to deny Pinkerton’s motion to dismiss.

6. **Patients Medical Center v. Facility Insurance Corporation**
   (Regarding which party bears the burden of proof when appealing a workers’ compensation medical fee dispute resolution finding)

Patients Medical Center provided inpatient surgical services for an injured worker in September 2009. The center was later paid $2,354.75 by Facility Insurance Corporation, an amount below the rate prescribed by the Texas Department of Insurance, Division of Workers’ Compensation (DWC), Outpatient Hospital Fee Guideline. Facility Insurance contended an informal network contract was applicable (an alternative manner to determine fees if appropriately agreed to by the parties – here it was not), and its claim adjustor applied network discounts. Patients Medical Center determined no informal network contract was applicable to the underlying claim, and it timely filed a request for medical fee dispute resolution with DWC to determine proper payment.

On March 13, 2013, DWC issued its medical fee dispute resolution findings and decision. DWC found Facility Insurance had failed to provide the required notice of its intent to access an informal or involuntary network. It accordingly reviewed the claim and determined Patients Medical Center was entitled, under the DWC Outpatient Hospital Fee Guideline, to an additional payment of $20,495.78. Dissatisfied with this decision, Facility Insurance demanded a contested-case hearing at the State Office of Administrative Hearings (SOAH) to challenge the DWC order. The SOAH judge found that Facility Insurance had the burden of proof in the contested case, and after a hearing, the judge found that Facility Insurance failed to meet its burden of proof and affirmed the DWC order.

Facility Insurance appealed to Travis County District Court. The court found the SOAH judge’s decision and order was supported by substantial evidence and affirmed the SOAH decision, consequently affirming the DWC order. Facility Insurance appealed again to the Third Court of Appeals in Austin.

The Third Court of Appeals reversed the trial court’s decision and remanded the case back to the trial court for another hearing on the matter, ruling that the SOAH judge should have placed the burden of proof on the Patients Medical Center. The medical center ultimately filed a petition for review, which was granted, bringing this matter before the Texas Supreme Court.

On Nov. 6, 2019, TMA filed its amicus brief in support of Patients Medical Center, making two arguments. First, the Third Court failed to show a justification for overturning the SOAH judge’s decision to assign the burden of proof to Facility Insurance. Second, the Third Court’s ruling creates bad public policy by giving insurance companies significantly more power in DWC’s medical payment dispute process. By placing the burden on appeal on the practitioner even if the practitioner agrees with DWC’s findings, the practitioner will bear the cost and initial burden of the insurance company’s appeal at each stage. This may deter practitioners from seeking fair payment through DWC’s process and encourage insurance companies to continually underpay practitioners for their services. Ultimately, the workers’ compensation system itself, and Texas’s patients in the system, may suffer because practitioners choose not to participate.
As of January 2020, the Texas Supreme Court had not issued a decision on this case.

7. Lewis v. Cook Children’s Medical Center
   (Regarding the Texas Advance Directive Act)

Ms. Lewis is the mother of a 10-month old girl who was born premature and suffers from a host of medical conditions, including a rare heart defect known as Ebstein’s anomaly. Among the many complications caused by her conditions, the most significant is that she cannot properly get oxygen from her lungs into her bloodstream. She has spent her entire life hospitalized in Cook Children’s cardiac intensive care unit. She requires full mechanical ventilator support to breathe, as well as constant sedation to ensure she does not interfere with the support. Cook Children’s doctors have concluded she has no hope of recovery and no possible surgical interventions would improve her condition or ease her suffering.

Cook Children’s has informed Ms. Lewis of its physicians’ conclusion that continued medical intervention is inflicting pain on the child without any corresponding therapeutic benefit. Ms. Lewis has stated that she disagrees and believes the girl will recover. Cook Children’s has contacted dozens of doctors and hospitals across the country, and none have disagreed with Cook Children’s conclusion or been willing to accept the girl as a patient.

Pursuant to the Texas Advance Directives Act, Cook Children’s submitted the issue to its ethics committee, which concluded there was no medical benefit to continuing treatment. To alleviate the girl's suffering, it would be in her best interest to cease medical intervention and allow her to die naturally.

Ms. Lewis was informed of the ethics committee decision on Oct. 30, 2019, and the girl was scheduled to be removed from the ventilator on Nov. 10, 2019. On that date, a temporary restraining order was issued to delay the removal.

On Dec. 11, 2019, TMA with the Texas Alliance for Life, Texas Catholic Conference of Bishops, Texans for Life Coalition, Coalition of Texans with Disabilities, Texas Alliance for Patient Access, Texas Osteopathic Medical Association, Texas Hospital Association, LeadingAge, and Tarrant County Medical Society, filed an amicus brief in support of the Texas Advance Directives Act, setting forth how it provides families and physicians with a framework for resolving difficult end-of-life decisions.

On Jan. 2, 2020, Ms. Lewis’ request for an injunction was denied in Tarrant County district court. Ms. Lewis appealed to the Second Court of Appeals in Fort Worth. On Jan. 3, 2020, the court ordered Cook Children’s to not withdraw treatment during the pendency of the appeal. The court ordered Ms. Lewis to file her brief by Jan. 16, 2020, and for Cook Children’s to file its response by Jan. 27, 2020.

8. Community Health Choice v. Dr. Courtney Phillips
   (Regarding whether HHSC must award a managed care contract to an eligible health plan owned and operated by a hospital district)

On Oct. 1, 2018, the Texas Health and Human Services Commission (HHSC) issued a request for proposal for the STAR+PLUS contract, for 13 service areas. STAR+PLUS is a Medicaid managed care program for individuals with disabilities or are age 65 or older. Community Health Choice submitted proposals for the Harris and Jefferson service areas; Community First Health submitted a proposal for the Bexar service area. On Oct. 29, 2019, HHSC announced its intent to
award contracts for the Medicaid STAR+PLUS program to seven managed care organizations (MCOs), which included neither Community Health Choice nor Community First Health.

In November 2019, Community Health Choice filed a lawsuit in Travis County District Court, alleging HHSC violated the requirement of Tex. Gov’t Code §533.004(a) that a managed care contract be with an MCO owned and operated by a hospital district. As Community Health Choice was the only MCO for the Harris and Jefferson service areas owned and operated by a hospital district, it should therefore have been awarded a contract. Community First Health subsequently intervened in the lawsuit, making a similar argument for a Bexar service area contract.

HHSC responded that Community Health Choice’s claims are barred by sovereign immunity and are also mooted by HHSC signing the STAR+PLUS contracts with the seven awarded MCOs. HHSC also asserted that in its evaluation of the submitted proposals, Community Health Choice’s proposals were ranked last for both the Harris and Jefferson service areas; they also did not comply with the terms and conditions that MCO are subject to under §533.004(b).

On Jan. 2, 2020, TMA joined with the Teaching Hospitals of Texas on an amicus brief in support of the hospital district health plans. The brief explains the role of hospital districts in treating a disproportionate share of uninsured patients and the legislative history of the statute at issue – specifically, that the legislative intent behind §533.004 was to ensure that these safety-net providers had access to the financial support of a managed-care contract.

As of January 2020, the Travis County District Court had not reached a decision.

D. COMMENTS TO ADMINISTRATIVE AGENCIES


In April 2018, the Health and Human Services Commission released and solicited comments on draft rules intended to implement Senate Bill 1107 (2017 legislative session), regarding telemedicine. Like the Medicaid benefits policy on telemedicine published one month prior, these draft rules made many changes to reflect the intended expansion under SB 1107. Some parts of the draft rules, however, did not accurately follow the provisions of the bill.

TMA, along with the Texas Association of Obstetricians and Gynecologists, Texas Academy of Family Physicians, and Texas Pediatric Society, commented that the rules should adhere to the bill’s provisions. TMA’s comments reiterated that Texas statute requires HHSC to pay for telemedicine under Medicaid for services that otherwise satisfy applicable requirements. The comments also stated there should be greater clarity regarding patient site restrictions and that notice to a patient’s primary care provider is conditional upon that patient’s consent.

As of January 2020, HHSC had not officially proposed these rules. TMA staff will continue to monitor the progress of these rules.

2. Texas Office of Inspector General Solicitation for Feedback on OIG’s Determination of Administrative Actions or Sanctions

In May 2018, the Texas Office of the Inspector General (OIG) published a solicitation for feedback regarding its current rules relating to the criteria it uses to determine administrative sanctions or actions to impose for provider violations, as found in 1 Tex. Admin. Code
§371.1603(f)-(h). In June 2018, TMA provided recommendations for improvements to those considerations. Generally, TMA’s comments focused on making the process fairer and ensuring all relevant considerations would be made in imposing sanctions against a provider.

TMA’s comments included clarifying already listed considerations that were ambiguous, following statutory language, adding consideration of mitigating factors, and limiting consideration of aggravating factors in a way that ensures only relevant aggravating factors are considered.

In 2019, OIG proposed draft rules relating to administrative actions and sanctions, including criteria OIG uses to determine administrative actions or sanctions to impose for alleged provider violations. TMA provided a comment letter in response and met with OIG in August 2019. OIG was favorable to many of TMA’s comments and suggestions. As of August 2019, formal proposed amendments have been published relating to this rule. TMA staff is monitoring any further development of what may be amendments to these rules. See No. 25 below for further information on TMA’s comment letter to OIG following its 2019 proposed draft rules.


In September 2018, the Texas Department of Licensing and Regulation (TDLR) proposed rule changes relating to the department’s regulation of lay midwives. Among other things, the proposed rules altered definitions relating to a midwife’s collaboration and consultation with other health care professionals and amended requirements relating to the transfer of care of a patient from a midwife to a physician or another professional.

TMA in conjunction with District XI of the American Congress of Obstetricians and Gynecologists and the Texas Association of Obstetricians and Gynecologists responded with comments in opposition to certain parts of the proposed rule amendments. TMA’s comments encouraged the rules be further amended to clarify the meaning of certain terms, to be internally consistent, and to require transfer or referral to Texas-licensed physicians (as opposed to a physician licensed in any state). TMA further encouraged TDLR to incorporate references to the Global Practice Standards for Midwifery, to require transfer to physicians under certain circumstances, and to require midwives to do more to record their care for patients and to transfer those records when a physician assumes responsibility for the patient.

In April 2019, TDLR adopted amendments to the rules. TDLR agreed with some of the changes and disagreed with others.


The Health and Human Services Commission proposed rules in October 2018 regarding Medicaid managed care. These proposed rules touched on network adequacy, access and expedited credentialing standards for managed care organizations participating in the Medicaid program.

TMA joined the Texas Pediatric Society, Texas Academy of Family Physicians, and Texas Association of Obstetricians and Gynecologists in commenting in response to these rules. TMA’s comments encouraged HHSC to amend the proposed rules to establish clear and well-defined standards and to create in the rules a comprehensive body of standards by incorporating standards
articulated or developed in other documents. TMA further asserted that the rules as proposed failed to meet the agency’s own recommendations for and stakeholder expectations about clear, well-defined network adequacy standards because the rules provided only ambiguous references to standards or criteria for compliance.

In April 2019, HHSC adopted the final rules. HHSC accepted most of TMA’s comments regarding clarifications of the proposed rules’ confusing language but declined to amend the rules to set forth clear and specific requirements for MCO networks.


In October 2018, the Texas Department of Insurance (TDI) published proposed changes to rules relating to the notification requirement for HMO terminations. Specifically, the proposed change would strike the minimum 90-day notice requirement for HMO terminations, as well as other language that provides important regulatory guidance on the implementation of certain provisions of the Texas Insurance Code.

The Texas Medical Association, Texas Orthopaedic Association, Texas Pediatric Society, Texas Society of Anesthesiologists, Texas Association of Obstetricians and Gynecologists, Texas Society of Pathologists, Texas Ophthalmological Association, Texas Radiological Society, and Texas Ambulatory Surgery Center Society responded with joint comments in strong opposition to the proposed changes. TMA’s comments encouraged TDI to maintain the minimum 90-day notice requirement for a variety of reasons, including that the rule is necessary to implement state statute and that it has been a longstanding part of TDI regulations.

In May 2019, TDI withdrew its proposed rules.


In November 2018, the Health and Human Services Commission proposed rule changes relating to supplemental payments to eligible teaching hospitals owned and operated by nonstate governmental entities. HHSC further solicited comment regarding expanding funding to hospitals owned by nongovernmental entities.

TMA commented to express support of adequate funding for graduate medical education (GME) and expanding the state’s GME capacity. TMA expressed the need (1) to increase the state’s physician workforce concomitant with population growth through the training of residents in the state and (2) for an adequate number of GME positions to ensure the increasing number of Texas medical school graduates have a reasonable opportunity to remain in the state for training. TMA thus supported HHSC’s expanded supplemental payments and further expressed support for possible expansion of payment to nongovernmental hospitals.

As of Jan. 25, 2019, HHSC finalized its proposed rules and expanded funding to nonstate government-owned and -operated teaching hospitals. Subsequently, HHSC proposed expanding funding to hospitals owned by nongovernmental entities in the May 10, 2019, *Texas Registrar* (44 Tex. Reg. 2323-2422). TMA submitted comments in support of the expansion. HHSC adopted the proposed amendment expanding funding to hospitals owned by nongovernmental entities on July 19, 2019 (44 Tex. Reg. 3625-3626).

In December 2018, the Texas Medical Board proposed rules relating to its regulation of certified medical radiological technicians and noncertified technicians (NCTs). The proposed changes made more significant changes to the regulation of noncertified technicians.

TMA’s comments in response to these proposed rules focused on regulations relating to NCTs. TMA explained that a physician’s use of NCTs is an effective way to meeting high clinical demands while managing costs of providing services to patients, and thus encouraged TMB to simply its regulation of and training requirements for NCTs. This included eliminating the requirement in the proposed rules for NCTs to pass the jurisprudence exam and ensuring the application and approval procedures are easy, transparent, and efficient.

In April 2019, TMB adopted the proposed rules. The board rejected TMA’s suggestions.

8. **TMA Comments to the Texas Medical Board Regarding the Corporate Practice of Medicine and Unauthorized Practice of Medicine**

During the Texas Medical Board’s public comment period associated with its December 2018 full board meeting, TMA submitted written comments regarding violations related to the prohibition on the corporate practice of medicine and the unauthorized practice of medicine. Specifically, TMA wrote to encourage and facilitate discussion regarding the ability of a physician to submit complaints relating to a nonprofit health corporation’s (NPHC’s) violation of certain laws prohibiting interference with a physician’s professional judgment. TMA noted that although there is a complaint form for licensees, there appears to be no avenue for a complaint against an entity like an NPHC. TMA further encouraged TMB to clarify on TMB’s website and complaint form that the board has cease-and-desist authority to enforce unauthorized practice of medicine.

As of January 2020, TMB had not responded to TMA’s comments. During the 2019 legislative session, TMA supported successful legislation (House Bill 1532) to require the changes urged in TMA’s earlier letter. As of January 2020, TMB had not yet taken steps to implement the legislation. On the TMB website, the complaint form only contemplates a complaint about a physician. Also, TMB has neither proposed nor adopted rules on this subject.


The Health and Human Services Commission in December 2018 proposed rule changes that would serve to inform stakeholders and Laboratory Services Section (LSS) customers that future changes to the public fee schedule would be posted on the LSS website. In response to these proposed changes, TMA submitted comments in support of the intent to increase transparency of fee changes. TMA further recommended that the department provide automatic email notification of changes to the fee schedule through an email subscription management system. TMA recommended that these automatic notices announce of final and adopted changes as well as the proposed changes. TMA asserted this procedure would more properly effectuate the department’s goals.

The commission adopted its amended rules on April 26, 2019, without incorporating TMA’s recommendations. The rules became effective May 2, 2019.

10. **Joint Comments to Health and Human Services Commission Relating to Medicaid Reimbursement for Telemedicine Medical Services**
In January 2019, TMA and the Texas Association of Health Plans, Texas Hospital Association, Texas Association of Community Health Plans, and Texas Pediatric Society submitted joint comments to HHSC to encourage the commission to update its billing policies relating to telemedicine.

The joint comments grew out of a series of summit meetings among the organizations to identify ways to improve the Medicaid program. TMA and the other organizations encouraged HHSC to bring its telemedicine payment policies in line with state law by allowing payment for all services that could be provided through telemedicine. HHSC had told TMA staff it was reviewing each service one at a time to examine its compatibility with telemedicine. TMA encouraged HHSC instead to identify only those codes that could not be compatible with telemedicine to avoid stifling the increased access to services that telemedicine could afford.

During the 2019 legislative session, TMA advocacy resulted in new legislation directing HHSC to expand the number of telemedicine medical services for which Medicaid fee-for-service and Medicaid MCOs will be able to pay. Other reforms included removing burdensome and unnecessary administrative prerequisites for Medicaid payment of telemedicine medical services. As of January 2020, HHSC had not proposed rules to implement this legislation.


In January 2019, the Texas Medical Board proposed rules relating to a physician’s delegation of authority. In the first set of changes, TMB proposed rules that would impose a reporting requirement on a physician who delegates an act to an individual who is otherwise unregulated (i.e., who does not have an occupational certification or license issued by a state agency). TMA expressed strong opposition in response to these proposed rules on the basis that they are not in compliance with statutory authority, leave many questions unanswered, lack an adequate framework, and may have unintentional consequences.

TMA explained in its comments that compliance with the rule proposal would be extremely difficult because it was unclear exactly what TMB expected these physicians to do. The proposed rules state only that a physician delegating an act to these unregulated professionals has a responsibility to “report” the professionals. The rules do state that the reporting obligation would relate to discipline or termination of the professional, but it is not clear whether this is the only thing to be reported, nor is it clear what type of discipline should be reported. TMA further explained that because the proposed rules would impose such a significant burden, it would have the consequence of either discouraging discipline of these professionals, or discouraging the delegation in the first place. TMA encouraged TMB to withdraw the proposed rules and hold a stakeholders meeting.

The proposed rules also related to delegation of radiological procedures to midlevel providers. Here again, the intent of TMB’s proposed rules was not clear, and TMA commented to encourage TMB to hold a stakeholders meeting to ensure the proposed rules would not disrupt collaborative team-based practice.

As of March 2019, TMB had not finalized these proposed rules. Prior to the submission of TMA’s comments, TMB did notify TMA that it would hold a stakeholders meeting on the second set of rules relating to delegation of radiological procedures. The board held a stakeholders meeting on June 4, 2019, after which it republished the rules for comments. TMA submitted another comment letter in response on Jun. 10, 2019. In response to TMA’s letter and other feedback, the board withdrew the proposed rules in August 2019.
TMB held another stakeholder meeting on Sept. 20, 2019, and formal proposed rules were published on Nov. 8, 2011. TMA responded with a comment letter in December 2019. TMA’s comments noted several concerns with the proposed rules. Among these are that the rules are unnecessary in light of existing delegation rules, would increase physician liability, would add to existing administrative burdens, and are confusing in their language regarding levels of training and scope of practice. As of January 2020, TMB had not adopted these rules.

12. Texas Department of Insurance Proposed Rules Relating to Utilization Review

In January 2019, the Texas Department of Insurance proposed rules concerning notice of determinations made in utilization review and written procedures for appeals of adverse determinations by utilization review agents. Specifically, the rules would require expedited appeals for denials of prescription drugs or intravenous infusions for which an enrollee is receiving benefits under the health insurance policy, and for adverse determinations of a step therapy protocol exception request under Ins. Code §1369.0546.

TMA commented to express strong support for the amendments, noting that the rule changes would be in line with recently enacted legislation. TMA stated that the proposed amendment would aid the regulated community and enrollees in understanding statutory requirements for expedited appeals, thereby increasing the value of important consumer protections in law.

On July 26, 2019, TDI adopted the rules without substantive amendment.


The Texas Board of Chiropractic Examiners (TBCE) proposed rule amendments on March 8, 2019, that would change the services for which a chiropractor could advertise and would clarify requirements for a chiropractor’s obtaining an acupuncture permit. The rule changes would remove from rule a reference to the statute that defines a chiropractor’s scope of practice. TMA submitted comments in opposition to the proposed rule amendments. In those comments, TMA argued that the reference to the underlying statute helps ensure chiropractors’ advertised services are within the chiropractic scope of practice, and that removing that reference would result in an express authorization to allow misleading advertising. “In other words,” TMA argued, “a chiropractor would be able to advertise claims for chiropractic services to treat ailments or injuries that the chiropractor has no statutory authority to treat.”

TMA also reiterated its opposition to rule amendments relating to acupuncture on the grounds that TBCE has no statutory authorization to permit its licensees to perform acupuncture.

TBCE adopted its rules without changes on May 31, 2019.


In March 2019, the Department of State Health Services (DSHS) published draft rules that would address the prescription and use of epinephrine auto-injectors in institutions of higher education. Similar rules were already in existence relating to epinephrine auto-injectors in school districts and open-enrollment charter schools. The underlying statutes for the prescription and use of epinephrine auto-injectors in institutions of higher education and school districts are very similar but contained one pertinent distinction with respect to who could issue the prescription. While the
underlying statute permits health professionals other than physicians to issue prescriptions for epinephrine auto-injectors to school districts and open-enrollment charter schools (as long as they have been delegated prescriptive authority under Chapter 157, Occupations Code), the underlying legislation applicable to public institutions of higher education (Senate Bill 1367, 2017 legislative session) requires that these entities get prescriptions for epinephrine auto-injectors from only physicians.

In its draft rules, DSHS failed to note this distinction. TMA submitted brief comments to encourage the department to ensure its rules were in accordance with applicable state law. The draft rules were never published as official proposed rules.

During the 2019 legislative session, the legislature passed House Bill 4260, allowing a physician, or an individual with delegated prescriptive authority, to prescribe to a private or independent institution of higher education. On Nov. 29, 2019, DSHS published proposed rules to implement SB 1367 and HB 4260. In January 2020, TMA submitted comments proposing a clarification to reflect the respective prescriptive authority under SB 1367 and HB 4260.

As of January 2020, DSHS had not published adopted rules.


In April 2019, the Texas Medical Board proposed rules that would provide two methods for an out-of-state physician to be approved to practice in the event of a disaster. One method is hospital-to-hospital credentialing, which will not require the physician to apply for and obtain a license. This method will allow qualified out-of-state physicians to come to Texas and practice medicine at a Texas-licensed hospital at the request of that facility. The second method allows a qualified out-of-state physician to obtain a limited emergency license if the physician has been requested by a Texas sponsoring physician to assist in the disaster or emergency.

TMA commented not only to express the intent and purpose behind the proposed changes but also to encourage TMB to revise the rules to ensure clarity, accuracy, and consistency. TMA further encouraged TMB to hold a stakeholder meeting to solicit additional feedback on the proposal.

In July 2019, TMB published adopted rules for §172.20 and §172.21, accepting some of TMA’s suggestions but characterizing them as nonsubstantive.

16. Texas Medical Association Comments to the Centers for Medicare & Medicaid Services Regarding Due Process Protections in the Conditions of Participation

TMA submitted comments to the Centers for Medicare & Medicaid Services (CMS) to encourage amendment of the Medicare Conditions of Participation to allow for greater due process protections for physicians practicing in hospitals. TMA promoted changes in response to three specific issues: (1) the hospital bearing the burden of proof and persuasion in proving up charges regarding privilege decisions for physicians on the medical staff, (2) physicians having an appeal mechanism to a physician board to challenge adverse privilege recommendations, and (3) a prohibition on waiving due process in any contract.

In June 2019, CMS responded to TMA’s comments directly, stating that similar issues have been raised in the past and that after thorough consideration and examination, it determined there is insufficient evidence that addressing TMA’s issues would directly or adversely impact the health

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and safety of patients and the quality of care provided in the hospital. CMS invited TMA to submit any peer-reviewed literature or evidence that would indicate these factors would have a negative impact on health or safety in hospitals, upon which time it would reconsider the issue.

TMA is in the process of providing a reply to CMS.


In June 2019, the Texas Medical Board published draft rules in advance of an enforcement stakeholder meeting held at the board’s offices. Among the draft rules being considered were rules the board previously had proposed formally in January 2019. The rules would impose ambiguous requirements on physicians to report to TMB regarding disciplinary or other actions taken against otherwise unregulated individuals to whom those physicians delegate medical acts (§193.5). In February 2019, TMA submitted comments opposing those rules, and in June, TMA reiterated its opposition in response to the draft version of those rules. TMA’s opposition was unchanged because the draft rules were unchanged from the version formally proposed in January. In essence, TMA commented, the rules have no statutory basis and are so ambiguous that compliance would be difficult and would lead to unnecessary enforcement actions.

TMB’s June draft rule publication also included amendments to rules relating to prescriptive authority agreements (§193.8). The draft rule amendments would eliminate from rules important details about minimum requirements for prescriptive authority agreements. TMB asserts that rules that merely repeat underlying statute are superfluous. TMA commented in opposition to these draft rule changes, arguing that having a comprehensive source of rules is helpful for physicians and members of the public who want to understand all applicable regulations on a topic. TMA thus encouraged the board to maintain the rules and to ensure the rules were comprehensive and consistent with statute.

Next, TMB put forward two alternative draft rules relating to the regulation of nonsurgical medical cosmetic procedures (§193.17). While both alternatives discussed requirements for providing notice to the public regarding complaint procedures applicable to these procedures, the second alternative additionally included a much more extensive overhaul of the regulation of these procedures. TMA commented to state its preference for the alternative that merely clarified notification requirements. In those comments, TMA expressed support for a notification requirement that was clear, easy to comply with, and consistent with other existing requirements relating to posting a notice in a physician’s office.

Finally, in §165.5, TMB’s draft rules would amend provisions relating to notification requirements upon a physician’s retirement or departure from a practice. TMA encouraged TMB to clarify that electronic means of notification should be in accordance with applicable state and federal law, to add more setting-specific exceptions, and to add a good cause exception.

In July 2019, TMB published proposed rules amending §§165.5, 193.8, and 193.17. TMB also withdrew proposed rules amending §193.5, which had been published in January 2019, as discussed above (however, TMB later would again publish proposed rules for §193.5 in November 2019, as set forth below). For the proposed rules amending §§165.5, 193.8, and 193.17, TMA submitted comments on July 31, 2019, reiterating many of the concerns expressed in its response to TMB’s June draft rules.
On Sept. 6, 2019, TMB published its adopted rules for §§165.5, 193.8, and 193.17. For the notification requirements in §165.5, TMB accepted some of TMA’s requested clarifications regarding references to other authorities but rejected TMA’s proposed substantive revisions. For the proposed elimination of details about minimum requirements for prescriptive authority agreements in §193.18, TMB (erroneously) stated it had received no written comments and adopted the repeal. For §193.17, TMB disagreed with TMA’s comments and adopted the proposed rules without revision.


The Texas Office of Inspector General published draft rules in June 2019. The draft rules were the next step in making amendments to sections of rule that govern how the office determines appropriate administrative penalties following a Medicaid overpayment. Previously, the office had solicited input on how the rules could be improved, and TMA submitted comments in May 2018 (see D.2).

The draft rules reflected many improvements in the regulations as suggested by TMA. In its comments in response to these rules, TMA expressed support for the improvements and made these further suggestions as to how the rule could be improved: allowing any provider to enter into an installment agreement for repayments, adding consideration of good cause for failing to make certain payments, clarifying parts of the rule that are ambiguous, adding consideration of certain mitigating factors, and maintaining mentions of certain due process protections in the rule.

On Dec. 13, 2019, OIG published proposed rules for §§371.1603 and 371.1715. Among other changes, the proposed rules added more remedial measures that may be considered as mitigating factors and set forth statutory due process protections. TMA will submit comments on the proposed rules in January 2020.

19. Texas Department of Insurance Solicitation for Comments on Issues for Discussion Regarding Senate Bill 1264 and Subsequent Rulemaking on SB 1264

In June 2019, the Texas Department of Insurance distributed notice of a series of issues it identified for discussion at a stakeholder meeting regarding the recently enacted Senate Bill 1264. The issues the department identified included the nonemergency disclosure exception to the bill’s prohibition on balance billing, the procedural fairness of the deadline for arbitration decisions, the use of access plans to ensure consumers are protected from balance billing that results from gaps in a health plan’s network, and benchmarking. The department further asked whether additional issues needed to be considered in the implementation of SB 1264.

On July 15, 2019, TMA and eight specialty societies jointly filed a 15-page comment letter in response to TDI’s stakeholder meeting notice/information request. Regarding the disclosure exception, TMA commented on the timing of the advance notice, the information that should be included in the notice, and whether a disclosure would ever be provided under duress. In response to the arbitration issue, TMA provided information on the arbitration system in New York and comments on opportunities to rebut information in arbitration and on arbitrator fee issues. TMA commented that HMOs should hold enrollees harmless in situations resulting from gaps in its coverage. TMA also contended TDI should develop rules requiring health plan issuer/administrator submission of claims to the benchmarking database selected by the commissioner, and also make it clear that TDI is responsible for providing data points from the benchmarking database to the arbitrator. Finally, TMA also recommended that TDI consider bundling of claims, exclusivity of arbitration factors, and global billing factors.
On July 29, 2019, TMA representatives attended the stakeholder meeting to discuss the issues described above. TMA President David Fleeger, MD, provided oral testimony. As follow-up, on Aug. 8, 2019, TMA submitted an additional briefing to TDI arguing that TDI did not have jurisdiction or authority to regulate the practice of medicine but must refer any alleged physician billing violations to the Texas Medical Board.

On Sept. 27, 2019, TDI proposed rules implementing the following components of SB 1264: (1) the arbitration and mediation processes under SB 1264, (2) TDI’s complaint resolution process, (3) explanation of benefit requirements under SB 1264, and (4) requirements related to benchmarking under SB 1264. On Oct. 28, 2019, TMA and 11 other societies submitted a joint 71-page letter, expressing general concerns that TDI’s rule proposal: (1) omitted details necessary to make the arbitration a meaningful and workable process for Texas’ physicians, and (2) included language that would unnecessarily increase the costs/burdens of arbitration and/or reduce access to the arbitration process. Additionally, TMA’s joint comment letter contained numerous specific objections to the rule proposal’s language and offered alternative language. On Oct. 23, 2019, TMA Council on Legislation Chair Debra Patt, MD, provided testimony at the TDI hearing on the formal SB 1264 rule proposal.

On Dec. 3, 2019, TDI filed an adoption order for its previously proposed rules. In it, TDI made some changes/clarifications recommended by TMA (e.g., TDI [1] clarified that the arbitration process is a document-review process – not an in-person process – and [2] removed its proposed requirement to use best efforts to resolve a claim dispute payment through a health benefit plan issuer’s internal appeal process before a party requests arbitration). However, the rules as adopted continue to contain much problematic language (e.g., requiring payment of arbitrators upon assignment by TDI and imposing a 20-day waiting period after initial payment before arbitration may be initiated). The rules as adopted also omit TMA-recommended language that would have promoted access to the arbitration process. For example, TDI declined to adopt the language regarding reasonable arbitrator fees.

On Dec. 18, 2019, TDI issued an emergency adoption for its rules implementing SB 1264’s exception to the prohibition on balance billing. This emergency rule and the related form are effective Jan. 1, 2020. This rule and related form were published for formal notice and comment on Jan. 10, 2020. Comments were due Feb. 10, 2020.

On Dec. 18, 2019, TMB issued “TMB Guide Statement on TDI Rules Related to Senate Bill 1264,” which explains, among other things, that “[p]hysicians and practitioners, under the authority and oversight of TMB, who seek to exercise the exceptions to the prohibitions against balance billing must comply with all provisions of SB 1264, including as interpreted by TDI rules.” The TMB Guidance Statement also explains TMB’s enforcement authority related to violations of SB 1264 and notes that “TMB will work on development of rules consistent with TDI’s rules.”


In October 2018, TMA and the Texas College of Emergency Physicians, Texas Neurological Society, and Texas Society of Anesthesiologists provided joint comments to the Department of State Health Services on draft rules regarding stroke facility designation requirements. In August 2019, DSHS put forth a second round of draft rules for comment. On Sept. 9, 2019, the associations jointly responded, thanking DSHS for incorporating several of the 2018 recommendations, and urging that the draft rules be amended to include the remaining 2018
recommendations. As of January 2020, DSHS had not officially published proposed rules for §157.133.


In October 2018, TMA, the Texas College of Emergency Physicians, and the Texas Orthopaedic Association provided joint comments to the Department of State Health Services on draft rules regarding stroke facility designation requirements. In September 2019, DSHS put forth a second round of draft rules for comment. On Sept. 30, 2019, the associations jointly responded, thanking DSHS for incorporating several of the 2018 recommendations, and urging that the draft rules be amended to include the remaining 2018 recommendations. On Sept. 20, 2019, DSHS published proposed rules for §157.125, which were adopted without amendment on Nov. 29, 2019.

22. Texas Medical Board Guidance Letter Regarding HB 2174’s 10-day Limit on Opioids

In August 2019, the Texas Medical Board offered initial guidance related to the state’s new 10-day limit on opioids, which was created by House Bill 2174, 2019 Texas Legislature. On Sept. 21, 2019, TMA submitted to TMB, jointly with the Texas Orthopaedic Association, a request for additional clarification. While noting that TMB’s guidance was helpful in that it answered the question as to whether a follow-up prescription could be written for an episode of care, it also implied that a follow-up prescription could be written only if the patient sees the physician in person, contradicting HB 2174. As of January 2020, TMB had not responded to TMA’s request or published proposed rules on this subject.

23. Texas Medical Board Proposed Rule Amendment to 22 Tex. Admin. Code §165.1 Regarding Retention of Medical Examination Records of a Sexual Assault Victim

On Sept. 6, 2019, the Texas Medical Board proposed an amendment to §165.1 to add a requirement that physicians retain forensic medical examination records of a sexual assault victim for 20 years from the date of the examination, in accordance with House Bill 531 (2019 legislative session). On Oct. 3, 2019, TMA submitted comments on the proposed rule and noted three major issues with the proposed language being inconsistent with the underlying statute. First, it is unclear in the extent of the record that needs to be maintained, i.e. whether it is just the forensic medical examination record or all the ensuing related treatment of the patient. Second, it incorrectly begins the retention period on the date of examination versus the date of the record’s creation, as specified in the statute. Third, it is broader in scope than the statute, which contains language limiting its applicability to examinations conducted under the Code of Criminal Procedure, i.e., those paid for by law enforcement for purposes of an investigation or prosecution. On Nov. 1, 2019, TMB published the adopted rule. Though stating that it disagreed with TMA’s comment, TMB nevertheless modified the language of §165.1 to simply reference the underlying statutory requirements.

24. Texas Department of State Health Services Request for Feedback on Informal Rule Proposals Regarding MEDCARES Grant Program

In September 2019, the Texas Department of State Health Services requested stakeholder feedback on proposed rules for the MEDCARES Grant Program. On Oct. 7, 2019, TMA jointly responded with the Texas Pediatric Society, noting that the draft rules (1) conflict with scope of practice laws in Texas, (2) are not well-tailored to the use of the grant outlined in the underlying statute and a related legislative report, and (3) contain terms that are confusing or are inconsistent

On Oct. 4, 2019, the Texas Board of Chiropractic Examiners published proposed rules allowing it to provide informal letter opinions about scope of practice. TMA responded with a comment letter on Oct. 24, 2019, objecting to the proposed rule, based on it conflicting with statute – specifically, sections of the Occupations Code setting forth TBCE’s rulemaking role in clarifying scope of practice, which the legislature passed to stop the TBCE practice of issuing informal opinions. As of January 2020, TBCE had not taken further action on the proposed rule.

26. Texas Medical Board, TMA Comments on Topics Discussed at Oct. 9, 2019, Opioid Workgroup

On Oct. 9, 2019, the Texas Medical Board held an Opioid Workgroup meeting, which TMA representatives attended. Following the meeting, on Oct. 24, 2019, TMA submitted its recommendations in three areas: (1) defining acute, chronic, and post-operative pain; (2) interpreting and enforcing Prescription Monitoring Program checks and e-prescriptions; and (3) interpreting and enforcing opioid CME legislation. As of January 2020, TMB had not published any proposed rules on these topics.


On Nov. 8, 2019, the Texas Medical Board published proposed rules amending §193.5, Physician Liability for Delegated Acts and Enforcement, and §193.13, Certified Registered Nurse Anesthetists. TMB also proposed a new §193.21, Delegation Related to Radiological Services. TMA submitted a comment letter on Dec. 2, 2019. For §193.13, TMA noted that the proposed language about a physician “ensuring” and being “ultimately responsible” is inconsistent with the underlying statute and the recent attorney general opinion that was a basis for the revisions. For §§193.5 and 193.21, TMA opposed the proposed rules and requested their withdrawal, for four main reasons. First, Chapter 157 of the Medical Practice Act already provides clear language on supervision and delegation. Second, the rules impose unnecessary documentation requirements. Third, the rules contain inappropriate liability language. Lastly, the rules contain confusing language that blurs scope lines and fails to clearly articulate the responsibility of the physician. As of January 2020, TMB had not taken further action on the proposed rules.

28. Texas Medical Board Proposed Amendment to 22 Tex. Admin. Code §193.17

On Nov. 8, 2019, the Texas Medical Board published proposed rules amending §193.17, Nonsurgical Medical Cosmetic Procedure. The expressed purpose behind the amendment was to add language clarifying the responsibilities of delegating physicians and providers while providing nonsurgical cosmetic procedures in medical spas. TMA and the Texas Society of Plastic Surgeons responded jointly on Dec. 6, 2019. Though thanking TMB for holding several stakeholder meetings on different informal versions of the proposed rules, TMA noted a concern that the proposed language still contains several ambiguities, drafting errors, and potential scope of practice conflicts that require further stakeholder feedback, as well as additional clarity in the language. Accordingly, TMA asked TMB to withdraw its proposed rule and continue to seek feedback from stakeholders to better clarify the physician’s responsibilities and notification requirements, refine the definitions to prevent unintended scope of practice conflicts, and
29. Texas Department of State Health Services State Plan for Alzheimer’s Disease 2019-2023, and Stakeholder Meeting

On Nov. 19, 2019, the Department of State Health Services held a meeting to present its recently released Texas State Plan for Alzheimer’s Disease 2019-2023 and receive stakeholder input. TMA representatives attended the meeting, and TMA submitted a comment letter on Dec. 19, 2019. TMA raised concerns with the language in the state plan regarding “best practices,” “validated standards” and stakeholder responsibility for implementation of the plan. TMA also noted that the 2019 legislature set forth specific instructions for the state plan, which the plan does not include or contradicts. As of January 2020, DSHS had not responded to TMA’s comments.

30. Texas Department of Insurance, Division of Workers’ Compensation Proposed Amendment of 28 Tex. Admin. Code §129.5, Work Status Reports

On Oct. 11, 2019, the Texas Department of Insurance, Division of Workers’ Compensation, proposed amendments to conform §129.5 to the changes made by House Bill 387 (2019). HB 387 allows a treating doctor to delegate authority to complete, sign, and file a work status report to a licensed advanced practice registered nurse. TMA provided comments on Dec. 19, 2019, requesting that DWC clarify an introductory clause – specifically, to clarify whether the authorization of the delegation is governed by the licensing statute of the physician or the delegatee. As of January 2020, DWC had not published adopted rules for §129.5.

31. Centers for Medicare & Medicaid Services Proposed Amendments to the Stark Law

In October 2019, the Centers for Medicare & Medicaid Services published proposed rules amending the physician self-referral law (Stark Law). The stated purpose of the changes is to adapt the rules to health care’s shift to coordinated care and alternative payment models. In December and January, TMA submitted comments on the proposed amendments, joining letters submitted by the Partnership to Empower Physician-Led Care (PEPC) and the Physicians Advocacy Institute (PAI), and submitting its own letter on the proposed rules relating to health information technology. In general, PEPC, PAI, and TMA’s comments encouraged CMS to adopt requirements that would be complementary to existing requirements in federal health law, and thus avoid adding to physicians’ existing regulatory burdens. As of January 2020, CMS had not published adopted rules.

32. Office of Inspector General, U.S. Department of Health and Human Services Proposed Amendments to the Antikickback Statute

In October 2019, the U.S. Department of Health and Human Services, Office of Inspector General (HHS-OIG) published proposed rules amending the antikickback statute. The stated purpose of the changes is to adapt the rules to health care’s shift to coordinated care and alternative payment models. In December and January, TMA submitted comments on the proposed amendments, joining letters submitted by the Partnership to Empower Physician-Led Care (PEPC) and the Physicians Advocacy Institute (PAI), and submitting its own letter on the proposed rules relating to health information technology. In general, PEPC, PAI, and TMA’s comments encouraged HHS-OIG to adopt requirements that would be complementary to existing requirements in federal health law, and thus avoid adding to physicians’ existing regulatory burdens. As of January 2020, HHS-OIG had not published adopted rules.
E. Letter Briefs to the Texas Attorney General

Texas Optometry Board Opinion Request to the Office of the Attorney General Regarding the Applicability of Tex. Occ. Code §351.408 to Physicians’ Optometrist Employees

In September 2019, the Texas Optometry Board (TOB) submitted an opinion request to the Texas attorney general on the authority of the board over activities of (1) licensed optometrists employed by physicians and of (2) retailers of ophthalmic goods leasing space to physicians that employ optometrists – specifically, on the applicability of an exception to TOB’s authority in Tex. Occ. Code §351.005 for physicians and persons working under a physician’s supervision. In its letter request and accompanying brief, TOB argues that optometrists, as independent licensees, do not fall within the meaning of supervised persons under §351.005.

MA filed a letter brief to the attorney general on Oct. 30, 2019, arguing that including physicians’ optometrist employees within §351.005’s exception is consistent with both the plain language and legislative history of the Optometry Act.

As of January 2020, the attorney general had not released an opinion on this issue.
Resolution 101-A-19, introduced by the Lone Star Caucus, was referred to the TMA Board of Trustees. It addresses moving all meetings of the Texas Medical Association from a Friday-Saturday format to a Saturday-Sunday format.

The resolution recommended that (1) all meetings of TMA be moved to a Saturday-Sunday format from the current Friday-Saturday format, and (2) this resolution be referred to the Board of Trustees to study the feasibility and economic impact on physicians and the association and report back to the House of Delegates in 2020.

Status
The board directed staff to prepare a report on the feasibility and economic impact on the association were the resolution passed. A report pertaining to the association’s expenses was reviewed at the 2020 TMA Winter Conference meeting. The board approved submitting this report to the house, however, it did not make a recommendation for or against altering the current Friday-Saturday meeting format, as the report could not predict how a schedule change would alter attendance at meetings.

Key Points
“All meetings of the association” are defined as Fall Conference, Advocacy Retreat, Winter Conference (hereinafter, collectively, “leadership conferences”), and TexMed. Average annual expenses for all conferences for the past five years is $506,000. See Figure 1 for direct conference expenses 2015-19.

- A format change would not impact revenue projections for any of the conferences.
- To evaluate impact on expenses, the board reviewed five years of expenses for food and beverage, sleeping rooms, audiovisual equipment and labor, travel, collateral production, staff time/labor, and marketing.
- Expense areas that could see a financial impact include:
Sleeping rooms. Rates could fluctuate $5-$10 per night, in either direction. Based on average room nights paid for by the association over the past two years, this could increase or decrease costs by $1,200 per leadership conference, and by $4,500 for TexMed. In all cases, that equates to less than 1.5% of total meeting cost.

Audiovisual costs. There would be no impact for leadership conferences. However, TexMed audiovisual costs are governed by a contract with Freeman AV through TexMed 2022, which stipulates overtime rates for all technician labor on Saturday and Sunday. Based on the past two years’ labor hours, a date pattern shift could increase labor costs by approximately $8,500 per year, or 6.5%. This equates to 2.1% of the total TexMed expenses.

Due to existing contracts, the earliest meeting that could be moved to the Saturday-Sunday format is the 2022 Winter Conference.

One unknown factor is how the format change would impact attendance, specifically for delegates, and therefore whether the House of Delegates would meet quorum to conduct business on Sunday morning.

Conclusion
A format change is feasible as early as the 2022 Winter Conference. Economic impact to the association would be minimal, with the largest impact on TexMed. Impact on delegate attendance could affect the association’s ability to conduct business on Sunday morning.

Since feasibility for and impact on individual physicians are not addressed in this summary, the board approved that the speakers conduct a straw poll of TMA members during Annual Session 2020 to determine delegate sentiment on a Saturday-Sunday meeting schedule.
REPORT OF COMMITTEE ON MEMBERSHIP

CM-M Report 1 2020

Subject: Membership Development

Presented by: Sara W. Dyrstad, MD, Chair

TMA Membership. TMA ended 2019 with 53,588 members, a net gain of 954 members and a year-over-year membership increase of 1.8%. Residents increased by 902 members or 13.9%. Students also increased by 473 members or 7%.

2019 Accomplishments:
• Reached 53,588 members;
• Maintained retention rate of 93%; and
• Delivered 75 Ambassador presentations, primarily through county medical societies.
• The Texas Medical Association Leadership College celebrated its 10th year. The program now has 184 graduates and a strong alumni group that is tapped regularly for leadership positions.
• The Texas Medical Association Women in Medicine Section (renamed the Women Physicians Section) was established at TexMed 2019 to strengthen female physicians’ engagement and representation in organized medicine through the development of relevant policy, programming, and services.

2020 Membership Recruitment and Retention Plans and Goals. TMA membership development staff are committed to increasing membership and market share. TMA staff will continue in-the-field recruitment efforts including frequent and consistent local and peer-to-peer outreach, assistance to county societies, and better targeting and messaging to various membership segments.

TMA 2020 membership goals:
• Increase membership in the association to 54,556, an increase of 968 members or 1.8%; and
• Retain 93% of recruitable members.

Key Priorities. Of note is the ongoing engagement of the Committee on Membership in addressing TMA priorities and the needs of various membership segments. Identified priorities include the following:

Women Physicians Section. Better serving the unique needs of women in medicine remains a top priority. The section is committed to leveraging its current momentum and expanding opportunities for women physicians to engage and grow professionally. The section plans to meet regularly during TMA conferences with the meeting format to include a combination of section business, an educational presentation, and networking opportunities. The section has also expressed a desire to broaden its reach at the regional and county levels by supporting county medical societies in providing high-quality professional development education and networking activities locally.

Physicians in Employed Settings. An ad hoc Committee on Employed Physicians studied and made recommendations on how to better serve this key membership segment and increase the value of TMA membership. Should the House of Delegates approve these recommendations, TMA staff will help implement the priorities and services outlined.

Leadership Development. This year, TMA will launch a second cohort known as the Lifelong Leadership cohort. The Lifelong Leadership program will tailor content to those whose age or years in practice make them ineligible to participate in the existing TMA Leadership College geared at young physicians.
Participation will be application- and fee-based, with tuition fees. The Lifelong Leadership curriculum will address leadership concerns likely to surface later in a physician’s career: strategic planning and fiduciary responsibility, ethical decision making, physician burnout, human resource management, and mentorship, among others.

**2019 Recruitment and Retention Campaigns.** Annually, TMA membership development and marketing staff develop a marketing plan meant to help maintain the visibility of the Texas Medical Association including the value, benefits, and services. Key recruitment and retention campaigns are noted here.

In addition to personalized emails, digital marketing channels including Facebook and Google ads were successful marketing tools for TMA in 2019 and will continue in 2020.

*Texas Medicine Today.* This campaign provided nonmembers with a three-month trial subscription to TMA’s daily members-only e-newsletter. Each issue arrived once a week and contained the top stories from the week prior, content marketing and ads featuring TMA services, practice management consulting case studies, and a “join today” call to action. During the first quarter, the target was former members. In the third quarter, the targets were those who have never been a member. A total of 246 new physician and resident members can be attributed to this campaign.

*Google Ads.* The campaigns highlighted TMA membership, services, practice compliance, and education. Ads for publications, on-demand programming, and general “free CME” performed very well, especially in the last quarter.

In 2019, more than 7.3 million ad impressions (from TMA and third-party contracts) have been viewed by site visitors. Top-performing membership, services, and education ads are shown here. All performed better than the platform benchmark of a 0.08% click-through rate. A total of 493 new physician and resident members can be attributed to these Google campaigns.

*Win Back Campaign.* A template email was created to be personalized and used by each field representative to reach out to potential members in their assigned areas. Each field rep was the sender rather than TMA, and a more informal, conversational-style message was used to see how it affected open rates.

The campaign ran the last quarter of the year and proved to be successful in open rates, click-through rates, nonmember data cleanup, and lead generation. A total of 173 new physician members can be attributed to this campaign. Feedback from physicians has been positive, with many expressing thanks for TMA taking the time to reach out and for the chance to have questions answered. Due to the success of this campaign, it will be part of regular outreach efforts.

*Facebook Ads.* The first campaigns highlighted practice management services. The practice management ads were shown 24,590 times, had a click-through rate of 2.03% (above the industry average on Facebook of 0.90%), and resulted in 67 new members at a very cost-effective cost per website click of 34 cents. The industry average cost per click on Facebook is $1.72.

The second set of ads featured TMA help with regulatory and compliance burdens. The ads were shown a total of 24,273 times, had a click-through rate of 1.35%, and resulted in 41 new members.

A total of 108 physician and resident members can be attributed to the Facebook campaigns. TMA staff will continue to evaluate previous and current Facebook ads to best design campaigns that highlight TMA benefits and services, and that promote membership in 2020.
**Newly Licensed.** This campaign targets physicians for the year following licensure. This campaign is primarily a print campaign due to the lack of email addresses for this population. However, digital ads are also now targeted to reach these physicians “where they are” online. First-class postcards contain a URL directing members to custom landing pages with more details and information on highlighted benefits.

Staff track response rates, conversion rates, cost per join, and average number of pieces (postcards) to conversion. In 2019, TMA added 306 new physician and resident members from the Newly Licensed mail campaign. The average cost per join went down from $67.17 in 2018 to $50.31 in 2019 due to a collateral revamp. Staff will continue to monitor and make adjustments to this campaign each year to refine messaging and reduce costs.
Subject: Distinguished Service Award, Josie R. Williams, MD

Presented by: Steven M. Petak, MD, Chair

Acting upon a nomination by the Lamar-Delta County Medical Society, the Board of Councilors selected Josie R. Williams, MD, to receive the association’s Distinguished Service Award. The award will be presented on Friday, May 1, 2020, at the opening session of the House of Delegates.

Taking the lead role in improving the quality of care has been a cornerstone of Dr. Williams’s career in medicine. Retired since 2015, she has been a physician in private practice, hospital administrator, military nurse, nursing administrator, associate professor, and quality institute director, among other professional roles. In addition, she served as TMA’s 143rd president in 2008-09. She has been a TMA member for 44 years, and a member of the Brazos and (currently) Lamar-Delta county medical societies.

Dr. Williams, who board certified by the American Board of Internal Medicine, received her medical degree in 1975 from The University of Texas Health Science Center at San Antonio Medical School, following distinguished service as a registered nurse in the U.S. Air Force. As a nurse, she served at Ellsworth AFB in South Dakota and Bergstrom AFB in Austin, where she was chief nurse and received a commendation medal for her work. After medical school, she returned to the Air Force for her internal medicine residency and gastroenterology training at Lackland AFB, graduating as colonel, USAF Medical Service Corps Reserve. This led to a practice in gastroenterology in Paris, Texas, with various leadership roles at her local hospital.

Both individual patients and populations of patients have benefited from Dr. Williams’ years of service. Interested in public health, she received advanced training in health care delivery improvement in Salt Lake City in 1997, followed by a master’s in medical management from Tulane University in 1998. This led to a host of public service appointments at the national and state level over the next 15 years related to quality, physician performance improvement, and patient safety. Among these, she was medical director of the Texas Health Quality Alliance, 1998-2001, and co-chair of the American Medical Association Physician Consortium for Performance Improvement, 2001-06. She also published more than 25 journal articles.

In 2002, Dr. Williams founded the Rural and Community Health Institute, the internationally recognized KSTAR Physician Assessment Program, and Institute for Healthcare Evaluation at the Texas A&M Health Science Center, serving as director of these programs until 2008, then codirector until 2012, and remaining involved until her retirement. She also was an associate professor of internal medicine and family and community medicine. She was named a Distinguished Alumnus (2001) and to the Academy of Distinguished Former Students of the College of Science (2010) at Texas A&M.

Dr. Williams has a long history of involvement with TMA. She served on the Board of Trustees (2001-10) and on the Texas Delegation to the AMA (1994-2008). She also served on TMA councils, committees, and sections on legislation, socioeconomics, quality, physician services, physician payment, organized medical staff, hospital medical staff, rural health, and town/gown relations.

This 2020 Distinguished Service Award tops off Dr. Williams’ legacy of excellence long recognized at TMA. She received a TMA commendation for services on the Organized Medical Staff Section in 1997 and the TMA C. Frank Webber, MD, Award in 2002. In 2009, she was honored with a Texas Legislature resolution of TMA Leadership Appreciation, and 2012 she received the TMA Young at Heart Award.
**REPORT OF BOARD OF COUNCILORS**

Subject: County Medical Societies Constitution and Bylaws

Presented by: Steven M. Petak, MD, Chair

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**Ector County Medical Society Constitution and Bylaws**

TMA Office of the General Counsel staff reviewed Ector County Medical Society Constitution and Bylaws and recommends that the TMA Board of Councilors approve Ector CMS Constitution and Bylaws with the interpretation provided below.

The TMA Board of Councilors interprets Section 1.208 of the TMA Bylaws to mean that the description of residents voting in and holding resident positions delineates specific exceptions to a general prohibition against residents voting and holding office. Accordingly, residents may not be elected as a county medical society delegate or alternate delegate.

**Tarrant County Medical Society Constitution and Bylaws**

The TMA Board of Councilors has approved amendments to the Tarrant County Medical Society Constitution and Bylaws.
Subject: Committee on Physician Health and Wellness Update

Presented by: Cheryl L. Hurd, MD, Chair

Background
In 1976, the TMA House of Delegates established the Impaired Physicians Committee and charged it with studying the impairment problem in Texas. The committee also was to devise mechanisms for the identification, treatment, and long-term follow-up of Texas physicians with diseases and illnesses that compromised their ability to practice medicine. Since that time, the committee’s duties have expanded to include education and prevention of illness. The name was changed to Committee on Physician Health and Rehabilitation in May 1978. In 2013, as a result of advanced understanding of physician health and wellness, the committee’s name was changed to the Committee on Physician Health and Wellness (PHW).

§10.621 Committee on Physician Health and Wellness. It shall be the duty of this committee to promote healthy lifestyles in Texas to medical students, residents, and physicians; to provide advocacy and support for and education on physician wellness; and to promote prevention of potentially impairing conditions. The committee shall be required to report its activities to the Board of Councilors. The committee shall maintain liaison with the Texas Medical Board and the Texas Physician Health Program. The committee shall be responsible also for making recommendations to the Council on Legislation in instances where there are needed changes in the laws relative to physician wellness and potentially impairing conditions.

Committee Functions
The function of the Committee on Physician Health and Wellness is three-fold: (1) to promote healthy lifestyles to Texas medical students, residents, and physicians, (2) to provide advocacy and support for and education on physician wellness, and (3) to promote prevention of potentially impairing conditions. The following items represent some of the PHW Committee’s activities that meet its charge from the House of Delegates and TMA goals.

- Produce and maintain programs and brochures to educate Texas physicians about ethical aspects of physician well-being, stress, potentially impairing conditions, and other relevant topics [1993];
- Encourage county medical societies, hospitals, medical schools, and residency training programs to utilize PHW resources in their educational programs [1993];
- Help hospitals meet The Joint Commission standard related to physician health [2001];
- Continue to have a close liaison with the TMA Alliance and encourage it to offer educational programs to its membership;
- Maintain close liaison with the Texas Medical Board (TMB) and Texas Physician Health Program (TXPHP) [TMB since formation of committee; TXPHP since it was created in 2009]; and
- Report activities to the TMA Board of Councilors in accordance with TMA policy.

The PHW Committee’s commitment to the health, well-being, and effectiveness of Texas physicians contributes to the health and welfare of all Texas citizens. These ever-increasing activities are offered to physicians throughout the state, as well as to hospitals, medical staffs, and other organizations.
Ad Hoc Committee on Education

The education team consists of 35 practicing, academic, and/or retired physicians. The education team responded to 44 live CME presentation requests in 2019. In 2018, the committee approved free educational live presentations for medical schools and residency programs. A total of eight free health and wellness educational presentations were given to residents and/or medical students at seven Texas academic medical centers in 2019 (up from two requests in 2018). In addition to these requests, the education team oversees the development and review of PHW continuing medical education activities.

Ad Hoc Committee on Physician and Trainee Health and Wellness

The committee recognizes that physicians, students, and trainees (residents and fellows) work and train alongside biomedical and health professions colleagues within learning health care systems. As a part of the committee’s outreach program to promote well-being within learning health care systems, the inaugural Physician Health and Wellness Exchange was developed.

2019 Annual Physician Health and Wellness Exchange

More than 80 Texas physicians, residents, medical students, health and wellness providers, academic medical center faculty, and staff representing seven Texas institutions participated in the inaugural PHW Exchange on March 3 in Houston at Baylor College of Medicine. Activities included a continuing medical education program, poster session, and Think Tank discussion. During the Think Tank, facilitators and participants addressed the health and wellness needs in learning health systems. Most participants described the conference as “very helpful and useful” and are looking forward to the next exchange in San Antonio at UT Health San Antonio Long School of Medicine on Saturday, Oct. 24, 2020. Activities will include:

• Continuing education programming,
• Workstation exercise session and/or kitchen workshop,
• Poster session,
• Think Tank discussion,
• TMA medical student resolution workgroup, and
• Training session for speakers.

Upcoming Projects

The committee has provided additional educational resources online regarding well-being, dimensions of meaning in work, burnout, stress, work-life integrations, fatigue, mental/emotional quality of life, and physical quality of life. As a part of the committee’s endeavors to establish a statewide collaboration to address the gaps in resources, authors from Baylor College of Medicine, McGovern Medical School at UTHHealth, UT Southwestern, and Texas A&M College of Medicine summarized the committee’s findings and recommendations in a manuscript that will be submitted to an outside journal.
2019 AMA ANNUAL MEETING

More than 100 Texas physicians, residents, and medical students, representing the Texas Medical Association and its various sections, and national specialty societies participated in the June 8-12 American Medical Association meeting in Chicago. When Texas delegation members left the gathering, they had installed Fort Worth allergist and former TMA president Sue Bailey, MD, as AMA president-elect and Russell W.H. Kridel, MD, a facial plastic surgeon from Houston, as chair-elect of the AMA Board of Trustees.

Elections and Appointments

Dr. Bailey was elected unanimously as president-elect. G. Sealy Massingill, MD, was appointed to the Council on Long Range Planning and Development by the AMA Board of Trustees. Greg Fuller, MD, a family physician from Keller, was elected to the governing council of the Integrated Physician Practice Section. Myphuong “Theresa” Phan, MD, MPH, a resident at Dell Family Medicine in Austin, was elected vice speaker of the Resident and Fellow Section. Five Texas medical students won officer positions in Region 3 of the Medical Student Section: vice chair: Rebecca Haines, Texas A&M University College of Medicine; secretary-treasurer: Jimmy Bunch, Texas Tech University Health Sciences Center School of Medicine; legislative chair: Rajadhar Reddy, Baylor College of Medicine; legislative vice chair: Joseph Camarano, The University of Texas Medical Branch School of Medicine; and community service chair: Natasha Topolski, McGovern Medical School at UTHealth.

Dallas psychiatrist Les Secrest, MD, chaired the Reference Committee on Science and Technology during the meeting; Melissa Garretson, MD, of Fort Worth, a delegate from the American Academy of Pediatrics, served on the Reference Committee on AMA Finance and Governance; Dr. Fuller served on the Reference Committee on Medical Service; and Austin emergency physician Robert Emmick Jr., MD, served on the Committee on Rules and Credentials.

AMA House Still “No” on Single Payer

Dr. Bailey, serving in her fourth term as speaker of the house, had barely gavelled the assembly together when several dozen sign-carrying activists – including some physicians and medical students – barged into the hall and took over the rostrum, chanting “AMA, get out of the way.” The contingent served as uninvited emissaries from a larger contingent of several hundred protestors who were marching outside the hall on behalf of “Medicare for All.”

Three days later, the question of how to provide health care to the nation’s 30 million uninsured arose again in the same room – this time in a manner more typical of House of Delegates proceedings. The house had just adopted a report from the AMA Council on Medical Service that called for AMA to advocate expanding eligibility for plans sold via the Affordable Care Act, as well as the amount of the premium tax credits and cost-sharing supports available.

A group of medical student delegates then proposed that the house remove all opposition to single-payer systems from existing AMA policy “while preserving support for pluralism, freedom of choice, freedom of practice, and universal access for patients.” The students argued that the growing number of national
politicians and organizations that support various versions of Medicare for All would eschew the views of
an organization that so blatantly opposed that approach. But the establishment pushed back. “We ought to
put a stake in the heart of single payer,” former AMA President Donald Palmisano, MD, of Louisiana
urged the delegates.

“The Texas Medical Association has strong policy that states we will not look at any single payer
system,” said Beaumont anesthesiologist Ray Callas, MD, speaking for the Texas delegation. “I cannot go
back to Texas and tell our physicians that AMA will take part in discussions about single payer.” The
delegates voted down the medical students’ proposal 292-254. But the final tally showed the strength of
their position among established physicians in the house, as the students collectively hold no more than
29 voting seats in the assembly.

“Irreducible Differences in Moral Perspectives”
Should it be called “aid in dying” or “physician-assisted suicide?” Is it ever morally acceptable for
physicians to relieve their patients’ suffering permanently? Does it matter that five states and the District
of Columbia have legalized the practice?

The House of Delegates has wrestled with these difficult questions since 2016, repeatedly refusing to
agree with the AMA Council on Ethical and Judicial Affairs (CEJA) that the association should hold fast
to the ethical guidelines against physician-assisted suicide originally adopted in 1994. CEJA tried a
Solomonic approach at the 2019 annual meeting – and it worked.

“While supporters and opponents of physician-assisted suicide share a common commitment to
compassion and respect for human dignity and rights,” the council wrote in its report to the house, “they
draw different moral conclusions from the underlying principle they share.”

On a vote of 360-190, the delegates agreed with CEJA’s plan to retain the term “physician-assisted
suicide” to describe the practice; keep the 1994 policy that states, in part, “Physician-assisted suicide is
fundamentally incompatible with the physician’s role as healer”; and reiterate an existing CEJA opinion
that states, in part, “Physicians should have considerable latitude to practice in accord with well-
considered, deeply held beliefs that are central to their self-identities.”

Policy
The Texas delegation scored some serious victories in the policy arena. They include:

- A commitment for AMA to study changes to laws and regulations to reduce the burden and financial
  risk that Medicare’s Quality Payment Program puts on physicians, especially those in small and rural
  practices;
- A directive for AMA to “work with relevant stakeholders” to support extending Medicaid coverage to
  12 months postpartum;
- A request for AMA to push the Centers for Medicare & Medicaid Services (CMS) to update the
  practice expense component of Medicare’s relative value unit system “so it accurately reflects current
  physician practice costs”; and
- New AMA policy recommending that physicians use the term “intellectual disability” instead of
  “mental retardation” in clinical settings.

Other Business of the House
Delegates addressed various other economic, legislative, and public health topics. The house:

- Celebrated the installation of Atlanta psychiatrist Patrice Harris, MD, as the new AMA president;
• Determined, in the words of Dr. Kridel, that government regulators should “pull back the curtain on pharmacy benefit managers” and the role they play in prescription drug pricing and availability;
• Voted to ask CMS to eliminate Medicare’s 48-hour observation period and “observation status in total”;
• To enthusiastic applause, voted for AMA to push for laws and regulations that give states incentives to eliminate nonmedical exemptions for mandatory childhood vaccinations;
• Said states should allow “mature minors” to override their parents’ refusal for vaccinations;
• Called for more federal, state, and local resources for preventing, detecting, and responding to the rising threat from vector-borne diseases;
• Directed AMA to study the factors behind physicians’ and medical students’ outsized susceptibility to depression, substance use, and suicide;
• Said AMA should support making “naloxone rescue stations” for opioid overdoses available publicly across the country, similar to automated external defibrillators;
• Directed AMA to work with the American Board of Medical Specialties (ABMS) to push for implementation of the Vision for the Future Commission’s recommendations on continuing board certification (ABMS’ new term for the revamped maintenance of certification process);
• Voted to study ABMS’s use of physicians’ fees to advertise to the public about the value of board certification;
• Rejected a call for AMA to advocate for limited primary care licenses for medical school graduates who do not match for or who have not completed residency training;
• Adopted policy stating that physicians can delegate the task of obtaining informed consent to “other qualified members of the health care team,” but physicians retain ultimate responsibility for the process;
• Called for AMA to develop a national education campaign on the dangers of distracted driving;
• Supported required warning labels on all nicotine vaping products; and
• Voted to oppose removing infants from their mothers based solely on a single positive prenatal drug screen.

2019 AMA INTERIM MEETING

Nearly 100 Texas physicians, residents, and medical students representing the Texas Medical Association and its various sections, and national specialty societies participated in the Nov. 16-19 AMA meeting in San Diego. Ten Texas medical students and residents won leadership posts at the meeting, and two Texas physicians announced they will run for AMA office at the June 2020 meeting.

Elections

Ten residents and medical students from Texas won leadership elections in San Diego. For the AMA Resident and Fellow Section: Michael Metzner, MD, a general surgery resident in San Antonio, was reelected as the section’s delegate in the AMA House of Delegates; and Dr. Phan and Jerome Jeevarajan, MD, of Houston, were elected as alternate delegates. Drs. Phan and Jeevarajan both have served as AMA and TMA leaders since they were medical students. For Region 3 of the AMA Medical Student Section: Swetha Maddipudi, a second-year student at UT Health San Antonio Long School of Medicine, is the new chair-elect; Matthew Hidalgo, a third-year student at The University of Texas Rio Grande Valley School of Medicine, is the new membership chair; James Bunch, a second-year student at Texas Tech University Health Sciences Center (TTUHSC) School of Medicine, will serve as the region’s delegate to the AMA house. Elected as alternate delegates were: Josh Bilello, a second-year student at The University of Texas Medical Branch School of Medicine; Abhishek Dharan, a second-year student at TTHUSC Paul L. Foster School of Medicine; Rajadhar Reddy, a second-year student at Baylor College of Medicine; and Ikram Rostane, a first-year student at the McGovern Medical School at UTHealth.
No Vaping

One year ago, the AMA house declared e-cigarettes and vaping “an urgent public health epidemic.” As a mysterious vaping-related lung disease spread around the country, the delegates went further at this meeting. They urged the federal government and the states to ban all e-cigarettes and vaping products except those Food and Drug Administration (FDA)-approved items prescribed by physicians to help their patients stop smoking.

“AAMA physicians stepped up to address the vaping epidemic by calling for a ban until the FDA can adequately address their safety and potential use as smoking cessation devices,” said John Carlo, MD, of Dallas, a member of the AMA Council on Public Health and Science.

The delegates went after traditional “combustible” tobacco products as well, expanding AMA’s campaign against flavored tobacco specifically to include menthol. More than 20 million Americans – including 85% of African American smokers – currently smoke menthol cigarettes, which are reportedly harder to quit.

MIPS Plan Rejected

Led by the Texas delegation, the house rejected as inadequate a plan to improve Medicare’s Quality Payment Program (QPP) and its highly flawed Merit-Based Incentive Payment System (MIPS) track.

“Quite simply, this program is not working,” Dr. Callas told delegates. “Now entering its fourth year, it has not been proven to improve quality or reduce costs, but it has been proven to harm physicians in solo and small practices nationwide. And this report does not commit our AMA to fight for the structural and operational changes that are needed to fix it.”

The house voted unanimously to send the report back to the AMA Board of Trustees for more work. The report was the board’s response to resolutions submitted over the two previous meetings of the house by the Texas, Pennsylvania, and Florida delegations. Those resolutions asked AMA to advocate for very specific changes that would relax the financial and paperwork burdens that MIPS and QPP impose on practicing physicians.

TMA physician leaders and staff complained that the AMA report glossed over most of the states’ requests, and its only substantive provision was a lukewarm directive to support legislation that “supplements budget neutrality” rather than eliminate it and do away with payment penalties.

“The report does state that our AMA supports changes that would allow small practices to ‘succeed’ in MIPS,” Dr. Callas said. “But you can’t succeed in MIPS and get a bonus unless another practice fails and pays a penalty. Budget neutrality undermines practice viability, demoralizes us, and threatens access to care.”

As they wait for a new report – likely to come in June 2020 – TMA, AMA, and many other state associations and national specialty societies will continue to fight for MIPS reform. “Physicians need relief now,” Dr. Callas added.

Texans Shine Brightly

Two Texas physicians played key roles in crafting the policy adopted at the meeting by serving on House of Delegates reference committees. E. Linda Villarreal, MD, an internist from Edinburg, served on the Reference Committee on Medical Practice and Insurance; and Little Elm internist John Flores, MD, worked on the Reference Committee on Legislation.
Two Texas physicians laid out their credentials for elected AMA positions. Tyler anesthesiologist Asa Lockhart, MD, announced he is running for the AMA Board of Trustees, and Cynthia Jumper, MD, an internist from Lubbock, said she is seeking reelection to the AMA Council on Medical Education. Those elections will take place at the June 2020 meeting of the house, where two more Texans will take big steps upward: Dr. Bailey will be installed as the AMA’s 175th president, and Dr. Kridel is scheduled to become chair of the Board of Trustees.

The AMA house:

- After years of wrangling over the issue, finally adopted a Council on Ethical and Judicial Affairs report outlining physicians’ duty to “recognize when they are and when they are not able to provide appropriate care for the patient in front of them or the patients in their practice as a whole”;
- Called on AMA to develop model state legislation and to work for federal legislation to ban conversion therapy for sexual orientation or gender identity;
- Directed AMA to study the best means for “expediting entry of competently trained international medical graduates” into practice in this country;
- Expanded AMA’s telemedicine policy to stop the insurance company practice of paying for telemedicine services only if they are provided by certain physicians;
- Supported arbitration between pharmaceutical companies and payers – rather than price controls – to address rising drug prices;
- Voted to oppose organizations that “board certify” physician assistants and other nonphysicians in a way that misleads the public about those practitioners’ qualifications;
- Said AMA should work with Medicare to develop more robust risk-adjustment methods for alternative payment models;
- Directed AMA to encourage all U.S. medical schools to adopt a pass/fail grading system for nonclinical courses;
- Called on Medicare to reverse its recent decision that would allow general supervision, rather than direct supervision, of inpatient radiation therapy and hyperbaric oxygen services;
- Rejected a call to support national benzodiazepine-specific prescribing guidelines for physicians;
- Said state licensing agencies should allow physicians 10 years – rather than the current seven – to complete all required state licensing examinations;
- Voted to create a task force to study the public health effects of legalized cannabis and cannabinoids; and
- Supported sunscreen giveaway programs “in public spaces where the population would have a high risk of sun exposure.”
As of Jan. 24, 2020, American Medical Association membership in Texas totaled 19,081 compared with 18,002 at year-end 2018, an increase of 1,079 members. The physician category (which includes nondues-paying retired, exempt, and honorary in addition to dues-paying active physicians) saw an increase of 158 members for a total physician membership of 10,573; resident members increased by 381 for a total resident membership of 4,412; and student members decreased by 121 for a total student membership of 3,435.

**Representation in AMA**

With the increase in membership, the Texas Delegation to the AMA saw an increase of one elected delegate and alternate delegate to the AMA House of Delegates; 20 physician delegates now represent Texas. Numerous Texas physicians and medical students hold positions of leadership within the AMA organizational structure: Susan R. Bailey, MD, was elected as president-elect; Russell W.H. Kridel, MD, will serve as chair of the Board of Trustees; and G. Sealy Massingill, MD, was appointed by the AMA Board of Trustees to serve on the Council on Long Range Planning and Development. Texans serving as ex officio members of the AMA House of Delegates are AMA past presidents J. James Rohack, MD, and Nancy W. Dickey, MD.

Additional Texas physicians holding elected or appointed positions on AMA entities are:

- John T. Carlo, MD, Council on Science and Public Health;
- Jose M. de la Rosa, MD, chair, Academic Physician Section;
- Hilary Fairbrother, MD, chair, Young Physicians Section;
- John G. Flores, MD, member-at-large, Organized Medical Staff Section Governing Council;
- Cynthia A Juniper, MD, Council on Medical Education;
- Greg Fuller, MD, member-at-large, Integrated Physician Practice Section;
- Monique A. Spillman, MD, PhD, Council on Ethical and Judicial Affairs; and
- Ken Mattox, MD, member, Senior Physicians Group Governing Council.
- Diana Fite, MD, member, House of Delegates Compensation Committee
- Michelle Berger, MD, member, Council on Long Range Planning and Development

Texans serving as resident representatives are Michael Metzner, MD, regional delegate, and Myphuong “Theresa” Phan, MD, MPH, and Jerome Jeevarajan, MD, as alternate regional delegates.

Texans serving as student representatives are Region 3 Chair-Elect Swetha Maddipudi, UT Health San Antonio Long School of Medicine, MS2; Region 3 Membership Chair Matthew Hidalgo, The University of Texas Rio Grande Valley School of Medicine, MS3; Region 3 delegate James Bunch, Texas Tech University Health Sciences Center (TTUHSC) School of Medicine, MS2; Region 3 alternate delegates Josh Bilello, The University of Texas Medical Branch School of Medicine, MS2; Abhishek Dharan, TTUHSC Paul L. Foster School of Medicine, MS2; Rajadhar Reddy, Baylor College of Medicine, MS2; and Ikram Rostane, McGovern Medical School at UTHealth, MS1B.
In addition to the 19 delegates and alternate delegates representing the Texas Medical Association in the AMA House of Delegates in 2018, many other Texas physicians serve in the AMA house as specialty society delegates and alternate delegates. They are:

- C. Bob Basu, MD, alternate delegate, American Society of Plastic Surgeons;
- Donna Bloodworth, MD, alternate delegate, American Academy of Pain Medicine;
- Sue Bornstein, MD, delegate, American College of Physicians;
- Tilden L. Childs III, MD, delegate, American College of Radiology;
- Ronald J. Crossno, MD, alternate delegate, American Academy of Hospice and Palliative Medicine;
- Gary Dennis, MD, delegate, National Medical Association;
- Daniel Dent, MD, delegate, American College of Surgeons;
- Seemal Desai, MD, alternate delegate, American Academy of Dermatology;
- John Early, MD, delegate, American Academy of Orthopaedic Surgeons;
- Hilary E. Fairbrother, MD, delegate, American College of Emergency Physicians;
- Melissa J. Garretson, MD, alternate delegate, American Academy of Pediatrics;
- Osvaldo Steven Gigliotti, MD, alternate delegate, Society of Cardiovascular Angiography and Interventions;
- John N. Harrington, MD, delegate, American Society of Ophthalmic Plastic and Reconstructive Surgery;
- Lisa Hollier, MD, alternate delegate, American College of Obstetricians and Gynecologists;
- Lynne M. Kirk, MD, delegate, American College of Physicians;
- Robert C. Kramer, MD, alternate delegate, American Society for Surgery of the Hand;
- Rashmi Kudesia, MD, alternate delegate, American Society for Reproductive Medicine;
- Keagan H. Lee, MD, alternate delegate, United States & Canadian Academy of Pathology;
- Jonathan D. Leffert, MD, delegate, American Association of Clinical Endocrinologists;
- David Lichtman, MD, delegate, American Society for Surgery of the Hand;
- Alnoor Malick, MD, delegate, American College of Allergy, Asthma & Immunology;
- G. Sealy Massingill, MD, delegate, American College of Obstetricians and Gynecologists, and Council on Long Range Planning and Development;
- Susan Dixon McCammon, MD, delegate, American Academy of Otolaryngology-Head and Neck Surgery;
- Kevin McMains, MD, delegate, American Rhinologic Society;
- Daniel M. Meyer, MD, alternate delegate, American Association for Thoracic Surgery;
- Vineet Mishra, MD, alternate delegate, American Vein and Lymphatic Society;
- Hernando J. Ortega Jr., MD, MPH, delegate, Aerospace Medical Association;
- Ray D. Page, DO, delegate, American Society of Clinical Oncology;
- Mary Dale Peterson, MD, alternate delegate, American Society of Anesthesiologists;
- Carlos J. Puig, DO, delegate, International Society of Hair Restoration;
- Daniel Shoor, MD, alternate delegate, Aerospace Medical Association;
- Divya Srivastava, MD, alternate delegate, American College of Mohs Surgery;
- Susan M. Strate, MD, alternate delegate, College of American Pathologists; and
- Crystal C. Wright, MD, alternate delegate, American Society of Anesthesiologists.

2020 Officers
At the Texas Delegation’s Jan. 24, 2020, meeting, David N. Henkes, MD, was reelected chair; Michelle A. Berger, MD, and Gary W. Floyd, MD, were reelected co-vice chairs; and Ray Callas, MD, and Gregory M. Fuller, MD, were reelected as at-large members of the Delegate Review Committee.
REPORT OF INTERNATIONAL MEDICAL GRADUATE SECTION

IMG Report 1 2020

Subject: Status of International Medical Graduate Section

Presented by: Marina C. George, MD, MBA, FHM, FACP, Chair

The International Medical Graduate (IMG) Section was established by the House of Delegates to provide a direct means for international medical graduates to participate in the activities of the association. Its purpose is to enhance TMA outreach, facilitate communication and interchange with IMGs, promote TMA membership growth, enhance the ability of IMGs to provide their perspective to TMA and the House of Delegates, and facilitate the development of information and educational activities on topics of interest to IMGs.

Section Activities
The IMG Section meets two times annually, during Winter Conference and TexMed. Additionally, the section hosts a mixer at Winter Conference the evening prior to its business meeting. The section mixer gives members time to network and remind attendees about the business meeting the next morning.

Every odd year the section has governing council elections at its business meeting at TexMed. During TexMed 2019, the following section members were elected for a two-year term:

- Chair-elect: Marcial Andres Oquendo Rincon, MD;
- Secretary: Goddy T. Corpuz, MD;
- Delegate: Anupama Gotimukula, MD;
- Alternate Delegate: Suresh Kumar, MD; and
- Members at Large: Arathi Shah, MD, and Jenny Jacob, MD.

The section has taken a keen interest in working towards greater international medical graduate membership within TMA as well as member involvement within the section. During their meeting at Winter Conference, section members discussed recruitment, retention, and involvement activities.

The section also created an award that recognizes IMG physicians who have taken steps beyond their regular workday to improve the health of their community. The section announced the award in 2018 and accepted nominations through January 2019 for the inaugural award. The chair of the IMG Section presented the inaugural award during TexMed 2019 to Nick Schroff, MD, for his outstanding volunteer service outside his practice.

Looking Ahead
The section will focus on increasing IMG membership, engagement, and meeting participation. The section also plans to provide educational programing relevant to its members.
Subject: Status of Medical Student Section

Presented by: Amanda Arreola, Chair

The Medical Student Section (MSS) was established by the House of Delegates to shape the future of medicine in Texas by active medical student involvement in the affairs of the various Texas county medical societies, the Texas Medical Association, and the American Medical Association. Its purpose is to foster dialogue between individuals and organizations within medicine, promote and aid in programs that may serve to unify and give direction to health-related activities at all levels of education, and provide a good and useful service to the medical students in Texas.

Membership
Medical student TMA membership reached an all-time high in 2019. As of Dec. 31, student membership was 7,139, a 467-student increase over the same time in 2018. The 2019 total includes the new Texas Christian University medical school, which enrolled 100% its students in TMA. Of the 13 Texas medical school chapters, 10 have joined TMA at 100% membership. TMA is anticipating medical school growth within Texas to reach 15 schools by 2020.

Leadership
With the continued addition of new medical schools in Texas, the section has seen tremendous growth in student participation and interest in leadership positions. In 2019, this was even more evident when more than 100 students applied for approximately 60 available TMA board, council, and committee positions.

During their Executive Council meeting at 2020 Winter Conference, members appointed the following executive council positions for a one-year term that begins after the conclusion of TexMed 2020:

- Alternate delegate, Texas Delegation to the AMA: Faith Mason, MS4 (UTMB), and
- Board of Trustees student representative: Ankita Brahmaroutu, MS4 (A&M).

During their business meeting at TexMed 2019, members elected the following students to a one-year term on the MSS Executive Council, beginning after the conclusion of TexMed 2020:

- Chair: Amanda Arreola, MS4 (UTRGV);
- Vice chair: Sarah Miller, MS3 (UTRGV);
- Secretary: Swetha Maddipudi, MS2 (UTSA);
- TMA delegate co-chairs: Pruthali Kulkarni, MS4 (TCOM), and Greta Smith, MS4 (A&M); and
- AMA delegate co-chairs: Donald Egan, MS3 (UTSA), and Lauren Fuller, MS4 (Baylor).

Additionally, several Texas students served at the national level. The following students were elected to national positions during AMA’s Annual and Interim meetings in 2019:

- Region 3 vice chair (A-19): Rebecca Haines, MS4 (A&M);
- Region 3 outreach and community service chair (A-19): Natasha Topolski, MS2 (McGovern);
- Region 3 legislative chairs (A-19): Rajadhar Reddy, MS2 (Baylor), and Joseph Camarano, MS3 (UTMB);
• Region 3 chair (I-19): Swetha Maddipudi, MS2 (UTSA);
• Region 3 membership chair (I-19): Matthew Hidalgo, MS3 (UTRGV);
• Region 3 secretary (A-19), delegate (I-19): James Bunch, MS2 (TX Tech);
• Reg 3 alternate delegates (I-19): Josh Bilello, MS2 (UTMB); Abhishek Dharaan, MS3 (PL Foster); Rajadhar Reddy, MS2 (Baylor); and Ikram Rostane, MS1 (McGovern).

Several students from Texas also were appointed or elected to leadership positions in various AMA-MSS standing committees, as well as those of other state and national specialty societies.

During the MSS Business Meeting at TexMed 2019, the section named 12 members to be part of the Leadership Honor Society, which recognizes fourth-year medical students who have actively participated in Texas organized medicine.

Advocacy
MSS delegates from across the state collaborated to write and submit 18 resolutions to the House of Delegates at TexMed 2019. Fourteen were adopted or adopted as amended. Among the resolution topics were risks of direct-to-consumer genetics tests, tax exemption for feminine hygiene products, and restricting electronic cigarettes sales to minors.

With the legislature in session in 2019, Texas students turned their attention to advocacy issues of importance to medical students. Approximately 200 students converged in Austin for 2019 First Tuesday events sponsored by TEXPAC. First Tuesdays was a valuable experience in the art of lobbying and a great example of medical students taking the future of their profession into their own hands.

Awards
The MSS Executive Council recognized The University of Texas Rio Grande Valley School of Medicine as the 2019 Chapter of the Year. Michael Bagg, UT Health McGovern Medical School, was named Student of the Year. Linda M. Siy, MD, Fort Worth, was selected as the recipient of the 2019 C. Frank Webber, MD, Award, for providing outstanding service to the TMA Medical Student Section. These awards were presented during TexMed 2019.

Chapter Service
Multiple chapters participated in one or more of TMA’s outreach programs: Walk With a Doc, Be Wise – Immunize™, and Hard Hats for Little Heads.

The TMA Foundation awarded multiple grants to chapters for these projects within their communities:

• Alliance Refugee Wellness Fair (Baylor);
• Dell Medical Student Flu Crew (Dell);
• Frontera de Salud: Improving Border Health with Medical Student-Community Health Worker Alliance (McGovern);
• Feed my Sheep Mobile Pediatric Clinic (A&M);
• Breast cancer screening in underserved populations (TX Tech);
• Smoking Cessation Program at The Free Clinic (TX Tech);
• Refugee Resettlement Needs Assessment (Baylor);
• Healthy Minds, Health Bodies (Baylor);
• Community Week Health Fair (A&M);
• UTHealthCares, 3rd Annual Health Fair at UT Physicians Jensen Clinic (McGovern);
• 4th Annual HOPE Health Fair (UTMB); and
• Smoking Cessation Program and lung cancer screenings in a Dallas homeless population (UTSW).
Chapters also coordinated or participated in local events such as human trafficking training, gun violence prevention and awareness, and Head Start physicals. McGovern chapter members helped coordinate and run a Mock House of Delegates, an educational session where students were invited to participate as a delegate debating and dissecting resolutions from past conferences as well as participate in a Mock Reference Committee. TMA leaders were invited to participate as well as students from nearby medical schools Baylor College of Medicine and The University of Texas Medical Branch. Additionally, UT Health San Antonio students implemented curricular changes at their school to include resolution writing as an advocacy tool within its ethics curriculum.
The Resident and Fellow Section (RFS) was established by the House of Delegates to encourage participation in shaping the future of medicine in Texas by active involvement in Texas county medical societies, the Texas Medical Association, and the American Medical Association. Its purpose is to foster dialogue between individuals and organizations within medicine; promote and aid in programs that may serve to unify and give direction to health-related activities at all levels of education; and provide a good and useful service to the residents and fellows in Texas.

Membership
Resident membership reached an all-time high in 2019. As of Dec. 31, resident membership was 7,853, an 820 increase over the same time in 2018. The increase in residents can be attributed to the number of programs now participating at 100% membership. These programs provide rosters and contact information that TMA otherwise would not have, enabling TMA to identify and communicate with these residents.

Section Activities
The RFS meets three times annually in conjunction with all TMA meetings. During winter and fall conferences, the RFS has joint meetings with the Young Physician Section (YPS). These joint meetings continue to be well received and attended. Additionally, the RFS and YPS host a mixer at all three conferences, which are also very popular.

During their meeting at TexMed 2019, RFS members elected the following residents to a one-year term on the RFS Executive Council:

- Chair-elect: Collin Juergens, MD;
- Secretary: Amir Ahmadian, DO;
- TMA delegates: Michael Dakkak, DO; Ronak Ghiya, MD; Jayapradha Kasaraneni, MD; Hussain Saleem Lalani, MD; Matthew McGlennon, DO; and Cristina Penon, MD; and
- TMA alternate delegates: Ivan Becerra, MD, and Jennifer Fan, MD.

The section meeting at 2019 Fall Conference featured an overview of TMA’s efforts during the 2019 Texas legislative session presented by TMA advocacy staff. TMA President David Fleeger, MD, also spoke regarding benefits and involvement, and how members are able to make an impact.

During its 2020 Winter Conference meeting, the section discussed resolutions introduced by section members. The section elected Kayla Riggs, MD, as TMA Board of Trustees resident representative and Matthew McGlennon, DO, to the resident alternate delegate position on the TMA Delegation to the AMA.

During the AMA RFS meeting at the AMA 2019 Interim meeting, Michael John Metzner, MD, was elected to be a delegate, and Myphuong “Theresa” Phan, MD, MPH, and Jerome Jeevarajan, MD, were elected to be alternate delegates.
Planned Activities
TMA provides free early career education for residents to help navigate contracts, develop negotiation skills, and much more. In addition to the live programming TMA currently offers, TMA will also produce online modules in 2020.

The section plans to continue conducting joint meetings with the YPS, improving the educational speakers offered at meetings, and increasing attendance and engagement.
The Texas Medical Association Young Physician Section (YPS) met in conjunction with the Resident and Fellow Section (RFS) twice in the course of 2019-20, at the TMA fall and winter conferences. Joint meetings with the RFS continue to be well-received and attended. The 2019 Fall Conference meeting featured a presentation on TMA engagement and leadership by TMA President David Fleeger, MD, as well as a legislative update from TMA advocacy staff.

During the 2020 Winter Conference meeting, announced candidates for the YPS position on the TMA Board of Trustees were presented, and AMA-YPS delegates were elected to one-year terms:

- Gates Colbert, MD (reelected);
- Matthew Brooker, DO (reelected);
- Marcial Oquendo, MD (reelected); and
- Brett Cooper, MD.

The remaining members of the Executive Council are listed below along with their terms:

Officers (one-year terms):
- Chair: Gates Colbert, MD;
- Chair-elect: Samuel Mathis, MD; and
- Immediate past chair: Jessica Best, MD.

TMA delegates (two-year staggered terms):
- Eman Attaya, MD (2019-21);
- Clay Cessna, DO (2018-20);
- Gates Colbert, MD (2019-21);
- Sara Woodward Dyrstad, MD (2018-20);
- Jennifer Liedtke, MD (2018-20);
- Sachin Mehta, MD (2018-20);
- Jason McKnight, MD (2019-21); and
- Jacob Stetler, DO (2019-21).

TMA alternate delegates (two-year staggered terms):
- Andy Chen, MD (2018-20);
- William Fox, MD (2018-20);
- Stephen Herrmann, MD (2019-21);
- Ann Hughes Bass, MD (2019-21);
- Samuel Mathis, MD (2018-20);
- Kanchan Phalak, MD (2019-21);
- Joshua Reed, DO (2019-21); and
- Jimmy Widmer, MD (2018-20).
The Council on Health Care Quality oversees and supports the direction for the Texas Medical Association’s activities including policy and advocacy on quality improvement, patient safety, performance measurement, and clinical effectiveness. The council has been very active in several educational, programmatic and strategic activities, summarized below.

Centers for Medicare & Medicaid Services’ Quality Payment Program
The Medicare Access and CHIP Reauthorization Act (MACRA) was enacted in 2015. Since that time, the council aggressively reviews and responds with opportunities for physician advocacy and education on the Quality Payment Program (QPP). The QPP is an annual quality program that affects Medicare Part B payment two years later. The Centers for Medicare & Medicaid Services (CMS) administers the QPP by using a framework of integrated policies to implement the two payment tracks required by MACRA: The Merit-Based Incentive Payment System (MIPS) and advanced alternative payment models (APMs). The objective of the program is to incentivize physicians to improve care, reduce costs, and advance health care information. The QPP undergoes annual updates and changes via the federal rulemaking process, a mechanism through which the federal government takes public input into consideration to finalize rules and regulations and implement policies that govern the program each year. The 2020 calendar year is the 4th year of the QPP. TMA’s focus is to help physicians navigate the program and avoid annual Medicare payment penalties, currently still achievable for most physicians who submit data. However, in 2022, CMS will reach full MACRA implementation stage, which will include more challenging performance requirements for practicing physicians to avoid a 9% payment penalty, likely resulting in Medicare pay cuts to numerous physician practices across the state and for some practices, penalties may be incurred annually.

Outside of the limited data presented in the 2017 QPP experience report published in March 2019 and 2018 QPP performance data infographic published this January, CMS has not published any data to date (at the time of this report) that demonstrate whether the QPP is meeting its aims as envisioned by MACRA and Congress, such as improving the care and population health of Medicare beneficiaries, lowering Medicare costs, and minimizing burden on practicing physicians. Instead, what has been proven over the last two years is that the program disproportionately harms physicians in solo and small practices nationwide, as it is these physicians who suffer and get hit with the payment penalty the most and are funding MIPS bonuses for other practices under MACRA’s budget neutrality requirement. Considering that TMA survey data show that 73% of Texas physicians are in solo and small practices, this issue is of significant concern to TMA. In addition, maximum Medicare bonus payments of only 1.88% in 2019 and 1.68% in 2020 are not an appropriate return on investment for many physicians and do not sufficiently facilitate the transition to APMs and value-based care in general.

It is important to note that TMA supports voluntary participation in MIPS and APMs, advocates for fair and ethical program policies, and appropriate financial risk levels for advanced APMs. Given that an overwhelming majority of Texas physicians are required to participate in the program, TMA places a strong emphasis on weighing in annually on CMS’ QPP proposed rules in accordance with TMA Policies 265.017 Pay-for-Performance Principles and Guidelines, 195.038 Improving the QPP and Preserving Patient Access, 195.033 Medicare Payment Incentives and Penalties, 118.002 Health Information
Technology – Electronic Health Records and Personal Health Records, 115.015 Accountable Care Organizations, 195.032 Federal Physician Compare Website, TMA survey data, and adopted resolutions by the House of Delegates, such as Resolution 316-A-19 Determinants of Health. In response to CMS’ proposed rules for the 2020 QPP performance year, and as part of TMA’s ongoing advocacy and policy analysis, staff from the TMA MACRA Task Force, with input from the councils on Health Care Quality and Socioeconomics and ad hoc Committee on Health Information Technology, composed a 57-page TMA comment letter to recommend improvements to the policies governing the program this year. TMA also contributed to the 2020 QPP comment letters by the American Medical Association (AMA) and the Physicians Advocacy Institute to amplify the association’s recommendations.

The 2020 QPP final rule was published in November 2019 and although TMA’s 2020 QPP comment letter was effective for some policies, CMS finalized flawed methodologies, complex policies, and more rigorous data requirements against TMA recommendations resulting in significant concern to the association. In addition, many program and scoring policies continue to disadvantage physicians and favor certain practices by size, model type, setting, and capabilities in health information technology and data analytics. Certain policies also penalize physicians who disproportionately treat patients from disadvantaged populations or who are impacted by socioeconomic variables or social determinants of health. TMA remains concerned about data requirements for measures that are not meaningful to physicians, lack of appropriate risk adjustment for quality and cost measures, lack of accounting for social risk factors, annual changes to EHR requirements and system updates, MIPS budget neutrality requirement, and no-to-minimal return on investment to participation. In addition, the level of financial risk required to earn 5% bonus payments under the APM track is not appropriate for many practices, and the overall limited number of APMs available to physicians, including specialists, remains an issue and shortcoming of the QPP resulting in many practices having no choice but to remain in the MIPS track. Furthermore, performance scores are publicly reported on Medicare’s Physician Compare website. TMA asserts that scores derived from flawed data are very misleading to the public and harmful to physicians.

Overall, while some physicians experience “success” in the program, current QPP policies have the potential to tarnish physician reputations, undermine practice viability, risk physicians’ continued participation in Medicare, and threaten access to care for Medicare beneficiaries.

In 2021, CMS will shift physicians from MIPS to a new reporting structure called MIPS Value Pathways (MVPs) to facilitate the transition to APMs. CMS claims MVPs will reduce reporting burden and move away from siloed activities and measures toward an aligned set of measure options more relevant to a clinician’s scope of practice that is meaningful to patient care. However, TMA stated to CMS in its 2020 QPP comment letter that the association is not convinced the new structure is much different than the existing MIPS program, will likely not improve quality outcomes or reduce costs, and believes administrative and cost burdens have the potential to increase. For example, TMA anticipates changes to existing reporting methods, such as requiring physicians to submit data only through electronic means or registry vendors, and that system updates to accommodate the new MVP framework within electronic health records (EHRs) would involve costs that EHR and other health information technology vendors would likely pass on to physician practices. In addition, because MVPs would include predefined sets of clinical measures and improvement activities, physicians would lose the freedom to choose their own configuration of measures and activities. Such a proposed change would require physicians to have to pay to collect and submit data on measures and activities that may not have any value to their practices and patients and make QPP performance feedback meaningless. TMA’s 2020 QPP comment letter offered explicit guiding principles to define and develop MVPs and provided numerous comments and recommendations to help shape MVP policies the association believes would result in significant improvements to the program, increase physician engagement, and accelerate the movement to value-based care and APMs for physicians who wish to do so. In the 2020 QPP final rule, CMS reported it...
would work with the physician community to refine the new MVP framework and present more detailed MVP policy proposals during the next federal rulemaking cycle for the 2021 QPP performance year.

Council Action in Response to TMA President’s 2019 QPP Report

Separate from the federal rulemaking process, TMA President Report 2 Improving the QPP and Improving Patient Access was unanimously approved at the 2019 TMA House of Delegates and was referred to the Councils on Health Care Quality and Socioeconomics for action under the TMA Audit Trail Process. The report recommended that 1) TMA strongly advocate for Congress to make participation in MIPS and APMs under the QPP completely voluntary; 2) TMA strongly advocate for Congress to eliminate budget neutrality in MIPS and finance incentive payments with supplemental funds that do not come from Medicare Part B payment cuts to physicians and other clinicians; 3) TMA call on CMS to provide a transparent, accurate, and complete QPP Experience Report on an annual basis so the association can analyze the data to advocate for additional exemptions, flexibilities, and reductions in reporting burdens, administrative hassles, and costs; 4) TMA establish formal policy that the CMS increase the low-volume threshold for the 2020 QPP and future years of the program for all physicians but continue to offer them the opportunity to opt in or voluntarily report; 5) TMA establish formal policy that CMS preserve patient access by exempting small practices (1-15 clinicians) from required participation in MIPS but continue to offer them the opportunity to opt in or voluntarily report; and 6) the Texas Delegation to the AMA ask the AMA House of Delegates to adopt similar policy and calls to action.

In June 2019, the TMA Policy Compendium was updated with the adopted policy, and while TMA included comments about these policies in the association’s 2020 QPP comment letter, the majority of the recommendations were outside the scope of federal rulemaking as Congressional action would be required to make these technical changes in MACRA and the QPP. For this reason, the Texas Delegation submitted a resolution to the 2019 Annual Session of the TMA House of Delegates with the same recommendations. However, because two separate resolutions advocating for significant changes to the QPP were previously submitted by the Pennsylvania and Florida delegations and referred for study, TMA’s QPP resolution was referred for study as well. At the 2019 Interim Session in November, the AMA Board of Trustees presented a comprehensive report on the QPP but TMA found the report to be inadequate. With TMA leading the charge, the report was ultimately rejected by the AMA House of Delegates and referred back to the AMA Board of Trustees for further consideration, with new recommendations likely to come in June 2020. TMA will continue to advocate for real reforms, monitor and track QPP implementation, and will inform membership of the latest developments and ongoing advocacy through TMA communication channels.

QPP Education and Resources

Due to the complexity of the QPP along with annual changes that occur as a result of federal rulemaking, developing physician education and resources to help physicians learn about and stay abreast of program requirements remains a top priority of the council. Under the direction of the council, staff from the TMA MACRA Task Force will continue to participate in workgroups facilitated by the Physicians Advocacy Institute (PAI) to update and produce in-depth educational materials for the 2020 performance year that will help physicians and groups succeed in the QPP and avoid Medicare payment penalties. In addition, TMA continues to offer a comprehensive array of education and resources to help physicians learn about and navigate the QPP. All information is located on the TMA MACRA Resource Center, including:

- where to get MACRA CME at no cost, information about TMA’s MACRA readiness assessment and customized on-site assistance by TMA Practice Consulting, free access to a separate MACRA QPP Resource Center and physician education initiative located on the PAI website (created with input from TMA), free QPP education and technical assistance by the TMF Health Quality Institute (TMF), a list of MACRA resource centers by national specialty societies; a list of federally funded initiatives that offer
education and technical assistance to help physicians transition to MIPS or APMs at no or low cost, and
TMA PracticeEdge services for physician-led accountable care organizations and value-based
arrangements. Lastly, the council will continue to provide physician education on MACRA and the QPP
during its annual quality track at TexMed 2020 and offer CME credits at no cost to all attendees. All QPP
education offerings, clinical tools, resources, and technical assistance are routinely promoted via TMA
communication channels.

TMA Resolutions Referred to the Council

TMA resolutions 108-A-19, 213-A-19 and 316-A-19 were referred to the council for consideration and
action.

Resolution 108-A-19, Initial Assessment and Treatment Recommendation by Specialists, resolved that
TMA recognize that the best practice of patient care dictates that it is the responsibility of the physician to
develop the diagnosis and treatment in the evaluation of a patient, while it is recognized under limited
circumstances that an initial evaluation may be conducted by a nurse practitioner or physician assistant.
The resolution was "referred for study and report back". The council along with the Interspecialty Society
Committee reviewed and discussed the resolution at fall and winter conferences and the resolution was
referred for further study to the council and Interspecialty Society Committee with a report back at

Resolution 213-A-19, Complying with Value-Based Care Quality Measures for Medication Adherence,
resolved that TMA work with payers to identify standard methodologies that address quality measure
requirements for medication adherence in response to marketplace influences beyond the
physician/providers control. The council discussed the resolution and recommended advocacy letters.
TMA sent formal letters advocating for standard methodologies and improvements to value-based care
quality measures for medication adherence. Formal letters were addressed to the U.S. Department of
Health and Human Services, Centers for Medicare and Medicaid Services, Center for Medicare and
Medicaid Innovation, National Committee on Quality Assurance, Blue Cross Blue Shield of Texas,
United Healthcare, Aetna, Humana, and Cigna. TMA further urged all payers and organizations to adopt
formal policy that ensures the use of only those quality measures that physicians can reasonably influence
and control, and that accurately reflect the quality of care they provide to their patients.

Resolution 316-A-19, Determinants of Health, resolved that TMA: 1) Educate physicians about the social
determinants of health for the purpose of assisting physicians to better understand their impact on patient
health outcomes and wellbeing; 2) Educate state and federal policy makers, business leaders, and
governmental and commercial payers about the influence of social determinants of health on overall
health care quality and health care costs; 3) Collaborate with innovative public and private partnerships to
address social determinants of health and advocate for their adoption by state policy makers; and 4) Advocate that governmental and commercial payers modify existing performance and quality programs
reflect the higher expected health care utilization and cost of population at greater risk of exposure to
social determinants of health and appropriately risk adjust physician compensation to reflect these higher
costs.

The council and TMA has undertaken numerous initiatives related to Social Determinants of Health
(SDOH), including: 1) offered continuing medical education on SDOH at the general session at Fall
Conference 2019 to educate physicians on their impact on health outcomes; 2) partnered with The
Physicians Foundation and The Health Initiatives to conduct a study on SDOH; 3) advocated that CMS
adopt new policies to implement risk adjustment methodologies related to SDOH and account for social
risk factors in the QPP and Medicare payment; 4) advocated that Texas Medicaid pursue a federal waiver
to broadly implement SDOH initiatives within the Medicaid program, including payment for physicians
and health systems that implement strategies to address SDOH; 5) actively participated in an SDOH
Learning Collaborative convened by a large health foundation, Texas Medicaid, and Medicaid managed
care plans; and 6) met with commercial health plan representatives to discuss how plans use SDOH data
in their value-based payment initiatives. Additionally, TMA has testified before multiple state legislative
and interim hearings on the need to better address SDOHs as part of Texas’ efforts to improve health
outcomes while lowering health care costs. The council will include a presentation at the Quality Track at
TexMed 2020 to educate physicians about SDOH and offer free CME to attendees. Over the next year,
avovacy and education relating to SDOH will remain a high priority.

Subcommittee on Quality Programs and Clinical Measures
At winter conference 2019, the council formed the Subcommittee on Quality Programs and Clinical
Measures. The vision of the subcommittee is to establish TMA as a meaningful and influential player in
the value-based care delivery in Texas. Its goals are to 1) create stronger relationships with both the
employer community and the medical directors of health plans in Texas; 2) explore the health purchasing
goals of large Texas employers; 3) learn and educate physician members about existing quality programs
and value-based models used in health plans, Medicare and Medicaid; 4) distinguish between the types of
measures used to access healthcare quality and make recommendations based on measures that are most
important in improving health status; 5) evaluate and recommend opportunities to streamline and reduce
duplicative clinical measure sets; and 6) advocate for quality health care for all patients. This includes
attention to methodology of performance measurement programs.

Over the past year, the subcommittee held employer panel meetings on health care value-based
purchasing with the Teachers Retirement System of Texas, HEB and its Total Rewards and Magenta
Health, City of Plano, Catalyst Health Network, Southwest Benefits Association, Dallas-Fort Worth
Business Group on Health, and the Texas Business Group on Health. The purpose of the meetings was to
obtain employer insights on value-based purchasing, gain a deeper understanding of their expectations of
physicians and the type of data they seek, and how TMA can best collaborate with them to achieve the
shared goal of improving the health of all patients. In addition, to obtain input from the broader employer
community, the council collaborated with the Texas Business Group on Health to survey 320 employers
on value-based purchasing in Texas.

Lastly, the subcommittee met with administrators from UT Physicians in Houston to learn about their
experience and challenges with managing multiple quality measures across public and private payers and
the impact it has on their organization. Comments and insights received were highly informative and
helped to informed the subcommittee’s work to develop a solution to this issue. After exploring approaches
to standardizing measures, the subcommittee evaluated the Core Quality Measures Collaborative
(CQMC), met with a representative from America’s Health Insurance Plans (AHIP) about the
collaborative, and recommended that the council consider membership.

Core Quality Measures Collaborative
At the urging of the subcommittee the council evaluated the CQMC. The collaborative is a broad-based
coalition of health care organizations convened by AHIP. The membership includes CMS, National
Quality Forum (NQF), health insurance providers, national medical associations (e.g. AMA, AAFP, ACP,
etc.), consumer groups, purchasers and employer group representatives, and other quality collaboratives
to recommend core sets of measures by clinical area to assess the quality of American health care. CQMC
aims are to 1) identify high-value, high-impact, evidence-based measures that promote better patient
outcomes, and provide useful information for improvement, decision-making and payment; 2) align
measures across public and private payers to achieve congruence in the measures being used for quality
improvement, transparency, and payment purposes; and 3) reduce the burden of measurement by
eliminating low-value metrics, redundancies, and inconsistencies in measure specifications and quality measure reporting requirements across payers.

The CQMC began in 2015 and launched its first core quality measure sets in 2016. The association informed TMA members of the first-ever standardized quality measures sets across payers through an article in the April 2016 issue of Texas Medicine magazine. After four years, the CQMC is under new leadership by AHIP, CMS and NQF, and is in the process of reconvening workgroups for the next iteration of core quality measures sets for publication later this year. The council believes TMA’s presence in the collaborative will give the association a crucial seat at the table to select quality measures, align quality measures across payers, and reduce physician burden. At winter conference, the council sought approval for TMA to become a member organization of the CQMQ and the Board of Trustees approved it. At the time of this report, TMA was accepted and admitted into the CQMC as a nonvoting member, but will be able to participate in its workgroups that select measure sets for different specialties. Of note, TMA is the first state medical association to join the collaborative. Given that the AMA is a voting member, AHIP informed TMA state medical associations that join the collaborative are encouraged to provide feedback on voting to the AMA.

TMF Health Quality Institute

In 2019, the TMF Health Quality Institute was awarded a new five-year contract by CMS to serve as the state’s Quality Innovation Network-Quality Improvement Organization. Under this contract, TMF Networks provide Texas physicians no-cost technical assistance and education on quality improvement and patient safety topics through the following networks: nursing homes and skilled nursing facilities; community coalitions; patients, families and caregivers; quality improvement initiative; and Medicare’s QPP. Of note, TMF has a robust QPP network and works with physicians and clinicians to help them transition to MIPS and successfully advance through the program’s performance categories by providing technical assistance, education, outreach, and distribution of learning modules at no cost. At the council’s urging, TMA continues to collaborate with and promote services provided by TMF, connecting members to free assistance that helps them improve patient and quality outcomes, as well as navigate Medicare requirements to avoid payment penalties and maximize value-based payments.

CMS Qualified Entity “The Health of Texas”

In 2017, The University of Texas School of Public Health (UTSPH) in Houston was approved by CMS to establish a Qualified Entity (QE) to research claims data by Medicare and other payers to evaluate physician performance and regional variations in Texas. Cecilia Ganduglia-Cazaban, MD, DrPH, codirector of the UTSPH Center for Health Care Research Data and her staff routinely present at council meetings to update members on the QE’s research progress and to collect feedback. UTSPH is in the process of finalizing data for the new The Health of Texas website to make research data accessible to physicians and the public. TMA will inform membership of the new website through TMA communication channels. Council member Marina C. George, MD serves on the QE’s physician workgroup to provide physician input and guidance for the QE’s ongoing research and will keep the council apprised of QE updates and solicit physician feedback, as needed.

HHS Quality Summit and Health Quality Roadmap

At winter conference, TMA member Robert David Martinez, MD, Executive Vice President, Chief Medical Officer, and Chief Physician Executive of DHR Health System in Edinburg presented to the council about the U.S. Department of Health and Human Services Quality Summit and its ongoing work to develop a Health Quality Roadmap for the federal government. Dr. Martinez is one of 15 non-governmental health care industry leaders and the only participant from Texas who was chosen out of 300-plus applicants to serve on the Quality Summit to offer insights into the modernization of HHS’ quality programs. Council members were informed that HHS is working to align and improve reporting
on data and quality measures across Medicare, Medicaid, the Children’s Health Insurance Program, the
Health Insurance Marketplace, the Military Health System, and the Veteran’s Affairs Health System. The
council provided input and offered feedback and will track HHS’ quality activity and inform membership
of pertinent information, as needed.

TMA Value-Based Payment Initiatives Workgroup and Prior Authorization Task Force
Under the auspices of the TMA Board of Trustees, the workgroup on Value-Based Payment (VBP)
Initiatives and Physician-Led Community-Based Health Care Delivery Models was revived and a new
Prior Authorization Task Force was formed. The VBP workgroup comprises chairs or designees from
select TMA components, county medical society leadership, and physicians with expertise in physician
led ACO models. The revived workgroup will continue to survey Texas’ VBP landscape; refine proposed
Community-Based ACO principles to meet Texas’ diverse geographic and specialty needs; develop a
Community-Based-ACO concept paper for consideration by HHSC; recommend potential educational,
training, and technical assistance tools to help TMA members transition to and succeed in a VBP arena;
and identify potential VBP policy recommendations for consideration by the TMA House of Delegates.
Council chair Jeffrey B. Kahn, MD and council member Ajay K. Gupta, MD serve on the workgroup and
will keep the council apprised of their work and obtain input and feedback, as needed. The Prior
Authorization Task Force comprises chairs or designees from select TMA councils and interested county
medical societies to strategically prepare solutions for advocacy that address and mitigate the burden of
prior authorization. Council member Nishant B. Jalandhara, MD serves on the task force and will keep
the council apprised of their work and obtain input and feedback, as needed.

TMA Publications on Health Care Quality
Council members regularly contribute to articles published in Texas Medicine on health care quality and
value-based care, stemming from topics discussed at its meetings. During 2019-20, several council
members were interviewed for topics on Medicare’s MIPS facility-based measurement policies, QPP
experience report, unfair quality measures on medication adherence, and the QPP proposed and final
rules. Specific articles in Texas Medicine include: More Pain for Small Shops? 2020 Quality Program
Rule Could Mean More Penalties, Medicine to CMS: Medicare Report Inflates Success of Quality
Adherence, and An Unfair Game: Quality Payment Program Rules Still Stacked Against Physicians. In
addition, TMA routinely published article on the QPP in its Texas Medicine Today e-newsletter.

TexMed 2020 Quality Quick Tips and Quality Track
Through generous sponsorship from the TMF Health Quality Institute, the council will again host quality
activities at TexMed 2020 which include quality quick tips (mini presentations at the Physician Lounge)
and a four-hour quality track with CME credits at no cost to attendees. Dr. Kahn will chair the quality
track. Quality quick tips will provide a “best practices” exchange in the field of quality improvement. The
quality track will provide physicians with current information on changes in the health care landscape
nationally and in Texas. The program will begin with a presentation on improving health care quality
across the continuum of care and where physicians can get support and guidance. Additional speakers will
address social determinants of health and their implications on health outcomes, an initiative to align
quality measures across payers, Texas Medicaid and value-based care initiatives, value-based purchasing
by employers, and include practice strategies for successful participation in innovative health care
delivery models. In addition, through the TexMed 2020 meeting app, quality and practice management
resources will be available to provide physicians with information about education and clinical tools on
quality that they can use throughout the year to establish protocols and improve health care for their
patients.
At TexMed 2019, the House of Delegates amended Resolution 212-A-19, submitted by the Harris County Medical Society, and adopted it as follows:

RESOLVED, That the Texas Medical Association study ways to protect the relationship of physicians and their patients after inpatient hospital referrals and report back to the TMA House of Delegates at its annual 2020 meeting; and be it further

RESOLVED, that TMA study ways to improve the representation of all practice types of physicians through hospital medical staff bylaws to include the business associate agreement, if any.

The resolution was referred to the Council on Health Service Organizations.

The council is reaching out to the TMA ad hoc Committee on Physician Employment, the American Medical Association Organized Medical Staff Section, and legal counsel with expertise on hospital medical staff issues to determine what information and assistance are available on these topics. Additionally, possible legal and other solutions are being researched to (1) prevent interference with a patient-physician relationship, and (2) increase independent physician representation on hospital medical staff boards.

A report with the findings of the council’s study will be provided at TexMed 2021.
Update on CME Providers in TMA’s Intrastate Accreditation Program

In 2019, 12 organizations received accreditation decisions. Eleven were granted full accreditation (two earned six years’ accreditation with commendation). One organization was placed on probation with full accreditation contingent upon improvement as demonstrated in a follow-up progress report. Organizations receiving accreditation with commendation were Driscoll Health System, Corpus Christi; and Hendrick Health System, Abilene. TMA’s Subcommittee on Accreditation, a team of 12 physicians and CME professionals, conducted the surveys and submitted reports to the committee for accreditation decisions.

Cook Children’s Medical Center, Fort Worth, voluntarily withdrew CME accreditation from TMA. The organization was granted Joint Accreditation. Joint-accredited organizations are accredited by the Accreditation Council for Continuing Medical Education (ACCME). Joint Accreditation for Interprofessional Continuing Education offers organizations the opportunity to be simultaneously accredited to provide dentistry, medicine, nursing, optometry, pharmacy, physician assistant, psychology, and social work continuing education through a single, unified application process, fee structure, and set of accreditation standards.

TMA’s current roster of CME-accredited organizations includes 52 organizations. The breakdown for type of organization is as follows: 39 hospitals or hospital systems, one physician group, three state specialty societies, one state agency, two regional health education centers, one university student health center, one quality improvement organization, one hospice, one regional medical staff organization for emergency services, one county medical examiner’s office, and one regional advisory council in emergency preparedness.

Texas CME Professional Development Conference

TMA offers an annual two-day conference for physicians and staff who plan and implement continuing medical education activities. The conference provides updates on CME issues, trains CME providers to meet accreditation requirements, and provides networking opportunities for CME providers. The 2019 Texas CME Professional Development Conference was held June 19-21 at the Sheraton DFW Airport Hotel and was attended by 113 CME professionals. The first day of the conference focused on preparing CME professionals to align CME programs with Maintenance of Certification (MOC), to demonstrate outcomes by aligning CME activities to the Centers for Medicare & Medicaid Services Merit-Based Incentive Payment System and Texas Health and Human Services Commission Waiver Measures, to use education technology tools during CME activities that support adult learner needs, to use a variety of communication tools for improving collaboration and value-building with multiple stakeholders, and to improve CME operational efficiency through process mapping. New in 2019, the last day of the conference was focused on the participants’ continuing professional development (CPD). Participants created value statements to highlight the “why” behind the work they do, explored the competencies required for success in CME, and received resources to conduct a self-assessment and create a CPD plan.

The 2020 Texas CME Professional Development Conference is scheduled for June 17-19 at the Embassy Suites by Hilton San Antonio Landmark.
Accreditation Council for CME Opened Call for Comment About Proposed Standards for Integrity and Independence in Accredited Continuing Education

ACCME’s goal is to streamline, clarify, and modernize the standards, and to ensure their continued relevance and effectiveness in the changing health care environment. First adopted in 1992, the standards were last updated in 2004. Over the past 15 years, the standards have become a national and international model, adopted by accreditors across the health professions. ACCME Standards for Integrity and Independence in Accredited Continuing Education (renamed in the proposal from the Standards for Commercial Support: Standards to Ensure Independence in CME Activities) are designed to create a clear, unbridgeable separation between accredited education and industry marketing and to ensure that accredited CE serves the needs of patients and the public.

The proposed revisions are the result of a year-long, inclusive review. To oversee the review, ACCME convened the Task Force on Protecting the Integrity of Accredited Continuing Education, with members representing diverse perspectives, including accredited continuing education providers and the public. The task force and ACCME leadership engaged with stakeholders in a variety of forums to identify new and existing challenges related to managing the complex issues of disclosure, conflicts of interest, and commercial support in a rapidly evolving health care environment. The proposed, revised ACCME Standards for Integrity and Independence in Accredited Continuing Education are based on the feedback ACCME received from the continuing education stakeholder community.

ACCME invited stakeholders to submit comments about the proposed revisions from Jan. 7-Feb. 21, 2020. The ACCME Board of Directors will review the responses to the call for comment at its March 2020 meeting. After the board makes modifications and adopts the revised standards, ACCME will release a transition plan for the accredited continuing education community.

CME in Support of MOC

Collaborations are in place with the American Board of Anesthesiology, American Board of Internal Medicine, American Board of Ophthalmology, American Board of Otolaryngology – Head and Neck Surgery, American Board of Pathology, and American Board of Pediatrics. Additionally, an ACCME and American Board of Surgery (ABS) collaboration (announced in 2019) that will enable accredited CME providers to register activities for ABS Continuous Certification will launch in 2020. Accredited providers will be notified when the details of the collaboration are available.

In November 2019, ACCME and the Royal College of Physicians and Surgeons of Canada announced a new collaboration to expand opportunities for Royal College fellows to earn MOC Program Section 3 credits by participating in accredited CME activities that meet MOC requirements. Previously, the Royal College recognized accredited CME activities in the ACCME system as meeting the requirements for MOC Section 1 (Accredited Group Learning Activities). This new recognition will further expand choice and flexibility for Royal College fellows. Activities that are available Nov. 1, 2019, to June 30, 2022, are eligible. Royal College fellows will report their participation directly to the Royal College. CME providers will not need to report participant information.
The Committee on Child and Adolescent Health presents the following informational report regarding the committee’s recent activities.

During the fall committee meeting, the group agreed to explore the following items: childhood obesity, nutrition, and physical activity; physicians’ skills in assessment and counseling adolescents on sexual health; suicide in adolescent and young adult populations and resources to reduce risk and promote mental health; and use of e-cigarettes and vaping products by children, adolescents, and young adults. The committee intends to explore options to provide TMA members with essential information or continuing education opportunities related to these topics.

The committee completed sunset review of the following TMA policies:

- 55.002 Comprehensive School Health Education in All School Districts,
- 55.005 Human Sexuality and Family Life as Mandated Health Education Curriculum,
- 55.016 Sexuality Education,
- 55.019 School Health Education,
- 55.035 Right to Confidential Care,
- 55.018 Mass School Audiometric Screening,
- 135.017 ImmTrac,
- 260.064 Family Comes First, and
- 260.084 Fireworks Education.

The committee has been called on to discuss or respond by email to state and federal proposals or calls for comment on such topics as implementation of state legislation to address school safety, mental health services, revisions to state guidelines regarding curriculum on physical and health education, and School Health Advisory Committee roles and responsibilities.

The committee members have been a resource to the TMA Division of Communications in developing responses to media inquiries and in child health initiatives such as concussion awareness. The members promoted use of the *Me&My Doctor* blog, resulting in pieces addressing vaping, concussion, smartphone and social media use, adolescent well visits, heat safety, and physical exercise.

Several members explored the idea of a collaborative summit to address school health issues. Although the summit was not feasible, they remained committed to engaging with other health and educational organizations as health-related issues surface in Texas.
The Committee on Reproductive, Women’s, and Perinatal Health presents the following informational report regarding the committee’s recent activities.

During the fall committee meeting, the group reviewed proposed priorities and agreed to: (1) explore developments in research on placenta health, and (2) address effects of implicit bias on ethnic and racial disparities in maternal and infant health. The committee intends to explore continuing education opportunities related to these topics.

Based on latest information on congenital syphilis from the Texas Department of State Health Services, committee members identified a need to update TMA webpage information and inform members of recent legislative change to testing requirements for pregnant women. Immediately following the fall meeting, TMA members received an advisory notice in *Texas Medicine Today* based on the committee’s guidance, corresponding to updates to the TMA webpage.

The committee prompted efforts to share information regarding new testing for X-ALD and the associated billing process for the Texas Newborn Screening Program. The TMA Newborn Screening Resource Center was updated accordingly.

Committee members continue to participate in leadership roles in statewide advisory or collaborative efforts that address maternal mortality and morbidity, women’s health programs, newborn screening, and perinatal quality initiatives. Members and consultants are serving on the following groups: Texas Alliance for Innovation on Maternal Health, Texas Collaborative for Healthy Mothers and Babies, Texas Maternal Mortality and Morbidity Review Committee, Texas Newborn Screening Advisory Committee, and Texas Perinatal Advisory Council.

The committee has been called on to jointly discuss or respond by email to state and federal issues, including implementation of state legislation to address expanded postpartum care, newborn hearing screening, and maternal and neonatal levels of care designations. The committee members have been a resource to the TMA communications division in responses to media inquiries and women’s health initiatives in the news.
The Patient-Physician Advocacy Committee presents the following informational report regarding the committee’s recent activities.

**Amicus Curiae “Friend of the Court” Brief Vetting**
The committee reviewed and provided input on numerous amicus curiae (“friend of the court”) brief requests. These requests were received from physicians seeking TMA briefs in support of their lawsuits on a variety of topics, ranging from restrictive covenants to Texas Medical Board disciplinary actions. The committee provided recommendations to TMA’s Office of the General Counsel (OGC) for use in OGC recommendations to the chair of the TMA Board of Trustees.

**Texas Medical Board**
The committee invited Texas Medical Board (TMB) representatives to its meetings to learn more about its processes and procedures and to offer improvements. The committee met with the board’s executive director on various occasions to discuss a variety of concerns, ranging from recent legislation related to opioid prescriptions to the need for a TMB complaint form for lodging complaints against nonprofit health care corporations certified by TMB (formerly known as 5.01[a] corporations).

**State Office of Administrative Hearings Issues**
The committee discussed concerns related to challenges faced by physicians who are successful before the State Office of Administrative Hearings and received updates regarding one physician’s lawsuit on this topic. The committee reviewed draft bill language prepared by TMA staff to address concerns brought before the committee and recommended that the House of Delegates adopt new policy relating to overturning and vacating certain temporary suspensions or restrictions of an individual’s medical license by the Texas Medical Board.
The Texas Medical Association Insurance Trust (TMAIT) operates under the authority of an eight-member board: five trustees appointed by TMA and three trustees elected by trust subscribers. The five appointees include the executive vice president of TMA and a member of the TMA’s Young Physician Section. During 2019, the trustees met in person in January, May, and September in conjunction with TMA conferences and the House of Delegates meeting. The trustees also held an annual three-day planning session in July.

The Board of Trustees is assisted by the TMAIT Advisory Committee, composed of nine TMA physicians and a TMA Alliance member appointed by the trustees to review claims and underwriting decisions appealed by the membership. The advisory committee, which includes a variety of medical specialists, provides a member the opportunity for a panel of his or her peers to review insurance carrier decisions concerning underwriting and claim matters. The advisory committee is one of the principal strengths of TMAIT, as it gives each member a forum for further consideration of decisions that affect insurance coverage.

To expand the insurance market for the trust and our members, in 2000 TMAIT established its own insurance agency, TMAIT Financial Services, Inc., to assist those members who feel they need to shop for coverage. Through the agency, we are able to offer a TMA member any insurance plan available on the open market.

TMAIT maintains a 20-person staff at TMA’s Austin headquarters. TMAIT staff are involved in every phase of the program: marketing, enrollment, billing, and claims assistance. With direct access to all membership information, TMAIT staff can supply an immediate response to a member’s inquiry about insurance benefits. Staff are assisted by actuarial, legal, financial, tax, and technology advisors who offer advice on a broad range of technical issues. Staff serve as a liaison between the membership and the insurance carriers, and provide a member service that generally is not available to an individual purchasing coverage through the commercial insurance market.

The TMAIT association group life, business overhead, and long term disability (LTD) plans are underwritten by Prudential Insurance Company of America. The association group health insurance plans are underwritten by Blue Cross and Blue Shield of Texas. In addition to providing financial security, the insurers are important members of the TMAIT administrative team. Working in partnership with the trustees, the advisory committee, and TMAIT staff, the insurers provide TMAIT the high level of insurance expertise and administrative assistance required to operate a cost-effective, state-of-the-art insurance program. TMAIT staff communicate throughout each day with our insurance representatives; this close contact allows TMAIT to provide first-class service to its membership.

Through the combined resources of TMAIT and the agency, we are able to offer TMA members access to an extremely broad range of insurance products — from the cost-effective association group insurance plans offered through the trust to individual insurance products tailored to specific needs.

2019 Financial Results
Overall, the insurance program experienced a gain of about $2.7 million in 2019 compared with a gain of about $4.8 million in 2018. The results by plan, with comparative information for 2019, are presented below.
• The life insurance plan experienced a gain of about $2.7 million for 2019 compared with a gain of about $500,000 in 2018. There were 20 death claims in 2019 compared with 23 in 2018. The total payments in 2019 were $1.2 million compared with $4.6 million paid in 2018.

• The business overhead plan experienced a loss of about $325,000 during 2019 compared with a gain of about $675,000 during 2018.

  • The LTD plan experienced a small loss of $525,000 in 2019 compared with a $3.5 million gain in 2018. After three consecutive years in which only eight new claims were incurred, the LTD plan experienced a sharp increase with 16 new claims in 2019.

  • In 2019, the health plans produced a gain of about $900,000 compared with a loss of $250,000 in 2018. This represents the first year with a significant gain since 2008.

In years like 2019 when the experience is favorable, gains are credited to the trust’s Premium Stabilization Fund (PSF), providing added security and stability for the insurance program. At the close of the 2019 policy year (Oct. 31, 2019), the insurance program had a combined PSF balance of $78 million.

2019 Program Initiatives and Accomplishments

TMA Insurance Trust’s partnership with the TMA Education Center to fund no-cost or reduced cost access to TMA’s online CME courses has been a success for TMA members and TMA.

TMAIT launched a new website in August 2019. The new segment-based design encourages members to explore the site and broaden their perception of the value TMA Insurance Trust offers.

Beginning in August 2019, TMAIT offered a 25% “Thank You Credit” for TMA Member Long-Term Disability Insurance and TMA Member Business Overhead Expense plans. This credit is equal to a 25% discount on member insurance premiums.

TMAIT was recognized by the Professional Insurance and Marketing Association (PIMA) for excellence in marketing at the 2019 Marketing Methods Competition. PIMA convenes the leaders and leading companies in affinity benefits distribution and direct marketing. TMAIT was awarded the Gold Award for our 2018 Affordable Care Act (ACA) open enrollment marketing campaign.

2020 Initiatives

To increase engagement with residency programs in the state, TMAIT will pay for TMA and county medical society dues for resident physicians throughout Texas. As of March, TMAIT has paid for the resident dues for The University of Texas Medical Branch at Galveston, Houston Methodist, UT Southwestern Medical Center, The University of Texas Health Science Center at Tyler, and JPS-Fort Worth.

From Feb.1 through March 31, 2020, TMAIT offered $20,000 of guaranteed issue critical illness insurance.

The Affordable Care has prevented new enrollment in the association group health plans since Nov. 1, 2013. Fortunately, the ACA allowed us to “grandfather” coverage for members who began participation prior to that date. While operating on a closed group basis presents significant challenges, those plans remain financially viable and continue to provide the same quality coverage they have in the past. The association group health plans and the assistance we provide in securing coverage in the individual and small group markets have allowed our staff to maintain a high level of expertise in the health insurance business. This places TMAIT and the agency in a great position to respond to any changes that may arise from any changes to the ACA or expansion of association health plans.
Subject: Audit Trail of 2018 Financial Statements and 2019-20 Operating Budgets

Presented by: E. Linda Villarreal, MD, chair

Audit of 2018 Financial Statements

The Audit of 2018 Financial Statements report was presented to the TMA Board of Trustees at its Sept. 13, 2019, meeting. Independent auditor Holtzman Partners, LLP, determined the consolidated financial statements “present fairly, in all material respects, the consolidated financial position of the Texas Medical Association and the Texas Medical Association Board Administered Organizations . . . in accordance with accounting principles generally accepted in the United States of America.” Copies of the audit report are available in the association’s offices for review by any TMA member.

2019 Operating Budget

For 2019, operating income was $26,787,916 and operating expenses were $26,904,050. At year-end, total actual operating income for the year exceeded the budgeted operating income by $176,856 (0.66%). Total actual operating expenses were over budget by $207,990 (0.78%), resulting in an actual net operating deficit of $116,134. This actual net operating deficit was greater than the budgeted net operating deficit by $31,134. An unaudited report on 2019 operations is attached.

The Audit of 2019 Financial Statements report by Holtzman Partners, LLP, will be completed and presented to the Board of Trustees at its 2020 fall meeting. The board will present the audit reports to the House of Delegates in 2021.

2020 Operating Budget

In December 2019, the Board of Trustees approved a 2020 operating budget projecting an income of $27,073,000 and expenses of $27,073,000, with a 2020 capital expenditure budget of $620,000. The operating budget will be presented to the house by Board of Trustees Chair E. Linda Villarreal, MD. The board also approved direct financial support of related organizations in 2020 as follows: TEXPAC request for support totaling $390,000; TMA Alliance request for support totaling $268,000; TMA Foundation request for support totaling $115,000; and Association Management Services request for support totaling $1,155,000. Offsetting these expenses are projected 2020 Association Management Services fees totaling $1,172,250; corporate contributions of $71,000 to TEXPAC; and $15,000 in grant revenue received for TMA Foundation programming.

The 2020 expense budget of $27,073,000 represents an increase of $376,000 from the final 2019 expense budget of $26,697,000. Supporting this expense budget is a projected income budget of $27,073,000. This represents an increase of $461,000 from the final 2019 income budget of $26,612,000. As a result, a break-even budget is projected for 2020.

The 2020 budgeting process included a review of all programmatic activities. TMA’s relevance and value to its members were used as benchmarks for evaluating programs and determining which areas to expand or reduce. As containing expenses for approved programs becomes increasingly difficult, programmatic growth must be restrained or new sources of income identified. The 2020 Operating Budget adopted by the board is attached.
Texas Medical Association  
Statement of Income and Expense by Program  
For the Year Ending December 31, 2019  

<table>
<thead>
<tr>
<th>Income</th>
<th>Total Income</th>
<th>Contingency Fund Income</th>
<th>Building Fund Income</th>
<th>Actual Income</th>
<th>Budgeted Income</th>
<th>Variance</th>
<th>Variance %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Membership Recruitment &amp; Retention</td>
<td>$18,902,923</td>
<td>$18,902,923</td>
<td>$16,800,000</td>
<td>$102,923</td>
<td>$16,800,000</td>
<td>0.61%</td>
<td></td>
</tr>
<tr>
<td>Royalty Income</td>
<td>2,217,822</td>
<td>2,184,750</td>
<td></td>
<td>32,872</td>
<td></td>
<td>1.50%</td>
<td></td>
</tr>
<tr>
<td>Rental Income</td>
<td>1,736,014</td>
<td>1,642,690</td>
<td></td>
<td>63,054</td>
<td></td>
<td>3.84%</td>
<td></td>
</tr>
<tr>
<td>Organizational Support Activities</td>
<td>1,253,363</td>
<td>1,119,180</td>
<td></td>
<td>134,183</td>
<td></td>
<td>11.99%</td>
<td></td>
</tr>
<tr>
<td>Related Organizations</td>
<td>1,203,388</td>
<td>1,237,250</td>
<td></td>
<td>(33,862)</td>
<td></td>
<td>(2.74%)</td>
<td></td>
</tr>
<tr>
<td>Communications</td>
<td>682,186</td>
<td>832,050</td>
<td></td>
<td>60,136</td>
<td></td>
<td>7.23%</td>
<td></td>
</tr>
<tr>
<td>Marketing and Member Services</td>
<td>643,970</td>
<td>1,016,470</td>
<td></td>
<td>373,391</td>
<td></td>
<td>(56.7%)</td>
<td></td>
</tr>
<tr>
<td>Investment Income</td>
<td>768,754</td>
<td>359,986</td>
<td></td>
<td>1,063,039</td>
<td></td>
<td>38.06%</td>
<td></td>
</tr>
<tr>
<td>TexMed and Conferences</td>
<td>497,538</td>
<td>421,000</td>
<td></td>
<td>76,538</td>
<td></td>
<td>18.18%</td>
<td></td>
</tr>
<tr>
<td>Educational Programs</td>
<td>406,655</td>
<td>579,400</td>
<td></td>
<td>(172,745)</td>
<td></td>
<td>(29.81%)</td>
<td></td>
</tr>
<tr>
<td>Medical Education</td>
<td>178,775</td>
<td>201,500</td>
<td></td>
<td>22,725</td>
<td></td>
<td>(11.28%)</td>
<td></td>
</tr>
<tr>
<td>Advocacy and Public Policy</td>
<td>117,695</td>
<td>60,000</td>
<td></td>
<td>57,695</td>
<td></td>
<td>49.16%</td>
<td></td>
</tr>
<tr>
<td>Public Health - Quality - Science</td>
<td>84,750</td>
<td>79,500</td>
<td></td>
<td>5,250</td>
<td></td>
<td>6.26%</td>
<td></td>
</tr>
<tr>
<td>Information Systems</td>
<td>23,192</td>
<td>19,000</td>
<td></td>
<td>4,192</td>
<td></td>
<td>22.06%</td>
<td></td>
</tr>
<tr>
<td>Legal</td>
<td>17,964</td>
<td>29,000</td>
<td></td>
<td>(11,036)</td>
<td></td>
<td>(38.06%)</td>
<td></td>
</tr>
<tr>
<td>Boards, Councils, Committees</td>
<td>9,625</td>
<td>0</td>
<td></td>
<td>9,625</td>
<td></td>
<td>100.00%</td>
<td></td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td><strong>$26,954,534</strong></td>
<td><strong>$-</strong></td>
<td><strong>$166,188</strong></td>
<td><strong>$26,878,916</strong></td>
<td><strong>$26,611,060</strong></td>
<td><strong>$176,856</strong></td>
<td><strong>0.66%</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expense</th>
<th>Total Expense</th>
<th>Contingency Fund Expense</th>
<th>Building Fund Expense</th>
<th>Actual Expense</th>
<th>Budgeted Expense</th>
<th>Variance</th>
<th>Variance %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organizational Support Activities</td>
<td>4,804,971</td>
<td>359,986</td>
<td></td>
<td>4,444,983</td>
<td>4,337,160</td>
<td>207,823</td>
<td>4.79%</td>
</tr>
<tr>
<td>Communications</td>
<td>2,998,416</td>
<td>2,998,416</td>
<td></td>
<td>3,016,290</td>
<td>(17,874)</td>
<td>(0.59%)</td>
<td></td>
</tr>
<tr>
<td>Advocacy and Public Policy</td>
<td>2,592,873</td>
<td>2,376,870</td>
<td></td>
<td>216,003</td>
<td></td>
<td>9.09%</td>
<td></td>
</tr>
<tr>
<td>Membership Recruitment &amp; Retention</td>
<td>2,381,138</td>
<td>2,375,880</td>
<td></td>
<td>5,258</td>
<td></td>
<td>0.22%</td>
<td></td>
</tr>
<tr>
<td>Building Operations</td>
<td>2,372,542</td>
<td>2,278,940</td>
<td></td>
<td>93,602</td>
<td></td>
<td>4.11%</td>
<td></td>
</tr>
<tr>
<td>Information Systems</td>
<td>1,887,285</td>
<td>1,790,690</td>
<td></td>
<td>96,395</td>
<td></td>
<td>5.38%</td>
<td></td>
</tr>
<tr>
<td>Related Organizations</td>
<td>1,874,781</td>
<td>1,842,570</td>
<td></td>
<td>32,211</td>
<td></td>
<td>1.75%</td>
<td></td>
</tr>
<tr>
<td>TexMed and Conferences</td>
<td>1,594,609</td>
<td>1,492,850</td>
<td></td>
<td>101,659</td>
<td></td>
<td>6.81%</td>
<td></td>
</tr>
<tr>
<td>Legal</td>
<td>1,389,084</td>
<td>1,386,480</td>
<td></td>
<td>2,604</td>
<td></td>
<td>0.19%</td>
<td></td>
</tr>
<tr>
<td>Depreciation</td>
<td>1,196,359</td>
<td>1,196,359</td>
<td></td>
<td>0.03%</td>
<td></td>
<td>0.03%</td>
<td></td>
</tr>
<tr>
<td>Public Health - Quality - Science</td>
<td>1,077,069</td>
<td>1,114,360</td>
<td></td>
<td>(37,291)</td>
<td></td>
<td>(3.35%)</td>
<td></td>
</tr>
<tr>
<td>Health Policy - Regulation</td>
<td>994,526</td>
<td>1,055,280</td>
<td></td>
<td>(60,754)</td>
<td></td>
<td>(5.76%)</td>
<td></td>
</tr>
<tr>
<td>Marketing and Member Services</td>
<td>818,863</td>
<td>909,460</td>
<td></td>
<td>(90,597)</td>
<td></td>
<td>(9.96%)</td>
<td></td>
</tr>
<tr>
<td>Medical Education</td>
<td>501,761</td>
<td>492,390</td>
<td></td>
<td>9,371</td>
<td></td>
<td>1.90%</td>
<td></td>
</tr>
<tr>
<td>Boards, Councils, Committees</td>
<td>453,482</td>
<td>522,390</td>
<td></td>
<td>(68,908)</td>
<td></td>
<td>(13.19%)</td>
<td></td>
</tr>
<tr>
<td>Educational Programs</td>
<td>228,279</td>
<td>508,150</td>
<td></td>
<td>(281,871)</td>
<td></td>
<td>(55.47%)</td>
<td></td>
</tr>
<tr>
<td><strong>Total Expense</strong></td>
<td><strong>$27,264,038</strong></td>
<td><strong>$359,986</strong></td>
<td><strong>$-</strong></td>
<td><strong>$26,904,050</strong></td>
<td><strong>$26,696,060</strong></td>
<td><strong>$207,990</strong></td>
<td><strong>0.78%</strong></td>
</tr>
</tbody>
</table>

| Net Income (Loss)                            | ($309,504)    | ($359,986)               | ($166,188)           | ($116,134)    | ($85,000)      | ($31,134) |                 |
| Realized Investment Gain (Loss)              | 1,823,888     | 174,274                  | 1,649,414            | 1,450,414     |                 | 97.66%   |
| Unrealized Gain (Loss) on Investments        | 2,627,214     | 672,798                  | 1,954,416            | (5,294)       |                 | (0.32%)  |
| Other Gain (Loss)                            | (5,294)       | (5,294)                  | (5,294)              |                 |                 |          |
| **Net Balance**                              | **$4,136,104** | **$359,986**             | **$1,013,690**       | **$3,482,402** |                 |          |
# Texas Medical Association
## 2020 Operating Budget

<table>
<thead>
<tr>
<th></th>
<th>2020 Budget</th>
<th>2019 Budget</th>
<th>Change</th>
<th>% of Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Membership Recruitment and Retention</td>
<td>$16,747,000</td>
<td>$16,823,000</td>
<td>($76,000)</td>
<td>(0.5%) 61.9%</td>
</tr>
<tr>
<td>Insurance Royalty Income</td>
<td>2,237,000</td>
<td>2,185,000</td>
<td>$52,000</td>
<td>2.4% 8.3%</td>
</tr>
<tr>
<td>Building Operations</td>
<td>1,732,000</td>
<td>1,643,000</td>
<td>$89,000</td>
<td>5.4% 6.4%</td>
</tr>
<tr>
<td>Related Organization Support</td>
<td>1,187,000</td>
<td>1,187,000</td>
<td>$0</td>
<td>0.0% 4.4%</td>
</tr>
<tr>
<td>Marketing and Member Services</td>
<td>1,129,000</td>
<td>1,244,000</td>
<td>($165,000)</td>
<td>(12.8%) 4.2%</td>
</tr>
<tr>
<td>Communications</td>
<td>925,000</td>
<td>857,000</td>
<td>$68,000</td>
<td>7.9% 3.4%</td>
</tr>
<tr>
<td>Organization and Support Activities</td>
<td>819,000</td>
<td>601,000</td>
<td>$218,000</td>
<td>36.3% 3.0%</td>
</tr>
<tr>
<td>Investment Income</td>
<td>665,000</td>
<td>369,000</td>
<td>$276,000</td>
<td>71.0% 2.5%</td>
</tr>
<tr>
<td>Education Center</td>
<td>444,000</td>
<td>579,000</td>
<td>($135,000)</td>
<td>(23.3%) 1.6%</td>
</tr>
<tr>
<td>Conferences</td>
<td>416,000</td>
<td>416,000</td>
<td>$0</td>
<td>0.0% 1.5%</td>
</tr>
<tr>
<td>Information Technology</td>
<td>254,000</td>
<td>229,000</td>
<td>$25,000</td>
<td>10.9% 0.9%</td>
</tr>
<tr>
<td>Continuing Medical Education</td>
<td>202,000</td>
<td>202,000</td>
<td>$0</td>
<td>0.0% 0.7%</td>
</tr>
<tr>
<td>Governance</td>
<td>151,000</td>
<td>68,000</td>
<td>$83,000</td>
<td>122.1% 0.6%</td>
</tr>
<tr>
<td>Advocacy and Public Policy</td>
<td>138,000</td>
<td>110,000</td>
<td>$28,000</td>
<td>25.5% 0.5%</td>
</tr>
<tr>
<td>Legal</td>
<td>27,000</td>
<td>29,000</td>
<td>($2,000)</td>
<td>(6.9%) 0.1%</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td>$27,073,000</td>
<td>$26,612,000</td>
<td>$461,000</td>
<td>1.7%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Expense</strong></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Organization and Support Activities</td>
<td>$3,520,000</td>
<td>$3,621,000</td>
<td>($101,000)</td>
<td>(2.8%) 13.0%</td>
</tr>
<tr>
<td>Communications</td>
<td>3,278,000</td>
<td>3,203,000</td>
<td>75,000</td>
<td>2.3% 12.1%</td>
</tr>
<tr>
<td>Advocacy and Public Policy</td>
<td>2,744,000</td>
<td>2,699,000</td>
<td>45,000</td>
<td>1.7% 10.1%</td>
</tr>
<tr>
<td>Building Operations</td>
<td>2,380,000</td>
<td>2,279,000</td>
<td>101,000</td>
<td>4.4% 8.8%</td>
</tr>
<tr>
<td>Information Technology</td>
<td>1,898,000</td>
<td>1,823,000</td>
<td>75,000</td>
<td>4.1% 7.0%</td>
</tr>
<tr>
<td>Membership Recruitment and Retention</td>
<td>1,782,000</td>
<td>1,814,000</td>
<td>($32,000)</td>
<td>(1.8%) 6.6%</td>
</tr>
<tr>
<td>Related Organization Administration</td>
<td>1,741,000</td>
<td>1,674,000</td>
<td>67,000</td>
<td>4.0% 6.4%</td>
</tr>
<tr>
<td>Marketing and Member Services</td>
<td>1,682,000</td>
<td>1,725,000</td>
<td>($43,000)</td>
<td>(2.5%) 6.2%</td>
</tr>
<tr>
<td>Governance</td>
<td>1,535,000</td>
<td>1,295,000</td>
<td>240,000</td>
<td>18.5% 5.7%</td>
</tr>
<tr>
<td>Legal</td>
<td>1,483,000</td>
<td>1,413,000</td>
<td>50,000</td>
<td>3.5% 5.4%</td>
</tr>
<tr>
<td>Public Health - Quality - Science</td>
<td>1,198,000</td>
<td>1,192,000</td>
<td>6,000</td>
<td>0.5% 4.4%</td>
</tr>
<tr>
<td>Health Policy - Regulation</td>
<td>1,161,000</td>
<td>1,052,000</td>
<td>109,000</td>
<td>10.4% 4.3%</td>
</tr>
<tr>
<td>Conferences</td>
<td>894,000</td>
<td>867,000</td>
<td>27,000</td>
<td>3.1% 3.3%</td>
</tr>
<tr>
<td>Continuing Medical Education</td>
<td>343,000</td>
<td>336,000</td>
<td>7,000</td>
<td>2.1% 1.3%</td>
</tr>
<tr>
<td>Education Center</td>
<td>228,000</td>
<td>508,000</td>
<td>($279,000)</td>
<td>(54.9%) 0.8%</td>
</tr>
<tr>
<td>Non-Cash Depreciation Expense</td>
<td>1,225,000</td>
<td>1,196,000</td>
<td>29,000</td>
<td>2.4% 4.6%</td>
</tr>
<tr>
<td><strong>Total Expense</strong></td>
<td>$27,073,000</td>
<td>$26,697,000</td>
<td>$376,000</td>
<td>1.4%</td>
</tr>
</tbody>
</table>

| **Net Budget Surplus** | $0 | $ (85,000) | $ 85,000 |
REPORT OF BOARD OF TRUSTEES

BOT Report 15 2020

Subject: Investments

Presented by: E. Linda Villarreal, MD, chair

The Texas Medical Association and Separate Fund Investments

Members of the TMA Board of Trustees also serve as trustees or as the board of trustees for two library funds, two student loan funds, one student and resident loan fund, the Physicians Benevolent Fund, and the TMA Special Funds Foundation. The investment portfolios for TMA, and for the funds for which members of the TMA Board of Trustees serve as trustees or as the board of trustees, are invested by the Board of Trustees by way of designated investment managers. The board acts on recommendations of its Investments Committee, which meets three times a year. The committee and the board review quarterly reports from TMA’s investments monitor, The Quantitative Group at Graystone Consulting. The Quantitative Group is the investment monitor for TMA funds and all funds managed by TMA. The committee and the board review quarterly composite reports prepared by The Quantitative Group and presented by W. Joseph Sammons, The Quantitative Group Senior Vice President, and Ronald Kern, The Quantitative Group Executive Director. The board establishes investment performance objectives for the investment portfolios of TMA and seven separate funds and sets policy for the mix of investment media (equities, fixed income, alternative mutual funds, and cash equivalents).

The Dec. 31, 2019, net assets of the funds managed by these investment managers were reported as follows: TMA, $34,409,614; Texas Medical Association Library, $2,866,544; Annie Lee Thompson Library Trust Fund, $3,829,014; May Owen Irrevocable Trust, $3,158,846; Dr. S. E. Thompson Scholarship Fund, $6,230,375; Physicians Benevolent Fund, $4,803,760; and Texas Medical Association Special Funds Foundation, $2,871,091.

Dec. 31, 2019 Investment Manager Performance Report

Since Dec. 31, 1993, the composite annualized performance for all equity investments has been 8.74% versus the equity composite index annualized rate of return of 9.37%. The one-year rate of return was 27.87% versus the equity composite index return of 29.31%. Equity investment allocation by manager is approximately 30% at Luther King Capital Management, 65% at iShares blended mutual funds, 3% in Dodge & Cox International Stock Fund, and 2% in the Invesco Developing Markets mutual fund.

The composite annualized performance for all fixed income investments has been 5.28% versus the Barclays Aggregate annualized return of 5.46% for the period of June 30, 1992 through Dec. 31, 2019. The one-year rate of return was 6.64% versus the index return of 8.72%. Fixed income investment allocation by manager is approximately 50% at Vaughn Nelson, 21% in the Metropolitan West Intermediate Bond Fund, 15% in the JP Morgan Strategic Income Bond Fund, and 14% in the FPA New Income Bond Fund.

Alternative mutual fund investments have experienced an annualized return of 7.04% versus the HFRI Fund of Funds Composite Index annualized return of 7.35% for the three-year period through Dec. 31, 2019. The one-year rate of return was 20.02% versus the benchmark return of 7.77%. Alternatives investment allocation by manager is 100% in the FPA Crescent Fund.
REPORT OF BOARD OF TRUSTEES

BOT Report 16 2020

Subject: TMA Disaster Board of Trustees Actions on Behalf of TMA House of Delegates

Presented by: Gary W. Floyd, MD, Chair

The TMA Board of Trustees declared March 29, 2020, that a national disaster, the COVID-19 pandemic, was occurring and called itself into session as a disaster board according to the TMA Bylaws 4.202:

4.202 Function as disaster board. In the event a catastrophe of national proportions such as war prevents the House of Delegates from acting, the Board of Trustees shall have the authority to receive and act on the reports of officers, boards, councils, and committees; to legislate; to elect and install officers; and to approve the president-elect’s nominees for council positions in accordance with regulations applying to the House of Delegates. In case of national catastrophe, the Board of Trustees shall be considered a disaster board and shall be called into session.

The disaster board voted on April 5 to cancel TexMed 2020 and suspend the TMA House of Delegates annual meeting, either virtual or in person, until an appropriate time when the COVID-19 crisis has subsided enough that the house is able to discharge its duties.

During this time, the disaster board took several actions on behalf of the house. This report is a summary of those actions.

Election of Uncontested Candidates

On May 2, the disaster board met in person and through teleconference to transition TMA leadership and allow the organization to move forward appropriately and deliberately. After confirming with the caucus chairs that there were no more candidates for uncontested races, the board voted to elect by acclamation uncontested positions, including TMA president-elect, secretary/treasurer, speaker, vice speaker, board of councilors, and Texas delegates to the American Medical Association. At this time, the board also confirmed the nominations of new council members.

Virtual TMA House of Delegates Meeting and Virtual Elections of Contested Candidates

TMA speakers and staff met regularly to consider and prepare for a 2020 meeting of the house using electronic virtual programs. TMA staff developed a robust, secure system to allow electronic, remote elections by credentialed delegates. Further, TMA staff explored options to allow an electronic virtual House of Delegates meeting to conduct limited essential business. On June 28, the disaster board, acting on behalf of the TMA House of Delegates, approved conducting a limited 2020 House of Delegates meeting using virtual meeting technology to allow delegates remote access for contested elections and action on essential house business. The board also closed nominations on contested elected positions.

Adoption of House Standing Rules and Creation of Formal House Advisory Body

Speaker Report 2 2020, House Standing Rules, previously submitted for the planned House of Delegates meeting in May 2020, creates basic standing rules as authorized in the TMA Bylaws 3.73.

3.73 Standing Rules. The House of Delegates shall have the authority to establish standing rules. The house shall be guided in its actions by its standing rules and this Constitution and Bylaws. In all instances not covered by this Constitution and Bylaws or its own standing rules, the American Institute of Parliamentarians Standard Code of Parliamentary Procedure shall govern.
Included in the standing rules in Speaker Report 2 2020 is the allowance for written testimony on business items for reference committee consideration. Accepting written testimony for a virtual house meeting would allow more TMA members to take part in the policymaking process by giving them the ability to submit testimony on their own time. In addition, Speaker Report 2 authorizes a House of Delegates advisory body, composed of caucus and section chairs, to support house efforts and provide guidance for planning a virtual meeting. At the June 28 meeting, the board approved the adoption of Speaker Report 2 2020.

House Standing Rules – Special Circumstances
Since a virtual TMA House of Delegates meeting had not occurred previously, the technology, rules, and bylaws to support this type of meeting had not been defined. Therefore, on June 28 the disaster board authorized and adopted the speakers’ right to create House Standing Rules – Special Circumstances, to be developed in conjunction with the House of Delegates advisory body for the 2020 House of Delegates meeting.

Limited Essential House Business
Due to the constraints of a virtual meeting and the complex requirements for parliamentary consideration of business, the speakers recommended limiting 2020 House of Delegates business to essential or consent items, based upon criteria developed in conjunction with the House of Delegates advisory body. The speakers recommended that informational reports and reports considered by the speakers and advisory body as uncontroversial be placed on the reference committee agenda for consideration, and resolutions be tabled to the 2021 house meeting. On June 28, the disaster board approved limiting 2020 house business to essential or consent items based upon these criteria.

First Approval of TMA Constitutional Amendments
Amending TMA’s Constitution is a two-year process, requiring approval of the amendment at two sequential annual sessions. At the first session, the amendment must be approved by a majority vote. At the second session, the approval must be by two-thirds vote, and the amendment must have been published in Texas Medicine and mailed to each House of Delegates member and county society prior to the annual meeting, according to Article XIII of the TMA Constitution:

Article XIII. Amendments. The House of Delegates may amend this Constitution by a two-thirds affirmative vote of its members present and voting at any annual session, provided that the proposed amendment shall (1) have received majority approval at the preceding annual session, (2) have been published in Texas Medicine, and (3) have been sent officially to each member of the House of Delegates and each component county society at least two months before the meeting at which final action is to be taken.

TMA’s 2020 annual session would have addressed two reports relating to constitutional amendments for three TMA member organizations: The Women Physicians Section, at-large members, and the proposed LGBTQ Health Section:

- Council on Constitution and Bylaws Report 1 2020, Amendments to the Constitution, Article V. House of Delegates: recommending amendment of the TMA Constitution to include House of Delegates representation for the Women Physicians Section and the at-large members.

- Council on Constitution and Bylaws Report 3 2020, Amendments to Bylaws and Constitution Establishing an LGBTQ Health Section: recommending (1) amendment of the TMA Bylaws to establish an LGBTQ Health Section, and (2) amendment of the TMA Constitution to include section representation in the House of Delegates.

On May 17, the disaster board, acting in lieu of the delayed House of Delegates, approved the constitutional amendments recommended by the Council on Constitution and Bylaws. This initiated the two-year process to amend the TMA Constitution, which would require a second round of approvals at the 2021 Annual Session. The disaster board took this action so as not to delay the proposed amendments until 2022, acknowledging that final approval of these amendments still rests with the full House of Delegates.
AGENDA
FINANCIAL AND ORGANIZATIONAL AFFAIRS BUSINESS
To provide testimony click HERE
Click on the agenda item to navigate to it

1. Board of Trustees Report 9 – Online Communications Policy for TMA Physician Leaders
2. Interspecialty Society Committee Report 1 – Sunset Policy Review
3. Board of Councilors Report 2 – Emeritus Nominations
4. Board of Councilors Report 3 – Honorary Nominations
6. Women in Medicine Section Report 1 – Women in Medicine Operating Procedures Changes
9. Council on Constitution and Bylaws Report 2 – Amendments to Bylaws Regarding Inactive and Small County Medical Societies
10. Council on Constitution and Bylaws Report 3 – Amendment to Bylaws and Constitution Establishing an LGBTQ Health Section
11. Council on Constitution and Bylaws Report 4 – Amendments to Bylaws Governing Sections
12. Council on Constitution and Bylaws Report 5 – Amendment to Bylaws Expanding Committee on Membership Section Representation

Agenda Items Tabled to 2021
The following items of business are tabled to the 2021 HOD meeting. However, one may make two motions: ‘Referral to the BOT for Action and report back’ (allowing TMA BOT to adopt policy and address the item and report back to the TMA 2021 HOD) or ‘Referral to the BOT and report back’ (allowing the BOT to consider the item and report back to the TMA 2021 HOD. Your Speakers strongly encourage the use of referral (of tabled items) be limited to urgent and essential items.

15. Board of Trustees Report 12 – Physicians in Employed Settings
17. Council on Constitution and Bylaws Report 1 – Amendments to Constitution, Article V. House of Delegates

18. Committee on Membership Report 2 – New Telemedicine TMA Dues Category


20. Resolution 102 – Expansion of TMA Ambassador Program


22. Resolution 104 – The Term Physician Should Be Used Rather Than Provider

23. Resolution 105 – Supporting Proportionate Representation of Special Interest Groups

24. Resolution 106 – Physician and Medical Student Promotion in Exchange for Gifts on Social Media

25. Resolution 107 – Educating Physicians on the Rights of Immigrant Patients

26. Resolution 108 – For the Creation of a Physician-Led Public Outreach and Education Organization to Defend the Integrity of the Medical Profession and Advocate for Sustainable, Evidence-Based Healthcare Policy
At the 2019 TMA Winter Conference, the Board of Trustees directed TMA staff to draft a policy statement for the board to consider regarding social media for TMA leaders. At the TMA 2019 Fall Conference, the board approved the Online Communications Policy for Texas Medical Association Physician Leaders. This proposed policy was developed by the Office of General Counsel with input from the TMA Human Resources and TMA Communications divisions. Since the policy applies to all TMA physician leaders, the board agreed the policy should be adopted by the full TMA House of Delegates.

**Recommendation:** Adopt the following Online Communications Policy for Texas Medical Association Physician Leaders:

This policy provides guidance for the Board of Trustees, Board of Councilors, and all Texas Medical Association council and committee members (“TMA physician leaders”) when participating in online communications. Online communications should be broadly understood for purposes of this policy to include personal blogs, wikis, Twitter, microblogs, message boards, chat rooms, electronic newsletters, online forums, social networking sites, medical practice websites, texts, and any other forms of online communications.

**Be Conscious of Public Image**

- TMA physician leaders should be aware of the effect their actions may have on their image, as well as the image of TMA and Texas physicians in general. Remember, the information posted or published on online communications may be public information and remains there indefinitely.
- TMA physician leaders who create or maintain their own online communications, including their medical practice websites, that reference their leadership role with TMA should include clear disclaimers that the views expressed by the author on his or her social media site or medical practice website are those of the author’s.
- Sometimes social media content generates press and media attention or legal questions involving TMA. TMA physician leaders should refer these inquires to the TMA Division of Communications.

**Uphold Confidentiality**

TMA physician leaders should not publish, post, or release any TMA information that is considered confidential or not public, such as sensitive company information. Divulging information about TMA’s internal operations and legal matters is prohibited. For additional information, please consult TMA’s confidentiality and disclosure policies before publishing information related to TMA online. If there are questions on what is considered confidential, please check with the TMA vice president and general counsel.
Be Respectful of Others

- TMA physician leaders should be aware that their conduct in online communications may be observed by other Texas physicians, TMA employees, and third parties. TMA physician leaders should use their best judgment and refrain from posting material that is inappropriate or harmful to TMA, TMA’s employees, and TMA’s vendors or suppliers.
- Although not an exclusive list, disrespectful conduct includes posting commentary, content, or images on social media that are defamatory, pornographic, proprietary, harassing, lewd, or libelous, or that create a hostile work environment.
- Any TMA physician leader who personally experiences or witnesses abuse of online communications under this policy should report the situation to TMA’s executive vice president immediately. Pursuant to TMA’s policy, TMA prohibits any form of retaliation for reporting abuse of online communications under this policy.
The Texas Medical Association periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness.

The Inter-Specialty Society Committee recommends amending the following policy:

**107.016 Public Recognition of Board Certification by Texas Medical Board**: The Texas Medical Association recognizes that the American Board of Medical Specialties (ABMS), American Osteopathic Association Bureau of Osteopathic Specialists (AOABS), American Board of Oral Maxillofacial Surgery (ABOMS), and non-ABMS/AOABS/ABOMS boards with equivalent standards and training, are the standard in specialty board certification for the specialties they encompass and actively oppose all efforts of any alternate certifying organizations in the State of Texas, or before the TMB, in current and proposed policies to recognize its members as “board certified” without the equivalent certification and training standards (Res. 304-A-10).

**Recommendation**: Amend.
REPORT OF BOARD OF COUNCILORS

Subject: Emeritus Nominations

Presented by: Steven M. Petak, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

The House of Delegates, upon nomination by the county medical society in which the member belongs and approval by the Board of Councilors, may elect a member of the association who has rendered exceptional and distinguished service to scientific or organized medicine, or both, to the status of member emeritus.

The TMA Board of Councilors has approved the nominations of Carlos Hamilton Jr., MD; John D. Oswalt, MD; Nick Nipank Shroff, MD; and J. James Rohack, MD, for emeritus membership and recommends their election by the House of Delegates. A brief sketch follows for each member.

Carlos R. Hamilton Jr., MD (Harris County Medical Society)

Dr. Hamilton received his medical degree with honors from Baylor College of Medicine.

He has been a member of the Harris County Medical Society and TMA for more than 30 years and is a long-term member of the American Medical Association.

Dr. Hamilton served previously as president of the following organizations: the American Association of Clinical Endocrinologists, the American College of Endocrinology, the American Society of Internal Medicine, the Texas Academy of Internal Medicine Services, the Houston Academy of Medicine, and Harris County Medical Society. As a TMA member, Dr. Hamilton served as a delegate to the House of Delegates and on the TEXPAC Board of Directors.

Dr. Hamilton is a fellow of the American College of Surgeons and American College of Endocrinology. He specializes in endocrinology and is board certified in internal medicine, endocrinology, diabetes, and metabolism.

Dr. Hamilton has been an educator for nearly 50 years. From 2000 to 2019, he was the special assistant to the president and professor of internal medicine at The University of Texas Health Science Center at Houston in the John P. and Kathrine G. McGovern Medical School. He previously was a clinical professor of medicine at Baylor College of Medicine in Houston. He also released numerous scholarly publications related to medicine.

John D. Oswalt, MD (Travis County Medical Society)

Dr. Oswalt received his medical degree from The University of Texas Medical Branch in Galveston.

He has been a member of the Travis County Medical Society, the American Medical Association, and TMA for 44 years.

Dr. Oswalt specializes in adult cardiothoracic surgery. He is a fellow of the American College of Surgeons and a diplomate of the American Board of Surgery and American Board of Thoracic Surgery.

Dr. Oswalt also has served as president of the Texas Transplant Society. He was named Cardiac Care Provider of the Year in 1999 by the American Heart Association. He is an active member of the Society of

Dr. Oswalt has authored many research articles in his specialty.

**J. James Rohack, MD (Galveston County Medical Society)**

Dr. Rohack received his medical degree with honors from The University of Texas Medical Branch at Galveston, where he completed post-graduate training in internal medicine and a cardiology fellowship, and was chief resident in medicine.

Dr. Rohack, a past president of both TMA and the American Medical Association, currently is a senior advisor to AMA. He also has served on TMA’s Board of Trustees, House of Delegates, and Board of Counselors, and on various councils and committees.

He is a past president Brazos-Robertson County Medical Society and served on the Executive Committee of the Bell County Medical Society.

He is an emeritus staff member at Baylor Scott & White Health, where he was the chief health policy officer and senior staff cardiologist. He is professor emeritus at Texas A&M University, where he was the inaugural holder of the William R. Courtney Centennial Endowed Chair in Medical Humanities. In addition, he has chaired the National Advisory Council to the Agency for Healthcare Research and Quality, and served on the Board of Commissioners of The Joint Commission, the Liaison Commission on Medical Education, the Accreditation Council on Continuing Medical Education, the Hospital Quality Alliance, and the High-Value Healthcare Collaborative.

Dr. Rohack has received many honors, including the TMA C. Frank Webber, MD, award. The AMA Medical Student Section created the J. James Rohack, MD, Award, to recognize students exhibiting the highest level of professionalism. He has more than 100 literature citations.

**Nick Nipank Shroff, MD (Collin-Fannin County Medical Society)**

Dr. Shroff received his medical degree from Christian Medical College & Hospital, Vellore, Tamil Nadu, India.

He has been a member of Collin-Fannin County Medical Society for two years, Midland County Medical Society 35 years, and Howard County Medical Society for one year, and a TMA member for 38 years.

Dr. Shroff has served in the TMA House of Delegates for more than 25 consecutive years and on the Board of Councilors as vice councilor and councilor (1997-2007). He has been a leader in the TMA International Medical Graduate Section, Texas Indo-American Physicians Society, TMA Foundation, and Midland County Medical Society, and has served on multiple councils and committees both in his county society and in TMA.

Dr. Shroff has received many honors and awards for his committed service and leadership.

**Recommendation:** Elect Carlos Hamilton Jr., MD; John D. Oswalt, MD; J. James Rohack, MD; and Nick Nipank Shroff, MD, to emeritus membership in TMA.
REPORT OF BOARD OF COUNCILORS

Subject: Honorary Nominations

Presented by: Steven M. Petak, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

The TMA Board of Councilors has approved the nominations of Roberto J. Bayardo, MD; Spencer R. Berthelsen, MD; Herbert L. Dupont, MD; and Teodoro A. Saieh, MD, for honorary membership and recommends their election by the House of Delegates. A brief sketch follows for each member.

Roberto J. Bayardo, MD (Harris County Medical Society)
Dr. Bayardo received his medical degree from Universidad de Guadalajara, Jalisco, Mexico.
He has been a member of the Travis County Medical Society for 28 years and of the Harris County Medical Society for 21 years, for a total of 49 years as a TMA member.
He served as an assistant to the medical examiner in Harris County and later chief medical examiner for Travis County, where he was a consultant for seven other counties. He has held academic positions at three Texas medical schools and is the recipient of the Andujar Citation of Merit Award from the Texas Society of Pathologists.
Since 1991, Dr. Bayardo has gifted the TMA Foundation a very generous $3.2 million to establish a trust fund to support the TMA Minority Scholarship Program and has enabled TMA to increase the scholarships for the first time, from $5,000 each to $10,000 each.

Spencer R. Berthelsen, MD (Harris County Medical Society)
Dr. Berthelsen received his medical degree from UT Southwestern Medical School, Dallas.
He has been a member of the Harris County Medical Society and TMA for 39 years.
He served on the TMA Council on Legislation, 2000-06, and was chair of the TMA Ad Hoc Committee of Physician Directed Networks, 1998-2000.
Dr. Berthelsen has a history of distinguished service in the medical community and has served organized medicine in numerous capacities.
He has received many awards and honors over the years. He has written several publications and is a member of several professional societies.

Herbert L. Dupont, MD (Harris County Medical Society)
Dr. Dupont received his medical degree from Emory University School of Medicine, Atlanta, Ga.
He has been a member of the Harris County Medical Society and TMA for 45 years.
He has spent 40 years in research in microbiology and immunology. He has served as president of the Infectious Diseases Society of America, the National Foundation for Infectious Diseases, and the American
Clinical and Climatological Association, and was the founding president of the International Society of Travel Medicine.

He has authored or coauthored more than 730 peer-reviewed scientific publications and 19 books.

Dr. Dupont has a history of distinguished service in the medical community and has received many scientific recognition honors over the years.

Teodoro A. Saieh, MD (Nueces County Medical Society)

Dr. Saieh received his medical degree from Facultad de Medicina de la Universidad del Valle (Colombia), Cali, Valle del Cauca, Colombia.

He has been a member of the Nueces County Medical Society and TMA for 37 years.

He served as a TMA alternate delegate.

Dr. Saieh is certified by the American Board of Plastic Surgery, and he is a respected member of the medical community in Corpus Christi. He is an active member of the American Society of Plastic Surgeons, American Society for Aesthetic Plastic Surgery, and Texas Society of Plastic Surgeons.

Recommendation: Elect Roberto J. Bayardo, MD; Spencer R. Berthelsen, MD; Herbert L. Dupont, MD; and Teodoro A. Saieh, MD, to honorary membership in the Texas Medical Association
REPORT OF THE COMMITTEE ON PHYSICIAN HEALTH AND WELLNESS

CM-PHW Report 2 2020

Subject: Sunset Policy Review

Presented by: Cheryl L. Hurd, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

TMA periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness.

The Committee on Physician Health and Wellness recommends retention of the following policy:

245.018 Specialty Board Recertification/Enrollment in a State Physician Health Program. The Texas Medical Association urges medical specialty boards that automatically rescind the diplomate status of physicians enrolled in a state’s physician health program to review their policies, work with physician health programs around the country, and modify those policies to allow physicians in recovery to maintain their board certification on a case-by-case basis. (Amended CM-PHR Rep. 5-A-10).

Recommendation: Retain.
The Women in Medicine Section was established by the House of Delegates to strengthen engagement and representation of female physicians in organized medicine through the development of relevant policies, programming, and services. Its purpose is to provide female member physicians with an effective means to participate in TMA activities and influence association policy through access to and representation in the House of Delegates.

The section approved its final operating procedures, attached to this report for adoption by the house. Although the working name of the section was Women in Medicine, once formed, the section unanimously voted to recommend its name be changed to the “Women Physicians Section” to align with its counterpart at the American Medical Association. If approved by the House of Delegates, the Council on Constitution and Bylaws will submit a constitutional amendment with the section’s new name.

Elections. The Women Physicians Section held its first two business meetings at 2019 Fall Conference and 2020 Winter Conference. These initial meetings were primarily organizational in nature, and were well-attended with high interaction among the approximately 60 participants at each session.

The following executive council was elected to interim terms that will conclude at TexMed 2020:

- Interim chair: Elizabeth Rebello, MD;
- Interim secretary: Neha Dhudsia, MD;
- Interim TMA delegate: Deborah Fuller, MD;
- Interim TMA alternate delegate: Ruhi Singh Soni, MD;
- Interim AMA-WPS associate: Josephine Fowler, MD; and
- Interim AMA-WPS alternate associate: Sejal Mehta, MD.

Priorities. The section identified a list of potential section priorities and educational topics. A draft vision document outlining section priorities was then presented to section members in an online survey to further refine strategies. The survey was disseminated to more than 13,000 section members and has received more than 1,200 responses to date. Survey results will be presented at the section’s meeting at TexMed 2020. Key findings include the top three objectives selected by respondents:

1. Empower women physicians to take an active role in organized medicine through recruitment and training for leadership positions;
2. Create diverse paths to leadership for women physicians through educational leadership and professional development programming; and
3. Encourage systemic culture change throughout medical and professional settings related to gender equity through the development of programming, position papers, and policy recommendations.

Workgroups. Additionally, a resolution workgroup to explore potential resolutions on behalf of the section was suggested and subsequently appointed by the chair. The workgroup drafted a resolution supporting paid parental leave policies.
Three additional workgroups have been recommended and will be appointed by the chair including a workgroup to further revise and refine the vision document. A joint subcommittee with the Council on Health Promotion will be convened to develop a comprehensive message and work plan for an education campaign to unify TMA around improving conditions for women physicians. Lastly, a workgroup to review potential options for implicit bias training to be offered to TMA membership will be formed. The development of the image campaign and bias training were charges assigned to the section as part of Resolution 112-A-19.

Next Steps. The section is committed to leveraging its current momentum and expanding opportunities for women physicians to engage and grow professionally. The section plans to meet regularly during TMA conferences with the meeting format to include a combination of section business, an educational presentation, and opportunities for networking. The section has also expressed a desire to broaden its reach at the regional and county levels by supporting county medical societies in providing high-quality professional development education and networking activities locally.

Recommendation 1: Adopt the section’s operating procedures.

Recommendation 2: Approve the section’s name change from “Women in Medicine Section” to “Women Physicians Section.” Amend the section’s operating procedures to reflect this change, and amend Chapter 3, House of Delegates, Section 3.25, 3.255 Women in Medicine Section, to reflect this change as follows:

3.255 Women Physicians Women in Medicine Section. The House of Delegates shall have a section named the Women Physicians Women in Medicine Section. Any TMA physician member may become a member of the section, and female physicians who are TMA members are members of the section automatically. The section shall have the authority to elect one voting delegate to serve in the House of Delegates. The section shall elect an alternate delegate who may serve as provided in 3.32. The section will be directed by an elected governing council and governed by operating procedures approved by the House of Delegates. The operating procedures shall provide the purposes, organization, and procedures of the Women Physicians Women in Medicine Section.
TEXAS MEDICAL ASSOCIATION
WOMEN IN MEDICINE SECTION OPERATING PROCEDURES

1.10 **NAME.** The name of the organization shall be Women in Medicine Section (WIM) of the Texas Medical Association (TMA).

2.10 **PURPOSE.** The purpose of the WIM is to give female physician members a way to participate in TMA activities and influence association policy through access to and representation in the TMA House of Delegates.

3.10 **MEMBERSHIP.** The membership shall consist of TMA female physician members and those who request to join the section.

4.10 **EXECUTIVE COUNCIL.** An executive council of the Women in Medicine Section shall direct the section’s programs and activities.

4.11 **COMPOSITION.** The section’s chair, chair-elect, secretary, delegate and alternate delegate to TMA, and the associate and alternate associate to the American Medical Association-Women Physicians Section shall compose the Executive Council. Should a member of the Executive Council cease to be a WIM member for any reason at any time prior to the expiration of the term for which the member was elected, the term of such member shall terminate and the position shall be declared vacant.

4.12 **ELECTION.** Elections shall be held at the section’s annual meeting unless otherwise specified. Any WIM member shall be eligible for election to the Executive Council. Approval by a simple majority of the votes cast, via ballot in person or via email, shall be required to elect members of the Executive Council. Vacancies shall be handled by the procedure set forth in 5.13.

4.13 **ASSUMPTION OF OFFICE.** All members of the Executive Council shall assume office at the conclusion of the section’s annual meeting.

4.14 **MEETINGS.** The Executive Council should meet at least once annually, and then as needed between meetings to direct section business.

4.15 **ATTENDANCE.** If any member fails to attend two consecutive section meetings, the office can be declared vacant and may be filled by appointment of the Executive Council until the next regularly scheduled section meeting, at which time an election for the vacancy will occur.

5.10 **CHAIR, CHAIR-ELECT, SECRETARY, IMMEDIATE PAST CHAIR.**

5.11 **DUTIES.** The chair shall preside at all section and Executive Council meetings. The chair-elect shall assist the chair and preside at meetings in the absence of the chair or at the chair’s request. The secretary shall cause a record to be made of the proceedings of the meetings of the WIM Section and Executive Council. The immediate past chair shall participate in section Executive Council meetings and advise the chair.
5.12 **TERM.** Term of office shall be one year. The chair-elect shall be elevated to the office of chair, and the chair shall serve as immediate past chair.

5.13 **VACANCY.** In the event of a vacancy in the office of chair, the chair-elect shall assume the office of chair. In the event the offices of chair and chair-elect become vacant, both offices shall be filled by election at the next meeting of the section, the office of chair being filled first. Their terms shall fulfill the unexpired terms of the officers replaced.

6.10 **DELEGATE AND ALTERNATE DELEGATE TO TMA HOUSE OF DElegates.**

6.11 **DUTIES.** The delegate and alternate delegate shall represent the section in the TMA House of Delegates.

6.12 **TERM.** The term of delegate and alternate delegate shall be two years. Tenure shall not exceed two terms, except that election to or assumption of an unexpired term shall not be regarded as tenure in office. Delegates and alternate delegates shall be elected at the section’s annual meeting.

6.13 **QUALIFICATION.** Any WIM member in good standing may be elected to serve as a delegate or alternate delegate from the section.

7.10 **ASSOCIATE AND ALTERNATE ASSOCIATE TO AMA WOMEN PHYSICIANS SECTION.**

7.11 **DUTIES.** The associate and alternate associate to the AMA-WPS shall represent the section at the AMA Women Physicians Section.

7.12 **COMPOSITION.** The number of associates and alternate associates elected shall be in accordance with the Bylaws of that organization. In the event that the number of seats for associates allotted to the section decreases, the corresponding number of delegates with the shortest tenure shall become alternate delegates.

If, after such reapportionment, there are more alternate associates than seats for associates, the appropriate number of alternate associates with the shortest tenure shall be dropped.

7.13 **TERM.** Associates and alternate associates shall be elected annually and shall assume office at the conclusion of the TMA annual meeting.

7.14 **ELECTION.** Elections shall be held at the section’s winter meeting. Any WIM member who also is a member of the AMA shall be eligible for election to the Executive Council.

8.10 **MEETINGS.**

The section shall meet upon call of its chair, at least once a year.

A section member vote on any matter may be conducted by mail, by facsimile transmission, by electronic message, or by a combination of those methods. Action may be
taken without a meeting if a signed written consent stating the action to be taken is received from a majority of voting members.

9.10 **VOTING AND VOICE.** Any section member may attend, introduce resolutions or reports, debate issues, and vote in elections. At the discretion of the chair, other TMA members may be permitted voice at section meetings. County medical societies are encouraged to send representatives to each meeting.

10.10 **QUORUM.** A simple majority of Executive Council members must be present for the Executive Council to transact business. At least ten women physician members must be present for the section to conduct business.

11.10 **RULES OF ORDER.** The deliberations of the section shall be governed by the TMA House of Delegates rules of order.

12.10 **NOTICE OF MEETINGS.** Notice of the meetings shall be provided to section members at least 30 days prior to the meetings. Any business, reports, or resolutions the section is to consider must be submitted in writing to the Executive Council at least 14 days prior to the meeting. Late reports and resolutions must be submitted to the Executive Council for consideration. All such reports and resolutions so presented shall require a two-thirds affirmative vote to be accepted as business to be acted upon by the section.

13.10 **AMENDMENTS.** Prior to being submitted to the TMA House of Delegates, these operating procedures may be amended by a two-thirds vote of the members present and voting at a section meeting. As provided in TMA Bylaws, amendments must be approved by the TMA House of Delegates to become effective.
Subject: Recommendation for the Laurance N. Nickey, MD, Award

Presented by: Wendy M. Chung, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

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**Biography of Laurance N. Nickey, MD**

A member of TMA for 61 years, Laurance N. Nickey, MD, died at the age of 87 in August 2018. Dr. Nickey was a graduate of Baylor College of Medicine and began his career in pediatrics in El Paso. He was in private practice for more than 20 years.

While practicing pediatrics in El Paso, Dr. Nickey became engaged in maternal and child health, public health, and infectious disease issues. In the 1960s, he organized the Oral Polio Immunization program, which vaccinated hundreds of thousands of people in southwest Texas and New Mexico in 1963-65, while also working strategically for years with the U.S. Public Health Service to organize a tuberculosis control unit to serve the El Paso area.

Noting that “diseases have no passports,” Dr. Nickey was active in U.S./Mexico border health issues and was among the first to advocate for the development of the United States-Mexico Border Health Commission. Dr. Nickey was critical in organizing support of TMA and county medical associations along the border, the American Medical Association, and other state medical associations to finally obtain federal approval to establish this binational commission in 1994. The commission has continued to work on health concerns associated with migration along the U.S. and Mexico border – providing a reliable venue where public health officials and physicians can deliberate on mutual health issues and concerns.

As long-time director of the El Paso City-County Health District, Dr. Nickey was instrumental in increasing access to prenatal care with implementation of the Improved Pregnancy Outcomes program, resulting in a decrease in the proportion of El Paso women with no prenatal care from 40% to 11%.

In 1995, Dr. Nickey retired from his formal role in public health, but his volunteer service continued with TMA, where he served as a member of TMA’s Council on Public Health, with a focus on TMA’s efforts on border health issues. *Texas Medicine*’s February 2007 Symposium on Border Health highlights some of TMA’s work and interest in border health.

In addition to his volunteer work, Dr. Nickey served as a mentor and inspiration to physicians and other health professionals in El Paso, throughout Texas, in other parts of the country, and beyond.

**Background**

At 2018 Fall Conference, David L. Lakey, MD, member and former chair of the Council on Science and Public Health, called to the attention of the council the passing of Dr. Nickey. Seeking a way to commemorate Dr. Nickey, the council discussed creating an award in his honor. This would acknowledge Dr. Nickey’s history of service while also recognizing a TMA physician with significant contributions to public health in Texas. At 2019 Winter Conference, the council under then-chair Alice K. Gong, MD, approved a proposal for the Laurance N. Nickey, MD, Award. At 2019 Fall Conference, council chair Wendy M. Chung, MD, appointed the following council members/consultants to a workgroup and selection committee to develop guidance for the award: Vincent P. Fonseca, MD; Dr. Lakey; Jeffrey L. Levin, MD; and Eduardo Sanchez, MD. Jose Manuel de la Rosa, MD, representing the El Paso County...
Medical Society, joined the selection committee. The medical society agreed to work with the council on a recognition program and would serve as a contact with Dr. Nickey’s family.

The selection committee worked with TMA staff to develop the eligibility criteria, scoring, and nomination process of the inaugural Nickey award. The call for nominations was open from September 2019 to November 2019. Only nominees who are TMA members and have demonstrated a professional focus on public health were considered for the award. Eligible nominees were evaluated on their commitment to community, leadership, mentoring, public health progress and achievements, and impact across geographies or jurisdictions. The nomination form is in Appendix A.

With guidance from the selection committee, nominations were scored and an inaugural recipient selected.

**Discussion and Recommendations**

Dr. Laurance N. Nickey was highly revered by physicians across the state, on the border, and across the U.S. and Mexico. He was a Texan, a pediatrician, a public health leader, a mentor to countless physicians and public health professionals, and an advocate for his patients. He looked beyond his clinic and community for solutions to inherent health and public health problems, toward neighboring communities, states, and countries. Because of Dr. Nickey’s inspirational legacy and commendable lifetime contributions to TMA’s mission to improve the health of all Texans, the Council on Science and Public Health agreed the award should come not from the council alone but from the association overall. Thus, the Council on Science and Public Health presents the following recommendations:

**Recommendation 1:** That TMA create the Laurance N. Nickey, MD, Lifetime Achievement Award to recognize a member physician who has made outstanding contributions to medicine through a significant commitment to public health.

**Recommendation 2:** That the recipient of the Laurance N. Nickey, MD, Lifetime Achievement Award be selected by the Council on Science and Public Health and be awarded every three to five years.
APPENDIX A: Laurance N. Nickey, MD Lifetime Achievement Award Nomination Form

Laurance N. Nickey, MD Lifetime Achievement Award Nomination Form

In January 2020, the Texas Medical Association will present the inaugural Dr. Laurance N. Nickey Lifetime Achievement Award, recognizing a Texas physician who has made outstanding contributions to medicine through a significant commitment to public health.

The award commemorates Laurance N. Nickey, MD (1931–2018), a pediatrician and longtime director of the El Paso City-County Health District. Dr. Nickey was a dedicated border health advocate who frequently reminded the public "diseases have no passports." To learn more about Dr. Nickey’s contributions to public health in Texas, please read Texas Medicine (2001) and the El Paso Times’ (2018) reviews of his life and work.

Instructions
The Texas Medical Association’s Council on Science and Public Health is pleased to accept nominations from September 16, 2019 through October 16, 2019. This nomination form will close on Friday, October 16 at 11:59 p.m. CT. Incomplete or late nominations will not be considered.

You may exit and return to the nomination form at any time. Your progress will be saved as long as you use the same computer and link each time.

The scored portion of the nomination contains seven (7) required short answer questions with a limit of 1000 characters per question. Narrative or list form is acceptable. You may find it easier to compose your responses in a Word document and paste them into the nomination form. If you prefer this method, the short answer questions begin on Page 3 of the form and can be copied into Word once you reach them.

Eligibility Criteria
Only nominees meeting all criteria will be considered.
- Texas Medical Association member physician
- Demonstrated professional focus on public health

Scoring
Eligible nominees will be evaluated on the following.
- Commitment to community (15 points)
- Leadership (15 points)
- Mentoring (5 points)
- Public health progress and achievements (10 points)
- Impact across geographies or jurisdictions (5 points)

Please email XXXXX@texmed.org with questions about the award or nomination form.
1
Click 'Next' to begin.

Section I. Nominee Information

Full name of nominee

Nominee credentials

Only physicians are eligible to receive this award.

▼ MD (1) ... DO (2)

Nominee e-mail

Nominee phone number
Nominee location

- City (1) ___________________________
- State (2) ___________________________
- Country (3) ___________________________

Nominee’s employment
("Self" may be entered if nominee is self-employed)

- Current employer (4) ___________________________
- Job title (5) ___________________________

How many years has the nominee been in practice?


\[ \text{\(0-9\) (1) ... 50+ (6)} \]

Is the nominee a current Texas Medical Association member?

- Yes (1)
- No (2)
- Unsure (3)

Display This Question:
If the nominee a current Texas Medical Association member? = Unsure
Or Is the nominee a current Texas Medical Association member? = No
STOP!

Only current Texas Medical Association members are eligible for this award.

If you are unsure of a nominee's current membership status, please email XXXXX@texmed.org to verify before completing a nomination.

Once you have verified the nominee is a current TMA member, please click 'Back' and select 'Yes' on the previous question before accessing the remainder of the nomination form.

Page Break

Section II. Nominator Information

* Your full name

__________________________________________________________

* Your e-mail

__________________________________________________________

* Your phone number

__________________________________________________________
Your location

☐ City (1) ____________________________

☐ State (2) ____________________________

☐ Country (3) ____________________________

Your employment

("Self" may be entered if you are self-employed)

☐ Current employer (4) ____________________________

☐ Job title (5) ____________________________

Which of these best describes your relationship to the nominee?

▼ Colleague (3) … Other (5)

Display This Question:
If Which of these best describes your relationship to the nominee? = Other

If you selected 'Other', please briefly describe your relationship to the nominee.

__________________________________________

Page Break

Section III. Public Health Focus
Please list up to five (5) professional activities or roles the nominee has held that provide evidence of a focus on public health. If possible, include dates.

- (1) _______________________________
- (2) _______________________________
- (3) _______________________________
- (4) _______________________________
- (5) _______________________________

Section IV. Commitment to Community (15 points)

How has the nominee demonstrated a commitment to community in their day-to-day professional role(s)?

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________

What are some examples of the nominee’s volunteer or philanthropic efforts to improve public health in their community?

____________________________________________________________________

____________________________________________________________________

____________________________________________________________________
Section V. Leadership (15 points)

How has the nominee demonstrated depth and breadth of leadership in public health issues?

What outstanding leadership qualities or skills does the nominee possess?

If applicable, please list specific leadership roles the nominee has held within TMA.
Section V. Mentoring (5 points)

How has the nominee demonstrated a commitment to mentoring other physicians or health professionals?

__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________

Section VI. Public Health Progress and Achievements (10 points)

What public health progress and achievements can be attributed to the nominee?

If you are able to provide measurable evidence of impact, please do so.
__________________________________________________________________
__________________________________________________________________
__________________________________________________________________
Section VII. Impact across Geographies and Jurisdictions (5 points)

To what extent has the nominee's work transcended geographic regions or had multi-jurisdictional impact? (e.g. local, state, federal, international)

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Page Break

You have reached the end of the nomination form.

Please click 'Back' if you wish to continue editing.

If you are finished, click 'Next' to submit your nomination. After your responses are submitted, you will no longer be able to edit.

After submitting, the following screen will display a summary of all responses in a downloadable form.
Subject: Sunset Policy Review

Presented by: Shannon Hancher-Hodges, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

The Texas Medical Association periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness.

The Patient-Physician Advocacy Committee recommends retention of the following policies:

165.007 Whistle-Blower Protections for Physicians. The Texas Medical Association will undertake efforts including legislation to modify Texas law to establish protection from retaliation tactics for private contracting physicians and physician employees when they comply with reporting obligations and requirements to state and federal agencies (CM-PPA Rep. 1-A-10).

175.015 Contested Cases of the Texas Medical Board. The Texas Medical Association will support legislation to change the Medical Practice Act, requiring the Texas Medical Board to propose and adopt a rule under the Administrative Procedure Act, Section 2001.058(f), Government Code, that would make the decision of the State Office of Administrative Hearing judge a final decision in a contested case (Res. 102-A-08).

Recommendation: Retain.
In 2018, an Ad Hoc Committee on Inactive County Medical Societies was appointed to study organizational challenges of small to medium-sized county medical societies. The committee’s findings were incorporated into a Board of Trustees Report (BOT Report 14-A-19), which was adopted at by the 2019 House of Delegates:

**Board of Trustees Report 14 – Inactive County Medical Societies:** That TMA: (1) define an active county medical society as one that provides the following annually: (a) a list of the reporting year’s elected officers and delegates with their terms of office; (b) a list of the reporting year’s meetings with attendance noted; (c) confirmation of the county medical society annual membership dues rate; and (d) evidence of filing county medical society annual federal nonprofit tax returns, such as IRS Form 990; (2) allow county medical societies with 50 or fewer members to reduce the number of required officers to three: president, president elect, and secretary/treasurer; and (3) refer Board of Trustees Report 14-A-19 to the Council on Constitution and Bylaws for recommended bylaws amendments to implement recommendations 1 and 2. **Adopted.**

**REferred to:** Council on Constitution and Bylaws

To define an active county medical society as one that provides the following annually: (a) a list of the reporting year’s elected officers and delegates with their terms of office; (b) a list of the reporting year’s meetings with attendance noted; (c) confirmation of the county medical society annual membership dues rate; and (d) evidence of filing county medical society annual federal nonprofit tax returns, such as IRS Form 990, the Council on Constitution and Bylaws recommends the following amendments:

**Recommendation 1:** The Council on Constitution and Bylaws recommends amending Chapter 1 of the Texas Medical Association Bylaws.

**CHAPTER 1. MEMBERSHIP**

**1.40 Membership in contiguous society**

A component county medical society may grant permission for a physician under its jurisdiction to apply for membership in another contiguous component county medical society.

Permission for a physician to apply for membership in a contiguous component county medical society, and consideration of that application by the contiguous society, shall be denied only for (1) a violation of the constitution and bylaws of TMA or the component county medical society, (2) a violation of the AMA Principles of Medical Ethics, (3) criminal conduct, or (4) unprofessional conduct likely to deceive, defraud, or injure the public.

Permission to apply for membership in another contiguous component county medical society is not required if (1) the physician is an at-large member; or (2) the county
medical society that would otherwise grant permission is an inactive society described
under Section 12.113.

Recommendation 2: The Council on Constitution and Bylaws recommends amending Chapter 5 of the Texas
Medical Association Bylaws.

CHAPTER 5. BOARD OF COUNCILORS

5.20 Duties

5.218 Determine Inactive Societies. The board may determine a county medical society
to be an inactive society if the society has failed to comply with the annual report
requirement under Section 12.111.

Recommendation 3: The Council on Constitution and Bylaws recommends amending Chapter 12 of the
Texas Medical Association Bylaws.

CHAPTER 12. COUNTY SOCIETIES

12.11 Activity Status of Society

12.111 Active Society. A county medical society is considered to be active for a calendar
year if the society provides an annual report containing the following information to the
executive vice president of the association 45 days prior to the annual session of the
House of Delegates:

(1) A list of the society’s current elected officers and delegates with their
respective terms of office;
(2) A list of the society’s meetings held in the previous calendar year with the
recorded attendance at each meeting;
(3) The amount of annual dues levied against a member of the society; and
(4) Evidence of compliance with federal tax reporting obligations for the
preceding calendar year.

12.112 Collection of Annual Society Dues on Behalf of Society. The association may, on
behalf of an active county medical society under Section 12.111, collect the society’s
annual dues and remit to the society. The association may not collect annual dues on
behalf of a society that has been determined to be inactive under Section 12.113.

12.113 Inactive Society. If a county medical society fails to submit an annual report in
compliance with Section 12.111, the Board of Councilors may designate a county
medical society to be inactive without revoking the society’s charter under Section 5.204.
A county medical society designated as inactive under this section may be considered an
active society subsequently without Board of Councilors review by complying with the
reporting requirements under Section 12.111.

12.114 Effect of Inactive Society. The status of a county medical society as active or
inactive has no effect on the association membership status of a member of the county
medical society or on the rights and obligations of the county medical society, other than
the effect stated in Sections 1.40 and 12.112.
For purposes of Section 1.11 of these Bylaws and Article III, Sec. 1 of the Constitution, an individual who is or is applying to be a member of a county medical society that has been determined to be inactive who, because of the county medical society’s inactivity, is unable to comply with the society’s requirements for membership, including the requirement to pay the appropriate county medical society dues, may nevertheless be considered to be an association member as long the individual complies with all other applicable conditions of association membership.

12.40 Structure

12.42 Officers.

12.424 Duties of the secretary/treasurer. The secretary/treasurer of a component county society shall:

(6) File the [an] annual report required under Section 12.111, on forms the executive vice president provides[,] showing the officers, delegates, and members of the society as of Dec. 31 of the previous year. The report shall be transmitted to the executive vice president no later than Feb. 1 of each year.

To allow county medical societies with 50 or fewer members to reduce the number of required officers to three: president, president-elect, and secretary/treasurer, the Council on Constitution and Bylaws recommends the following amendments to the TMA Bylaws, Chapters 1, 5, and 12.

Recommendation 4: The Council on Constitution and Bylaws recommends amending Chapter 1 of the Texas Medical Association Bylaws.

CHAPTER 1. MEMBERSHIP

1.10 Admission

1.14 Board of Censors examination and report. The boards of censors of component county societies shall examine and report on the qualifications of applicants for membership in their respective organizations.

Within 60 days of the date an application is completed, the Board of Censors shall complete its examination of the applicant’s qualifications; approve or disapprove the application; and provide to the executive board (or to the other officers if there is no executive board) its report on the applicant’s qualifications and on the Board of Censors’ decision to approve or disapprove membership.

The president, president-elect, and secretary/treasurer of a county medical society electing officers in accordance with Section 12.4211 shall perform the examination under this section and are not required to report a recommendation to any other officer or entity. Notwithstanding Section 1.15, upon the examination of the applicant’s qualifications and decision by the majority of the president, president-elect, and secretary/treasurer to approve the applicant’s membership, those officers shall declare the applicant a member.
1.15 Approval of membership. Within 10 business days following receipt of the report of
the Board of Censors’ decision to approve membership, or at the next regularly scheduled
meeting, whichever comes first, the executive board (or other officers if there is no
executive board) shall declare the applicant a member.

1.16 Disapproval of membership. The Board of Censors shall make the initial decision to
disapprove an application for membership. Within 10 business days of its denial of
membership, the Board of Censors shall notify the applicant of its decision as well as the
applicant’s right to appeal the Board of Censors’ denial to the executive board. A copy of
the notice to the applicant shall be sent to the executive board.

The applicant then must give written notice of appeal to the executive board within 30
days of the Board of Censors’ notice of denial. If the applicant does not request a hearing,
or after the hearing is complete, the executive board shall vote to deny or accept the
applicant for membership. The executive board shall notify the applicant promptly of its
decision to approve or deny membership.

If the Board of Censors denies the application for membership, the secretary of the
component county medical society shall report promptly to the Board of Councilors the
name of the physician thus denied membership.

For a county medical society electing officers in accordance with Section 12.4211, the
president, president-elect, and secretary/treasurer shall, upon an initial decision to disapprove
an application for membership, notify the applicant of the decision as well as the applicant’s
right to appeal the denial to the councilor of the county medical society’s district, and the
secretary/treasurer shall report promptly to the Board of Councilors the name of the physician
denied membership. A copy of the notice to the applicant shall also be sent to the applicant’s
district councilor and vice councilor by the secretary/treasurer. The chair of the Board of
Councilors shall be notified if the councilor and vice councilor do not reach a unanimous
decision. The chair will then appoint a member of the Board of Councilors to resolve the
impasse. With respect to the appeals process for membership into a county electing officers in
accordance with Section 12.4211, the councilors act as the executive board.

Recommendation 5: The Council on Constitution and Bylaws recommends amending Chapter 5 of the Texas
Medical Association Bylaws.

CHAPTER 5. BOARD OF COUNCILORS

5.40 Councilors

5.41 Duties.

(2) Councilors shall receive and, if possible, decide matters that the component
county societies have brought on appeal to the councilor. Appeals that the
councilor cannot decide shall promptly be passed on to the Board of Councilors.
Councilors shall resolve, if possible, complaints made by members of component
county societies or by physicians in the district who are not members and who
feel that they have grievances against a component county society.
5.44. Recusal. Councilors who decide matters that a component county medical society brings on appeal to the councilors, including the appeal of the disapproval of membership under Section 1.16, must recuse themselves if the appeal is passed on to the Board of Councilors.

**Recommendation 6:** The Council on Constitution and Bylaws recommends amending Chapter 12 of the Texas Medical Association Bylaws.

**CHAPTER 12. COUNTY SOCIETIES**

12.42 Officers.

12.421 Definition. Except as provided under Section 12.4211, officers [Officers] shall be a president, a secretary/treasurer, and the members of the board of censors as set forth in Sections 12.431 and 12.432. No member shall hold more than one office at the same time. Other officers may be elected as required including the members of the executive board in incorporated county medical societies. Officers shall be elected by the county medical society membership.

12.4211. Officers for county medical societies with membership of less than 50. A county medical society with a membership of less than 50 members may, by amendment of the society’s bylaws and constitution and after approval by the Board of Councilors in accordance with Section 5.209, appoint only a president, president-elect, and secretary/treasurer as the society’s officers.

12.422 Term of office. The term of office for all officers, except [the] members of the board of censors, shall be one year. The term of the office of secretary/treasurer may be extended to two or three years.

12.4231 Duties of a president-elect of certain county medical societies. The president-elect of a county medical society electing officers in accordance with Section 12.4211 shall assist the president in the performance of the president’s duties. The president-elect automatically shall assume the office of president at the expiration of his or her term as president-elect.

12.43 Board of censors.

12.431 Composition and election. Except as provided under Section 12.4211, each [Each] component county medical society shall form a board of censors of those members elected as provided in Section 12.42.

12.434 Board of censors responsibilities for certain counties. The president, president-elect, and secretary/treasurer of a county medical society electing officers in accordance with Section 12.4211 shall perform the duties of the board of censors described under Section 12.433 and elsewhere in these Bylaws. With respect to a county medical society election of officers in accordance with Section 12.4211, a reference in these Bylaws to a county medical society’s board of censors means collectively the society’s president, president-elect, and secretary/treasurer.

12.45 Election and vacancies.
Elections of officers and delegates to the association shall be held annually by the county medical society membership. A county medical society electing officers in accordance with Section 12.4211 that does not already have a president-elect shall, in its first year electing officers under that section, elect a president, president-elect, and secretary/treasurer, and in each subsequent year, shall annually elect a president-elect and secretary/treasurer. Vacancies in the offices referred to in this chapter shall be filled by the county medical society president until the next annual election, unless otherwise specified by the county medical society bylaws.
During the 2019 Fall Conference, members of the Board of Trustees met with the chair of the Council on Science and Public Health and members of the LGBTQ Health Workgroup to discuss the future organizational structure of the workgroup. The discussion outlined the potential benefits and challenges of the creation of a LGBTQ section. Numerous advantages were presented in terms of leadership, action, and policy making inherent in a House of Delegates section. Following the discussion, all workgroup members present agreed that establishing a section would provide the best alternative to continue the necessary work to meet the unique health care needs of the LGBTQ population.

After contacting members not in attendance to confirm the recommendation, the full LGBTQ Health Workgroup unanimously supported the creation of a LGBTQ section. The Board of Trustees approved the recommendation. The Board of Trustees directed the Council on Constitution and Bylaws to draft language for an amendment to establish LGBTQ Health Section and report to the House of Delegates at their annual session in May 2020. In April 2020, the Council on Constitution and Bylaws submitted recommended amendments to Chapter 3 of the TMA Bylaws and Article V of the TMA Constitution. The former sets forth a general overview of the section’s purpose and procedures, while the latter allows for the section’s representation in the TMA House of Delegates.

Due to the COVID-19 pandemic, on March 29, 2020, the TMA Board of Trustees called itself into session to function as a Disaster Board, pursuant to TMA Bylaws Section 4.202. On April 5, 2020, the Disaster Board voted to suspend the 2020 TMA House of Delegates meeting, until an appropriate time in the future when the crisis has subsided.

To amend the TMA Constitution, the proposed change must be approved at two consecutive TMA annual sessions. To avoid delaying the constitutional amendment process, on May 17, 2020, the Disaster Board, acting in lieu of the delayed House of Delegates, considered the constitutional amendments that normally would have been presented to the May 2020 House of Delegates. The Disaster Board approved the recommended amendment to Article V of the TMA Constitution; it did not address the recommended amendment of Chapter 3.

The LGBTQ Health Section would not have delegate representation until the recommended constitutional amendment to Article V is approved a second time at the 2021 House of Delegates. In the interim, approval of the recommended amendment to Chapter 3 of the Bylaws would allow the LGBTQ Health Section to begin the process of establishing the section, including the formulation of its operating procedures.

**Recommendation:** To establish a LGBTQ Health Section, the Council on Constitution and Bylaws recommends the following amendments to the Bylaws, Chapter 3, Subsection 3.25, and that the subsection be renumbered accordingly:

3.252 LGBTQ Health Section. The House of Delegates shall have a section named the LGBTQ Health Section. The section will address important issues of interest to LGBTQ medical students, resident and fellows, and physicians. Any TMA physician member may become a member of the section. The section shall have the authority to elect one voting delegate to serve in the House of Delegates. The section shall elect an alternate delegate who may serve as provided in 3.32. The section will be directed by an elected governing
council and governed by operating procedures approved by the House of Delegates. The operating procedures shall provide the purposes, organization, and procedures of the LGBTQ Health Section. The LGBTQ Health Section shall (1) study and advance the scientific basis for the care of LGBTQ patients; (2) develop policy and resources on LGBTQ health and advance the association as a leader in providing physicians with evidence-based scientific information on the care of LGBTQ patients; (3) address the unique issues in practice management, billing, and maintaining medical records in the care of LBGTQ patients; and (4) communicate association policy and expertise on LGBTQ health.
The Board of Trustees appointed the Sections Workgroup to examine guidelines for creating and maintaining sections within the House of Delegates. Items reviewed by the workgroup included Chapter 3 of the TMA Bylaws and Chapter 7 of the American Medical Association Bylaws related to section composition. The operating procedures for each section also were referenced during the workgroup discussion. The workgroup recommended modifying language from AMA Bylaws, Chapter 7, Sections, to adopt as amendments to the TMA Bylaws, Chapter 3, House of Delegates, Section 3.25, Sections. It submitted the amendments to the Council on Constitution and Bylaws for final recommendation to the House of Delegates at its annual session in 2020.

**Recommendation.** To establish guidelines governing the establishment and maintenance of sections within the House of Delegates, the Council on Constitution and Bylaws recommends the following amendments to the Texas Medical Association Bylaws, Chapter 3, Subsection 3.25, and that the subsection be renumbered accordingly.

### 3.25 Sections Procedure

**3.251 Missions of the sections.** A section is a formal group of physicians or medical students directly involved in policymaking through a section delegate representing unique interests related to professional lifecycle or demographics. Sections shall be established by the House of Delegates for the following purposes:

1. **Involvement.** To provide a direct means for membership segments represented in the sections to participate in the activities, including policymaking, of TMA.
2. **Outreach.** To enhance TMA outreach, communication, and interchange with the membership segments represented in the sections.
3. **Communication.** To maintain effective communications and working relationships between the American Medical Association and organizational entities that are relevant to the activities of each section.
4. **Membership.** To promote TMA membership growth.
5. **Representation.** To enhance the ability of membership segments represented in the sections to provide their perspective to TMA and the House of Delegates.
6. **Education.** To facilitate the development of information and educational activities on topics of interest to the membership segments represented in the sections.

**3.252 Informational reports.** Each section may submit at the annual session an informational report detailing the activities and programs of the section during the previous year. The report(s) shall be submitted to the House of Delegates. The House of
Delegates may make such nonbinding recommendations regarding the report(s) to the sections as it deems appropriate.

3.253 Governing council. There shall be a governing council for each section to direct the programs and the activities of the section. The programs and activities shall be subject to the approval of the House of Delegates as follows:

(1) Qualifications. Members of each section governing council must be members of TMA and of the section.

(2) Voting. Members of each section governing council shall be elected by the voting members of the section present at the business meeting of the section.

(3) Additional requirements. Each section shall adopt rules governing the composition, election, term, and tenure of its governing council.

3.254 Officers. Each section shall select a chair and other necessary and appropriate officers with the following guidelines:

(1) Qualifications. Officers of each section must be members of TMA and the section.

(2) Voting. Officers of each section shall be elected by the voting members of the section.

(3) Additional requirements. Each section shall adopt rules governing the titles, duties, election, terms, and tenure of its officers.

3.255 Delegate and alternate delegate. Each section shall elect a delegate and alternate delegate to represent the section in the House of Delegates, unless otherwise provided in these Bylaws.

3.256 Business meeting. There shall be a minimum of one business meeting of the members of each section per year. Section business meetings shall occur in accordance with the operating procedures of that section. Section chairs may call meetings at any time.

3.256.1 Purposes. The purpose of the business meeting shall be to (1) hear such reports as may be appropriate, (2) consider other business and vote upon such matters as may properly come before the meeting, (3) adopt resolutions for submission by the section to the House of Delegates, and (4) hold elections.

3.256.2 Meeting procedure. The procedures of the business meeting are such that (1) the business meeting shall be open to all members of TMA, (2) only section members who are TMA members shall have the right to vote at the business meeting, and (3) the business meeting shall be conducted pursuant to rules of procedure adopted by the section governing council.

3.257 Rules. All rules, regulations, and procedures adopted by each section shall be subject to the approval of the House of Delegates.
3.258 Establishment of new sections. Through the Board of Trustees, the Committee on Membership may submit a report to the House of Delegates recommending creation of a section. County societies, existing House of Delegate sections, and voting members of the House of Delegates may submit resolutions resolving that a section be created. The report or resolution will contain a defined mission and criteria outlined in Section 3.251.

3.259 Section status. A section must reconfirm its qualifications for continued section status and associated representation in the House of Delegates by demonstrating at least every three years that it continues to meet the mission and criteria adopted by the House of Delegates.
Subject: Amendment to Bylaws Expanding Committee on Membership Section Representation

Presented by: William Gilmer, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

The Committee on Membership has requested an amendment to its governing language in the TMA Bylaws – Section 10.612 – to allow a member to be appointed from the Women in Medicine Section and any other House of Delegates section later added under Section 3.25 of the TMA Bylaws.

**Recommendation.** To allow appointment to the Committee on Membership of a member from the Women in Medicine Section – and from any other House of Delegates section later added under Section 3.25 of the TMA Bylaws – the Council on Constitution and Bylaws recommends the following amendments to the TMA Bylaws, Chapter 10, Subsection 10.60:

10.612 Committee on Membership. The committee shall have 15 members be composed of members appointed to represent county medical societies and House of Delegates sections. One member shall be appointed from each of the eight component county societies with the largest number of members; three members shall be appointed to represent other county societies. The TMA president shall appoint a member from the Young Physician Section, International Medical Graduate Section, Resident and Fellow Section, and Medical Student Section each of the House of Delegates sections.
At the 2019 Annual Session, the House of Delegates referred to the Council on Legislation Resolution 107-A-19, Physician Dispensing of Prescriptions. The resolution stated:

RESOLVED, That physicians licensed by the Texas Medical Board (TMB) be allowed to prescribe, dispense, and sell prescriptions, over-the-counter medications, and medical devices to patients in Texas with regulation only by TMB.

As noted in the Reference Committee on Financial and Organizational Affairs report, “Your reference committee heard conflicting testimony both in support of, and in opposition to this resolution. There is existing TMA policy in favor of allowing physicians to dispense certain pharmaceuticals.”

The Texas Medical Association does have existing policy that favors physician dispensing. Passed in 2010, TMA Policy 95.034, Legislation to Allow Physicians to Dispense Pharmaceuticals, states:

The Texas Medical Association supports legislation that will allow physicians to dispense and charge for dispensing pharmaceuticals other than Schedule I through V controlled substances, as defined in the Texas Health & Safety Code, Chapter 483 (2010) (Res 302-A-11).

This policy has guided TMA actions in the Texas Legislature on this issue. In the 86th Texas Legislature (2019), TMA supported House Bill 1622 by Rep. Tom Oliverson, MD (R-Cypress), relating to the authority of a physician to provide and dispense and to delegate authority to provide and dispense certain drugs. HB 1622 would not have allowed physicians to dispense controlled substances and required only that physicians register with the Board of Pharmacy that they were dispensing under the provisions of the act. Physicians would have been authorized to collect a fee that covered the cost of the dispensed drugs. We believed these safeguards to be useful.

Ultimately, the bill remained in committee and was not passed. It is expected to be reintroduced in 2021.

We believe the existing policy on physician dispensing has served the association well and will for the foreseeable future.

**Recommendation:** That Texas Medical Association Policy 95.034, Legislation to Allow Physicians to Dispense Pharmaceuticals, be reaffirmed in lieu of Resolution 107-A-19.
Subject: Establish a Coalition of Medical Societies to Protect Competition and Sustainability in the Health Insurance Marketplace, Resolution 106-A-19

Presented by: E. Linda Villarreal, MD, chair

Referred to: Reference Committee on Financial and Organizational Affairs

Resolution 106-A-19, Establish a Coalition of Medical Societies to Protect Competition and Sustainability in the Health Insurance Marketplace (Harris County Medical Society) was referred to the TMA Board of Trustees for study with a report back at TexMed 2020. The resolution recommends that:

(1) TMA, in collaboration with other state and specialty medical societies, create and provide support for a permanent coalition that, through political advocacy and public outreach, advocates for incremental health care reform that preserves patient choice, physician autonomy, competition in the health insurance marketplace, and sustainability within the health care system; (2) TMA, in collaboration with other medical societies, search out and provide support for a distinct entity whose purpose is to study the current health care system and compare it to other systems as a means to develop and support model state and national legislation that is responsible, incremental, and sustainable; (3) TMA, in collaboration with other medical societies, search out and provide support for a distinct entity whose function is to educate the public on issues pertinent to potential health care legislation. This entity will promote greater public awareness of the benefits of competition in health care and the health insurance marketplace; and (4) the Texas Delegation to the American Medical Association carry this resolution to the AMA House of Delegates.

This resolution asks TMA to create and support coalitions that already exist. TMA is a member of multiple coalitions and organizations that advocate and educate on the issues outlined in the resolution. These coalitions comprise both state and specialty medical associations. They not only provide political advocacy but also support independent physician practices and conduct public outreach. One of the organizations, The Physicians Foundation, conducts a biennial study specifically on patients and their thoughts about the current health care system. TMA is currently working with The Physicians Advocacy Institute as it develops resources to help physicians maneuver the complex payment and reporting policies that are part of Medicare’s Quality Payment Program. In addition, TMA is one of the founding members of the Partnership to Empower Physician-Led Care.

- **Partnership to Empower Physician-Led Care**’s mission is to support value-based care to reduce costs, improve quality, empower patients and physicians, and increase access to care for millions of Americans through a competitive physician and health care provider market.

- **Physicians Advocacy Institute** (PAI) was established to help physicians navigate complex contractual and payment-related issues and to support state medical associations’ work in these areas. PAI is a not-for-profit 501(c)(6) advocacy organization established in 2006 with funds from the multidistrict litigation class-action settlements against major national for-profit health insurers. PAI’s mission is to advance fair and transparent payment policies and contractual practices by payers and others to sustain the profession of medicine for the benefit of patients. TMA is one of the 10 state medical societies that participate in PAI.
The Physicians Foundation was founded in 2003 after a class-action lawsuit brought about by physicians, 19 state medical societies, and three county medical societies against private third-party payers resulted in a significant monetary settlement. The foundation’s goals include understanding physician practice trends, helping physicians deliver quality care to their patients, and providing practicing physicians with resources and support to manage health care reform and succeed in today’s challenging health care environment. The foundation conducts two biennial studies – one on physicians and one on patients. These surveys serve as a way to monitor how physicians and patients feel about the health care system as it evolves.

The Board of Trustees recommends that the Texas Medical Association continue its active and robust involvement with existing coalitions and advocacy groups and that Resolution 106-A-19 not be adopted.

In recognition that physicians are increasingly entering employment relationships, TMA President David C. Fleeger, MD, announced his appointment of an Ad Hoc Committee on Employed Physicians to study and make recommendations on how to better serve this membership segment. The committee’s charge is:

- Better define the needs of employed physicians in various practice settings and employment arrangements,
- Develop recommendations for how best to address unique advocacy and service needs, and
- Determine strategies to increase the value of TMA membership for employed physicians.

Individuals, counties, and special societies submitted names of employed physicians for representation on the committee. Members who accepted and served on the committee are:

- Lindsay K. Botsford, MD, chair, family medicine, Houston, Iora Primary Care;
- Charlotte Akor, MD, pediatric ophthalmology, Abilene, Hendrick Health System;
- Maya Bledsoe, MD, endocrinology, Austin, Austin Regional Clinic;
- Mark Casanova, MD, palliative medicine, Dallas, Sammons Cancer Center;
- M. Brett Cooper, MD, pediatric adolescent medicine, Dallas, UT Southwestern Medical Center;
- Michael McNeal, MD, internal medicine, Temple, Baylor Scott & White Health;
- Peter Nutson, MD, internal medicine, Austin, WellMed at Midtown;
- Stuart Pickell, MD, internal medicine/pediatrics, Fort Worth, Texas Health Family Care;
- Autumn Pruette, MD, pediatrics, Baytown, Texas Children’s Pediatrics; and
- Nora Vasquez, MD, internal medicine, San Antonio, CommuniCare Health Center.

**Discussion**

The committee evaluated employment trends in Texas, reviewed solutions used by other medical societies and professional associations outside of medicine, and developed a recommended list of prioritized needs and services.

**Environmental Assessment.** Physicians are shifting away from independent practice and towards employment for many reasons, e.g., reduced financial and regulatory burden and work-life balance. According to the American Medical Association, most recent data show 47.4% of physicians are now employed, while 45.9% are practice owners.

Texas data indicate 38% of physicians are employed. Results from TMA’s Biennial Physician Survey show that since 2012, the number of solo practitioners has steadily decreased, while the number of group practice employees has increased. Further, the combined percentage of group practice employee, hospital employee, and academic or administrative positions has nearly doubled since 2012, from 22% to 42%.

**Definition.** The committee defined an employed physician as an employee of a physician group practice, hospital or health system, nonprofit health corporation, academic institution, U.S. Veterans Affairs, or a
corporation such as a health plan or a practice management company. Physicians in employed settings do not generally have ownership rights, and their compensation and benefits are determined by the employer.

Additionally, the group determined the phrase “physicians in employed settings” was better than “employed physicians” to address the variety of practice settings.

**Services and Representation.** Committee members recommended the following as priorities:

**Advocacy**
- Explore (and fight) the legality of noncompete clauses,
- Advocate for compensation equity and transparency, and
- Seek fair professional benefits from employers and support for involvement in organized medicine.

**Representation**
- Utilize a forum for physicians in employed settings, and
- Better promote meetings and volunteer opportunities, e.g., provide a roadmap to TMA involvement.

**Services**
- Provide career-long leadership training, e.g., communication skills and public speaking;
- Share compensation and practice benchmarks, and provide access to employment contract analysis and negotiations;
- Develop specific resources, e.g., white papers on leaving a practice or “you’ve just been fired”;
- Provide relevant continuing medical education, e.g., management training, oversight of midlevel providers; and
- Support telementoring, e.g., Project ECHO Model (Extension for Community Healthcare Outcomes).

**For Employer**
- Market to upper management on value of TMA, e.g., align goals with employers and academia;
- Promote membership as a benefit of employment for 100% groups; and
- Invite executives to TMA conferences and add to the distribution list of TMA publications.

The group determined that suggested strategies relevant to membership and communications could go to appropriate TMA staff or governance bodies for evaluation. Ideas ranged from targeted value marketing and additional questions on TMA’s membership survey to *Texas Medicine Today* topics on how to get involved.

TMA strives to be the constant throughout the career span of a Texas physician, regardless of practice setting or role in medicine. To this end, committee members felt strongly that TMA communications and messaging should support the concept that TMA serves all physicians regardless of practice setting and that a false divide not be made between physicians in employed settings and others.

**Forum.** The development of a forum garnered particular interest and was discussed as a unique strategy to improve representation and involvement. The forum would provide a platform to discuss issues, share best practices, educate members, and communicate advocacy priorities or service needs to TMA. The forum community would be inclusive and not limited in terms of voice or scope, and activities would include virtual communications (e.g., via virtual meetings, electronic mailing lists) throughout the year, with in-person programming at TexMed. It was not felt that a dedicated section or representative body was required at this time to accomplish the objective of connecting members and discussing issues. As participation in a forum evolves in the future, consideration could be given to other ways to more formally organize should there be felt to be a need.
The TMA Board of Trustees concurs with the ad hoc committee and recommends the following be adopted:

**Recommendation 1:** That the Texas Medical Association pilot a forum for physicians in employed settings, combining virtual communications with in-person programming at TexMed 2021.

**Recommendation 2:** That TMA approve the evaluation and implementation of these priorities and services, with assignment to appropriate councils, committees, and staff units:

**Advocacy**
- Explore (and fight) the legality of noncompete clauses,
- Advocate for compensation equity and transparency, and
- Seek fair professional benefits from employers and support for involvement in organized medicine.

**Representation**
- Utilize a forum for physicians in employed settings, and
- Better promote meetings and volunteer opportunities, e.g., provide a roadmap to TMA involvement.

**Services**
- Provide career-long leadership training, e.g., communication skills and public speaking;
- Share compensation and practice benchmarks, and provide access to employment contract analysis and negotiations;
- Develop specific resources, e.g., white papers on leaving a practice or “you’ve just been fired”;  
- Provide relevant continuing medical education, e.g., management training, oversight of midlevel providers; and
- Support telementoring, e.g., Project ECHO Model (Extension for Community Healthcare Outcomes).

**For Employer**
- Market to upper management on value of TMA, e.g., align goals with employers and academia;
- Promote membership as a benefit of employment for 100% groups; and
- Invite executives to TMA conferences and add to the distribution list of TMA publications.
Subject: Licensure Status on TMA Membership Applications, Resolution 109-A-19

Presented by: Steven M. Petak, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

Resolution 109-A-19 was referred for study to the Board of Councilors with a report back to the House of Delegates. The resolution relates to limiting a county medical society’s board of censors’ review of an applicant solely to whether the applicant is properly licensed with the Texas Medical Board or meets some other licensure exception. This suggestion, offered by the Tarrant County Medical Society (TCMS), is premised on the fact that a county medical society has few resources to investigate applicants, and that the discretion a board of censors might exercise could subject counties to liability. Therefore, as TCMS proposes, the investigation in the character and background of the applicant should be left up to the Texas Medical Board.

If this amendment were adopted, it would require an amendment to the TMA membership application and to the TMA Bylaws.

The TMA Board of Councilors does not recommend that the TMA Bylaws be changed to allow any licensed physician, medical resident, or medical student applying to be a member of TMA and a county medical society to become a member without going through the screening process currently provided in TMA Bylaws.

**Recommendation:** That Resolution 109-A-19 not be adopted.
In recent years, the TMA Bylaws have been amended to add delegate representation in the House of Delegates. In 2012, the bylaws were amended to allow at-large members to elect one delegate for the first 100 at-large members or less and elect one additional delegate for each additional 100 at-large members or fraction thereof. In 2019, the bylaws were amended to establish the Women in Medicine Section, which would have the authority to elect one delegate. (To align with its American Medical Association counterpart, the Women in Medicine Section has submitted a report to the 2020 House of Delegates recommending that its name be changed to Women Physicians Section.).

When these two bylaws amendments were adopted, there was not a corresponding amendment of the TMA Constitution. Under Article XIII of the constitution and Section 16.20 of the bylaws, amending the constitution requires that the amendment be approved at consecutive annual sessions.

Recommendation: The Council on Constitution and Bylaws recommends amending Article V of the Texas Medical Association Constitution as follows:

ARTICLE V. HOUSE OF DELEGATES.

Sec. 1. The legislative and policy-making body of the association shall be the House of Delegates. The House of Delegates shall transact all business of the association not otherwise specifically provided in this Constitution and Bylaws, shall elect the officers except as otherwise provided in the Bylaws, and shall meet as provided in the Bylaws.

Sec. 2. House of Delegates membership shall consist of:

(1) Delegates representing county medical societies, elected in accordance with this Constitution and Bylaws; and

(2) Ex officio members, including
   (a) The president, president-elect, immediate past president, secretary/treasurer, and speaker and vice speaker of the House of Delegates;
   (b) Councilors;
   (c) Nine members elected at large to the Board of Trustees plus the young physician, resident, and student members of the board.
   (d) Texas delegates and alternate delegates to the American Medical Association;
   (e) Chairs of standing councils and members of the Council on Legislation;
   (f) Delegates from the International Medical Graduate Section, Resident and Fellow Section, Women Physicians Section, and Young Physician Section;
   (g) Delegates representing the Medical Student Section from each approved and active Medical Student Section Chapter;
(h) Delegates of medical specialty societies selected in accordance with this Constitution and Bylaws;
(i) Past presidents of the association who are active or emeritus members; and
(j) As nonvoting members, the chair of TEXPAC and delegates emeritus of the AMA delegation; and
(k) Delegates representing at-large members, with one delegate for the first 100 at-large members or less, and one additional delegate for each additional 100 at-large members or fraction thereof.
REPORT OF COMMITTEE ON MEMBERSHIP

Subject: New Telemedicine TMA Dues Category

Presented by: Sara W. Dyrstad, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

Background. The Texas Medical Board issues an out-of-state telemedicine “limited” license that allows a qualified physician to practice medicine across state lines. An out-of-state telemedicine license holder is not authorized to practice medicine physically in the state of Texas.

The license holder’s practice of medicine is limited to:

- Interpretation of diagnostic testing and reporting of results to a Texas fully licensed physician practicing in Texas, and
- Follow-up of patients where the majority of patient care was rendered in another state.

The holder of an out-of-state telemedicine license is subject to the Texas Medical Practice Act and the same rules of the board as a person holding a full Texas medical license, including paying the same fees and meeting all other requirements (such as CME) for issuance and renewal of the license as a person holding a full Texas medical license.

Telemedicine Licensure in Texas
Since the program began, 370 physicians who live in 36 states have been licensed, but none are current members of Texas Medical Association.

<table>
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Existing TMA Out-of-State Membership Categories
Currently, TMA has two dues categories for physicians licensed in Texas who live out of state.  
**Associate membership** (three members) is available to physicians who currently are members in a state and county society adjacent to where they are applying. The associate membership category requires the physician to be licensed in Texas and to be a member of his or her current state medical society. Dues are half of TMA full active dues or $286.50.

1.210 **Associate.** Physicians licensed to practice medicine in Texas, who are currently active (or equivalent) members in good standing of a state medical association within the United States of America, shall be eligible for associate membership in TMA.

Associate members hold direct membership in the association and are not required to be members of a Texas county medical society.

Associate members shall have all rights and privileges of membership except the right to vote and hold elective position.

**Affiliate membership** (170 members) is available to physician members who leave the state to practice but wish to retain membership in TMA. Dues are half of TMA full active dues or $286.50.

1.211 **Affiliate.** Active, military, and resident members who leave the state permanently, and against whom no charges of unethical or unprofessional conduct that could lead to denial of membership, as provided in 1.11, are pending, may become affiliate members of the association on application to the executive vice president, provided they maintain a current Texas medical license, except as provided in Article III.

Affiliate members hold direct memberships in the association and are not members of a Texas county medical society.

Affiliate members shall have all rights and privileges of membership except the right to vote and hold elective position.

**Recommendation 1:** The Texas Medical Association create a new telemedicine membership category at one-half of TMA full active dues.

1.213 **Telemedicine.** Physicians licensed to practice in Texas with an out-of-state telemedicine license and who do not reside or work in Texas and do not hold a full Texas medical license shall be eligible for telemedicine membership in TMA.

Telemedicine members hold direct membership in the association and are not required to be members of a Texas county medical society.

Telemedicine members shall have all rights and privileges of membership except the right to vote and hold elective position.

**Recommendation 2:** If approved, that the TMA Board of Trustees direct the Council on Constitution and Bylaws to recommend the necessary bylaw amendments.
Subject: The Creation of an Independent Physician Section

Introduced by: Lone Star Caucus

Referred to: Reference Committee on Financial and Organizational Affairs

Whereas, The Texas Medical Association has sections dedicated to help meet the needs of both employed and academic physicians; and

Whereas, Physicians in independent practice experience unique challenges, both financially and legislatively; and

Whereas, Physicians in independent practice comprise a large percentage of the members represented by the Texas Medical Association; therefore be it

RESOLVED, That the Texas Medical Association take steps to create a section dedicated to help meet the unique needs of physicians in private practice who reside in this state; and be it further

RESOLVED, That the Texas Delegation to the American Medical Association take a similar resolution to the AMA House of Delegates for consideration.

Related TMA Policy:
None.

Related AMA Policy:
None.
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 102
2020

Subject: Expansion of the Texas Medical Association Ambassador Program

Introduced by: Lone Star Caucus

Referred to: Reference Committee on Financial and Organizational Affairs

Whereas, County medical societies are the backbone of the Texas Medical Association and one of the key reasons for the Texas Medical Association's strength; and

Whereas, The Texas Medical Association depends on efforts by the local county medical societies to recruit and retain members in order to grow as an organization and have more clout with government leaders when advocating on behalf of physicians and patients; and

Whereas, Many county medical societies are finding it increasingly challenging to get good attendance by members and potential members at their meetings; and

Whereas, Many county medical societies have found that continuing medical education presentations on topics of interest to physicians are a good way to boost attendance at their meetings; and

Whereas, Such presentations help county medical societies remind members and potential members of some of the benefits of Texas Medical Association membership; and

Whereas, The Texas Medical Association has been helping county medical societies since 2006 via its Ambassador Program, which arranges for speakers to present a variety of different continuing medical education topics during county medical society meetings without charging a speaker's fee to the county medical society; and

Whereas, Many county medical societies have found that offering continuing medical education presentations through the Ambassador Program at least twice a year is the best way to keep their members active and engaged; therefore be it

RESOLVED, That the Texas Medical Association House of Delegates express its gratitude for the Ambassador Program; and be it further

RESOLVED, That the Texas Medical Association allocate additional resources so the Ambassador Program is able to add at least two new continuing medical education topics each year to its list of presentations that are currently available.

Related TMA Policy:
None.

Related AMA Policy:
None.
Subject: A Systematic and Precise Method for AMA Public Endorsements of Proposed Legislation

Introduced by: Wendell H. Williams III, MD

Referred to: Reference Committee on Financial and Organizational Affairs

Whereas, Our national health care system remains a popular subject among politicians, with some advocating for extensive change soon; and

Whereas, Some of the proposed reforms directly conflict with Texas Medical Association and American Medical Association policy that health care reform should be evidence-based, responsible, sustainable, and incremental, and preserve freedom of choice and practice, as described in TMA Policy 120.010 and AMA H-165.838; and

Whereas, Omnibus health care reform legislation is massive, opaque, and often unproven. Without the benefit of evidence-based policymaking or existing models, the downstream consequences of such legislation are unpredictable and riddled with unintended consequences; and

Whereas, The respected position which our AMA holds within the community is derived from its membership of trusted physician-scientists. Given the imperfect, imprecise, and potentially deleterious nature of omnibus legislation, broad public endorsement of legislation by our AMA may be counterproductive, give the impression that all measures within the bill are supported, forfeit leverage in negotiating for further revisions, and ultimately erode the public trust; therefore be it

RESOLVED, that the Texas Delegation to our AMA introduce a resolution to the AMA House of Delegates that calls upon AMA to (1) avoid giving general, nonspecific public endorsements of large, omnibus national health care legislation; (2) instead, develop and adopt a more precise endorsement mechanism that can better inform the public of the specific provisions within the proposed legislation, the strength of any underlying evidence, and the AMA position of support or opposition; and (3) maintain an emphasis on the most problematic elements of a bill, present or omitted, that AMA finds to be likely detrimental to the quality or sustainability of our health care system, freedom of choice and practice.

Related TMA Policy:
120.010 Principles for Evaluating Health System Reform

Related AMA Policy:
Health System Reform Legislation H-165.838
Subject: The Term Physician Should Be Used Rather Than Provider

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Financial and Organizational Affairs

Whereas, The term “provider” is used colloquially as an all-encompassing definition for an individual who works in the health care service industry; and

Whereas, The term “provider” does not offer any clarity for patients about the level of training or education of the person providing the care; and

Whereas, The term “provider” may create confusion among patients who perceive no difference in the care received from “providers” with varied education or training; and

Whereas, The term “provider” is used by insurance companies, hospitals, and health care systems, and nonphysician providers to encourage patients to seek care from lesser trained nonphysician providers rather than physicians, which could compromise medical standards and patient safety; and

Whereas, Patients are entitled to truth and transparency about who will be involved in their medical care; and

Whereas, Physicians have onerous educational admissions processes, standardized board exam processes, and requirements for supervised post-graduate education through accredited residency programs; and

Whereas, The Texas Medical Association and its members are dedicated to the highest quality medical standards for their patients; therefore be it

RESOLVED, That the Texas Medical Association, in its publications, policies, and conferences, shall cease using the term “provider” to describe physicians, substituting “physician,” “resident,” “fellow” or other term that recognizes the education, training, and experience of its members; and be it further

RESOLVED, That TMA encourage physicians, its local components, and the media to use the term “physician” instead of “provider” when describing physicians; and be it further

RESOLVED, That TMA refer the process of creating a formal position paper for the use of the term “provider” to the most suited committee or council.

Related TMA Policy:
245.002 Health Care Provider
245.013 Appropriate Title Nomenclature in Medical Settings
245.017 Clear Identification
Subject: Supporting Proportionate Representation of Special Interest Groups

Introduced by: Medical Student Section

Referred to: Reference Committee on Financial and Organizational Affairs

Whereas, The Texas Medical Association called for and established a special interest section, Women in Medicine, to increase the representation of female physicians in the TMA House of Delegates; and

Whereas, The Association of American Medical Colleges (AAMC) has defined underrepresented minority physicians as those whose numbers in medicine are disproportionately lower than in the general population, and includes African Americans, Native Americans/American Indians, Mexican Americans, mainland Puerto Ricans, and some Asian subgroups; and

Whereas, The AAMC Diversity in Medicine data depicts that the percentage of practicing physicians of white origin is 51.6%, and the cumulative percentage of active physicians of underrepresented minority origin, per the AAMC definition, is 12%; and

Whereas, The American Medical Association provides forums such as professional interest sections for the representation for physicians of underrepresented minority origin; and

Whereas, The Yale University School of Medicine Diversity in Medical Career Development Study utilized a sample size of 1,886 individuals, with 18.98% of study participants identifying as lesbian, gay, bisexual, or transgender, across a sampling distribution of U.S. medical students, residents, and physicians; and

Whereas, AMA provides a mechanism for the representation of physicians through the Advisory Committee on LGBTQ Issues which provides a forum within AMA to address the needs of LGBTQ physicians, medical students, and patients; be it therefore

RESOLVED, That the Texas Medical Association study the proportionate representation of special interest groups such as LGBTQ+ and underrepresented minorities among active osteopathic and allopathic TMA physician members; and be it further

RESOLVED, That our TMA create mechanisms like advisory committees or special interest subcommittees that increase interest and involvement in organized medicine among individuals who fall into special interest group strata on both a state and a county medical society level.

Relevant TMA Policy:
185.009 Promotion of Medicine and Health Careers to Underrepresented Minorities
200.031 Medical School Admissions

Relevant AMA Policy:
Professional Interest Medical Associations D-600.966
Representation in the House of Delegates. B-8.1
References:
4. AMA Policy Finder. About the Minority Affairs Section
6. AMA. Advisory Committee on LGBTQ Issues.
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 106
2020

Subject: Physician and Medical Student Promotion in Exchange for Gifts on Social Media

Introduced by: Medical Student Section

Referred to: Reference Committee on Financial and Organizational Affairs

Whereas, Trust between physicians and the public is important to preserve and maintain; and
Whereas, Physicians may feel enticed to accept and promote items in exchange for monetary compensation or complimentary products; and
Whereas, Lack of transparency about promotional items, such as not identifying advertisements per Federal Trade Commission guidelines, may falsely imply items are physician-recommended; and
Whereas, Physicians are less inclined to investigate if a product is beneficial to patient health if they receive them free of charge; and
Whereas, Sixty-five percent of physicians interact for professional reasons with social media platforms, where there is great potential to influence health outcomes; and
Whereas, An increasing number of physicians use social media as a marketing tool, especially in surgical or aesthetic specialties that have tangible results; and
Whereas, Forty percent of patients who actively use social media use it to choose their physician; and
Whereas, Many patients use social media to connect with others with similar conditions or ailments and may be susceptible to predatory tactics regarding resolution of their illness; and
Whereas, Patients and physicians might be misinformed or not fully understand how HIPAA standards apply to social media; and
Whereas, Social media has become a new platform by which physicians connect with the public and as of yet has not been integrated into American Medical Association or Texas Medical Association policy; however, it should be, to keep up to date with other medical organizations and the current direction of medicine; therefore be it

RESOLVED, That the Texas Medical Association amend Policy 9.6.2 Gifts to Physicians From Industry as follows:

Relationships among physicians and professional medical organizations and pharmaceutical, biotechnology, and medical device companies help drive innovation in patient care and contribute to the economic well-being of the community to the ultimate benefit of patients and the public. However, an increasingly urgent challenge for both medicine and industry is to devise ways to preserve strong, productive collaborations at the same time that they take clear effective action to prevent relationships that damage public trust and tarnish the reputation of both parties.
This should include not only gifts received in person but also on any social media platforms, including but not limited to Instagram, Facebook, Twitter, LinkedIn, and Snapchat, where physicians represent their position in the field of medicine.

Gifts to physicians from industry create conditions that carry the risk of subtly biasing—or being perceived to bias—professional judgment in the care of patients.

To preserve the trust that is fundamental to the patient-physician relationship and public confidence in the profession, physicians should:

(a) Decline cash gifts in any amount from an entity that has a direct interest in physicians’ treatment recommendations.

(b) Decline any gifts for which reciprocity is expected or implied.

(c) Accept an in-kind gift for the physician’s practice only when the gift:

(i) will directly benefit patients, including patient education; and

(ii) is of minimal value.

(d) Academic institutions and residency and fellowship programs may accept special funding on behalf of trainees to support medical students’, residents’, and fellows’ participation in professional meetings, including educational meetings, provided:

(i) the program identifies recipients based on independent institutional criteria; and

(ii) funds are distributed to recipients without specific attribution to sponsors.

(e) Disclose any industry relationships related to products the physician promotes on social media.

And therefore be it

RESOLVED, That TMA inform physician members of appropriate social media marketing practices related to this amendment through the relevant member channels.

Related TMA Policy:
9.6.2 Gifts to Physicians from Industry

Related AMA Policy:
2.3.2 Professionalism in the Use of Social Media

References:

6. Denecke K. Ibid.
WHEREAS, An undocumented immigrant is defined as someone who crossed a U.S. border without
authorization or who is not living within the terms of an entry visa or other authorization; and

WHEREAS, Immigrants face several unique barriers to accessing health care, including adequately
conveying their symptoms and medical history; and

WHEREAS, Training physicians and providers to recognize cultural and language barriers may alleviate
these challenges; and

WHEREAS, The majority of U.S. immigrants live in 20 metropolitan areas in the United States, and health
care professionals in safety-net settings likely will encounter patients whose access to care is impacted by
immigration policies; and

WHEREAS, Current immigration enforcement priorities have harmed health care access for documented and
undocumented immigrants, as well as U.S. citizens in mixed-status families, who have the concern that
interaction with the health care system will result in detention or deportation; and

WHEREAS, The federal public charge regulation that took effect Feb. 24, 2020, will allow the government
to reject applications for permanent residency status based whether the applicant used health-related
programs, such as Medicaid or the Supplemental Nutrition Assistance Program, which could make
immigrants even more reluctant to access the health care system; and

WHEREAS, Physicians and providers are not required by law to report individuals who are undocumented to
legal authorities and may refuse to provide information about patients to law enforcement officers unless
that information is covered under an active warrant for a specific individual; and

WHEREAS, Hospitals and other health care facilities are considered “sensitive locations” where actions of
immigration enforcement agencies are to be avoided without prior approval or a warrant; and

WHEREAS, Enforcement officers must have a warrant or the consent of an authorized person to enter areas
of a health care facility designated as private; and

WHEREAS, Educating physicians on the rights of immigrants pursuing health care can improve the quality
of care delivered to this population and reduce reluctance to seek care among members of this
community; therefore be it

RESOLVED, That the Texas Medical Association advocate for the adoption by health care facilities of
policies that protect the rights of immigrants when seeking care, such as designation of private areas of
the clinic, and discourage routine collection of patient immigration status information; and be it further
RESOLVED. That our TMA support the education of physicians, health care providers, and patients about their rights when seeking medical care, such as their right to refuse to answer questions from immigration agents and to insist that their lawyer be present if they are questioned.

Related TMA Policy:
55.057 Health Care of Undocumented Children

Related AMA Policy:
Patient and Physician Rights Regarding Immigration Status H-315.966
Presence and Enforcement Actions of Immigration and Customs Enforcement (ICE) in Healthcare D-160.921
Medical Care Must Stay Confidential H-270.961
Addressing Immigrant Health Disparities H-350.957
Opposition to Regulations That Penalize Immigrants for Accessing Health Care Services D-440.927
Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients H-440.876
Support of Health Care to Legal Immigrants H-290.983

References:
Subject: For the Creation of a Physician-Led Public Outreach and Education Organization to Defend the Integrity of the Medical Profession and Advocate for Sustainable, Evidence-Based Health Care Policy

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Financial and Organizational Affairs

Whereas, Evidence suggests growing support among national politicians and the general public for expansive health care reform. It is feasible that national legislation creating a universal Medicare or single-payer system will be proposed soon; and

Whereas, In the absence of clear and accessible evidence derived from the scientific method and rational skepticism, such reform is driven by anecdotes, assumptions, emotion, and politics; and

Whereas, Despite the aforementioned public support for significant change to our health care system, the implications for patient choice, physician autonomy and the “rationing of care” are often poorly understood; and

Whereas, Some of the proposed reforms directly conflict with Texas Medical Association and American Medical Association policy – that health care reform should be evidence-based, responsible, sustainable, incremental, and preserve freedom of choice and practice, as described in TMA policy 120.010; and

Whereas, An organization with a mission that is entirely focused on public outreach and education can more forcefully and without compromise encourage public support for health care policies that are evidenced-based, effective, and sustainable as well as defend the integrity and trustworthiness of the medical profession; and

Whereas, The startup investment provided by medical societies for the creation of the proposed entity can be structured in the form of a loan to be repaid at a future date. The initial phase of development could include the minimum personnel and resources necessary to create a website, solicit additional sources of funding from individuals and organizations, and recruiting essential staff; therefore be it

RESOLVED, That the Texas Medical Association, in collaboration with other medical societies, create and support a permanent, physician-led, independently funded public outreach entity to use multiple media platforms (conventional, online, and social media) to engage the public, share information, promote an educated dialogue, advocate for evidenced-based, incremental, and sustainable health care policy and defend the integrity of the medical profession; and be it further

RESOLVED, That the Texas Delegation to the American Medical Association carry a similar resolution to the AMA House of Delegates which calls upon the AMA to support the aforementioned permanent, physician-led, independently funded public outreach entity.

Related TMA Policy:

60.004 Freedom of Choice
110.003 Private Individualized Medical Care
110.009 Health Care Coverage
120.001 Health Care Reform
120.002 Health System Reform Cost Control
120.003 Health System Reform Managed Care
120.010 Principles for Evaluating Health System Reform
145.005 Single Payer Systems
145.007 Competitive Insurance Models
145.009 Individual Responsibility for Health Care
145.012 Health Insurance Individual Ownership
145.013 Private Healthcare System, Impact of Uninsured
190.032 Medicaid Coverage and Reform

Related AMA Policy:
165.838 Health System Reform Legislation
H-165.844 Educating the American People About Health System Reform
H-165.888 Evaluating Health System Reform Proposals
H-165.904 Universal Health Coverage
D-165.935 Protecting Patient Access to Health Insurance Coverage, Physicians, and Quality Health Care
AGENDA
MEDICAL EDUCATION AND HEALTH CARE QUALITY BUSINESS

To provide testimony click HERE
Click on the agenda item to navigate to it

1. Council on Medical Education Report 1 – Amendment to Policy 185.023 Support of Rural
3. Council on Medical Education Report 3 – Opposition to Diversion of Medicare Funding for Graduate Medical Education From Physicians to Training Programs for Midlevel Practitioners
7. Council on Medical Education Report 4 – Amendments to Policy 200.047 Clinical Training Resources for Texas Medical
8. Council on Medical Education Report 5 – Amendment of Policy 320.007 Town Gown Medical School Funding
9. Council on Medical Education Report 7 – Referral of Res. 211-A-19, The Integration of LGBTQ Health Topics into Medical Education

Agenda Items Tabled to 2021
The following items of business are tabled to the 2021 HOD meeting. However, one may make two motions: ‘Referral to the BOT for Action and report back’ (allowing TMA BOT to adopt policy and address the item and report back to the TMA 2021 HOD) or ‘Referral to the BOT and report back’ (allowing the BOT to consider the item and report back to the TMA 2021 HOD. Your Speakers strongly encourage the use of referral (of tabled items) be limited to urgent and essential items.

11. Resolution 201 – Augmented Intelligence (AI) in Health Care
12. Resolution 202 – Admission of Deferred Action for Childhood Arrivals (DACA) Students in Texas Medical Schools
13. Resolution 203 – Supporting Implicit Bias Training for Perinatal Physicians
14. Resolution 204 – Promoting Careers in Geriatrics Among Medical Students
15. Resolution 205 – Service Animal Assisted Therapy in Healthcare
16. Resolution 206 – Amending the Mental Health Question on Physician Licensure Application to Reflect Current Impairment
Subject: Amendment to Policy 185.023 Support of Rural Residency Training and State Grant Program for Promoting Rural Training Tracks

Presented by: Ronald L. Cook, DO, Chair

Referred to: Reference Committee on Medical Education and Health Care Quality

TMA Policy 185.023 Support of Rural Residency Training and State Grant Program for Promoting Rural Training Tracks was adopted by the House of Delegates in 2017. The policy supports state legislation for creation of a grant program for the development of rural training tracks. It was determined this program is needed to provide an incentive for urban and rural hospitals to create residency programs specifically designed to train physicians for the unique patient care needs and practice demands of rural medical practice. In 2019, the Texas Legislature passed, and the governor signed, House Bill 1065 to create a state rural training track grant program. However, no funds were appropriated in the state budget for 2020-21 to allow the new program to be established.

Given the state’s continuing geographic maldistribution of physicians in many rural areas, as demonstrated by the disparity in the physician to population ratio (per 100,000) of 89.8 for rural areas vs. 201.7 for urban areas, and the degree of medical underservice for many Texans living in rural and isolated communities, the council recognizes the ongoing need for this program. It has been estimated that at least $1 million is needed to provide a sufficient incentive for urban and rural hospitals to partner in the creation of more rural training tracks in the state. For House Bill 1065 to be implemented and the aims of Policy 185.023 to be realized, this amount of state funding is needed.

Recommendation: The council recommends amending Texas Medical Association Policy 185.023 to support TMA advocacy for a minimum of $1 million in state funding in the 2022-23 state budget to allow the state’s Rural Resident Physician Grant Program to become operational.

185.023 Support of Rural Residency Training and State Grant Program for Promoting Rural Training Tracks: Texas needs more targeted programs to diminish the persistent shortage of physicians in rural areas. Recognizing the well-established linkage between where a resident trains and where he or she enters practice, it is important to institute residency training programs in rural areas with the resources to support such training. The Texas Medical Association (TMA) recognizes the documented benefits of rural training track programs to rural communities and in preparing physicians for rural practice, as supported by research studies.

Accordingly, the Texas Medical Association (TMA) supports legislative efforts to establish a state program to provide grants to incentivize the development of rural training tracks and other models of residency training designed for rural settings. TMA should advocate for a minimum of $1 million in state funding to administer the grant program in the 2022-23 state budget. To promote the success of the grant projects, TMA supports the use of eligibility criteria that take into account the likelihood a residency training program will be able to meet and maintain national graduate medical education (GME) accreditation standards and produce physicians who are well prepared for rural practice.

TMA will promote awareness of the grant opportunities among potential applicants. TMA recognizes the stifling effect that Medicare graduate medical education (GME) funding policies have had on GME residency expansions. TMA strongly supports retention of the current federal
payment provision that allows urban and rural hospital sponsors of rural training tracks to qualify
for an exception to their respective Medicare GME funding caps. It is important for this exception
to continue to allow rural training tracks to qualify for both direct and indirect Medicare GME
funding (CME Rep. 4-A-17).
REPORT OF COUNCIL ON MEDICAL EDUCATION

C-ME Report 2 2020

Subject: Sunset Policy Review

Presented by: Ronald L. Cook, DO, Chair

Referred to: Reference Committee on Medical Education and Health Care Quality

The Texas Medical Association periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness.

The Council on Medical Education recommends retention of the following policies:

- **185.005 Physician Shortage:** TMA voted to be of assistance to medical education institutions as they address the issue of furnishing an adequate supply of physicians for the citizens of Texas (Res. 28V, p 193, I-92; amended CME Rep. 6-A-03; reaffirmed Res. 301-A-10).

- **200.036 Community-Based Medical Education:** TMA believes that community-based medical education is a viable model that should be evaluated in each community (BOT Rep. 6-I-00; reaffirmed CME Rep. 2-A-10).

- **205.019 Instructional Costs for GME:** TMA advocates that the Texas Legislature should provide adequate support for the instructional costs of graduate medical education (CME Rep. 6-A-00; reaffirmed CME Rep. 2-A-10).

- **295.012 Medical School Support of Medical Student Involvement in TMA and AMA:** TMA encourages medical school administrations and residency faculty to provide a mechanism through which students and residents may participate in meetings as an excused absence that does not represent allotted vacation time (Res. 101-A-10).

**Recommendation 1:** Retain.

The Council on Medical Education recommends amending the following policy to reflect recent changes in the state’s physician workforce:

- **200.028 Medical School Expansion:** Given current physician shortages in many medical specialties, projected state demographics, the professional liability crisis, and the decreasing numbers of out-of-state physicians moving into the state, and the aging of the physician workforce, Texas is approaching a physician shortage. TMA supports medical school and residency program expansions. This evidence supports a need to consider enhancement of the physician pipeline through expansion of Texas medical school and residency program slots, with more immediate attention needed to expand resident slots. Expansions of student and resident slots should be based on a methodology that seeks to address unmet Texas health care needs. There also is the need to maintain a favorable stabilizes the state’s physician practice environment to improve recruitment and retention and to promote awareness of specialty shortages among medical students. Further, expansions should not jeopardize the viability of existing programs, and the outcome of any expansion should be to improve the health care of the people of Texas (Substitute Resolution 28D, p 196, A-96; substitute CME Rep. 6-A-03; reaffirmed Res. 301-A-10).

**Recommendation 2:** Amend.
The U.S. General Accounting Office (GAO) released a report on Dec. 18 that examined the possibility of diverting Medicare graduate medical education (GME) funding from residency programs for physicians to training programs for advanced practice registered nurses and physician assistants. Medical schools and teaching hospitals are already greatly challenged to provide the funding needed to support existing residency training positions and to create additional positions needed for the growing number of medical school graduates. Many residency positions in Texas receive no support from the Medicare GME funding program. This is the result of a freeze placed on the number of residency positions Medicare will support as directed by the Balanced Budget Amendment of 1997 (105th Congress). The freeze serves as a direct impediment to the creation of needed GME positions for physicians in response to the high rate of population growth in the state. Recognizing that GAO conducts research on behalf of congressional members, the council is gravely concerned about the possibility of congressional action to divert the already-limited federal support for residency programs to training programs for midlevel practitioners.

Recommendation 1: The council recommends the following be adopted as Texas Medical Association policy:

Opposition to Diversion of Medicare Funding for Graduate Medical Education to Training Programs for Midlevel Practitioners

The Texas Medical Association (1) strongly opposes reallocating Medicare funding for physician training programs to training programs for advanced practice registered nurses and physician assistants; (2) strongly opposes caps on the funding of graduate medical education programs through Medicare, as mandated by the federal Balanced Budget Amendment of 1997; and (3) advocates for the Texas congressional delegation to take action to lift the Medicare funding caps for the training of physicians in Texas.

Recommendation 2: That Texas Delegation to the American Medical Association take a resolution to the AMA House of Delegates to adopt policy that opposes the diversion of Medicare funding for graduate medical education from physicians to training programs for advanced practice registered nurses and physician assistants.

Related TMA policy:
None.

Related AMA policy:
None
The burden of extraordinarily high education-related debt on young physicians is widely recognized. In recent years, average debt for medical school graduates has steadily increased. The median debt for allopathic medical school graduates who have debt has reached $200,000; for osteopathic graduates, it is above $250,000. Almost 10% of allopathic graduates with debt have median debt above $300,000.

Research studies have determined that high debt can deter the selection of primary care careers. In recognition of this, a physician in training alerted the committee about a federal bill that would qualify residents to halt the accrual of interest on educational loans until completion of residency training. The Resident Education Deferred Interest Act (REDI Act, HR 1554, 116th Congress 2019-20) by U.S. Rep. Brian Babin (R-Texas) would make student loan borrowers eligible for interest-free deferment of loans under the William D. Ford Federal Direct Loan Program if the borrowers are serving in medical or dental internships or residency programs. This legislation would not forgive debt.

Residents living on stipends during their training have average incomes of $60,000 a year. This level of income makes it difficult to cover living expenses and pay back student loans, even if payments are limited to interest charges and not loan principal. The committee determined it was important to support residents in training and to help promote careers in primary care among medical students by promoting measures to reduce education-related debt.

**Recommendation:** The committee recommends adopting the following as Texas Medical Association policy:

Support for Interest-Free Deferment of Education Loans for Residents in Training

The Texas Medical Association supports federal legislation to allow student loan borrowers to be eligible for interest-free deferment of loans while physicians are in residency training.

**Related TMA policy:**

205.001 Student Loan Deferment

**Related AMA policy:**

None.

**Sources:**

Subject: Sunset Policy Review

Presented by: Evan Pivalizza, MD, Chair

Referred to: Reference Committee on Medical Education and Health Care Quality

TMA periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness.

The Committee on Physician Distribution and Health Care Access recommends retention of the following policies:

205.001 Student Loan Deferment: The Texas Medical Association supports deferment of federal medical student loan repayment by residents until completion of their postgraduate training (Committee on Rural Health, p 167, A-90; amended CME Rep. 5-I-00; reaffirmed CME Rep. 2-A-10).

See also the committee’s handbook report on support for the REDI Act (CM-PDHCA Report 2 2020 Support for Interest-Free Deferment of Education Loans for Residents in Training).

205.003 Entry-Level RN Educational Program Funding: The Texas Medical Association supports the state’s entry-level registered nurse educational programs in their activities to seek increased state funding for expansion of faculty and space resources to accommodate qualified applicants (Substitute Res. 27V, p 181C, I-90; reaffirmed CME Rep. 5-I-00; amended CME Rep. 2-A-10).

Recommendation 1: Retain.

The Committee on Physician Distribution and Health Care Access has concluded that the policies below have been accomplished and that other TMA policies support adequate funding for this program. They recommend deletion of the following policies:

205.031 Restore Funding of Statewide Preceptorship Program: TMA strongly encourages the Texas Legislature to provide increased funding for the Statewide Preceptorship Program through various state, federal, or other funding mechanisms (Res. 303-A-10).

205.035 Restore Funding of Statewide Preceptorship Program: As a top priority, TMA will encourage the 2013 Texas Legislature to restore funding to the Statewide Preceptorship Program and ensure its viability through the remainder of this decade (Res. 208-A-12).

Recommendation 2: Delete.
Subject: Initial Assessment and Treatment Recommendation by Specialists, Resolution 108-A-19

Presented by: Council on Health Care Quality and Interspecialty Society Committee

Referred to: Reference Committee on Medical Education and Health Care Quality

Background
The 2019 House of Delegates considered Resolution 108-A-19, Initial Assessment and Treatment Recommendation by Specialists, from the Young Physician Section. The resolution pertains to the responsibility of the specialist physician within the context of conducting an initial evaluation of a patient referred from a primary care physician. The resolution expressed concern that nonphysician practitioners do not provide the level of expertise that primary care physicians seek when they refer patients to a physician specialist. The resolution sought to establish TMA policy recognizing “that the best practice of patient care dictates that it is the responsibility of the physician to develop the diagnosis and treatment in the evaluation of a patient, while it is recognized under limited circumstances that an initial evaluation may be conducted by a nurse practitioner or physician assistant.” The resolution was presented at the Reference Committee on Financial and Organizational Affairs, which recommended adoption with amendments. However, testimony at the House of Delegates recommended a thorough review of language that would be more appropriate for all physicians, both primary care physicians and physician specialists. Therefore, the House of Delegates recommended referral for study with report back. The resolution was referred to the Council on Health Care Quality and Interspecialty Society Committee for study and consideration.

Discussion
The Council on Health Care Quality and Interspecialty Society Committee reviewed and discussed Resolution 108-A-19 during their meetings held at TMA’s fall and winter conferences. Members expressed professional opinions ranging from support of the existing language or amendments to strong opposition for a new policy on the subject. There was concern that TMA should not set policy on the initial assessment and treatment by physician specialists that would interfere with physicians’ ultimate authority on how to run their practice and to decide the proper course of care for the individual patient and practice settings. In addition, there was concern that the language as proposed or amended could overreach standard delegation as laid out in the Medical Practice Act. Furthermore, input from the TMA Office of the General Counsel cautioned against using “best practice” in this context, as it could lead to unintended consequences from a legal standpoint. However, given the differing opinions, consensus reached was that with further study several amendments could be made in the “resolved” statement that would be acceptable to all viewpoints. Both councils will meet jointly at the next conference for further discussion and final recommendation.

In 2012, the council brought forward TMA Policy 200.047 Clinical Training Resources for Texas Medical Students in response to an effort by the American University of the Caribbean to buy clerkship positions in Texas for its medical students. This policy includes the position that “foreign medical students should not displace Texas medical students in clinical training positions at Texas health care facilities. Priority should be given to Texas medical students and other health care professionals for clinical training.” In response to this policy, TMA collaborated with Texas medical schools to gain passage of a law that prohibits medical schools chartered in foreign countries from buying medical student clerkship positions in Texas training institutions.

For some time, medical students from Burrell Osteopathic Medical School, a for-profit medical school in Las Cruces, N.M., have been completing clinical clerkships in El Paso. Additional medical schools in other states have sent students to Texas for clerkships. This raises the question about the adequacy of the clerkship capacity in the state to meet the growing demand from Texas medical students as well as students from medical schools in other states.

The council has concerns about this level of competition and whether Texas has sufficient training capacity for Texas medical students. These concerns are based on several factors:

- No evidence of a surplus of clinical clerkship positions in the state to meet the growing demand from out-of-state students;
- An outdated assessment of medical student clinical clerkship capacity for Texas by the Texas Higher Education Coordinating Board; since its last study was completed in 2013, three medical schools have opened in Texas, two more will open in 2020, and another will open in the near future, raising the state total from 10 to 16;
- A projected increase to 2,300 by 2021 in the total number of first-year students at Texas medical schools, with this number going up by several hundred after full development of the three new medical schools;
- An increased competition for clinical clerkship training space from multiple other health care professions, such as advanced practice registered nurses and physician assistants, many of which are increasing at two to three times the rate of new physicians; and
- A growing shortage of clinical clerkship capacity across the country for physicians and other health care professionals, resulting in ever-greater demands on existing training facilities.

In response to recent events, the council determined TMA Policy 200.047 should be amended to take a position that opposes the displacement of Texas medical students from clerkship positions by students enrolled in medical schools in other states. This would be in addition to the current policy that opposes displacement by students enrolled in medical schools in other countries. The revised policy also would clarify that students enrolled in Texas medical schools should receive first priority for clinical clerkship positions in the state.
Recommendation: Amend Texas Medical Association Policy 200.047 Clinical Training Resources for Texas Medical Students as follows:

TMA adopted the following principles as policy regarding clinical training resources for Texas Medical Students:

1. Policies governing the accreditation of U.S. medical education programs specify that core clinical training be provided by the parent medical school; consequently, the Texas Medical Association strongly objects to the practice of substituting clinical experiences provided by U.S. institutions for core clinical curriculum of foreign medical schools. Moreover, our association strongly disapproves of the placement of any medical school undergraduate students in hospitals and other medical care delivery facilities that lack sufficient educational resources for the supervised teaching of clinical medicine.

2. Institutions that accept students for clinical placements should ensure that all such students are trained in programs that meet requirements for curriculum, clinical experiences, and attending supervision as expected for programs accredited by the Liaison Committee on Medical Education or the Commission on Osteopathic College Accreditation.

3. TMA opposes extraordinary payments by any medical school for access to clinical rotations.

4. Foreign medical students should not displace Texas medical students in clinical training positions at Texas health care facilities. Priority should be given to Texas medical students and other health care professionals for clinical training. Texas medical students should not be displaced from clinical clerkship positions at Texas health care facilities by students from medical schools outside of Texas, including other states and countries, or by other health care professionals seeking clinical clerkship training. Top priority for clinical clerkship training in the state should be given to Texas medical students followed by other health care professionals enrolled in Texas programs (CME Rep. 3-A-12).
Subject: Amendment of Policy 320.007 Town Gown Medical School Funding

Presented by: Ronald L. Cook, DO, Chair

Referred to: Reference Committee on Medical Education and Health Care Quality

TMA Policy 320.007 Town Gown Medical School Funding contains a message for academic medical centers in the state that seeks to restrict their business options. This policy states: “The Texas Medical Association (TMA) believes that medical schools should refrain from income-generating activities and services that would result in the generation of funds in excess of those needed to support their education, patient care and research missions, and that Texas medical schools should refrain from using their state agency/nonprofit status tax exemptions in advertising and promoting their medical services.” The full text of 320.007 is as follows:

320.007 Medical School Funding Town Gown. TMA supports the use of state appropriations to medical schools and graduate medical education (GME) programs for their education, work force, and research missions. However, TMA believes that medical schools should refrain from income-generating activities and services that would result in the generation of funds in excess of those needed to support their education, patient care and research missions, and that Texas medical schools should refrain from using their state agency/nonprofit status tax exemptions in advertising and promoting their medical services. TMA strongly supports requiring Medicaid managed care organizations to include any GME training programs located in their geographic coverage areas among their network(s) of providers serving Medicaid enrollees (Board of Trustees, p 18, I-96; amended CSE Rep. 1-A-08; amended CSE Rep. 1-A-18).

The council believes all but the last sentence of this policy is outdated, detrimental, and needs to be reevaluated. The last sentence should be retained as TMA policy. In reevaluating the other components of the policy, consideration should be given to the current prevalence of advertising in health care at all levels. The council also questions whether TMA should seek to influence the business practices of academic health centers. No applicable legal restrictions on advertising are known to the council to serve as an underpinning for this policy. The council is uncertain how TMA has or will implement this policy.

It is also important to consider how this policy is viewed by academic physicians. Last year, the council heard concerns about this policy from a medical school dean. Physicians in employed positions, including academic physicians, are particularly challenging to recruit as TMA members. This policy is not expected to be helpful in overcoming those challenges. Rather, this policy is viewed as an impediment to academic membership recruitment and collaboration with medical school leadership.

Prevalence of Advertising in Today’s Health Care Market
When 320.007 was adopted in 1996, advertising by physicians and medical centers was not pervasive, but this has changed, and advertising is now widespread throughout the health care market. Many now view advertising as an absolute necessity.

Reductions in State Funding of Academic Medical Centers
The council believes this policy may have been based on a misconception about the amount of public funding provided to academic health centers and teaching hospitals. Teaching institutions have seen a drastic decline in state funding. In recent years, the Texas Legislature has repeatedly directed academic health centers to reduce their dependence on public funding by establishing alternative sources of
revenues. The experience of The University of Texas Medical Branch (UTMB) in Galveston demonstrates the decline in public funding, as shown below.

**EXAMPLE: HISTORIC TREND FOR STATE FUNDING OF UTMB**
The amount of public funding received by UTMB is considerably less than in prior years, dropping from 56% of revenues in 1981 to 17% in 2017 and 2018. The sharp decline is demonstrated by the red line in the graph.

![UTMB Revenue Trend](image)

Texas academic health centers receive a range of an estimated 14% to 19% of their revenues from state appropriations. This clearly demonstrates that public funding is grossly insufficient for maintaining operations. Given the large role of these institutions in the delivery of health care services, their economic strength is of importance to all physicians and residents of Texas.

**Shared Goals and Values**
The council believes physicians share many common goals, regardless of practice setting:

- All physicians share a common goal of providing the best possible medical care for their patients.
- Academic physicians are TMA members, too, numbering more than 10,000 or 17% of the physician membership.
- TMA members in all practice settings should work together to support academic programs that seek to prepare the next generation of physicians for Texas.
- Although the practice settings may be different, physicians in academic medicine and physicians in private practice share the same work ethic.
• Academic health centers are nonprofit, safety-net institutions for the sickest and poorest Texas residents, serving high numbers of Medicare, Medicaid, underinsured, and uninsured patients. This benefits all Texans.

• As educators and trainers, academic health centers produce the health professions workforce for every part of the health care delivery system.

Fiscal Realities
• Texas strives to keep medical school tuition and fees at reasonable levels to promote access to medical education and prevent high debt for future physicians. Consequently, tuition and fees are a miniscule portion of an academic health centers’ budget: about 1% to 2%.

• The state does not provide sufficient funding to support the full cost of educating medical students and residents. The medical schools’ faculty practice plans are used to fund many residency positions along with basic science and clinical research programs.

• Compensation models for physician faculty are typically predicated on specific performance targets for clinical practice.

• Need for academic health centers to generate clinical revenues is not unique to Texas and is prevalent across the country. As evidence: In 1977, clinical service represented only 20% of medical school revenues in the U.S., and now it is closer to 60%.

The council believes it is more reflective of TMA’s values to have policies that display mutual respect between physicians in different practice settings. For all the reasons detailed in this report, the council recommends the following deletions and amendments to this policy.

Recommendation: Amend Texas Medical Association Policy 320.007 as follows:

Medical School Funding Town Gown Support for Graduate Medical Education Involvement in Medicaid Managed Care Organization Networks TMA supports the use of state appropriations to medical schools and graduate medical education (GME) programs for their education, workforce, and research missions. However, TMA believes that medical schools should refrain from income-generating activities and services that would result in the generation of funds in excess of those needed to support their education, patient care and research missions, and that Texas medical schools should refrain from using their state agency/nonprofit status tax exemptions in advertising and promoting their medical services. TMA strongly supports requiring Medicaid managed care organizations to include any graduate medical education GME training programs located in their geographic coverage areas among their network(s) of providers serving Medicaid enrollees (Board of Trustees, p 18, 1-96; amended CSE Rep. 1-A-08; amended CSE Rep. 1-A-18).
Subject: Referral of Res. 211-A-19, The Integration of LGBTQ Health Topics into Medical Education

Presented by: Ronald L. Cook, DO, Chair

Referred to: Reference Committee on Medical Education and Health Care Quality

Resolution 211-A-19, The Integration of LGBTQ Health Topics into Medical Education (2019), from the TMA Medical Student Section, was referred to the Council of Medical Education and the Council on Science and Public Health for a report back in 2020. This report was prepared by the Council on Medical Education and is supported by the Council on Science and Public Health and the TMA Workgroup on LGBTQ Health.

The resolution sought adoption of the following as TMA policy:

RESOLVED, That TMA support the integration of LGBTQ health care topics into undergraduate and graduate medical education; and be it further

RESOLVED, That TMA work with the appropriate parties to develop best practices for the integration of LGBTQ health care education into undergraduate and graduate medical education as well as CME.

The reference committee at its TexMed 2019 meeting heard testimony both for and against Res. 211. The council testified that this type of education is covered by current medical school and residency program accreditation standards. The reference committee agreed but determined this was a timely and important issue that warranted additional study. The house concurred and referred the resolution.

Research on Current Teaching of LGBTQ Patient Care in Medical Education

To understand the goals of the resolution, the council invited the author to its meeting on Jan. 24 to speak about his objectives in drafting the resolution. In evaluating its merits, both councils recognized they did not have specific expertise on the teaching of LGBTQ patient care to medical students, residents, and physicians as referenced in the resolution and that few resources were available for measuring this. For this reason, the council researched how this topic is covered in medical education to assess whether resources are already available for identifying best practices. The councils:

- Searched national accreditation standards for medical schools and residency programs,
- Consulted with a member of the TMA Workgroup on LGBTQ Health who is also involved in academic medicine, and
- Reviewed relevant TMA and AMA policies.

The results of these activities are summarized below to assist the house in evaluating this proposal.
Relevant Policies, Accreditation Standards, and Resources

TMA Policy – 265.028 Improving LGBTQ Health Care Access
TMA recognizes that LGBTQ individuals have unique health care needs and suffer significant barriers in access to care that result in health care disparities. TMA will provide educational opportunities for physicians on LGBTQ health issues to increase physician awareness of the importance of building trust so LGBTQ patients feel comfortable voluntarily providing information on their sexual orientation and gender identity, thus improving their quality of care. TMA also will continue to study how best to reduce barriers to care and increase access to physicians and public health services to improve the health of the LGBTQ population. (CSPH Rep. 8-A-18).

AMA Policy – Medical Spectrum of Gender D-295.312
Given the medical spectrum of gender identity and sex, our AMA: (1) will work with appropriate medical organizations and community based organizations to inform and educate the medical community and the public on the medical spectrum of gender identity; (2) will educate state and federal policymakers and legislators on and advocate for policies addressing the medical spectrum of gender identity to ensure access to quality health care; and (3) affirms that an individual’s genotypic sex, phenotypic sex, sexual orientation, gender and gender identity are not always aligned or indicative of the other, and that gender for many individuals may differ from the sex assigned at birth.

Liaison Committee for Medical Education Accreditation Standards, 2020-21
7.6 Cultural Competence and Health Care Disparities
The faculty of a medical school ensure that the medical curriculum provides opportunities for medical students to learn to recognize and appropriately address gender and cultural biases in themselves, in others, and in the health care delivery process. The medical curriculum includes instruction regarding the following:
- The manner in which people of diverse cultures and belief systems perceive health and illness and respond to various symptoms, diseases, and treatments;
- The basic principles of culturally competent health care;
- Recognition of the impact of disparities in health care on medically underserved populations and potential solutions to eliminate health care disparities;
- The knowledge, skills, and core professional attributes (e.g., altruism, accountability) needed to provide effective care in a multidimensional and diverse society.

ACGME Common Program Requirements (Residency)
IV.B.1.a).(1).(e) respect and responsiveness to diverse patient populations, including but not limited to diversity in gender, age, culture, race, religion, disabilities, national origin, socioeconomic status, and sexual orientation; (Core) Effective July 1, 2019.

Compelling Factors
In researching the potential benefits of education on health care for LGBTQ patients, the council identified the following compelling factors. These help quantify the vast numbers of at-risk patients and the potential adverse health conditions for these vulnerable populations.
- An estimated 8 million adults in the U.S. identify as lesbian, gay, or bisexual, and 700,000 identify as transgender.
- Individuals with disorders/differences of sex development (DSD) have “congenital conditions in which development of chromosomal, gonadal, or anatomic sex is atypical,” as defined by a 2006 Consensus Statement. They represent 1% of the population and are at increased risk of cancer, infertility, psychosocial distress, and other health care issues.
Other research identified additional health risk factors, including:

- Modifiable risk factors for cardiovascular disease such as mental distress, obesity, hypertension, and abnormal blood glucose levels;
- Breast cancer;
- Substance use disorders;
- Sexually transmitted infections; and
- Mental health disorders.

Healthy People 2020 identified the following potential benefits of addressing health concerns and reducing disparities:

- Eliminating LGBT health disparities and enhancing efforts to improve LGBT health are necessary to ensure that LGBT individuals can lead long, healthy lives. The many benefits of addressing health concerns and reducing disparities include:
  - Reductions in disease transmission and progression;
  - Increased mental and physical well-being;
  - Reduced health care costs; and
  - Increased longevity.

Current Resources for Best Practices

A major objective of the resolution was to establish policy directing TMA to develop best practices for the integration of LGBTQ health care education into medical education. In evaluating this proposal, the councils made the following determinations:

- Neither of the two TMA councils have the expertise to draft best practices for developing the curricula or delivering this type of education to medical students, residents, and physicians; and
- Curricular content is already readily available.

Current Resources for Medical School Curriculum

The Association of American Medical Colleges (AAMC) offers an extensive catalogue of resources to help medical schools prepare students to provide medical care to LGBTQ patients. In 2014, AAMC’s Advisory Committee on Sexual Orientation, Gender Identity, and Sex Development published a competency-based report, Implementing Curricular and Institutional Climate Changes to Improve Health Care for Individuals who are LGBT, Gender Nonconforming, or Born with DSD: A Resource for Medical Educators. This is designed to help medical schools mitigate educational barriers by offering multimodal approaches and best practices for U.S. and international medical programs.

This report served as a framework for a pilot developed by the University of Louisville School of Medicine to “implement these competencies as part of an integrative curriculum revision that could be modeled by other programs.” This resulted in the development of the eQuality Toolkit. Although it was designed for use in educating medical students, it is readily accessible at no cost and may be beneficial for residents, physicians in practice, and other health care professionals. It is intended for broad distribution, and experts point to this educational model as an excellent resource. This relieves individual medical schools from having to develop their own curriculum.

TMA Survey of Texas Medical School Curriculum Deans

To understand the integration of this education at Texas medical schools, the council in mid-December conducted an email survey of curriculum deans at each Texas medical school. The schools were asked to respond to the following survey questions:
1. Does your medical school curriculum have specific content intended to prepare students to provide health care that meets the unique medical needs of LGBTQ patients?

2. If so, how is it integrated into the curriculum? Is it longitudinal? Is it a discrete component of the curriculum, such as the eQuality Toolkit prepared by the University of Louisville School of Medicine, or integrated more broadly into other topics?

3. If it is a discrete component, please estimate how much of the curriculum is dedicated to this activity, such as percentage of the course/activity.

4. If it is integrated into other topics, please identify those topics.

Through the survey, the council learned that six of the seven responding schools (out of 12 surveyed) have integrated this education into their curriculum: Baylor College of Medicine, Texas Tech University Health Sciences Center (TTUHSC) Lubbock, TTUHSC Paul L. Foster School of Medicine, The University of Texas at Austin Dell Medical School; McGovern Medical School at UTHealth, UT Health San Antonio Long School of Medicine; and UT Southwestern Medical School. Only one responding school, the University of North Texas Health Science Center, Texas College of Osteopathic Medicine, reported the curriculum does not include this topic. It was also reported that individual students at this school have been active in various educational activities on the topic.

Most schools reported that this education represents 2% to 3% of the overall curriculum. Some courses are discrete components while others are woven into broader subjects and clerkships. Examples: Society, Community, and the Individual; Sexual Orientation and Gender Identity; Determinants and Social Health of Populations; Unconscious Bias in Healthcare; Reproductive Medicine; and Endocrine and Female Reproductive Health.

Developing Best Practices for Residency Program Curricula

Res. 211 also sought best practices for the inclusion of this education in residency training. The council did not have expertise on curricula used by residency programs and determined it was not feasible to collect this information through a survey, for the following reasons:

1. Texas has 668 residency programs accredited by the Accreditation Council for Graduate Medical Education and 41 designated institutional officials responsible for those programs. It was not practical for TMA to survey the residency programs in the same manner as the curriculum deans for the medical schools to assess curricular content for residency training. The council recognized, however, that the accreditation requirements for residency programs require programs to show “respect and responsiveness to diverse patient populations, including diversity in sexual orientation.”

2. Given the specificity of residency training, it would be difficult for TMA to develop best practices that would be applicable for all specialties.

Developing Best Practices for CME

As previously noted, the council identified a multitude of CME courses on this topic that are readily available to physicians, including a course produced by TMA, as listed below.

- TMA’s on-demand webinar, Inclusive Health Care for LGBTQ Patients, was released in 2019 and is free of charge to TMA members.
- More than 60 CME programs are available at no charge at the National LGBT Health Education Center, a program of the Fenway Institute.
- Additional information on CME programs is provided in the eQuality Toolkit.
- Many other sources of CME on this topic were identified for physicians.
Simplification of Nomenclature

As part of this research, the council learned that the American Medical Association made a determination in November that the term “LGBTQ” may not represent individuals who are “nonbinary,” and that leaving the language open to sexual orientation and gender identity may be more inclusive. In response, the council incorporated these terms in its policy recommendation.

Summary

The council determined that some Texas medical schools have integrated LGBTQ health teaching into their curricula. The Council on Medical Education and the Council on Science and Public Health support this activity at Texas medical education institutions and recommend the adoption of new TMA policy that reflects this support. It was further determined that TMA does not have the expertise or resources to develop best practices to be offered for use by the medical schools. And, finally, the council’s research identified ample resources for use by the schools.

Recommendation: Adopt as new policy in lieu of Resolution 211-A-19:

Promoting Education of Sexual Orientation and Gender Identity Health Issues in Academic Health Centers. To reduce health disparities and enhance access to care for diverse patient populations, TMA supports the integration by Texas academic health centers of education on sexual orientation and gender identity health issues in medical education, graduate medical education, and continuing medical education curricula. This includes support for discrete evidence-based educational components as well as the inclusion of appropriate references throughout the basic science, clinical care, and cultural competency curricula for medical education.

References

- Association of American Medical Colleges. AAMC Videos and Resources about LGBT Health and Health Care.
- University of Louisville School of Medicine. Undergraduate Medical Education Office. eQuality.
REPORT OF COUNCIL ON MEDICAL EDUCATION

C-ME Report 6 2020

Subject: Referral of Resolution 202-A-18 Addressing Gender Bias in Undergraduate Medical Education and Implicit Bias Training

Presented by: Ronald L. Cook, DO, Chair

Referred to: Reference Committee on Medical Education and Health Care Quality

Resolution 202-A-18, Addressing Gender Bias in Undergraduate Medical Education and Implicit Bias Training (Medical Student Section) was referred to the Council on Medical Education by the house in 2018. Referral was recommended due to conflicting testimony both for and against. Also, requests were also made to expand the scope to include training on implicit bias related to race/ethnicity in addition to gender. To evaluate the merits of the resolution, the council conducted extensive research on implicit bias and held extensive discussions over various meetings. The decision was not unanimous, but there was consensus in support of bias training for learners, faculty, and staff at academic health centers. In addition to gender, the council determined the training should include racial/ethnic biases. The council also reached a consensus in support of mentorships at the academic health centers and/or teaching hospitals for medical students in medical specialties for which medical schools recognize there is a significant degree of underrepresentation by gender and/or race/ethnicity within the physician workforce. An example is women in surgical specialties.

The resolution proposed that TMA (1) support the implementation of implicit bias training for all Texas medical school faculty, and (2) advocate for the creation and implementation of formal mentorship programs at medical schools between residents, fellows, or attending physicians and female medical students for specialties in which women are underrepresented.

Results of Council’s Research
The council started by reviewing existing TMA policy and identified the following related policies:

TMA Policy 60.008 Rejection of Discrimination: TMA does not discriminate, and opposes discrimination, based on race, religion, disability, ethnic origin, national origin, age, sexual orientation, sex, or gender identity. TMA supports physician efforts to encourage that the nondiscrimination policies in their practices, medical schools, hospitals, and clinics be broadened to include “race, religion, disability, ethnic origin, national origin, age, sexual orientation, sex, or gender identity” in relation to patients, health care workers, and employees (CSPH Rep. 1-A-18).

Policy 185.012 supports greater diversity in the state’s physician workforce, with the goals of improving the geographic maldistribution of physicians and reducing potential health disparities:

TMA Policy 185.012 Physician Recruitment: TMA supports expanded efforts by Texas medical schools to recruit and retain students and residents from underrepresented race/ethnic groups as well as underrepresented geographic areas of the state to enhance the diversity of the state’s physician workforce, affect geographic maldistribution, and reduce potential health disparities (Committee on Physician Distribution and Health Care Access, p 76, I-95; substitute CME Rep. 2-A-06; reaffirmed CME Rep. 2-A-16).
In addition, Resolution 112 Equal Pay for Equal Work (Dallas County Medical Society), adopted by the house in 2019, included a directive for TMA to create implicit bias training for both male and female TMA members. TMA’s Council on Practice Management Services has been working to identify an appropriate CME program on implicit bias training for TMA members in response to this policy.

In the 24 years since TMA Policy 185.012 on the recruitment of a diverse physician workforce was adopted, little has improved in racial/ethnic diversity among the state’s physicians. Currently, far less diversity exists among Texas physicians than among the Texas population, as shown in the graph below.

The following statistics help to demonstrate how the state’s population is far more diverse than the state’s physician workforce:

**Race/Ethnicity**
- Five times more Hispanic Texans than Hispanic physicians,
- Twice as many black/African American Texans than among physicians, and
- 1.5 times more white Texas physicians than white Texans.

**Gender**
- Women make up 50.3% of Texans, but only 34% of Texas physicians.
- In academic medicine in the U.S., women represent:
  - 16% of permanent deanship positions,
  - 15% of department chairs,
  - 21% of full professors,
  - 34% of associate professors, and
  - 38% of full-time medical school faculty.
  (Note: Data were not available at the state level.)

In researching the potential for bias in medicine, the council identified numerous prominent research studies that found:
• Although multiple federal laws such as the 1964 Civil Rights Act and the 1965 Medicare and Medicaid Act legislate against overt discrimination in health care, a large body of research identified disparities in health care in the U.S. based on gender and racial/ethnic status.
• Unconscious bias can exist, and most individuals are unaware of their own biases and how they are manifested.
• When individuals are made aware of unconscious biases, change is possible.
• There is a positive association in racial/ethnic concordance between patients and their physician.
• Diversity of faculty, administration, and medical school enrollments is an important component of learning.
• There are specific examples of how training programs on implicit bias at academic health centers have caused institutional changes that resulted in greater diversity in hiring and in student admissions.

As proposed in Resolution 202, the council supports mentorship for women and underrepresented minorities during medical education and residency training, as well as women and minorities working in academic medicine. The goal for this type of mentorship is to promote greater diversity in medicine.

**Recommendation:** Adopt new Texas Medical Association policy as follows in lieu of Resolution 202-A-18:

**Support of Bias Training for All Texas Medical School Students, Resident Physicians, Staff, and Faculty of Academic Health Centers.** The Texas Medical Association supports bias training for all Texas medical school students and resident physicians, as well as staff and faculty at academic health centers. TMA supports providing evidence-based educational programs at medical schools that help residents, fellows, and attending physicians mentor medical students in medical specialties for which medical schools recognize there is a significant degree of underrepresentation by gender and/or race/ethnicity within the physician workforce.
WHEREAS, From 2010 to 2018, there were 79,936 patent applications filed in the United States involving augmented intelligence (AI), of which nearly one-third were in health care; and

WHEREAS, AI will have a growing role in health care; and

WHEREAS, The statutory and regulatory framework around AI in Texas may evolve rapidly, providing physicians an opportunity for input; and

WHEREAS, Physicians will require education and guidance on AI-related matters such as liability and clinical validation; and

WHEREAS, Because the quadruple aim in health care includes provider satisfaction, physicians stand to inform the use of AI in patient care towards this goal; therefore be it

RESOLVED, That the Texas Medical Association Council on Socioeconomics, TMA Committee on Health Information Technology, and TMA Council on Medical Education collaboratively study the effects of augmented intelligence (AI) on health care in Texas; and be it further

RESOLVED, That TMA ensure this effort includes guidance on how physicians may be affected and how physicians may prepare for the challenges and the opportunities AI creates.

Related TMA Policy:
None

Related AMA Policy:
Augmented Intelligence in Health Care H-480.940
Augmented Intelligence in Medical Education H-295.857
Subject: Admission of Deferred Action for Childhood Arrivals (DACA) Students in Texas Medical Schools

Introductory Text:

Whereas, In 2012, the U.S. Department of Homeland Security established the Deferred Action for Childhood Arrivals (DACA) program, which provides temporary legal status to young, undocumented immigrants brought to the U.S. as children by their guardians; and

Whereas, The DACA program allows this population to receive work permits; and

Whereas, The DACA program currently has 700,000 recipients nationwide and 115,290 (16% of all recipients) in Texas alone; and

Whereas, Despite political debate over this policy, the DACA program is currently active, and recipients can renew their status for the foreseeable future; and

Whereas, Seventy-three percent of Americans, including majorities of both Democrats and Republicans, support permanent U.S. legal status for DACA recipients; and

Whereas, Since 2001, undocumented students in Texas are considered Texas residents for purposes of admission to Texas public institutions of higher education and are eligible for in-state tuition and state financial aid; and

Whereas, The Association of American Medical Colleges and the American Association of Colleges of Osteopathic Medicine support protections for DACA medical students due to their role in diversifying the physician workforce, treating underserved communities, and reducing physician shortages; and

Whereas, Of the 141 medical schools granting MD degrees in the U.S., 73 report willingness to admit DACA students; and

Whereas, Of the 34 medical schools granting DO degrees in the U.S., seven report willingness to admit DACA students; and

Whereas, Only one of 12 Texas medical schools (The University of North Texas Health Science Center Texas College of Osteopathic Medicine) reports willingness to admit DACA students; and
Resolution 202 2020
Page 2

Whereas, Anecdotal evidence indicates at least one case of multiple Texas medical schools rescinding acceptances from a Texas DACA student after discovering his immigration status; therefore be it

RESOLVED, That the Texas Medical Association encourage Texas medical schools to implement admissions policies that allow admission of DACA students, for as long as the DACA program is intact.

Relevant TMA Policy:

200.022 Medical Education Admissions
200.031 Medical School Admissions
200.040 Joint Admission Medical Program
205.018 Hopwood v Texas
185.012 Physician Recruitment

Relevant AMA Policy:

D-350.986 Evaluation of DACA-Eligible Medical Students, Residents and Physicians in Addressing Physician Shortages
D-200.982 Diversity in the Physician Workforce and Access to Care
H-350.960 Underrepresented Student Access to US Medical School
Texas Medical Association House of Delegates

Resolution 203
2020

Subject: Supporting Implicit Bias Training for Perinatal Physicians

Introduced by: Medical Student Section

Referred to: Reference Committee on Medical Education and Health Care Quality

Whereas, The World Health Organization defines maternal mortality as “the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes”; and

Whereas, Although maternal mortality in most of the world has been declining, in the United States it has more than doubled since 1987, from 7.2 deaths per 100,000 live births to 16.7 deaths per 100,000 live births in 2016; and

Whereas, Maternal mortality and morbidity rates in Texas are even higher than the national average, at 18.5 per 100,000 births; and

Whereas, A study by the Centers for Disease Control and Prevention found that approximately three in five pregnancy-related deaths were preventable; and

Whereas, There is a disproportionate number of pregnancy-related deaths among women of color, as African American and Native American/Alaska Native women are three to four times more likely to die from pregnancy-related issues than Hispanic and white non-Hispanic women; and

Whereas, Implicit bias refers to the “attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious manner”; and

Whereas, Implicit bias can affect the quality of care given by physicians providing perinatal care; and

Whereas, Implicit bias training brings unconscious biases to one’s conscious attention; and

Whereas, In a longitudinal case study with physicians and nurses, it was shown that implicit bias recognition provoked critical questioning and awareness, allowing for reflection on biases and leading to explicit behavioral changes; and

Whereas, Precedent for implicit bias training legislation has been established, such as in California Senate Bill No. 464, California Dignity in Pregnancy and Childbirth Act; and

Whereas, Implicit bias training for perinatal physicians will allow for improved health outcomes for women and their newborns through access to more informed, sensitive, and empathic care; therefore be it

Resolved, That the Texas Medical Association advocate for and support the use of implicit bias training for perinatal physicians in order to improve maternal health outcomes.
Related TMA Policy:
330.015 Physician-Led Initiatives to Address Maternal Mortality and Morbidity

Related AMA Policy:
Racial and Ethnic Disparities in Health Care H-350.974

References:
1. World Health Organization. Maternal mortality ratio (per 100,000 live births).
Subject: Promoting Careers in Geriatrics Among Medical Students

Introduced by: Medical Student Section

Referred to: Reference Committee on Medical Education and Health Care Quality

Whereas, The United States has 49 million people older than age 65, and individuals over 65 account for 12.6% of the Texas population; and

Whereas, The number of individuals over age 65 will continue to increase each year, thereby requiring more physicians and resources to care for this population; and

Whereas, Up to 30% of these individuals will need the expertise of a geriatrician to manage their care; and

Whereas, There were only 405 board-certified geriatricians in the Texas as of 2018, for nearly 3.5 million individuals; and

Whereas, The Texas Medical Association and the American Medical Association do provide support for primary care specialties, TMA does not specifically have a policy that supports including geriatric medicine in medical student education; and

Whereas, TMA already supports preceptorship programs for some primary care specialties as a way to encourage medical student involvement in these specialties but has not expanded these efforts to include geriatrics; therefore be it

RESOLVED, That the Texas Medical Association recognize and support the need for more geriatricians by providing medical students educational information concerning geriatrics and its opportunities to encourage them to become involved in geriatrics; and it be further

RESOLVED, That TMA support the efforts of medical schools in fostering interest in geriatrics through interest groups and shadowing opportunities.

Related TMA Policy:
- 185.002 Physician Workforce – Primary Care and Specialty Training
- 185.022 Promoting Careers in Psychiatry Among Medical Students
- 255.002 Primary Care
- 255.003 Undergraduate Medical Education

Related AMA Policy:
- Geriatric Medicine H-295.981
- Geriatric and Palliative Care Training For Physicians D-295.969
- Principles of and Actions to Address Primary Care Workforce H-200.949
- Definition of Primary Care H-200.969
References:
Subject: Service Animal Assisted Therapy in Health Care

Introduced by: Medical Student Section

Referred to: Reference Committee on Medical Education and Health Care Quality

Whereas, The Americans With Disabilities Act (ADA) defines a service animal as one individually trained to perform tasks for people with disabilities; and

Whereas, The ADA and Texas Human Resources Code Section 121.002 require public places, such as health care facilities, to permit service animals to accompany qualifying individuals; and

Whereas, Mixed-model analyses showed a decrease in the symptoms of post-traumatic stress disorder from a baseline level after the use of service animals compared with standard care; and

Whereas, People with epilepsy who have service animals experience an improved quality of life and fewer seizures; and

Whereas, The American Medical Association supports public education about service animals; and

Whereas, The Texas Medical Association has no policies with regard to service animals and emotional support animals; therefore be it

RESOLVED, That the Texas Medical Association encourage physicians to use Americans With Disabilities Act material concerning service animals in their inpatient and outpatient settings as a part of their patients’ therapeutic plans; and be it further

RESOLVED, That our TMA support the provision of resources in the community to individuals with service animals to inform them how their service animals can be part of a therapeutic plan to better treat their medical needs.

Related TMA Policy:
None.

Related AMA Policy:
Service Animals, Animal-Assisted Therapy, and Animals in Healthcare H-90.966

References:


Subject: Amending the Mental Health Question on the Physician Licensure Application to Reflect Current Impairment

Introduced by: Medical Student Section

Referred to: Reference Committee on Medical Education and Healthcare Quality

Whereas, Any person applying for a medical license in Texas is required to report all mental health diagnoses and treatment in the past five years, which may require students who receive psychiatric treatment while in medical school to report this on their initial licensure application; and

Whereas, Current Texas licensure applications include questions related to mental illness likely in violation of Title II of the Americans With Disabilities Act (ADA); and

Whereas, There is a substantial prevalence of mental illness among physicians and medical students, with 11.3% of physicians in one study reporting moderate to severe depression and another study estimating the rate of depression in medical students at 27.2%; and

Whereas, Three-quarters (75%) of surgeons who experienced suicidal thoughts within one year of being surveyed reported they had not sought help because they were concerned that doing so would affect their ability to renew their license; and

Whereas, Medical students with depression cited lack of confidentiality (37%), stigma associated with using mental health services (30%), and fear of documentation on academic record (24%) as barriers to receiving treatment; and

Whereas, Physicians working in a state where the mental health question/s violate ADA standards were 20% more likely to be reluctant seeking help, with 40% of those surveyed reporting reluctance to seek formal medical care for their mental health conditions; therefore be it

RESOLVED, That the Texas Medical Association support policy change as it relates to the Texas Medical Board licensure process, such that only current or active mental health conditions need be reported; and

RESOLVED, That TMA support policy and judicial decisions in line with the American Medical Association, such that physicians are not required to disclose previous treatment for mental health conditions but are evaluated solely on performance and current impairment.

Relevant TMA Policy:
None

Relevant AMA Policy:
Licensure Confidentiality H-275.970
Depression and Physician Licensure D-275.974
References:
AGENDA
SCIENCE AND PUBLIC HEALTH BUSINESS
To provide testimony click HERE
Click on the agenda item to navigate to it

3. Committee on Cancer Report 1 – Addressing Cancer Health Disparities
6. Committee on Infectious Disease Report 1 – Sunset Policy Review

Agenda Items Tabled to 2021
The following items of business are tabled to the 2021 HOD meeting. However, one may make two motions: ‘Referral to the BOT for Action and report back’ (allowing TMA BOT to adopt policy and address the item and report back to the TMA 2021 HOD) or ‘Referral to the BOT and report back’ (allowing the BOT to consider the item and report back to the TMA 2021 HOD. Your Speakers strongly encourage the use of referral (of tabled items) be limited to urgent and essential items.

11. Resolution 301 – Advocating Against Electronic Nicotine Delivery Systems (ENDS)
12. Resolution 302 – Elimination of Human Abuse and Persecution
13. Resolution 303 – Use of Human Tissue for Beneficial Applications
15. Resolution 305 – Suicide Prevention Education in Medical School
16. Resolution 306 – Facilitating Brain and other Postmortem Tissue Donation for Research and Educational Purposes
17. Resolution 307 – Decommissioning Existing and Not Constructing New Wastewater Treatment Plants in or Near Flood Plains and Waterways
18. Resolution 308 – Recurrent Flooding in Texas Must Be Resolved
19. Resolution 309 – Education and Action to Arrest the Effects of Climate Change on Health
20. Resolution 310 – Access to Direct-acting Antiviral Therapy for Texas Medicaid Beneficiaries Infected with Hepatitis C
21. Resolution 311 – Advocating for the Improvement of Access to Mental Health Services Among Minority Teens
22. Resolution 312 – Support for the Texas-CARES Program
23. Resolution 313 – Advocating for Increased Capacity of Local State Mental Health Facilities and Coordination of Behavioral Health Services
24. Resolution 314 – Required Platelet Products at a Facility in Maternal Levels of Care Designation
25. Resolution 315 – Designating Texas Hospitals as Sensitive Locations
26. Resolution 316 – Concurrent Prescribing of Opioid Antagonists with Opioid Prescriptions
27. Resolution 317 – Employee Rights to Lactation Accommodation
28. Resolution 318 – Updating Texas Medical Association Teenage Sexual Health Guidelines
30. Resolution 320 – Maternal Health and Postpartum Depression Screening
32. Resolution 322 – Recommendation for the Use of Low Titer Group O Whole Blood for Hemorrhagic
33. Resolution 323 – Recognizing the Effect of Climate Change on Public Health
34. Resolution 324 – Mandatory Waiting Period for Firearm Purchases
35. Resolution 325 – Promoting and Improving Health Literacy
36. Resolution 326 – Pediatric Iron Deficiency Anemia Treatment and Diagnosis Guidelines
37. Resolution 327 – Improving Access to Immediate Postpartum Long-Acting Reversible Contraception for Adolescents
38. Resolution 328 – Lowering the Legal Age for Minors to Access Contraceptive Services
39. Resolution 329 – Flu vaccinations in Immigrant Holding Facilities at the Border
40. Resolution 330 – Expanding Access to Regularly-Scheduled Dialysis for All Individuals with ESRD
41. Resolution 331 – Incorporating Helmet Safety Education to Texas Elementary Schools
Subject: Sunset Policy Review

Presented by: Wendy M. Chung, MD, Chair

Referred to: Reference Committee on Science and Public Health

The Texas Medical Association periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness.

The Council on Science and Public Health recommends retention of the following policies:

55.032 Baby Moses Law: The Texas Medical Association supports the Baby Moses Law which allows for the emergency possession of a child appearing to be 60 days old or younger who has been abandoned through the EMS system (Amended CM-EMS Rep. 3-I-00; amended CPH Rep. 3-A-10).

100.009 Transporting Injured Athletes: The Texas Medical Association recommends that until appropriate medical evaluation can be made on an injured athlete, stretchers or other immobilization should be used to decrease risk of further injury when transporting injured athletes (Committee on Sports Medicine, p 98, A-95; reaffirmed CPH Rep. 3-A-10).

285.005 Salt Use in Athletics: Salt should not be provided indiscriminately to participants at athletic events. Physicians should stress instead the importance of adequate fluid replacement (Committee on Sports Medicine, p 126, A-94; reaffirmed CPH Rep. 3-A-10).

Recommendation 1: Retain.

The Council on Science and Public Health recommends amending the following policies:

25.010 Impaired Operation of Motor Vehicles: The Texas Medical Association supports terminology, methodology, and strategies that accurately and effectively define, detect, and prevent the impaired operation of motor vehicles.

Driving While Intoxicated/Driving Under the Influence. The Texas Medical Association supports the expansion of the term “DWI” to “DUI (driving under the influence)” and broadening the definition to include driving under the influence of intoxicating drugs. TMA supports legislation to broaden the definition and to allow suspected offenders to be tested by breathalyzer, blood, urine, saliva tests, or other tests that may be developed to detect the levels of intoxicating substances by those operating a motor vehicle.

Blood Alcohol Levels and Drug Screens. The Texas Medical Association supports actively working with law enforcement officials to ensure that scientifically proven and accurate body fluid samples to detect alcohol or other mind-altering substances, blood alcohol levels, or drug screens are obtained on all drivers involved in motor vehicle collisions in which there have
been one or more on-scene or emergency department fatalities or serious injuries requiring hospitalization.

Stricter Penalties. The Texas Medical Association strongly endorses the strict enforcement of strongest penalties – such as confiscation of the vehicle – for conviction of driving under the influence, as established in existing state laws and insurance requirements, and according to best practices for handling this conviction.

National Drug Policy: The Texas Medical Association endorses supports the 1997 Consensus Statement of the Physicians and Lawyers for Leadership on National Drug Policy as a rational approach to influencing national policy on drugs, legal and illegal; promotes medical approaches to substance use disorders by continuing to encourage physician involvement in case identification, diagnostic assessment, clinical therapeutic interventions, medical evaluation and management, and ongoing public health and chronic disease management, as appropriate, for cases of alcohol and other drug addiction of legal and illegal drugs; and opposes the legalization of illicit drugs as contrary to the best interests of public health. TMA supports an emphasis on public health solutions as opposed to criminal justice solutions for legal and illegal drug abuse. Support for the positions of the Physician Leadership on National Drug Policy ought not be construed as support for such legislation. Alcohol and tobacco should be included and emphasized in any program to reduce drug use in the United States.

Physicians and Lawyers for Leadership on National Drug Policy 1997 Consensus Statement: Addiction to illegal drugs is a major national problem that creates impaired health, harmful behaviors, and major economic and social burdens. Addiction to illegal drugs is a chronic illness. Addiction treatment requires continuity of care, including acute and follow-up care strategies, management of any relapses, and satisfactory outcome measurements.

We are impressed by the growing body of evidence that enhanced medical and public health approaches are the most effective method of reducing harmful use of illegal drugs. These approaches offer great opportunities to decrease the burden on individuals and communities, particularly when they are integrated into multidisciplinary and collaborative approaches. The current emphasis—on use of the criminal justice system and interdiction to reduce illegal drug use and the harmful effect of illegal drugs—is not adequate to address these problems.

The abuse of tobacco and alcohol also is a critically important national problem. We strongly support efforts to reduce tobacco use, including changes in the regulatory environment and tax policy. Abuse of alcohol causes a substantial burden of disease and antisocial behavior which requires vigorous, widely accessible treatment and prevention programs. Despite the gravity of problems caused by tobacco and alcohol, we are focusing our attention on illicit drugs because of the need for fundamental shift in policy.

As physicians, we believe that (1) it is time for a new emphasis in our national drug policy by substantially refocusing our investment in the prevention and treatment of harmful drug use. This requires reallocating resources toward drug treatment and prevention, utilizing criminal justice procedures which are shown to be effective in reducing supply and demand, and reducing the disabling regulation of addiction treatment programs; (2) concerted efforts to
eliminate the stigma associated with the diagnosis and treatment of drug problems are essential. Substance abuse should be accorded parity with other chronic, relapsing conditions insofar as access to care, treatment benefits, and clinical outcomes are concerned; (3) physicians and all other health professionals have a major responsibility to train themselves and their students to be clinically competent in this area; (4) community-based health partnerships are essential to solve these problems; and (5) new research opportunities produced by advances in the understanding of the biological and behavioral aspects of drugs and addiction, as well as research on the outcomes of prevention and treatment programs, should be exploited by expanding investments in research and training (CPH Rep. 5-A-00; amended CPH Rep. 3-A-10).

100.006 Emergency Room-Department Services to Survivors of Sexual Assault: The Texas Medical Association will advocate for hospital policies that are encouraging to the provision of and publicize the availability of full emergency services to survivors of sexual assault, including evidence collection, treatment to prevent sexually transmitted diseases and pregnancy, emergency contraception, and referral to available social service and/or crisis intervention sources. TMA supports those hospitals unless such hospital is in close geographic proximity to another facility already offering this service opting to publicize their lack of these services. TMA will work with allied health organizations to promote public awareness of the hospitals offering these services (CPH, p 109, A-94; amended CPH Rep. 3-A-10).

165.006 Supplemental Nutrition Assistance Program Reform: The Texas Medical Association advocates for reform of the federal Supplemental Nutrition Assistance Program (SNAP) before its constituent U.S. senators and representatives, as well as through its delegation to the AMA-American Medical Association, and supports/advocates effective SNAP education programs about nutrition and physical activity to help influence overall positive food selections, designed to: (a) promote adequate nutrient intake and reduce food insecurity and obesity; (b) decrease the price gap between calorie-dense, nutrition-poor foods and naturally nutrition-dense foods to improve health in economically disadvantaged populations; and (c) incentivize healthful foods and disincentivize or eliminate unhealthful foods (CPH Rep. 2-A-10).

215.020 Improved Funding for Mental Illness and Substance Abuse Disorder(s); No Closure of Psychiatric Hospitals: The Texas Medical Association advocates for: (1) improved prevention, identification, funding and treatment of mental illness and substance abuse disorder(s); (2) treatment and that increased funding for mental illness and substance use disorders in areas of the state to be proportional to the service requirements of the area; and (3) advocate that no psychiatric hospital beds to be closed based solely on budgetary concerns in Texas (Res. 402-A-10).

Recommendation 2: Retain as amended.

The Council on Science and Public Health recommends deletion of the following policies:

25.002 Drunk Driving Stricter Penalties: The Texas Medical Association strongly endorses the concept of enforcement of stricter and stronger penalties, up to and including confiscation of the vehicle for conviction of driving under the influence, for accepted, existing, and established insurance laws, driving under the influence practices, and insurance requirements

25.006 Driving While Intoxicated Driving and Under the Influence: The Texas Medical Association supports the expansion of the term “DWI” to “DUI (Driving Under the Influence)” and broadening the definition to include driving under the influence of intoxicating drugs. TMA supports legislation to broaden the definition and to allow suspected offenders to be tested by breathalyzer, blood or urine tests, or other tests which may be developed to detect the levels of intoxicating substances by those operating a motor vehicle. In addition, TMA supports legislation to stiffen penalties for persons found to be DUI (Committee on Addictive Diseases, p 114, A-94; reaffirmed CPH Rep. 3-A-04; reaffirmed CSPH Rep. 2-A-14).

215.018 Patients Awaiting Orders of Protective Custody: Legislation should be sought to allow for expeditious transport of involuntary psychiatric patients to appropriate facilities including state hospitals (Res. 107-I-00; reaffirmed CSA Rep. 1-A-10).

260.026 Football Helmet Use: Coaching techniques which call for players to use the head as the contact point and the helmet as an offensive weapon represent a danger to the players and should be discontinued (Committee on Sports Medicine, p 126, A-94; reaffirmed CPH Rep. 3-A-10).

Recommendation 3: Delete.
At TexMed 2019, the Texas Allergy, Asthma and Immunology Society and the Harris County Medical Society submitted Resolution 304 that called on TMA to advocate for a state mandate that all food service establishments display a poster primarily for employees on food allergen awareness. These posters should include information on the risk of an allergic reaction and major food allergens, and on anaphylaxis and the need to call 911. The authors further called for mandatory biennial training for food service employees on food allergy awareness including the foods that cause the most reactions, on cross-contamination, and on the signs and symptoms of anaphylaxis.

One author of the resolution spoke at the reference committee hearing about the high proportion of people at risk of a food allergy emergency (one out of 13 children; one out of 10 adults) and how most people are unaware of their allergies or of all the ingredients in the food they consume in a restaurant. The author also noted that food service employees are unaware of the life-threatening risks some people may face and that deaths from an allergic reaction are more common than a person choking on food.

The Council on Science and Public Health did not make a recommendation on the resolution as council members found the issue to be outside of the scope of TMA. The Reference Committee on Science and Public Health recommended that the House of Delegates not adopt the resolution as it is recognized that the high employee turnover in food service establishments would make employee training costly and prohibitive. The House of Delegates supported referral for study with a report back, sending the resolution to the council and the Council on Legislation.

**Food Allergy and Anaphylaxis**

Much of the public awareness on food allergies appears to focus on allergies in children. The Centers for Disease Control and Prevention (CDC) estimates that 4% to 6% of children have a food allergy – representing millions of children. Estimates vary on the proportion of U.S. adults with food allergies:

- The U.S. Food and Drug Administration’s (FDA’s) Food Safety Survey notes that self-reports of food allergy among U.S. adults increased to 13% in 2010 from 9.1% in 2001. The most commonly reported allergens were milk, shellfish, and fruits, although these were not all associated with a physician diagnosis.
- The National Institute of Allergy and Infectious Diseases estimates that food allergies affect about 5% of children and 4% of adults.
- A 2015-16 population-based survey provided more recent estimates on U.S. adults with a food allergy:
  - 10.8% of adults reported having one or more food allergies; 19% believed they had a food allergy.
  - The most common allergies among the adults were shellfish (7.2 million adults), milk (4.7 million), peanuts (4.5 million), tree nuts (3 million), and fin fish (2.2 million).
More than 50% reported they had experienced a severe food allergic reaction.

48% reported their food allergies developed as an adult.

Federal Policies and Guidance

FDA is responsible for defining the federal guidelines for foods and food safety. Last updated in 2017, the FDA’s Food Code outlines food safety guidelines. These include adherence to federal law that requires listing any of the eight most commonly known allergens (“major food allergen”) used in a packaged food on its label. Federal law generally does not require reporting or warnings of food allergens and other ingredients of the foods served in restaurants or other retail food settings.

- The Food Code covers definitions of food; compliance and enforcement; the physical facilities where food is processed or prepared; and the equipment, materials (e.g., sanitizers, gloves), and systems that support or contaminate these facilities (such as storage systems, water, plumbing, temperature control, and waste).
- Section 2-102.11 (Management and Personnel) of the Food Code recommends that the food service manager in a restaurant have knowledge of the risks of food allergies; FDA has developed resources on how restaurants can support customers with food allergies.

FDA has provided public guidance on food allergies and how to reduce the risks by advising consumers to:

- Wear a medical alert bracelet or necklace stating they have a food allergy and are subject to severe reactions;
- Carry an auto-injector device containing epinephrine to give to themselves if they think they are experiencing a food allergic reaction; and
- Seek medical help immediately if they experience a food allergic reaction, even after being given epinephrine, either by calling 911 or getting transportation to an emergency department.

Restaurant Training and Signage on Food Allergens

Employees of retail food establishments and restaurants have a role in ensuring food safety, including reducing the risk for a severe food allergy reaction. While there is not a federal requirement for a restaurant to post warnings on potential exposure to common allergens, several states have enacted legislation on food allergy awareness signage (Massachusetts, Maryland, New Jersey, Rhode Island, and Virginia). Research on the actual effectiveness of food allergy awareness posters on changing food service workers’ behaviors, as well as preventing severe allergic reactions, is limited.

The federal Food Code and Texas statute allow local government entities to ensure compliance with national and state regulations for food safety – both in food retail stores and in restaurants and other types of food establishments. The minimum requirements for retail food safety in Texas are outlined in the Health and Safety Code. Texas requires certification of food managers and food handlers in a fixed or mobile retail food setting. Certification requires training as part of a program approved by the Texas Department of State Health Services (DHS) or the American National Standards Institute but does not appear to require training on food allergies. Local government entities may also require certification of food managers. Texas’ requirements for food handlers and other food service employees and other measures related to foods are established in Health and Safety Code §437 and §438.

- A 2012 survey of food operators conducted by the National Restaurant Association (NRA) found that food operators were aware of food allergies generally, with wheat/gluten and peanuts identified as the most critical allergens (www.foodallergy.org). More than half of the operators reported training of staff on allergens. The most common method for alerting food patrons of food allergens was in
response to patron inquiries, followed by information on the menu and in signage posted in the
restaurant. NRA sponsors the ServSafe Allergens Online Training program for food operators. The
Texas Restaurant Association offers this training for restaurant staff to its members.

- CDC, FDA, the U.S. Department of Agriculture, and state and local public health staff conducted a
survey (2015-16) of a random sample of restaurant managers and staff on their knowledge, attitudes,
and practices on food allergens. About half had a designated person on duty to respond to customer
questions and requests on allergens, and almost all (87%) felt they could meet customer requests
regarding food allergens. Almost all staff knew how to recognize an allergic reaction and the need to
call for emergency services. Overall it was found that the workers had a general knowledge about
food allergens (almost 71% of the managers had a plan), but knowledge gaps were identified; and for
some, employee training did not appear to address some knowledge gaps.

- The nonprofit Food Allergy, Research and Education (FARE) organization has developed a
legislative toolkit to inform and advocate on model legislation to promote “food-allergy friendly”
restaurants in the U.S. FARE also provides training programs for restaurant staff on food allergy
awareness.

- In 2015, CDC developed guidelines for school settings for the management of allergens.

- Texas restaurants are required to have postings on several topics such as their most recent health
inspection report; smoking; employee hand washing; and most recently, their pet-friendly status. The
signage on how to help someone who was choking was recently removed from the requirements.

Recent Texas Activities on Food Allergies

As directed by the Texas Legislature, DSHS leads the development of guidance on school-related food
allergy planning, prevention, and response. Much of the initial legislation on allergens has focused on the
school setting:

- In 2011, DSHS convened an ad hoc committee to develop guidelines for the care of students with a
risk of anaphylaxis to be used by local school districts, boards of trustees, and open-enrollment
charter schools.

- With the passage of Senate Bill 66 in 2015, DSHS has convened and staffed the Stock Epinephrine
Advisory Committee (SEAC) to advise the agency on the storage and maintenance of epinephrine
auto-injectors on school campuses, training of school employees and volunteers on administration,
and on the development of a plan for training individuals on campus.

Texas Legislation

Texas legislators continue to express concern about those who are at risk of anaphylaxis because of a food
allergy. Legislators have begun to focus on other settings where preventive measures could be
implemented to avoid or reduce severe food allergy emergencies. For example:

Senate Bill 1827 by Sen. José Menéndez and Rep. Stan Lambert, passed in 2019 and effective Sept. 1,
allows law enforcement officers who have received approved training to possess and administer
epinephrine in an emergency. Physicians can develop a standing order for a law enforcement entity for
unassigned auto-injectors and be responsible for regularly reviewing the standing order and providing
support as requested.

Senate Bill 869 by Sen. Judith Zaffirini and Rep. Tan Parker, passed in 2019 and effective Sept. 1,
provides for the development of guidelines for school district and open-enrollment charter school policies
for the care of certain students at risk for anaphylaxis. SB 869 establishes a committee to assist the DSHS
commissioner in regularly updating the Guidelines for the Care of Students with Food Allergies At-Risk
for Anaphylaxis.
House Bill 1015 by Rep. Armando Martinez died on the 2019 House calendar. This was a refile of House Bill 3208 from the 2017 session that would require “warning signs” in a food establishment if it has a menu item that contains peanuts. Senate Bill 1683 by Sen. Eddie Lucio (and companion House Bill 3743 by Rep. Philip Cortez) was similar legislation also filed in 2017. This was passed in the Senate but did not get a hearing in the House. SB 1683 called for more general signage – primarily for employees – on food allergy awareness and risks associated with the eight major food allergens.

Discussion and Conclusion
At TexMed 2019, the Reference Committee on Science and Public Health expressed concerns about the high turnover of restaurant staffing and the potential cost of continuously having to train new food service employees. There also was concern about the cost of a state mandate for all food service establishments to display a poster primarily for employees on food allergen awareness, as research on the actual effectiveness of posters to change behavior or prevent allergic reactions is limited. The same concerns over the costs and burden of these potential mandates on the restaurant industry were echoed during council discussion at 2019 Fall Conference. Also reiterated during council discussion was the perspective that this likely treads outside the scope of organized medicine, and that further, mandates are generally not supported by the association.

However, the council recognizes a need for more to be done to protect consumers from inadvertent food allergen exposures. Texans with severe food allergies depend on food service workers and their knowledge of the food, ingredients, and preparation methods to protect themselves against potentially severe or even deadly allergic reactions. Increasing awareness and improving training where possible, without the strict constraints, costs, and burden of a statewide mandate, is a key step to protect patients who are most vulnerable to potentially dangerous food allergens.

Thus, in lieu of adopting Resolution 304, the council makes the following recommendations.

Recommendation 1: TMA encourages statewide efforts to increase the general public’s food allergen awareness in all food service establishments, including dissemination of information on the list of major food allergens, the risk of an allergic reaction, methods to prevent cross-contamination in food preparation, and the signs and symptoms associated with anaphylaxis with instructions to call 911.

Recommendation 2: TMA supports efforts to strengthen food service employee training provided by the Texas Department of State Health Services on food allergy awareness, and to include information on the list of major food allergens, methods to prevent cross-contamination in food preparation, and the signs and symptoms associated with anaphylaxis with instructions to call 911.

Related TMA Policy:

55.053 Childhood Anaphylactic Reactions
100.029 Requirement for Epinephrine Auto-Injectors in Texas Schools
170.001 Good Samaritan and Charitable Immunity Laws
170.002 Charitable Immunity

Related AMA Policy:

Preventing Allergic Reactions in Food Service Establishments D-440.932
Childhood Anaphylactic Reactions D-60.976
Food Allergic Reactions in Schools and Airplanes H-440.884

Sources:
Factors for Food Allergy and Relationship to Asthma, *Journal of Allergy and Clinical Immunology*, 2010.

2. FDA, Center for Food Safety and Applied Nutrition, Prevalence of self-reported food allergy in U.S. Adults.


5. In an on-site inspection, areas of knowledge by “the person in charge” include “describing foods identified as major food allergens and the symptom that a major food allergen could cause in a sensitive individual who has an allergic reaction.” *Food Code*, US Public Health Service, U.S. FDA, 2017, accessed Aug. 19, 2019.


8. FARE Restaurant Legislation Tool Kit.

9. CDC. *Voluntary Guidelines for Managing Food Allergies in Schools and Early Care and Education Programs*.

10. DSHS, Guidelines for the Care of Students with Food Allergies At-Risk for Anaphylaxis.
Background

Cancer is the second leading cause of death among adults and the most common cause of disease-related death for children and adolescents in Texas. According to the American Cancer Society Cancer Statistics Center, an estimated 41,810 Texans – more than 114 people per day – will die from cancer in 2020, and an estimated 129,770 new cancer cases will be diagnosed in Texas. From 1995 to 2016, Texas had a 46.6% increase in the number of new cancer cases, from 74,422 to 109,084. Similarly, Texas had a 21.1% increase in the number of cancer deaths from 1995 to 2016, from 31,573 to 39,999. The overall age-adjusted cancer incidence rates* and age-adjusted mortality rates† declined in Texas from 1995 to 2016; however, as Texas’ population continues to grow and age, the actual number of Texans who are diagnosed with cancer and who die from cancer annually will likely continue to rise.

Texas has one of the largest cancer registries in the U.S. The statewide, population-based Texas Cancer Registry (TCR) collects, maintains, and disseminates the highest quality cancer data. TCR serves as the foundation for measuring the cancer burden in Texas, thereby gauging Texas’ progress in effective cancer screening, diagnosis, treatment, and survivorship. As cancer care continues to be a priority for Texas oncologists and generalists, among others, these TCR data highlight areas where Texas doctors can best direct their focus. One such focus would be the substantial cancer health disparities in Texas. Cancer health disparities are adverse differences in cancer measures between certain population groups, such as incidence (new cases), prevalence (existing cases), morbidity (cancer-related health complications), mortality (deaths), survivorship and quality of life after cancer treatment, screening rates, and stage at diagnosis, among others.

Racial/Ethnic Disparities

Though racial and ethnic disparities exist in various cancers in Texas, this report focuses on the three cancers with the most substantial disparities in health outcomes as determined by TCR: liver, female breast, and uterine.

Liver Cancer

Though incidence rates for most cancers are declining, liver cancer rates in Texas are increasing. Texas has the second highest rate of new liver cancer diagnoses and fourth highest rate of liver cancer deaths in the U.S. Texas data show that Hispanics are two times more likely to be diagnosed with liver cancer than their non-Hispanic white counterparts. Similarly, non-Hispanic blacks and non-Hispanic Asian/Pacific Islanders are significantly more likely to be diagnosed with liver cancer than non-Hispanic whites. Hepatocellular carcinoma (HCC) constitutes 78% of all primary liver cancers diagnosed in Texas. Major risk factors of HCC are fatty liver disease, smoking, heavy alcohol use, overweight/obesity, diabetes, and

* age-adjusted incidence rate = number of new cancers diagnosed per 100,000 individuals in the population at risk, adjusted for age; Texas’ age-adjusted incidence rate declined from 474.5 per 100,000 in 1995 to 391.8 per 100,000 in 2016.
† age-adjusted mortality rate = number of new cancer deaths per 100,000 individuals in the population at risk, adjusted for age; Texas’ age-adjusted mortality rate declined from 207.5 per 100,000 in 1995 to 148.6 per 100,000 in 2016.
chronic infections by hepatitis B virus (HBV) or hepatitis C virus (HCV). These factors are more common in certain minority populations with higher incidence rates, highlighting the importance of preventive strategies targeted to these groups, such as screening for and treating HCV, vaccinating for HBV, preventing diabetes, maintaining a healthy body weight, and avoiding tobacco use and excessive alcohol consumption.

Breast Cancer
Breast cancer is the leading cancer diagnosis and the second leading cause of cancer death among women in Texas. Non-Hispanic blacks have the highest breast cancer mortality rates compared with all other racial/ethnic groups. Though both non-Hispanic whites and non-Hispanic blacks have the highest rates of breast cancer diagnoses compared with other racial/ethnic groups (in fact, incidence rates are lower for blacks than whites), non-Hispanic blacks have a 41% higher mortality rate. A likely factor influencing this large disparity is the difference in the molecular subtype of breast cancer. Incidence rates of triple negative breast cancer, which grows and spreads faster than other molecular subtypes and is more difficult to treat, is almost twice as high in non-Hispanic blacks as in non-Hispanic whites. Further, breast cancer diagnoses for all subtypes are diagnosed at a much later stage than in non-Hispanic whites, resulting in lower survival rates. Additionally, non-Hispanic black women tend to be diagnosed at an earlier age, indicating that younger non-Hispanic black women with an earlier average disease onset are disproportionately affected by screening age guidelines. Other contributing factors to these significant racial/ethnic disparities are greater rates of diabetes and hypertension, disparities in cancer care and treatment (low non-Hispanic black enrollment in clinical trials, low use of adjuvant radiation therapy and systematic therapy), and limited health care access.

Uterine Cancer
Uterine cancer is the fourth leading cancer diagnosis and the seventh leading cancer cause of death among Texas women. Hispanic and non-Hispanic black women have the highest incidence rates in the country. Further, the mortality rate among non-Hispanic black women is more than twice that of non-Hispanic white women in Texas. Similar to breast cancer, the key factor influencing the racial/ethnic disparities in uterine cancer incidence and mortality rates is the difference in cancer stage at diagnosis. A greater proportion of non-Hispanic black women are diagnosed with uterine cancer beyond the localized stage, with a lower chance of survival. However, even when comparing both non-Hispanic white and non-Hispanic black patients diagnosed at the same localized stage, the five-year survival rate for non-Hispanic blacks (88%) is lower than that of non-Hispanic whites (94%). Also, the particular types of carcinomas, carcinosarcomas, and sarcomas higher in non-Hispanic black women include more aggressive histologies with lower symptoms, leading to later-stage diagnoses. However, survival is notably lower for non-Hispanic black women than non-Hispanic white women, even when diagnosed with the same histological type and stage. Socioeconomic issues such as limited health care access and differences in treatment decisions also contribute to these disparities.

Socioeconomic and Geographic Disparities
Individuals from low socioeconomic backgrounds often bear a greater burden of disease and cancer compared with the general U.S. population. These patients are often low-income, lack health insurance, and are medically underserved with limited to no access to adequate health care. Texas has the highest overall uninsured rate in the country, at 17.7%, or about 5 million Texans. Research has well documented that a lower socioeconomic status is associated with higher cancer incidence and mortality. A study by Risser et al. assessed county-level socioeconomic status and cancer rates in Texas, finding that the highest cancer incidence and mortality rates were lowest in counties with high socioeconomic status. Rural Texans have higher poverty rates than the national average and are less likely to have health insurance. Rural residents often encounter travel and transportation barriers to adequate cancer care and tend to have higher rates of cancer incidence, later-stage cancer diagnoses, and mortality compared with urban
populations. Socioeconomic and geographic disparities overall limit Texans’ access to adequate cancer care, such as routine cancer screenings for early detection. Compared with the rest of the country, Texas scores dismally low on cancer screenings. Texas ranks 47th in up-to-date mammographies, screening 64% of the population compared with 68% in the U.S. For stool tests/endoscopies, Texas ranks 48th at 62% compared with 70% in the U.S. Further, for pap/HPV tests, Texas screens 82% compared with 85% in the U.S., ranking 47th.

Overall, racial/ethnic, socioeconomic, and geographic disparities contribute to significant cancer health disparities among Texas populations. Studying these disparities and prioritizing effective ways to address them may help Texas’ most vulnerable, underserved populations get the cancer care they need.

Where Physicians Can Help
Because cancer health disparities stem from a variety of factors, such as poverty and genetics, addressing them is complicated. However, research so far does point to a few of the most impactful ways to address cancer disparities, including access to care. Improving patients’ access to cancer care through programs that pay for screening, treatment, and patient navigators (to coordinate culturally relevant screening and cancer care) have shown to be effective. Physicians may play an effective role by advocating for their patients and supporting initiatives that provide access to comprehensive cancer care among rural residents, as well as the low-income, underserved, uninsured, and underinsured.

Regarding racial/ethnic disparities, other factors that may lead to unequal treatment in clinical care are unconscious/implicit bias, stereotyping, racism, limited health literacy, poor interpretation quality, and other challenges in cross-cultural communication. Unconscious or implicit bias refers to the attitudes or stereotypes that affect our understanding, actions, and decisions in an unconscious way. Stereotypes of certain racial/ethnic groups may play a role; an implicit stereotype is the unconscious attribution of a particular quality to a member of a certain social group and is a learned association influenced by experience. Racism, including unconscious or institutionalized, may affect how different patients receive different cancer care. A few recommendations to address racial/ethnic cancer health disparities are:

1. Humanize the patient, i.e., connect your humanness with the patient’s humanness;
2. Identify and monitor conscious and unconscious bias;
3. Help patients learn about their disease/condition;
4. Do a teach-back with patients, e.g., asking them to describe, in their own words, what they understand their health problem to be and what they need to do to address the health problem;
5. Use a qualified medical interpreter as appropriate;
6. Consider the patient’s health literacy;
7. Encourage the patient to ask questions; and
8. Hold institutions accountable for providing comprehensive, inclusive, appropriate care.

Statewide Efforts
Texas is fortunate to have the Cancer Prevention & Research Institute of Texas (CPRIT), a state agency dedicated to curing and preventing cancer by funding innovative research and prevention programs and services in Texas. CPRIT also supports academic and product development research. Ten percent of CPRIT funds support the delivery of evidence-based cancer prevention interventions specifically to underserved populations in Texas. CPRIT was established in 2007 via a constitutional amendment vote, and underwent another vote to continue its funding during the 2019 Texas legislative session. Supporting CPRIT has consistently been a legislative priority for the Committee on Cancer and for TMA. As CPRIT was up for debate during last legislative session, TMA needed stronger policy to guide its continued support of such a key statewide initiative for cancer research and prevention.
Conclusion

Though this report focuses on racial/ethnic, socioeconomic, and geographic cancer health disparities, other health care disparities, not only in cancer care, affect patients—including but not limited to gender, sexual identity, disability, weight, religion, and age. Because TMA currently does not have policy on disparities in health care overall, the Committee on Cancer recommends a workgroup to focus on other disparities in health care not covered in this report.

Recommendation 1: Adoption of new Texas Medical Association policy, as follows:

Addressing Cancer Health Disparities: The Texas Medical Association: (1) recognizes racial/ethnic, socioeconomic, and geographic cancer health disparities as public health issues that hinder effective cancer screening, diagnosis, treatment, supportive care, and survivorship; (2) supports physician awareness initiatives and education to address cancer health disparities; and (3) encourages research aimed at identifying effective strategies to eliminate disparities in cancer health outcomes in all at-risk populations.

Recommendation 2: That TMA convene a cross-component workgroup to study and develop policy on disparities in health care.

Related TMA Policy:
60.008 Rejection of Discrimination
50.007 Cancer Diagnosis, Treatment, and Follow-Up
50.009 Cancer Screening

Related AMA Policy:
Cancer and Health Care Disparities Among Minority Women D-55.997
Racial and Ethnic Disparities in Health Care H-350.974
Disparities in Health Care 8.5
Disparities in Maternal Mortality D-420.993
Health Insurance Differences Contribute to Health Care Disparities and Poorer Outcomes H-185.943

Sources:
REPORT OF COMMITTEE ON CANCER

Subject: Sunset Policy Review

Presented by: Marian “Yvette” Williams-Brown, MD, Chair

Referred to: Reference Committee on Science and Public Health

TMA periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness.

The Committee on Cancer recommends retention of the following policy:

50.009 Cancer Screening: The Texas Medical Association supports the importance of providing routine, evidence-based cancer screening to Texans. The decision to have regular cancer screenings should be in support of the full body of evidence and recommendation of professional health organizations that provide recommendations, and should take into account patient values regarding specific benefits and harms of any screening test (CM-C Rep. 1-A-10).

Recommendation 1: Retain.

The Committee on Cancer recommends amending these policies as follows:

50.002 Statewide Cancer Registry: The Texas Medical Association encourages medical staffs of each hospital in the state to appoint a committee on cancer as a standing committee of the medical staff organization, responsible for analysis of the cancer care provided in the facility and development of continuing education programs. TMA endorses and encourages medical staffs to support the establishment and maintenance of a committee on cancer and cancer registry in the hospitals to provide the data on cancer needed for reporting, planning, monitoring, evaluation of cancer management, and development of continuing education programs. TMA supports full implementation of the statewide cancer registry which was established by the 66th Texas Legislature effective Sept. 1, 1979, and amended by the 69th Texas Legislature in HB 4 effective in 1985, and commends the Texas Department of State Health Services for implementation and ongoing maintenance of a program that meets national high-quality data standards (Committee on Cancer, p 146, A-92; amended CM-C Rep. 2-A-10).

50.003 Cancer Unproven Methods: Unorthodox Treatment of Cancer: The Texas Medical Association recognizes the dangers to the health of Texans by treatments for cancer with unorthodox methods that lack a proven scientific basis for effectiveness particularly when these treatments are offered as an alternative to proven, conventional treatments. TMA strongly advises that patients with cancer receive evidence-based treatment that has withstood scientific scrutiny or is part of a science-based clinical trial (Committee on Cancer, p 132, A-94; amended CM-C Rep. 2-A-10).

280.034 Pain Management: The Texas Medical Association: (1) supports more effective promotion and dissemination of educational materials for physicians and other health care professionals on pain management including the Centers for Disease Control and Prevention Guideline for Prescribing Opioids for Chronic Pain, and the associated online training series for primary care physicians and other health care professionals; and (2) recognizes that patients in pain are a vulnerable population, and that pain is: (a) a symptom, for which the cause should be identified and specific treatment tailored to the specific cause and pain type, or (b) a chronic
condition related to or independent of various chronic disease states that may require ongoing multidisciplinary, multimodal management strategies; and (3) collaborates with colleagues affiliated with the Texas Pain Society to promote awareness, education, and advocacy efforts to address problems of pain using the best available evidence-based clinical care (CM-C Rep. 3-A-08; amended CSPH Rep. 5-A-18).

315.000 Tobacco: In Texas, tobacco stands out as the agent most responsible for avoidable illness and death. Its use brings premature death to one-half of all tobacco users and contributes to profound disability and pain in millions of Texans. In addition, secondhand smoke is one of the most dangerous and unregulated occupational chemical exposures in America’s workplaces.

The vast majority of adult tobacco users report a strong desire to quit, and current treatments for tobacco dependence offer physicians their greatest single opportunity to staunch the loss of life, health, and happiness caused by this chronic condition.

While physicians are uniquely qualified to advocate for smoke-free policies because of the dangerous health effects of tobacco use, physicians also must be aware of the economic costs of tobacco use in Texas - totaling $20 billion each year for health care and from lost work productivity and premature death. Physicians must advocate for measures that will reduce the impact of tobacco use in health and the state’s economy.

The Texas Medical Association supports the following policies to help physicians reduce, and eventually eliminate, tobacco use and its impact on Texans.

Tobacco Use. TMA strongly encourages all people who currently do not use tobacco products to remain tobacco-free and all people who currently use tobacco products to quit. TMA further encourages people who are ready to quit to actively participate in a proven tobacco cessation program, consulting their physician or other health care professional as appropriate. TMA urges public and private agencies, institutions, and businesses to establish tobacco prevention and cessation programs to help their employees, faculty, staff, and students quit their tobacco use. TMA condemns the use of tobacco as a behavior modification reward under all circumstances.

Tobacco Products. TMA opposes the sale of all tobacco products (including but not limited to cigarettes, cigars, smokeless tobacco, pipe tobacco, e-cigarettes, and “heat not burn” devices); and tobacco substitutes (including but not limited to nicotine mints, nicotine gum, nicotine water, clove cigarettes, snus, shisha, nicotine strips, and other dissolvable tobacco products) for use other than tobacco cessation pharmacotherapy. TMA also opposes the sale of tobacco look-alike candy, gum, and jerky that are made to resemble real tobacco products and potentially encourage tobacco use.

Tobacco Regulation. TMA opposes any state or federal law exempting tobacco products from product liability or litigation and supports the classification of tobacco smoke as a Class A carcinogen and supports its stringent regulation with other Class A carcinogens regulated by the Occupational Safety and Health Administration and the Environmental Protection Agency. TMA supports the inclusion of all tobacco products under the regulations and jurisdiction of the Federal Drug Administration (FDA) and encourages strong FDA regulatory action such as a requirement for color picture warning labels and plain packs as done in other countries. If tobacco products are sold in Texas, TMA suggests the packaging of all tobacco products in a
plain white container with only the name of the brand and all of the following: a colored
warning label covering at least 50 percent of the surface area of the front and back of the
package, a label listing all ingredients, and an insert that presents in detail all health and safety
risks associated with tobacco use.

Smoke-Free Environments. TMA prohibits smoking at all of its official functions and calls for
all future TMA contracts for hotel and event venues to include a prohibition on smoking.
TMA supports regulations and legislative action establishing all public places and workplaces,
including any place where people seek medical care, day care facilities, residential day care
facilities, public and private schools, prisons, and airplanes, and bars and restaurants as
smoke-free environments. Surrounding grounds also should be made smoke-free for a distance
sufficient not to expose others to secondhand smoke. TMA urges its members, county and
state medical societies, and the American Medical Association to facilitate and support the
establishment and enforcement of smoke-free policies and ordinances in the above locations
and to promote, honor, and help publicize companies and governmental agencies that become
smoke-free. No exemptions should be made for concerts for theatrical performances

Tobacco-Free Environments. TMA endorses any proposal to make the following entities
completely tobacco-free: hospitals or any place people seek medical care, psychiatric
hospitals, and prisons. Additionally, physicians should assist in eliminating the sale of tobacco
products on these premises.

Physician Education. TMA strongly encourages all physicians to become formally trained in
tobacco prevention and cessation methods and to utilize these proven techniques in their daily
practices. TMA encourages physicians to be aware of effective tobacco cessation programs
that support integration of tobacco cessation in health care settings.

Physician Advocacy. TMA encourages its members to support anti-tobacco education within
their local communities and strive to gain cooperation from other health care professionals in
these efforts. TMA rejects the tobacco industry and its affiliates as credible sources of health
information or materials and discourages municipalities and schools from using tobacco
industry-sponsored information or materials.

Physician Screening and Interventions. TMA recommends that all physicians and other health
care professionals screen each patient for tobacco use and encourage and facilitate tobacco
cessation for tobacco users. This intervention should include prompts to Ask the patient
regarding their tobacco use and Assess their willingness to make a quite attempt. If ready,
refer the patient to the state Quitline or provide cessation support and pharmacotherapy. If the
patient is not ready to quit, the use of Motivational Interviewing (MI), a directive, patient-
centered counseling intervention, is effective in increasing future quit attempts. Physicians are
strongly advised to routinely use a vital sign template that includes tobacco use in clinic charts
and document all interventions and follow-up, including referral to a tobacco cessation
specialist. Furthermore, TMA urges physicians to advise patients and patient caregivers to
maintain a smoke-free home to promote recovery and prevent additional illness.

Reimbursement for Tobacco Cessation. TMA believes tobacco cessation therapy is one of the
most cost-beneficial prevention activities available to physicians and encourages
reimbursement by all third parties for tobacco cessation counseling and treatment services,
including pharmacotherapy.
The Affordable Care Act requires all new private health insurance plans to cover services recommended by the U.S. Preventive Services Task Force (USPSTF) with no cost-sharing. Cost-sharing includes co-payments, co-insurance and deductibles. Beginning September 23, 2010, non-grandfathered group coverage and non-grandfathered individual health insurance policies must cover evidence-based items or services that have in effect a rate of A or B in the current recommendations of the USPSTF.

TMA recommends that the Texas Department of Insurance Essential Health Benefits standard for Texas include coverage for at least two quit attempts per year with up to four tobacco cessation counseling sessions of at least 30 minutes each, including proactive telephone counseling, group counseling, and individual counseling. Coverage should include all prescription and over-the-counter drugs approved by the FDA to treat tobacco dependence for smoking cessation.

Tobacco Advertising. TMA supports a ban on tobacco advertising in all forms, both explicit and subliminal. This ban includes but is not limited to television, radio, newspapers, magazines, billboards and other outdoor signage, and the internet. This also includes all grocery stores, convenience stores, and other retail outlets. All tobacco products should be behind enclosed cabinets with no advertising on the outside. TMA also urges all athletes and sports figures to dissociate themselves from all forms of tobacco advocacy and use. Until all tobacco ads are banned, TMA supports ending tax deductions for advertising tobacco products. Further, TMA encourages its members not to subscribe to waiting room publications containing tobacco advertisements, or to mark the covers of such publications with a disclaimer stating that they do not support the use of tobacco products.

Tobacco Sales. TMA recognizes the danger that tobacco use and nicotine addiction poses to the public health and opposes the sale and use of all tobacco products. TMA recommends that the following entities prohibit the sale of tobacco products at their locations of business and provide tobacco cessation information for their customers: hospitals or any place people seek medical care, psychiatric hospitals, pharmacies, and prisons. TMA further supports the complete ban on tobacco sales from vending machines, the free distribution of tobacco samples, the free distribution or sale of tobacco at discounted rates through any organization or the military, the sale of tobacco products over the internet or through the mail, and the licensing of tobacco vendors with appropriate penalties, as well as the revocation of license for selling tobacco to minors. TMA believes that where tobacco continues to be sold, all tobacco products should be kept secure behind the counter.

Tobacco Taxes. TMA supports sudden and significant increases in taxes on tobacco products as a proven method for decreasing rates of tobacco use and to increase revenue for tobacco prevention and cessation efforts. TMA supports bringing rolling tobacco and pipe tobacco up to an equivalent price with cigarettes. A portion of tobacco excise tax revenues should be used to completely fund a statewide tobacco cessation Quitline with counseling and FDA-approved over the counter pharmacotherapy.

Tobacco Investment Divestiture. TMA supports divestiture of tobacco investments, especially among physicians and health-related institutions.

Tobacco Funding for Research. TMA strongly discourages all colleges, universities, medical schools, and all associated faculty from accepting research funding, both directly and indirectly, from the tobacco industry, its subsidiaries, and its affiliates.
Tobacco Subsidies. TMA supports ending all agricultural price supports for tobacco, including crop support and crop buy-out with storage subsidies.

Reporting of Tobacco Research and Data. TMA urges the medical community and related groups, educational institutions, and government agencies to effectively and consistently report scientific data demonstrating the health hazards inherent in tobacco use, including but not limited to cigarettes, cigars, dissolvable tobacco products, e-cigarettes, and smokeless tobacco. In addition, TMA supports the inclusion of tobacco use history on death certificates and encourages physicians to complete this section of the certificate. Texas uses the expanded, revised birth certificate that allows for collection of either the average number of cigarettes or the average number of packs of cigarettes smoked in each of four time periods (three months before pregnancy and each of three trimesters). Providers should assess and record in the prenatal care record and delivery record of these four values so that they can be recorded on the birth certificate. TMA urges the Texas Department of State Health Services to release regular reports on deaths attributable to tobacco use.

Preemption of Local Laws. TMA supports cities and municipalities that have passed strong local laws and ordinances regulating tobacco sale and use and county restrictions on tobacco use on county-owned properties. TMA does not support the adoption of relaxed state legislation regarding tobacco regulation that may preempt these stronger local laws already in effect.

Tobacco Use in Entertainment. Recognizing the influence the entertainment industry has on culture in the United States, TMA requests that the entertainment industry stop portraying the use of tobacco as glamorous, sophisticated, or rebellious in movies, television, music, and music videos, video games, and professional sporting events, and strive to show the true devastation and disease that tobacco use causes.

Lawsuits Against the Tobacco Industry. TMA supports the prosecution of tobacco companies and their executives, board members, and affiliates for all violations of applicable state and federal laws.

Tobacco Settlement Monies. TMA affirms that the state’s lawsuit against the tobacco industry was conceived and filed with the intent of compensating Texans for health care costs associated with tobacco-related diseases, and, as a matter of unwavering principle, will work diligently to convince the Texas Legislatures that all tobacco settlement monies be dedicated to improving the health of Texans, not for general purposes (i.e., roads and bridges). Furthermore, TMA supports the following prioritization of initiatives to be funded by tobacco settlement and tax monies:

- Establish a comprehensive tobacco prevention advertising campaign with funding equal to the amount spent in Texas on promoting tobacco products.
- Establish a statewide tobacco cessation campaign, including advertising, cessation counseling, and coverage for cessation pharmacotherapy.
- Fund educational campaigns in support of tobacco-free workplaces.
- Establish a comprehensive program to limit minors’ access to tobacco products, including random unannounced vendor compliance surveys and enforcement activities.
Establish a school-based tobacco education curriculum that includes nicotine addiction, tobacco-related diseases, and tobacco industry activities and advertising.

Establish programs to train physicians and other health care professionals to identify and treat people at risk for tobacco-related diseases.

Fund the screening and treatment of patients with tobacco-related diseases.

Fund increased research on tobacco-related diseases and tobacco addiction.

Fund other public health-related activities.

Tobacco Prevention. TMA supports other community-based efforts such as increasing the unit price of tobacco products, health communication, mobile phone-based interventions, and reducing the out of pocket costs for cessation treatments and other evidence-based interventions recommended in the U.S. Guide for Community Preventive Services.


Recommendation 2: Retain as amended.

The Committee on Cancer recommends deletion of the following policies:


50.005 Cigar Smoking and Cancer: Cigar and Smokeless Tobacco: The medical community and related groups, educational institutions, and government agencies are urged to more effectively report the scientific data demonstrating the health hazards inherent in the use of cigars and smokeless tobacco. The Texas Medical Association supports required health warnings on cigar and smokeless tobacco packaging (CM-C Rep. 3-A-00; amended CM-C Rep. 2-A-10).

Recommendation 3: Delete.
TMA periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness.

The Committee on Child and Adolescent Health recommends amending the following policies:

55.005 Human Sexuality and Family Life as Mandated Health Education Curriculum: The Texas Medical Association believes all children and adolescents (grades K-12) should receive supports legislation which would direct the State Board of Education to include evidence-based comprehensive education on both human sexuality and family life as part of the mandated health education curriculum in Texas schools. TMA supports legislation to promote this (Medical Student Section, p 132, I-91; reaffirmed CM-CAH Rep. 2-A-03; reaffirmed CM-CAH Rep. 4-A-10).

55.016 Sexuality Education: The Texas Medical Association supports age and developmentally appropriate sexuality education from comprehensive kindergarten through college. Sexuality education that is theory based, research based, and skills oriented. Effective, evidence-based comprehensive curricula should focus address on abstinence, avoidance of sexual risk-taking behaviors, and availability of reproductive health choices, and include information on responsible decision-making, social influences, and peer pressures.

TMA will act as a resource and offer recommendations to state and local governmental agencies and other interested organizations based on scientific, medically accurate information on adolescent sexuality, dispelling medical misinformation.

TMA should promote through visible and vocal leadership, to the state and other interested organizations and associations, its policy advocating comprehensive programs in sexuality education.

TMA will act as a resource and clearinghouse for scientific, medically accurate information on adolescent sexuality, dispelling medical misinformation, and for information on sexuality education programs.

TMA will continue to work with the Texas Education Agency and the state legislature to develop and implement curricula on sexuality education (e.g., education for self-responsibility).

TMA will monitor and encourage research on the effectiveness of different sexuality curricula.

TMA will actively seek community, business, and corporate support for this policy.
TMA will lead a coalition to promote comprehensive sexuality education in schools throughout Texas.


55.018 **Mass School Audiometric Screening:** Mass screening of children in schools should be performed by pure-tone audiometry according to evidence-based recommendations and standards of the American Academy of Pediatrics (CPH, p 91, A-95; amended CPH Rep. 3-A-10).

55.019 **Comprehensive School Health Education:** The Texas Medical Association encourages physicians to become involved with school health education planning committees in their communities and to recommend and promote evidence-based comprehensive school health education (Committee on School Health and Children with Disabilities, p 96, A-95; reaffirmed CM-CAH Rep. 1-A-06; reaffirmed CM-CAH Rep.1-A-16).

55.035 **Right to Confidential Care:** The Texas Medical Association upholds the right of adolescents to receive confidential care to protect their health, except in situations where physicians and other health care professionals must abide by state and federal law. TMA encourages and supports parental involvement, acknowledging that evidence indicates that requiring parental involvement in sexual and contraceptive health care may reduce access to care without reducing sexual activity or increasing communication between parents and teens. In addition, TMA supports a health care environment that encourages adolescent access to care without involvement by law enforcement officials, except in cases of suspected child physical or sexual abuse as identified by the health care provider using his or her professional clinical judgment. (CM-MPH Rep. 2-A-03; reaffirmed CM-CAH Rep. 4-A-10).

135.017 **ImmTrac:** The Texas Medical Association (1) requests that the Texas Department of State Health Services (DSHS) develop a monitor, evaluate, and revise ongoing implementation plans with a timeline outlining the state’s recommendations on to improving the compatibility of ImmTracII and electronic health record systems; and (2) advocates for resources dedicated to DSHS for improving the statewide immunization database so that immunization information can be readily transferred between ImmTracII and all electronic health record systems; and (3) supports development of a mechanism to allow individuals access to their immunization records (CM-CAH Rep. 2-A-10).

260.084 **Fireworks Education:** The Texas Medical Association (1) cooperates with other associations, state agencies, and others to raise awareness and provide education on the dangers of fireworks to patients; and (2) recommends age-appropriate patient and community education on potential injuries related to use of fireworks. Education be included as a component of the Texas Health Steps program (CM-CAH Rep. 3-A-10).

Recommendation 1: Retain as amended.

The Committee on Child and Adolescent Health recommends deletion of the following policies:

55.002 **Comprehensive School Health Education in All School Districts:** The Texas Medical Association believes the Texas Education Agency should have statutory authority to require comprehensive school health education in all school districts of the state, and that the process

**260.064 Family Comes First:** The Texas Medical Association affirms the value of family and good parenting in raising children and encourages all parents to seek support and guidance in their parenting roles (CPH Rep. 4-A-00; amended CPH Rep. 3-A-10).

**Recommendation 2:** Delete.
Subject: Sunset Policy Review

Presented by: Thomas A. Kaspar, MD, Chair

Referred to: Reference Committee on Science and Public Health

The Texas Medical Association periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness.

The Committee on Infectious Diseases recommends amending the following policies:

260.060 Hepatitis C: The Texas Medical Association supports legislation aimed at providing funds to address the promotion of appropriate screening and treatment of hepatitis C in adults and children and other communicable diseases as public health threats (CM BTU 2-A-99; amended CM-ID Rep. 2-A-10).

245.019 Physician Immunizations Against Communicable Diseases: The Texas Medical Association strongly endorses immunization of all physicians and other health care workers with the recommended vaccines available for preventable, communicable diseases. Vaccinations protect not only patients but also physicians and other health care workers against the significant threat that infectious diseases pose in a health care setting (CM-ID Rep. 2-A-10).

Recommendation: Retain as amended.
Subject: Regulation of Electric Scooters, Resolution 308-A-19

Presented by: Richard N. Bradley, MD, Committee Chair, and Wendy M. Chung, MD, Council Chair

At the 2019 annual meeting, the House of Delegates adopted Resolution 308, Regulation of Electric Scooters, from the Bexar County Medical Society, calling on the Texas Medical Association to work with the Texas Department of Public Safety (DPS) to regulate electric scooters (e-scooters) as bicycles. These regulations would require e-scooter operators to follow traffic laws as bicycle operators, work with DPS to place an age restriction on electric scooter operators, allow only one operator per scooter, require the use of the helmets when operating electric scooters, and add safety features so that car drivers can see them. This resolution was referred to the Council on Science and Public Health and the Committee on Emergency Medical Services and Trauma for further study.

This report will examine the onset of electric scooters in major Texas cities in the past three years. The Austin Public Health Department commissioned the Centers for Disease Control and Prevention (CDC) to collect data on injuries involving rentable dockless scooters. This report will examine the data and analyze the e-scooter-related health and safety policies enacted by other state legislatures and local municipalities, to craft feasible policy solutions for Texas.

Texas’ History of E-Scooters

Texas first saw e-scooters in Austin in April 2018. These scooters are electric vehicles operating on two wheels with a platform for a single rider to stand on and a handlebar at about waist height for steering. E-scooters can reach speeds up to 20 mph. These e-scooters are operated by mobile app and usually cost a dollar to unlock and 15 cents per minute to ride. As of 2019, 10 e-scooter companies operate more than 14,000 vehicles in Austin alone. As of June 2019, e-scooters also were appearing in San Antonio, Dallas, Corpus Christi, and El Paso. The Houston City Council has resisted the presence of scooters thus far, claiming it is developing a regulatory framework and watching how other cities handle the vehicle.

E-scooters are part of the proliferation of micro mobility in the U.S, or the use of shared bikes and e-scooters for transportation, particularly in urban areas. The number of micro mobility trips throughout the U.S. doubled in 2018 over 2017, when shared scooters were used for 38.5 million trips. CDC studied e-scooter use in Austin from early September through November 2018 and found that during this time, “there were a total of 182,333 hours of e-scooter use, a total of 891,121 miles ridden on e-scooters, and a total of 936,110 e-scooter trips. Our calculations show that there were 20 individuals injured per 100,000 e-scooter trips taken during the study period. ... On average, two injuries occurred per day.”

Texas’ Public Policy on E-Scooters

Texas law is beginning to regulate e-scooters. The vehicles can be used on streets or highways where the posted speed limit is 35 mph or less. Traffic laws such as speed limits and signal turns that apply to bicycles also apply to scooters. Some laws that apply to larger motor vehicles do not apply to e-scooters, including safety inspections, driver’s licenses, registration, or insurance to operate the scooter. During the 2019 legislative session, Senate Bill 549 proposed prohibiting e-scooters on sidewalks, limiting speeds to 15 mph, and setting 16 as the minimum age to ride. It passed the Senate but not the House.
However, Austin increased regulatory measures beyond state requirements in May 2019. The Austin City Council reiterated that micro mobility riders must obey the same traffic laws as other motorists, although city council members express concerns regarding enforcement. The city website says children aged 17 and under are required to wear a helmet. E-scooters are allowed on sidewalks “in a responsible and prudent manner,” but a parked scooter cannot obstruct pedestrian traffic or sidewalks. Using an electronic device while operating an e-scooter, as with a bicycle, is prohibited, and only one rider can use the scooter at a time. A rider who causes injury to a person or property should provide reasonable assistance and exchange contact information. Visibility requirements only apply to bicycles.

**CDC Studies Austin**

During its September-November 2018 study, CDC studied the emergency medical impacts of e-scooter use. The study tracked the number of e-scooter rides resulting in medical care in an emergency department. CDC also analyzed the demographics and scooter experience of the subjects. In the 87 days of study, 190 injuries were logged. Of these, “almost half (80) of the injured riders had a severe injury. The severe injury for these riders included: bone fractures (excluding nose/fingers/toes) (84%), nerve, tendon, or ligament injuries (45%), spending more than 48 hours in the hospital (8%), severe bleed (5%), and sustained organ damage (1%).” Most accidents occurred on streets, and most riders were men. Thirty-eight percent of riders receiving emergency care stated they would ride a scooter again.

CDC refutes the claim that motor vehicles are responsible for e-scooter accidents, stating that “perceptions may be that most e-scooter riders are injured because of collisions with motorized vehicles. The findings of this study do not support that perception. While more than half of the interviewed riders were injured while riding a scooter in the street, few (10%) riders sustained injuries by colliding with a motor vehicle. Nevertheless, continuing education for motorized vehicle drivers and e-scooter riders is needed to prevent collisions.” This claim is relevant to the resolution’s request for visibility regulations for scooters. The study also states that “sixteen percent of the incidents with injured riders involved a motorized vehicle. These incidents include colliding and swerving, stopping, and jumping off the scooter to avoid a collision.”

Alcohol consumption while using an e-scooter should be explored more deeply. CDC reported that the record number of injuries occurring during a single day was 10 injuries on Oct. 13, 2018, the Saturday of Austin City Limits. The study showed that 39% of the injured riders in Austin were injured on a weekend, and 39% were injured between 6 pm and 6 am. Although these may just be high-traffic times, 29% of interviewed riders reported drinking an alcoholic beverage in the 12 hours preceding their injury. Bird, an e-scooter company based in Santa Monica, Calif., turns off all scooters between midnight and 5 a.m.

Regarding helmet use, of the 190 injuries captured, nearly half of subjects had injuries to the head. CDC stated: “Traumatic brain injuries include concussions and other forms of altered mental status or bleeding such as subarachnoid hemorrhage and subdural hematoma. Fifteen percent of riders had evidence suggestive of a traumatic brain injury.” Only one of the 190 scooter riders receiving emergency care was wearing a helmet. CDC continued: “[S]tudies have shown that bicycle riders reduce the risk of head and brain injuries by wearing a helmet. Helmet use might also reduce the risk of head and brain injuries in the event of an e-scooter crash.”

The study also noted that speed may be a contributing factor in injuries. “More than one-third (37%) reported that excessive scooter speed contributed to their injury.” In response to these concerns, The University of Texas at Austin used geofencing, or GPS technology, to regulate scooter speed within a defined area, to mandate speed limits on campus.
CDC also noted, “This is believed to be the first study to conduct interviews with injured e-scooter riders. This study likely underestimates the prevalence of e-scooter related injuries. The number and characteristics of injured riders seeking medical care at an urgent care center or physician’s office were not determined. This study was limited to investigating only those injured e-scooter riders and non-riders who sought care at a hospital emergency department or had care provided by emergency medical services. These riders are believed to experience more severe injuries compared with injured e-scooter riders whose injuries did not require care from a hospital emergency department or EMS.”

Public Policy in Other States
Numerous states and municipalities are attempting to regulate e-scooter use and safety. Often, states have broader recommendations and allow cities to create more detailed policies. New York state has a complete ban on the scooters. While Florida allows scooters, they are not allowed on sidewalks or bike paths. In California, riders under the age of 18 must wear a helmet by law, “unless [the scooter] is equipped with a brake that will enable the operator to make a braked wheel skid on dry, level, clean pavement.” California e-scooter users must carry a valid driver’s license or instruction permit. They also cannot ride while carrying an item that prohibits them from using the handlebars. The handlebars must be kept below shoulder height while riding on the highway. The scooters cannot be used on roads with speed limits greater than 25 mph. The state mandates that no motorized scooter can be operated at a speed over 15 mph on all highways and bikeways. In addition, Venice Beach, Los Angeles, and Beverly Hills in California, as well as Seattle and Washington, D.C., enacted measures either banning the e-scooters or capping the number of vehicles that each scooter company can release.

Discussion
The injuries caused by electric scooters in Texas should be of serious concern to physicians. Although the importance of helmet safety is widely known (although not always followed), users’ perception of scooter safety does appear analogous, as only one rider of the 190 emergency-level injuries studied by CDC wore a helmet. The shared, rental nature of the scooters makes the logistics of helmet use more difficult than for those who own their own bike, as some will use an e-scooter for only one leg of their trip and would have to carry the helmet for long periods. Doctors should talk to patients about helmet safety in these circumstances and/or support measures to make helmets more accessible to scooter riders. A new moped company, Rebel, provides passengers with helmets, although these vehicles are larger than e-scooters.

Many of the regulations crafted in this arena will fall under DPS’ umbrella, and physicians should be a part of this conversation. EMS and trauma doctors can communicate the severity of the issue from the physician’s perspective.

It should be acknowledged that e-scooters have benefits in addition to risks, although they are outside of the scope of emergency medicine. These include easing traffic congestion by taking cars off the road and reducing carbon emissions through electronic transportation.

Conclusion
The micro mobility regulatory environment is new and quickly evolving. As Austin has more experience with electric scooters than other cities in Texas and was studied by CDC, it is logical to follow its lead on policy to increase safety for e-scooter users, cyclists, pedestrians, and other transportation users.

First, physicians should support e-scooter helmet use to the same degree as TMA’s position on bicycles. The risks of head trauma are the same in both cases. The only difference may be increased speed on electric scooters, further displaying the need for helmet use.
Regarding speed, multiple states and municipalities enacted speed limits to reduce risk of crash and injury. This is easier to enact and enforce than setting speed traps for scooters, as governments could collaborate with scooter companies to create a geofence, a virtual boundary that enables scooter companies to adjust scooter speeds within a defined area. UT-Austin used this technology to drop scooters from their top speed of 20 mph to 8 mph. Geofencing likely could be used within city limits, too.

In response to the evidence that riders often use electric scooters while under the influence, applying motor vehicle blood-alcohol-content laws to e-scooter users could help mitigate crash and injury risks. Hourly use requirements, such as Bird’s disabling its scooters between midnight and 5 am, could also be an easier enforcement mechanism to curb drinking and riding.

Although CDC seemed to brush off motor vehicle and scooter interactions as an issue, 16% of emergency department-level injuries in the study did occur when an e-scooter dodged or hit a motor vehicle. This statistic is still significant, and could be lowered by more visible, reflective, or neon scooter colors.

CDC did recommend continuing education for e-scooter riders, as 33% of injuries studied affected first-time riders. Although 60% of riders received training on e-scooters via a phone app prior to riding, 63% of injured riders had ridden a scooter nine or fewer times before their crash. Expanding training or making phone app education more extensive may help prevent injuries.

Overall, TMA members should keep in mind that although these policy recommendations apply to electric scooter users, they are helping to keep all Texans safe on the road, sidewalk, and bike lane. If Texans want to adopt unsafe e-scooter practices, like speeding, running stop signs, or driving drunkenly, they put us all at risk.

Recommendation 1: That the Texas Medical Association develop a policy for electronic scooters like TMA Policy 55.021 Bicycle Helmets.

Recommendation 2: That TMA support the use of geofencing in cities where electric scooters are used to reduce speeds and therefore the impact of collisions.

Recommendation 3: That TMA develop and support policy that prevents the use of electric scooters while under the influence of drugs or alcohol. Such policy should include holding electric scooter users to motor vehicle blood-alcohol-content standards, making e-scooter users eligible for a driving under the influence charge when applicable, and supporting state or city councils implementation of curfew hours by turning off scooters, for example, from midnight to 5 a.m. on weekends, to prevent riding while intoxicated.

Recommendation 4: That TMA support the use of brightly colored, neon, or reflective materials on electric scooters to make them more visible to those operating motor vehicles in the vicinity.

Recommendation 5: That TMA expand its opposition to the use of electronic handheld devices while operating a motor vehicle to include electric scooters. Electric scooters should build infrastructure compatible with using an electronic map hands-free if that is a consumer need.

Recommendation 6: That TMA support regulating only one rider at a time on scooters to ensure riders can hold the handlebars.

Recommendation 7: That TMA support parking fines or impounding when riders block the sidewalk or other pedestrian routes with scooters.
Related TMA Policy:

1. 55.021 Bicycle Helmets
2. 25.002 Driving Under the Influence Stricter Penalties
3. 25.006 Driving While Intoxicated/Driving Under the Influence
4. 260.085 Driving While Using Hand-Held Electronic Communication Devices
Improving Medical Clearance Policies for Traumatic Brain Injury Patients, Resolution 303-A-19

Presented by: Wendy M. Chung, MD, Chair

Referred to: Reference Committee on Science and Public Health

Resolution 303 by the Dallas County Medical Society was presented at the 2019 House of Delegates in support of improvements in medical clearance policies for patients with traumatic brain injury (TBI). The resolution called for TMA to reaffirm its firearm policy on Texas gun laws and regulations relating to medical need and public safety. Other recommendations called for TMA legislative advocacy for:

- Amending Texas law to clearly prohibit symptomatic TBI patients from obtaining or retaining a license to carry a firearm until medical clearance;
- State legislation to expand both the medical clearance requirements and the firearm purchasing restrictions in Texas’ license-to-carry statute;
- Legislation to promote and emphasize the need for physician reporting to the Texas Medical Advisory Board all patients with prohibitive conditions, including symptomatic TBI patients; and
- Expanding the role of the Medical Advisory Board to include oversight of impaired persons with gun licenses and increasing physician awareness of the board and on required reporting.

Finally, the resolution called for the adoption of new TMA policy related to TBI and access to firearms and taking the policy to the American Medical Association for consideration.

The author of the resolution reported that each day up to 6,000 people in the U.S. sustain a traumatic brain injury and that those with a TBI are twice as likely to commit suicide, including veterans. Also, a large proportion of people with moderate to severe TBI are subsequently diagnosed with a psychiatric disorder. And while TMA has studied and developed policy on firearm-related injuries and fatalities, there has not been a focus on the impact of cognitive or mental deficits associated with TBI and access to firearms.

Resolution 303 was referred to the Council on Science and Public Health, the Council on Legislation, and the Office of General Counsel for study.

Traumatic Brain Injury

The Centers for Disease Control and Prevention (CDC) reports it is difficult to confirm the incidence and prevalence of TBI but notes that based on health facility-related data, the most common causes of TBI are falls, motor vehicle accidents, and strikes or blows to the head – often associated with a sport injury. A blow or bump to a person’s head is a force to the brain that can cause temporary or permanent physical damage including cognitive and behavioral impairments. Secondary disorders are not uncommon such as the development of attention deficit disorder in children following an acquired brain injury.

- CDC states that in the U.S. those most likely to have TBI are children aged 0-4 years and adolescents aged 15-19 years. Those older than 75 years are most likely to have an emergency department visit or to be hospitalized for a TBI.
The Texas Brain Injury Alliance reports that more than 381,000 Texans live with TBI-related disability, and there are more than 144,000 new TBI cases in Texas each year. Most of those with TBI are identified as having a mild TBI with symptoms such as loss of consciousness, memory loss, an inability to concentrate, mood changes, fatigue, or anxiety. Such symptoms are generally thought to be resolved within three months after the trauma. However, a recent meta-study notes that about half of those with a single mild TBI can have long-term cognitive impairment.

Federal and State Law on Firearm Possession/Purchase

Federal. The federal government defines a firearm (18 USC §921[3]) as a weapon that can expel a projectile by an explosive or is or can be converted to expel a projectile. Possession or receipt of a firearm is prohibited under federal law (18 USC §92[g] and [n]) by a person who is a felon (or awaiting trial on a felony charge); is drug user or addict; has a prior conviction for domestic assault or is subject to a domestic protective order; is a fugitive or who is in the U.S. illegally; or was dishonorably discharged from the U.S. military; or people with a history of certain mental health conditions (e.g., committed to a mental health institution or declared to have a severe mental illness).

Texas. Subchapter H of Government Code 411, Section 172, outlines Texas law on licensure for the carrying of a handgun. State law allows handgun licensure for those who are legal residents of Texas (six months prior to application), and:

- Without a conviction of a felony and not charged with a Class A or B misdemeanor or another offense under the state Penal Code (§42.01), or of a felony under an information on indictment;
- Not a fugitive from justice or chemically dependent, and capable of exercising sound judgment on proper handgun use and storage; and
- Not a respondent under a protective order and not be found delinquent in child support payments or other tax payment and also qualified under federal law to purchase a handgun.

In Section 172(d) of the Government Code, “incapacity to exercise sound judgment to possess and store a handgun” refers to a person who has been diagnosed by a physician to have a psychiatric disorder that can cause impairment in judgment, perception, impulse control, or intellectual ability.

- Evidence of a psychiatric disorder includes involuntary and voluntary psychiatric hospitalization; inpatient or residential treatment in the prior five-year period for substance use disorder; diagnosis that the person is dependent on alcohol, a controlled substance, or another similar substance; or diagnosis of a history of certain psychiatric disorders (schizophrenia or delusional disorder; bipolar disorder, chronic dementia, intermittent explosive disorder, or an antisocial personal disorder).
- A licensed physician whose primary practice is psychiatry may provide information that the person is in remission or is not likely to develop a psychiatric disorder.
- Those under age 21 cannot purchase handguns, but state law provides an exception for adults aged 18-20 years if they are a member or veteran of the U.S. armed forces or were discharged under honorable conditions and otherwise would be eligible to purchase a handgun under federal law.

Texas follows federal law on the purchase of firearms, which applies only to federally licensed firearm vendors. Texas statute defines a firearm and outlines the unlawful carry of weapons where weapons are prohibited as well as the licensure for concealed carry (licensure is required in Texas to carry a handgun). The Texas Department of Public Safety (DPS) is responsible for the licensure of individuals to carry a concealed handgun and those who want a license to drive a vehicle in Texas. The state’s rules are outlined in the state administrative code.
**Medical Advisory Boards**

Most states (37 states in 2017) have a medical advisory board, although the responsibilities of these entities can vary by state. The Texas Legislature established this state’s board to support DPS’ licensure for those seeking a license to drive a motor vehicle or a school bus, or to carry a concealed handgun. DPS seeks a medical review of those who already have or are applying for licensure who self-report (e.g., when they apply for a license and identify a particular health condition or limitation); are reported by others including physicians; or are tagged due to an event associated with law enforcement (e.g., a penalty for a motor vehicle accident when driving under the influence). The DPS referral triggers a medical review by the Medical Advisory Board.

The Texas Department of State Health Services (DSHS) administers and supports the board, whose members are physicians of specialties as set in state statute (board certified in internal medicine, physical medicine, neurology, psychiatry, ophthalmology, or optometry) and are recommended by DSHS and TMA or the Texas Optometric Association. A DSHS report for July 2018-August 2019 indicates that 7,501 people were referred to the Medical Advisory Board in this period for medical clearance review. Almost 97% of these were for the review of someone seeking a driver’s license, 2.5% were for someone applying for a concealed handgun license, and the remaining were for a license as school bus driver. DSHS indicates there are insufficient appointments to the advisory board to meet the above demand. Mandatory reporting would dramatically escalate this shortage.

Finally, DPS is solely responsible for the licensure for a concealed handgun, driver’s license, or school bus driver’s license. The Medical Advisory Board members conduct an independent record review and offer their opinion on the person’s capacity to drive or safely possess a concealed handgun. Per state statute, physician members of the board cannot be held liable for providing information or their professional opinion. However, participating physicians are volunteers and currently must travel to Austin for meetings, for which they receive nominal compensation. Figure 1 below shows the process the Texas board follows for its review of Texas residents referred by DPS.

**Physician Reporting of Patients**

While there is generally not a requirement to report, all states allow physicians to report to law enforcement or public safety officials a patient they are treating if they believe the patient may pose a risk to self or to others. In Texas, this exception to patient-physician confidentiality is outlined in Health and Safety Code, Section, 12.096, which allows any licensed physician to inform DPS or the Medical Advisory Board in writing or orally of a patient 15 years or older whom they have diagnosed as having a disorder or disability as noted in the DPS requirements (see also “impaired drivers” TMA Board of Councilors Current Opinions).

The laws also address physician reporting in Texas:

- Chapter 92 of the Texas Health and Safety Code on injury prevention and control requires the reporting of certain injuries by physicians, medical examiners, hospitals, and justices of the peace. It calls for mandatory reporting of traumatic brain injuries, defined as an acquired injury to the brain including injuries caused by anoxia but does not include brain dysfunction associated with birth trauma or congenital or degenerative disorders. These injuries are reportable to the Texas Brain Injury Reporting Registry supported by DSHS.
- The Texas Mental Health Code allows mental health professionals to disclose confidential patient information only to medical or law enforcement personnel if they believe there is a high probability that the patient or others are at risk of immediate mental or emotional injury. Texas law prohibits the sharing of similar information with a patient’s family or known loved ones.
Figure 1. Medical Advisory Board for Driver Licensing and Evaluation for Concealed Handgun

**Self Referral**
- Concealed handgun application re: psych. history
- Driver licensing application re: medical history

**Law Enforcement Referral**
- Incident reports to DPS Concealed Handgun Section
- Officer reports to DPS Driver Improvement Bureau

**Physician Referral**
- Voluntary report to DPS Driver Improvement Bureau
- EMS personnel report to physician

DPS clerks screen reports and refer to Texas Dept of Health MAB section, according to Govt. Code §411.172 or 37 TAC §15.58 guidelines

Medical history forms sent to licensee/applicant

MAB staff prepares cases for MAB physicians

MAB physicians review cases and write opinions

MAB physician opinions sent to DPS

**DPS Driver Licensing Office Referral**
- Driving record
- Observed or admitted medical conditions
The National Traffic and Safety Administration notes there are several states with mandated physician reporting of certain impaired drivers, e.g. those with specific conditions: epilepsy, dementia, or other cognitive or medical impairments. States requiring reporting are Delaware, New Jersey, Oregon, Pennsylvania, Nevada, California, and Utah.

Discussion and Recommendations

Resolution 303 addresses a range of complex and important issues, but it primarily calls for TMA to develop policy and/or seek legislative action to ensure certain symptomatic individuals with brain injuries undergo medical clearance for firearm possession if their condition puts them at risk of harm. Firearm safety is a concern for physicians, and TMA has expended much time and study in this area. The resolution calls for reaffirmation of strong national and Texas gun laws, which is already reflected in TMA’s recently updated policy on firearms. TMA Policy 260.015 recognizes gun violence as a public health issue and calls for medical professionals to speak out on the prevention of firearm-related injuries and deaths.

The definition of a “symptomatic TBI” patient is broad and varies greatly, from mild to severe, with symptoms ranging from a short-term headache to long-term cognitive impairment. The variability of what exactly constitutes a symptomatic TBI patient poses potential difficulties in the implementation, regulation, and enforcement of state statute. TMA policy specifically does not support the erosion of physicians’ professional freedoms and seeks to limit the increasing excessive paperwork imposed on doctors; thus, the association would not support any reporting requirements or mandates on physicians. Mandatory reporting may also lead to elevated legal risks for Texas physicians, as well as escalate the shortage of physician appointments to the Medical Advisory Board, which is already insufficiently meeting growing demand. As firearm violence continues to be a concern in the U.S., the advisory board’s medical clearance process is a potential target for those who either support or oppose increased firearm restrictions. For example, if a red flag statute were adopted in Texas, it would possibly involve some form of medical clearance processes at the local or state level.

Resolution 303 calls for the prohibition of symptomatic TBI patients from obtaining or retaining their license to carry (albeit temporarily until medical clearance is received); however, a potential unintended consequence may be the deterrence of individuals reporting their own brain injuries. Caution must also be taken should more physician referrals for prohibitive conditions lead to potential patient distrust and strain on the patient-physician relationship. Another consideration about amendments to state law is potential stigmatization of Texans with TBI-related injuries or disabilities.

Overall, after careful consideration and study, in lieu of adopting Resolution 303, the Council on Science and Public Health makes the following recommendations:

Recommendation 1: That the Texas Medical Association support and promote the Texas Medical Advisory Board process by increasing physician awareness and TMA member participation on the Medical Advisory Board to ensure adequate representation, and support potentially needed expansion of this important public service to Texas.

Recommendation 2: That TMA promote physicians’ awareness of their ability to report their patients to law enforcement or the Department of Public Safety with concerns regarding their patient’s ability to safely drive or possess firearms.

Recommendation 3: That TMA promote a review of the funding of the Medical Advisory Board by the Texas Legislature to assess the potential for expanding the scope of this key public service.
Related TMA Policy:

260.015 Firearms
260.079 Mandated Patient Information
260.094 Head Injuries and Sport-Related Concussion
280.021 Stroke Prevention Awareness
115.018 Overwhelming Compliance Mandates and Payment Uncertainty
165.009 Excessive Federal Paperwork Requirements
245.003 Professional Freedom Erosion

Related AMA Policy:

H-470.963 Boxing Safety
H-470.954 Reduction of Sports-Related Injury and Concussion
H-470.984 Brain Injury in Boxing
H-145.974 Increasing Toy Gun Safety
H-145.979 Prevention of Unintentional Shooting Deaths Among Children
H-145.997 Firearms as a Public Health Problem in the United States - Injuries and Death
H-145.978 Gun Safety
H-145.975 Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care
D-145.995 Gun Violence as a Public Health Crisis
H-145.996 Firearm Availability
D-145.997 Physicians and the Public Health Issues of Gun Safety
H-145.985 Ban on Handguns and Automatic Repeating Weapons
H-145.989 Safety of Nonpowder (Gas-Loaded/Spring-Loaded) Guns
H-60.947 Guns in School Settings
H-215.977 Guns in Hospitals
H-145.999 Gun Regulation
H-145.988 AMA Campaign to Reduce Firearm Deaths
H-145.972 Firearms and High-Risk Individuals
H-145.999 Waiting Period Before Gun Purchase

Sources:

   https://statutes.capitol.texas.gov/Docs/HS/htm/HS.92.htm
9. Texas Health and Safety Code, Sec. 611.004. Authorized Disclosure of Confidential Information Other Than in Judicial or Administrative Proceeding.


15. Texas Department of Public Safety. Texas Medical Evaluation Process for Driver Licensing.


Resolution 305 by the Harris County Medical Society and the Texas Allergy, Asthma & Immunology Society (TAAIS) was considered at TexMed 2019. The resolution called for TMA to support increasing access to epinephrine auto-injectors (such as EpiPens) in certain public locations. Public locations (certain entities as defined and regulated in state statute) identified in the resolution were amusement parks, child care facilities, camps, restaurants, sports venues, concerts, state government entities, retail facilities, churches, synagogues, youth centers, higher education institutions, and any other entities the executive commissioner (Texas Health and Human Services Commission) determines as appropriate. Other resolves in the resolution called for:

- Annual training of employees or volunteers at these sites;
- State development of policies for these entities; and
- Ensuring immunity for those who, in good faith, initiated treatment using an epinephrine auto-injector as authorized under state rules.

At the TexMed 2019 Reference Committee on Science and Public Health hearing, the author spoke about the effectiveness of increased access to emergency treatment in the school setting and how anaphylaxis occurs among students, teachers, and other school staff. The author also discussed the critical need to have auto-injectors on site in many public locations. Another testifier expressed concern about the high cost of implementing the resolves. The council did not take a position on the resolution at the reference committee hearing. However, the committee noted the complexity of diagnosing anaphylaxis and the potential for inappropriate use of epinephrine. The reference committee recommended the resolution not be adopted. The House of Delegates approved referral of the resolution, and it was referred to TMA’s Council on Science and Public Health and Council on Legislation.

More than a decade ago, Texas passed legislation allowing students (with parent approval and physician instructions) to possess and administer prescribed medicine for asthma or anaphylaxis while at school or at a school-related event. Over recent legislative sessions, TMA has remained engaged with TAAIS and others on policy development related to guidelines for care for those at risk for anaphylaxis, including access to auto-injectors (e.g., Senate Bill 27 [Zaffirini, 2011], House Bill 742 [Hunter, 2011], and Senate Bill 66 [Hinojosa, 2015].

TMA supported House Bill 4260 by Rep. Philip Cortez in the 2019 Texas legislative session. This bill passed the House passed early in May 2019 (prior to TexMed). A Senate committee considered the bill in mid-May and finally passed and signed it on the last day of the legislative session. As amended, HB 4260 addresses many of the entities and requirements identified in Resolution 305 – allowing these entities to offer access to epinephrine auto-injectors by employees or volunteers. Governmental entities were excluded. This legislation was signed by the governor in June, effective Sept. 1, 2019. (Refer to Appendix
A: Recent Texas Legislation on Allergens and Anaphylaxis, which provides a table identifying relevant legislation TMA has monitored and supported).

The Health and Human Services Commission has charged the Texas Department of State Health Services (DSHS) with developing rules to implement House Bill 4260. TMA is in contact with DSHS on its rulemaking for this and related legislation.

Discussion and Recommendations

Food allergies may have a significant negative impact not only on the person with the allergy but also on family and household members. A food allergy can place a person at risk in a restaurant and in almost every setting where food or other contamination can occur, such as a school or even a place of worship. Texas has adopted legislation to support access to emergency treatment for anaphylaxis in a variety of public settings. However, TMA should monitor the implementation of legislation on food allergens.

Current state efforts include the DSHS Food Allergy Ad Hoc Committee, charged with developing guidelines as directed by Senate Bill 869 and other legislation addressing food allergens, and a DSHS standing committee, the Stock Epinephrine Advisory Committee, which has strong allergy and immunology representation from TMA and a key role in how schools – including higher education campuses and now, potentially other settings – should store, maintain, and provide training on the use of auto-injectors.

Entities in individual communities may seek physician support in developing standing orders and providing prescriptions for unassigned auto-injectors in various settings. These are licensed venues, but the definitions, regulations, and the population at these entities seem to vary widely – requiring strong local input to ensure safe access and use. The requirement for training employees in the various venues would likely be tremendously prohibitive, especially in venues where seasonal employees and volunteers change continuously.

Because state legislation has been passed and efforts are already underway, in lieu of adopting Resolution 305, the Council on Science and Public Health makes the following recommendations:

Recommendation 1: That TMA monitor and confer with the Texas Department of State Health Services as it convenes the new Food Allergy Ad Hoc Committee, as well as develop and share information for members on the role of this new ad hoc group.

Recommendation 2: That TMA members be informed of opportunities to be engaged in, monitor, and contribute to the important work of the standing DSHS Stock Epinephrine Advisory Committee.

Recommendation 3: That TMA members be made aware of entities in their communities that may seek physician support in developing standing orders and providing prescriptions for unassigned auto-injectors in various settings.

Recommendation 4: That TMA develop communications for physicians on the expansion of access to unexpired auto-injectors in various public settings.

Related TMA Policy:

55.002 Comprehensive School Health Education in All School Districts
55.019 School Health Education
55.053 Childhood Anaphylactic Reactions
100.029 Requirement for Epinephrine Auto-Injectors in Texas Schools
115.004 Indemnification of Physicians
170.001 Good Samaritan and Charitable Immunity Laws
170.002 Charitable Immunity

Related AMA Policy:
Childhood Anaphylactic Reactions D-60.976
Preventing Allergic Reactions in Food Service Establishments D-440.932
Food Allergic Reactions in Schools and Airplanes H-440.884
Decreasing Epinephrine Auto-Injector Accidents and Misuse H-115.968
## Appendix A: Recent Texas Legislation on Allergens and Anaphylaxis

<table>
<thead>
<tr>
<th>Legislation/Authors/Status</th>
<th>Key points</th>
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<tr>
<td><strong>86th Legislative Session (2019)</strong></td>
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<tr>
<td><strong>House Bill 4260</strong> by Representative Cortez and Senator Lucio – passed</td>
<td>In effect Sept. 1, 2019. Directs DSHS to develop rules for the guidelines and for implementation. A physician may prescribe unassigned auto-injectors under a standing order.</td>
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<tr>
<td><strong>House Bill 1015</strong> by Representative Martinez approved in committee but died on the House calendar</td>
<td>Allows for the placement of warning signs on the use of peanuts in the preparation of foods in certain food service establishments.</td>
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<tr>
<td><strong>House Bill 1849</strong> by Representative Klick – passed</td>
<td>Effective immediately. Allows for the possession and administration of epinephrine auto-injectors in day care centers. Allows physicians to prescribe epinephrine auto-injectors for a day care center under a standing order for administration. Provides immunity for liability.</td>
</tr>
<tr>
<td><strong>Senate Bill 869</strong> by Senator Zaffirini – passed</td>
<td>Signed by the governor June 14, 2019, and effective immediately. Amends the health and safety requirements in the education code by requiring DSHS to work with an ad hoc committee to develop “Guidelines for the Care of Students With Food Allergies At-Risk for Anaphylaxis.” Applies to school districts and open-enrollment charter schools. The guidelines are to be regularly reviewed and updated.</td>
</tr>
<tr>
<td><strong>Senate Bill 1827</strong> by Senator Menendez – passed</td>
<td>In effect. Amends both the Occupations and the Health and Safety codes to allow for peace officers to possess and use an epinephrine auto-injectors in an emergency. Provides requirements for training in accordance with guidelines developed by DSHS and approved by the Texas Commission on Law Enforcement. Physicians are authorized to prescribe unassigned auto-injectors to law enforcement under a standing order. The physician must periodically review the order and be available for consultation and direction. Allows a pharmacist to dispense the auto-injectors to a law enforcement agency. Requires reporting of the use of an auto-injector and provides immunity from liability for the person who acts in good faith in using the auto-injector.</td>
</tr>
<tr>
<td><strong>House Bill 2243</strong> by Representatives Oliverson and Bowers – passed</td>
<td>Signed by the governor May 24, 2019; effective immediately, amends the state education code by adding access to prescription asthma medicine on public and private school campuses to align with access to epinephrine auto-injectors.</td>
</tr>
</tbody>
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| **85th Legislative Session (2017)** | |
| **Senate Bill 1367** by Senator Menendez – passed | Effective September 2017, directs public health education institutions to develop policies on the administration of epinephrine auto-injectors; provides immunity. Directs DSHS to establish an advisory committee to review the maintenance, training on, and administration of epinephrine auto-injectors to include public higher education institutions and representatives of these institutions on the advisory committee. |
| **Senate Bill 1683** by Senator Lucio – Senate passed but no House hearing | Required a food service establishment to have a poster on food allergen awareness for food service employees |
| **Senate Bill 579** by Senator Taylor; comp HB 1583 by Representative Cortez – passed | Allows private schools to adopt policies for access to epinephrine auto-injectors – to be the same as allowed in public and open-enrollment charter schools. Extended to include the transit time to and from school events. |
Resolution 307-A-19 was considered at TexMed 2019, calling for the Texas Medical Association to support increased regulation to manage the health effects associated with bed bugs (Cimex lectularius). Identifying an increase in bed bug infestations, the resolution noted that certain individuals such as children, the elderly, and those who are disabled were facing physical, mental, and financial harm.

The resolution recommended that TMA consider bed bugs a public health issue and called on TMA to:

- Collaborate with the Texas Association of City and County Health Officials (TACCHO) to develop guidelines for local health authorities using an integrated pest management approach to bed bugs;
- Collaborate with the Texas Department of State Health Services (DSHS) to support regulatory changes that encourage the reporting, treatment, and study of bed bugs in state-supported living;
- Seek legislation to address the public health issue of bed bugs in Texas, especially when affecting vulnerable populations or inhabitants of multifamily dwelling units (MDUs); and
- Carry this resolution, or a similar one, to the American Medical Association to develop public health recommendations and seek regulatory or legislative action for the management of health effects associated with bed bugs as a national public health issue, especially in regard to the collection, study, and public reporting of data on the impact of bed bugs on the public health of Texans, and to:

Prior to this resolution submission, Alice Gong, MD, 2018-19 chair of the council, sent a letter in response to a related inquiry describing TMA’s review of the issue and the authority local public health has in bed bug management. This letter is provided for reference at the end of this report as Appendix A.

Revisiting the issue at TexMed 2019, the council reviewed the resolution and took no formal position on the resolves but noted that some of the information in the resolution lacked scientific evidence and that there was a high administrative burden for local public health to implement the proposed activities. Resolution 307-A-19 was referred to the council for study, and the council referred Resolution 307-A-19 to the Committee on Infectious Diseases to study and compile a joint report to address the resolution.

Bed Bugs and Bed Bug Management

Bed bugs are ectoparasites that thrive throughout the United States and the world. These parasites have been common in American households for decades, but their presence began to decline in the 1940s when dichlorodiphenyltrichloroethane – known as DDT – and other insecticides became available. However, due to increased resistance to insecticides, in combination with increased air travel and waning societal...
awareness of bed bug prevention methods, bed bugs reemerged as a significant problem in the U.S. beginning in the 1990s, and reports of infestations have only continued to increase since that time.

No federal agency or other national entity monitors bed bugs in the U.S., but the Centers for Disease Control and Prevention (CDC) affirms that bed bugs have been reported in all 50 states. Only one state, Kansas, requires mandatory reporting of bed bugs found in lodging establishments to a state-level agency, the Office of Agriculture. Several states have laws dictating the necessity of maintaining bed bug-free environments but do not assign responsibility to a specific party. Some cities around the country have issued ordinances for the reporting or disclosure of bed bugs; these are overwhelmingly focused on landlord/tenant relations and hotel management.

Following a 2010 joint statement on bed bugs by CDC and the Environmental Protection Agency (EPA), the Federal Bed Bug Workgroup was convened to develop a strategy on bed bugs. Made up of representatives from several federal agencies that are involved in different critical components of bed bug management (EPA, Department of Housing and Urban Development, CDC, National Institutes of Health, Department of Defense, and Department of Agriculture), the workgroup released its Collaborative Strategy on Bed Bugs in 2015. This strategy identifies key stakeholders as state and local governments and community entities, specifically listing housing providers, pest management firms, and local health departments as essential to lowering the cost of prevention and treatment and to understanding the needs of a specific area. The integrated pest management approach, which focuses on comprehensive and responsible bed bug prevention and treatment through education, engagement, and multi-organizational cooperation, is deemed the best practice for bed bug management.

Bed bugs survive by feeding on the blood of sleeping humans and certain animals. At present, there is no recorded case of bed bugs transmitting disease to humans. Potential health effects identified by CDC include itching and skin irritations from bed bug bites, insomnia, stress, and anemia. CDC states these are usually rare, and in the case of anemia, are concurrent with other risk factors for anemia and present in cases of enormous and extreme infestations.

EPA has approved 300-plus pesticide products of different categories for use in bed bug management, most of which are available over the counter to the public. EPA notes the difficulty in eliminating bed bugs if pesticides are not used according to the labeling of the products. This could be a factor in the increasing resistance of some bed bugs to certain types of pesticides and the increasing presence of bed bugs. Due to the potential of misuse and resistance, many bed bug experts recommend using professional services, although there is a recognized financial barrier to this option.

**Texas Bed Bug Statutes**

Texas Health and Safety Code Chapter 341, *Minimum Standards of Sanitation and Health Protection Measures*, defines bedbugs as a public health nuisance and requires a person to abate the nuisance in the place the person possesses. It also directs the local health authority to order the person responsible to abate the nuisance, once the authority is aware of the problem.

The term “nuisance” is based on common law. CDC has referred to a nuisance as an “unreasonable interference with a right common to the general public, such as a condition dangerous to health.” This is consistent with Texas Health and Safety Code Chapter 343, *Abatement of Public Nuisances*, which concerns sanitation and environmental quality matters and identifies several issues that can be considered a public nuisance. Texas also has nuisance abatement statutes for other common nuisances (see Chapter 125 of the Civil Practice and Remedies Code) involving certain unlawful activities on private property.
At the state level, the Texas Department of State Health Services can receive public nuisance complaints, which it will refer to the appropriate municipality or county. In counties that do not have a local health department or public officials to enforce local health codes, DSHS’ regional staff respond to public nuisance complaints.4

Local jurisdictions commonly receive and have authority to abate a nuisance in a wide manner based on the type of nuisance. A public official can identify a nuisance on private property as a public nuisance when the matter has an impact on the public. The response from public officials includes confirming the nuisance and providing information on how to address the nuisance. For example, a recommendation could involve the removal of rubbish causing foul odors, used tires, abandoned automobiles, or a dilapidated/unsafe building, or spraying mosquito pools. A property owner who does not comply with addressing the nuisance could be found in violation and be penalized.

Expert Commentary
Both the council and the committee have thoroughly studied and sought the expertise from various local, regional, and state-level public health experts, researchers, associations, and other organizations regarding bed bugs, data, management, and statutes. A general overview of the findings are as follows.

• The Texas Association of City and County Health Officials confirmed that local health departments have full authority to respond to bed bug infestations, but enforcement is difficult in many settings and “becomes a revolving door of complaint, investigation, remediation and compliance.” Bed bugs can become a significant problem for many; however, they do not transmit disease and are not identified as a public health threat. TAACHO also recognized that although laws could be strengthened to require certain entities to use pest control services, this will not completely address the common issues of ongoing noncompliance.

• Texas Department of State of State Health Services:
  • The Division of Laboratory and Infectious Disease Services reported that because no evidence supports bed bugs as disease vectors, it was not active in addressing bed bug infestations.
  • The Zoonosis Control Branch reported that the lack of a connection between disease transmission and bed bugs meant the branch did not address them as a public health threat.
  • The Consumer Protection Division does address bed bugs and has plans to work with the Regional and Local Health Operatives Division at DSHS to establish a stronger process in the regulation of public health nuisances, including bed bugs, in areas where there is no local health authority. In instances where bed bugs affect private citizens in their private homes, DSHS has no regulatory authority.

• Texas A&M AgriLife Extension Service, which specializes in developing educational and training materials and programs on integrated pest management for the public, has data showing bed bugs are an increasing problem with their resurgence, partially due to pesticide resistance and to endemic populations left in multifamily housing units after insufficient treatments.7 Although more research on the subject would be beneficial, data are not needed to sufficiently address bed bug infestations, and any mandate or legislation would also have to address the financial burden of treatment, especially in affordable housing complexes.

• Texas Tenant’s Union stated that bed bug infestations seemed to be increasing and are a significant concern for tenants across the state. A major barrier to reducing the occurrence of bed bug infestations is the Bed Bug Addendum, used almost universally in the state by those leasing
apartments and rental properties. The limited time a tenant has to declare the leased space bed bug-
free per the addendum is unrealistic, and the subsequent financial burden on tenants when they do
find bed bugs disproportionately affects lower-income individuals.

- Cities of Dallas and Garland public health officials: Although the two cities had variances in their
  approaches, they both expressed no need for more data to define bed bugs infestations as a growing
  problem or to appropriately address the issue. Both cities did mention their ordinances could be
  strengthened to encourage enforcement and that on a state level there could be better-defined
  responsibility for bed bug management in landlord/tenant agreements.

Although research on bed bugs is limited, studies have looked at the emotional and mental health
consequences of bed bugs, the possibility of disease transmission, and cases of severe health outcomes
such as iron-deficient anemia. No study conclusively established bed bugs as disease vectors. In the rare
cases of severe anemia with bed bugs present, studies showed that bed bug infestations were extreme and
that other risk factors such as poor diet, cognitive impairment, and financial barriers to pest treatment
were present. Cross-sectional studies have shown that those exposed to bed bug infestations are at risk
for sleep disruption, anxiety, and depression.

An analysis (summary table in Appendix B) of current practices in other states and cities found that
although some states do have specific statutes addressing bed bugs, they are almost always designed to
define responsibility in landlord/tenant relationships. Very few issue detailed mandates. This is likely due
to the variability in resources and needs of cities throughout a state. Since integrated pest management
requires the collaboration of various stakeholders using their expertise to address the unique challenges of
pest management in a community, the best examples of successful bed bug infestation reduction are
municipally led. Links to examples of some cities’ approaches are provided at the end of this document.

Discussion and Recommendations

The resolution called for TMA to recognize bed bug infestations as a public health issue. While there is
not a definition of “public health issue,” in its process of setting priorities, the council has always assessed
the prevalence of an issue; the population harmed; the cost/burden of disease; the available options and
measures for prevention; the potential for increasing risk and burden with the disease/harm; and finally,
an awareness of the physician role in addressing the issue. Other factors to consider are these:

- The cost of bed bug management can indeed be high for a family and certainly for residential
  facilities such as long-term care facilities.
- In a multifamily residential facility such as an apartment complex, identifying who is to be
  responsible for bed bug management can vary; a local ordinance may require the apartment owner or
  landlord to manage the infestation, not the resident.
- There are many different types of products for bed bug management, and not all are effective/tested;
  in most cases, multiple applications are needed. Nationally, concerns are growing about pesticide
  misuse/overuse, which could be associated with increasing resistance to these products.
- Many local jurisdictions have developed public information campaigns on bed bugs. Considerations
  may be given to the effectiveness of campaigns on informing the public how to identify infestations
  early (when they are most manageable).
- Regulatory measures may be considered to manage bed bug infestations in facilities where vulnerable
  residents live and are cared for, such as long-term care facilities or assisted living centers.
It is important to note that these concerns are not medical in nature; although there are established negative consequences from a bed bug infestation, it remains unclear what role a physician could play in resolving them, considering the lack of a connection between bed bug infestation and disease transmission.

Based on this point and the research detailed in this report, both the Committee on Infectious Diseases and the Council on Science and Public Health recommend the following, in lieu of passing Resolution 307-A-19:

**Recommendation 1:** That Texas Medical Association support the joint statement by the Centers for Disease Control and Prevention and the Environmental Protection Agency (EPA), which defines bed bugs as a pest of significant public health importance and recognizes that bed bugs are a continuing problem for residents in the state of Texas.

**Recommendation 2:** That TMA encourage the further development of effective and affordable pest treatment options and expanded access to current evidence-based options approved by EPA or other reputable entities.

**Recommendation 3:** That TMA supports better public and physician education on bed bug identification, treatment, and threats to public health.

**Recommendation 4:** That TMA supports additional research on bed bug incidence to the extent that is practical and feasible and in line with methods used for similar public health pests.

**Recommendation 5:** That TMA encourages municipal efforts to implement measures based on the published integrated pest management approaches and on other evidence-based examples for bed bug treatment practices.

**Resources on Bed Bugs**
- Integrated pest management: [Collaborative Strategy on Bed Bugs](http://www.cdc.gov/parasites/bedbugs/health_professionals/index.html)
- Environmental Protection Agency: [Bed Bug Clearinghouse by Audience](http://www.cdc.gov/parasites/bedbugs/health_professionals/index.html)
- Texas A&M AgriLife Extension: [Insects in the City](http://www.cdc.gov/parasites/bedbugs/health_professionals/index.html)
- City and state examples of bed bug management:
  - Chicago
  - Michigan
  - New York City
  - Ohio
  - Seattle
  - Toronto

**References:**
   *Archives of Dermatological Research* (October 2016).
Appendix A.

March 5, 2019

Wendell H. Williams, MD
Sent via email at: WHWilliams@mdanderson.org

Dear Dr. Williams,

Thank you for reaching out to the Texas Medical Association on potential action for the prevention of bed bug infestations. I serve as the chair of TMA’s Council on Science and Public Health, which considers physician requests on science and public health matters.

The council’s review of each issue includes getting input from members and consultants to the council and from those with experience and expertise on the topic. State statute directs that the management of bed bug infestations is the responsibility of local public health entities, in their role of “nuisance management.” As such, we conferred with physicians who serve in public health positions as well as the Texas Association of City and County Health Officials and the medical officer on infectious diseases at the Texas Department of Health Services.

Based on the information we have received, the council is not recommending that TMA develop policy or encourage legislation on this topic. We recognize this is a significant concern for many families and especially households with members with a chronic health condition, but we have not identified data indicating this warrants legislative action. We do understand that physicians can be better informed on the prevalence of such infestations and the potential for harm to some individuals and will propose developing an information sheet for physicians on this topic.

As a neonatal-perinatal physician who cares for fragile newborns, I understand the discomfort and financial and social stress a family faces when its home is infested with bed bugs. However, state law already has designated how this is to be addressed. You have increased our awareness of this issue, and we encourage you to consider developing a blog post for TMA so it can be more widely understood, especially as there is some indication that infestations increase as the season gets warmer.

The council greatly appreciates your interest and your efforts to engage others in the prevention and management of infestations; we hope you help us promote awareness of this topic in the future.

Sincerely,

Alice Gong, MD Chair
TMA Council on Science and Public Health
## Table

### Appendix B.

**State Bed Bug Laws, November 2016** – *(pulled from National Pest Management Association with added TMA comment)*

<table>
<thead>
<tr>
<th>State</th>
<th>Citation &amp; Title</th>
<th>Summary</th>
<th>TMA Comments</th>
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<tr>
<td>Alabama</td>
<td><strong>ALA. ADMIN. CODE § 420-3-11-.12, Construction, Maintenance, and Operation of Hotels - Insect and Rodent Control</strong></td>
<td>Hotels shall be kept in such condition as to prevent the harborage or feeding of insects or rodents. Insects include “bed bugs.” Guest rooms shall be immediately closed if an infestation is discovered, until it is determined the problem is abated.</td>
<td>- Not unique to bedbugs (included as “insects”); &lt;br&gt;- Relates specifically to hotels; &lt;br&gt;- No reporting requirements; &lt;br&gt;- No mention of medical/health concern or physician involvement</td>
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<tr>
<td>Arizona</td>
<td><strong>ARIZ. REV. STAT. § 9-500.31, Prohibition on adopting landlord tenant bedbug control requirements, city or town</strong></td>
<td>A city or town shall not adopt requirements by ordinance or otherwise for landlords or tenants that relate to the control of bedbugs as defined in section 33-1319, other than the requirements prescribed by section 33-1319. A city or town may adopt requirements relating to the proper disposal of items that are infested with bedbugs.</td>
<td>- Relates to defining landlord/tenant responsibilities; &lt;br&gt;- No reporting requirements; &lt;br&gt;- No mention of medical/health concern or physician involvement</td>
</tr>
<tr>
<td>Arizona</td>
<td><strong>ARIZ. REV. STAT. § 11-269.11, Prohibition on adopting landlord tenant bedbug control requirements, Board of Supervisors</strong></td>
<td>The Board of Supervisors shall not adopt requirements by ordinance or otherwise for landlords or tenants that relate to the control of bedbugs as defined in section 33-1319. The Board of Supervisors may adopt requirements relating to the proper disposal of items that are infested with bedbugs.</td>
<td>- Relates to defining landlord/tenant responsibilities; &lt;br&gt;- No reporting requirements; &lt;br&gt;- No mention of medical/health concern or physician involvement</td>
</tr>
<tr>
<td>Arizona</td>
<td><strong>ARIZ. REV. STAT. § 33-1319, Bedbug control; landlord and tenant obligations; definitions</strong></td>
<td>The landlord shall provide bedbug educational materials to existing and new tenants. Landlord shall not knowingly rent a unit that has a bed bug infestation. Tenant shall not knowingly bring materials into the rental unit have been infested by bed bugs.</td>
<td>- Relates to defining landlord/tenant responsibilities; &lt;br&gt;- No reporting requirements; &lt;br&gt;- No mention of medical/health concern or physician involvement</td>
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<tr>
<td>Arizona</td>
<td><strong>ARIZ. REV. STAT. § 36-601, Public nuisances dangerous to public health</strong></td>
<td>The presence of ectoparasites, such as bedbugs, in any place where sleeping accommodations are offered to the public is declared a public nuisance dangerous to the public health.</td>
<td>- No reporting requirement; &lt;br&gt;- Relates only to public spaces</td>
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| California | **CAL. CODE REGS. Section 1942.5, 1954.05, 3, Pt. 4, Title 5, Ch. 2.8, 1954.600, 1954.601, 1954.602, 1954.603, 1954.604, 1954.605** | Lists the duties of landlords and tenants with regard to the treatment and control of bed bugs. The law requires a landlord to provide a prospective tenant information about bed bugs, as specified. The law requires that the landlord provide notice to the tenants of those units inspected by the pest control operator of the pest control operator’s findings within 2 business days, as specified. The law prohibits a landlord from showing, renting, or leasing a vacant dwelling unit that the landlord knows has a bed bug infestation, as specified. | - Relates to defining landlord/tenant responsibilities;  
- No mention of medical/health concern or physician involvement |
| Colorado | **Colo. Rev. Stat. § 38-12-10**                                                   | Concerns bed bugs in residential premises, and, in connection therewith, establishes duties for landlords and tenants in addressing the presence of bed bugs.                                                                                                                                                                                                                                           | - Relates to defining landlord/tenant responsibilities;  
- No mention of medical/health concern or physician involvement |
| Connecticut | **CONN. GEN. STAT. § 47a-7a**                                                    | Establishes a framework to identify and treat bed bug infestations in residential rental properties, including public housing but excluding detached, single-family homes. It sets separate duties and responsibilities for landlords and tenants, including notice, inspection, and treatment requirements. It also gives landlords and tenants remedies when either party fails to comply with these duties and responsibilities. | - Relates to defining landlord/tenant responsibilities;  
- No mention of medical/health concern or physician involvement |
| Florida | **FLA. STAT. § 83.51, Landlord's Obligation to Maintain Premises**                | Landlords are required to take reasonable steps to exterminate bed bugs within the rental property                                                                                                                                                                                                                                                                                                              | - Relates to defining landlord/tenant responsibilities;  
- No reporting requirements;  
- No mention of medical/health concern or physician involvement |
| Georgia | **GA. RULES OF DEPT. OF PUBLIC HEALTH 511-6-2-.13, Tourist Accommodations - Insect and Rodent Control** | Effective and appropriate measures shall be taken to eliminate the presence of rodents and flies, roaches, bed bugs, and other insects on the premises.                                                                                                                                                                                                                                                     | - Relates to tourist accommodations;  
- No reporting requirements;  
- No mention of medical/health concern or physician involvement |
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<td>Illinois</td>
<td>610 ILL. COMP. STAT. 85/1 to 85/4, Railroad Sanitation Act</td>
<td>No owner or operator of a railroad shall permit any railroad car to be dispatched for the transportation of or occupation by passengers unless such cars are in a clean and sanitary condition and is free from cockroaches, body lice, bedbugs and other vermin.</td>
<td>- Relates to railcars</td>
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<td>Iowa</td>
<td>IOWA ADMIN. CODE § 138.13, Migrant Labor Camps - Conditions for Permit</td>
<td>In migrant labor camps effective measures shall be taken to control bedbugs within the camp premises.</td>
<td>- Relates to migrant labor camps</td>
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<td>Kansas</td>
<td>KAN. ADMIN. REGS. § 4-27-2, Lodging Establishments - Definitions</td>
<td>Defines Bed Bugs as an &quot;imminent health hazard&quot;.</td>
<td>- Relates to lodging establishments</td>
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<td>KAN. ADMIN. REGS. § 4-27-5, Lodging Establishments - Imminent Health Hazard</td>
<td>Licensees of lodging establishments shall cease operations in areas where an “imminent health hazard” has been found and notify Secretary of Agriculture within 12 hours.</td>
<td>- Only specifies reporting for lodging establishments not private residences; - Assigns reporting responsibility to Sec of Agriculture (not state health dept.)</td>
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<td>KAN. ADMIN. REGS. § 4-27-9, Lodging Establishments - Guest Rooms</td>
<td>No guest room that is infested by insects, rodents, or other pests shall be rented until the infestation is eliminated. The presence of bed bugs, which is indicated by observation of a living or dead bed bug, bed bug carapace, eggs or egg casings, or the typical brownish or blood spotting on linens, mattresses, or furniture, shall be considered an infestation. The presence of bed bugs shall be reported to the secretary of Agriculture within one business day upon discovery or upon receipt of a guest complaint. All infestations shall be treated by a licensed pest control operator.</td>
<td>- Only specifies reporting for lodging establishments not private residences; - Assigns reporting responsibility to Sec of Agriculture (not state health dept.)</td>
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<tr>
<td>Maine</td>
<td>ME. REV. STAT. ANN. tit. 14 § 6021-A, Rental Property - Treatment of Bedbug Infestation</td>
<td>Defines landlord and tenant duties with regards to bed bugs an also provides available remedies.</td>
<td>- Relates to defining landlord/tenant responsibilities</td>
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<td>Michigan</td>
<td>MICH. ADMIN. CODE r. 400.57, Family Services Administration Inspection and Licensing - County Infirmaries Care of Residents</td>
<td>Requires county infirmaries to implement procedures to prevent and treat bedbug infestations.</td>
<td>- Relates to county infirmaries</td>
</tr>
</tbody>
</table>
| Minnesota | MINN. R. 4625.1700, Lodging Establishments - Insect and Rodent Control          | Every hotel, motel, lodging house, and resort shall be so constructed and equipped as to prevent the entrance, harborage, or breeding of, bedbugs. The commissioner may order the facility to hire an exterminator licensed by the state to exterminate pests when: 1.) the infestation is so extensive that it is unlikely that a nonprofessional can eradicate the pests effectively; or 2.) the extermination method of choice can only be carried out by a licensed exterminator; and 3.) upon reinspection, it is found that an establishment has not been brought into compliance with a prior order to rid the establishment of pests. | - Relates to lodging establishments;  
- No reporting requirements;  
- No mention of medical/health concern or physician involvement |
| Minnesota | MINN. R. 4665.2300, Supervised Living Facilities, Insect and Rodent Control       | Every facility shall be so constructed or equipped as to prevent the entrance, harborage, or breeding of flies, roaches, bedbugs, rats, mice, and all other insects and vermin. Cleaning, renovation, or fumigation by licensed pest control operators for the elimination of such pests shall be used when necessary. | - Relates to all insects;  
- No reporting requirements;  
- No mention of medical/health concern or physician involvement |
| Nebraska  | 25 NEB. ADMIN. CODE § Chap.2 - 005.02B(A)(a), Structural Health Related Pest Control | Insects and other pests that create health issues for humans and pets such as vector diseases, bed bugs, and fleas may involve outdoor applications for those pests on individual property. Applicators must demonstrate practical knowledge of environmental conditions particularly related to this activity, since outdoor applications can carry off-site by drift or runoff. Applicators shall demonstrate knowledge of the risks involved with handling and use of pesticides used indoors and in conjunction with structural pest control, and the appropriate application equipment to be used. | - Relates to all insects;  
- No reporting requirements; |
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<td>Nebraska</td>
<td>175 NEB. ADMIN CODE § Chap. 2 - 004.12,  Developmentally Disabled Facilities</td>
<td>Every facility shall or equipped so as to prevent the entrance, harborage, or breeding of flies, roaches, bedbugs, rats, mice, and all other insects and vermin. Cleaning renovation, or fumigation by licensed pest control operator for the elimination of such pests shall be used when necessary.</td>
<td>- Relates to all insects; - No reporting requirements; - No mention of medical/health concern or physician involvement</td>
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<tr>
<td>Nevada</td>
<td>NEV. REV. CODE § 447.030, Hotel Rooms - Extermination of Vermin</td>
<td>Any room in any hotel in this state which is or shall be infested with vermin or bedbugs or similar things shall be thoroughly fumigated, disinfected and renovated until such vermin or bedbugs or other similar things are entirely exterminated.</td>
<td>- Relates to hotels; - No reporting requirements; - No mention of medical/health concern or physician involvement</td>
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<td>NEV. ADMIN. CODE § 444.552, Labor Camps - General Standards&quot;</td>
<td>Effective measures must be taken to control rats and flies, mosquitoes, bedbugs and other insects or parasites within the camp premises.</td>
<td>- Relates to labor camps; - No reporting requirements; - No mention of medical/health concern or physician involvement</td>
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<td>New Hampshire</td>
<td>N.H. REV. STAT. ANN. § 48-A:11, Housing Standards - Minimum Standards</td>
<td>Any municipality may enact, in the sections of their housing codes dealing with infestations of insects, provisions directed at the unique problems posed by infestations of bed bugs, provided that such provisions are no less protective of the residents of dwelling units in which bed bug infestations are found than are the provisions dealing with infestations of other kinds of insects.</td>
<td>- No reporting requirements; - No mention of medical/health concern or physician involvement</td>
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<td>N.H. REV. STAT. ANN. § 48-A:14, Housing Standards - Minimum Standards Landlord</td>
<td>No Landlord shall rent the premises if it is infested by bed bugs and the landlord is not conducting a periodic inspection and remediation program. In this paragraph &quot;remediation&quot; means action taken by the landlord that substantially reduces the presence of bed bugs in a dwelling unit for a period of at least 60 days; The lessor or owner of non-restricted property may terminate any tenancy by giving to the tenant or occupant a notice in writing to quit the premises if the tenant willful failure by the tenant to prepare the unit for remediation of an infestation of insects or rodents, including bed bugs, after receipt of reasonable written notice of the required preparations and reasonable time to complete them.</td>
<td>- Relates to defining landlord/tenant responsibilities; - No mention of medical/health concern or physician involvement</td>
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<td>N.H. REV. STAT. ANN. § 540:2, Termination of Tenancy</td>
<td>The lessor or owner of non-restricted property may terminate any tenancy by giving to the tenant or occupant a notice in writing to quit the premises if the tenant willful failure by the tenant to prepare the unit for remediation of an infestation of insects or rodents, including bed bugs, after receipt of reasonable written notice of the required preparations and reasonable time to complete them.</td>
<td>- Relates to defining landlord/tenant responsibilities; - No mention of medical/health concern or physician involvement</td>
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<tr>
<td>N.H. REV. STAT. ANN. § 540:13-e, Bed Bug Remediation Liability</td>
<td>The landlord shall bear the reasonable costs of remediation of an infestation of bed bugs but may recover those costs if the tenant is responsible for the infestation.</td>
<td>- Relates to defining landlord/tenant responsibilities; - No mention of medical/health concern or physician involvement</td>
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<tr>
<td>N.H. REV. STAT. ANN. § 540-A:3, Landlord Prohibited Acts</td>
<td>No landlord shall willfully fail to investigate a tenant's report of an infestation of insects, including bedbugs</td>
<td>- Relates to defining landlord/tenant responsibilities; - No mention of medical/health concern or physician involvement</td>
<td></td>
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<tr>
<td>New York</td>
<td>N.Y. CITY ADMIN. CODE § 27-2018.1, Notice of bed bug infestation history</td>
<td>For housing accommodations subject to this code, an owner shall furnish to each tenant signing a vacancy lease, a notice in a form promulgated or approved by the state division of housing and community renewal that sets forth the property's bedbug infestation history for the previous year regarding the premises rented by the tenant and the building in which the premises are located.</td>
<td>- Relates to defining landlord/tenant responsibilities; - No mention of medical/health concern or physician involvement</td>
</tr>
<tr>
<td>N.Y. EDUC. LAW § 920 (McKinney), Public Schools - Infestation of Bed Bugs</td>
<td>Public schools; infestation of bedbugs (Cimex lectularius). In a city school district having a population of one million or more inhabitants, the principal of each public school shall provide immediate notification to all parents or persons in parental relation disclosing a finding relating to the infestation of bedbugs (Cimex lectularius) in such school.</td>
<td>- Relates to public schools; - No mention of medical/health concern or physician involvement</td>
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<tr>
<td>Ohio</td>
<td>OHIO REV. CODE ANN. § 3731.13, Hotels - Bedding, Floors and Carpet Must be Kept Sanitary</td>
<td>All bedding used in any hotel must be thoroughly aired, disinfected, and kept clean. No bedding which is infested with vermin or bedbugs shall be used on any bed in any hotel. All floors, carpets, and equipment in hotels, and all walls and ceilings shall be kept in sanitary condition.</td>
<td>- Relates to hotels; - No reporting requirements; - No mention of medical/health concern or physician involvement</td>
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<td>Oregon</td>
<td><strong>OR. REV. STAT. § 570.880</strong>, Confidentiality of Bed Bug Infestation Report</td>
<td>The location, occupier identity, and detailed facts of a bed bug infestation reported to an agency shall remain confidential.</td>
<td>- No mention of medical/health concern or physician involvement</td>
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<td></td>
<td><strong>OR. ADMIN. R. 333--030-0070</strong>, Campgrounds - Insect and Rodent Control</td>
<td>Campground buildings and structures must be maintained and cleaned to prevent bed bug infestations.</td>
<td>- Relates to campgrounds; - No reporting requirements; - No mention of medical/health concern or physician involvement</td>
</tr>
<tr>
<td>Pennsylvania</td>
<td><strong>7 PA. CODE § 82.15</strong>, Seasonal Farm Labor Camps - Insect Rodent Control</td>
<td>Effective control measures and environmental changes approved by the Department shall be taken to prevent or eliminate infestation by and harborage of animal or insect vectors to include rodents, flies, mosquitoes, bedbugs, cockroaches, lice and other pestiferous insects.</td>
<td>- Relates to farm labor camps; - No reporting requirements; - No mention of medical/health concern or physician involvement</td>
</tr>
<tr>
<td>Rhode Island</td>
<td><strong>25-3 R.I. CODE R. § 24:7</strong>, Categories for Commercial Applicators</td>
<td>Specifically includes “bed bugs” in the definition of pesticide applicators who use restricted use pesticides.</td>
<td>- No reporting requirements; - No mention of medical/health concern or physician involvement</td>
</tr>
<tr>
<td>South Dakota</td>
<td><strong>S.D. ADMIN. R. 44:02:08:05</strong>, Vacation Homes - Vermin Control</td>
<td>A vacation home establishment must be constructed, equipped, and maintained to prevent the entrance, harborage, or breeding of flies, roaches, rats, mice, bed bugs, and all other insects and vermin. Specific means necessary for the elimination of such pests, such as cleaning, renovation, or fumigation, must be used. The department may require the facility to hire a professional exterminator to exterminate pests</td>
<td>- Relates to vacation homes; - No reporting requirements; - No mention of medical/health concern or physician involvement</td>
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<td>State</td>
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<td>Texas</td>
<td>TEX. HEALTH &amp; SAFETY CODE ANN. § 341.011, Nuisances and General Sanitation</td>
<td>The presence of bedbugs is considered a public health nuisance and a person shall be required to abate the nuisance when it is known.</td>
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<tr>
<td>West Virginia</td>
<td>W.VA. CODE R. § 16-6-16, Hotels and Restaurants - Bed Bugs</td>
<td>In every hotel, any room infected with vermin or bedbugs shall be fumigated, disinfected and renovated until said vermin or bedbugs are exterminated.</td>
<td>- Relates to hotels and restaurants; - No reporting requirements; - No mention of medical/health concern or physician involvement</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>WIS. ADMIN. CODE DEPT. OF HEALTH SERV. § 190.08, Institution Sanitation - Pest Control</td>
<td>Establishes standards of hygiene and safety in institutions that house orphans, indigents and delinquents. Concerning eradication, all means necessary shall be taken for the elimination of rodents, flies, roaches, bedbugs, fleas, lice and other household pests shall be used. Extreme care shall be taken in the use of poison to prevent accidental poisoning of domestic animals and people.</td>
<td>- Relates to specific housing institutions; - Not unique to bedbugs; - No reporting requirements; - No mention of physician involvement</td>
</tr>
</tbody>
</table>
Subject: Advocating Against Electronic Nicotine Delivery Systems (ENDS)

Introduced by: Lone Star Caucus

Referred to: Reference Committee on Science and Public Health

Whereas, The Food and Drug Administration (FDA) has acknowledged that consumers of e-cigarette and vape products currently have no way of knowing whether e-cigarettes and other electronic nicotine delivery systems (ENDS) are safe or how much nicotine or other potentially harmful chemicals they inhale when using them; and

Whereas, FDA found that e-cigarettes and other ENDS contain various toxins, carcinogens, and components suspected of being harmful to humans; and

Whereas, E-cigarettes and other ENDS contain nicotine, which is a highly addictive drug and has immediate biochemical effects on the brain and body; and

Whereas, According to the Centers for Disease Control and Prevention (CDC), phone calls to poison control centers related to toxic levels of nicotine exposure from e-cigarettes and other ENDS increased more than 14-fold since 2011; and

Whereas, Manufacturers and distributors of e-cigarettes claim they are an effective and healthy alternative to tobacco smoking since the user does not inhale harmful tobacco smoke, which contains well more than 4,000 toxic chemicals; and

Whereas, CDC reports that e-cigarette and other ENDS use among students in grades 6-12 tripled in one year and are the most commonly used tobacco products among youth; and

Whereas, The Cochrane study published in December 2014 shows minimal effectiveness of e-cigarettes in smoking cessation; and

Whereas, Many retail “health” clinics sell e-cigarettes in the same facility where they counsel patients about healthy lifestyle choices; and

Whereas, The American Academy of Family Physicians (AAFP) Tar Wars program was revamped in 2019 to include information on e-cigarette use and use prevention; and

Whereas, AAFP and other specialty societies already have developed physician education tools; therefore be it

RESOLVED, That the Texas Medical Association educate its members on the various aspects of e-cigarette use through ongoing CME and articles in Texas Medicine Today; and be it further

RESOLVED, That TMA advocate for legislation that bans the sale of flavored, mint, and menthol tobacco products including both e-cigarette products and combustible products; and be it further
RESOLVED, That TMA advocate against social media companies using influencers to advertise electronic nicotine delivery systems; and be it further

RESOLVED, That TMA advocate against the sale of e-cigarettes and their component products and accoutrements at retail clinics.

Related TMA Policy:
None.

Related AMA Policy:
H-495.986 Sales and Distribution of Tobacco Products and Electronic Nicotine Delivery Systems (ENDS) and E-cigarettes
D-495.992 Legal Action to Compel FDA to Regulate E-Cigarettes
H-495.988 FDA Regulation of Tobacco Products
Subject: Elimination of Human Abuse and Persecution

Introduced by: Lone Star Caucus

Referred to: Reference Committee on Science and Public Health

Whereas, It has been long recognized by cultures of the East and West alike that a healthy mind promotes a healthy body as exemplified by the sayings “Swastha mun swastha shareer” (Sanskrit) and “Mens sana in corpore sano” (Latin); and

Whereas, Various forms of physical, mental, and sexual abuse and torture are often used by one human being or a group to persecute another human being or a group, with the goal of coercing the other person or group (victim or victims) to act in a manner that yields various financial, religious, political, or countless other personal or collective gains to the persecutor(s), while serving as a major cause of stress for the persecuted; and

Whereas, Persecution of various forms is underrecognized and is generally inadequately addressed in patient-physician encounters but is one of the most common causes of unexplained illnesses; pain syndromes; and chronic conditions such as tension headaches, pseudo paralysis, psychogenic or nonepileptic seizures, and sundry other unexplainable illnesses known in the past as hypochondriasis and presently as somatization disorder(s); and

Whereas, Women who have been abused have a 50% to 70% increase in central nervous system and stress-related problems; and

Whereas, Children subjected to abuse have a higher incidence of anxiety, depression, and drug abuse and may suffer impairment of brain structure and function; and

Whereas, As physicians we may be the only people in whom the patient may confide regarding such matters; therefore be it

RESOLVED, That the Texas Medical Association urge the Texas Legislature to make laws to protect physicians from persecution in passing confidential information without personal liability to various governmental agencies; and be it further

RESOLVED, That TMA encourage physicians to make inquiry into patients’ well-being a matter of routine medical practice; and be it further

RESOLVED, That TMA urges physician to document instances of alleged abuse or persecution in the patient’s medical records.

Related TMA Policy:

55.040 Child Abuse Reporting Laws
325.010 Physicians’ Role in Identifying Violence and Abuse
Related AMA Policy:

8.10 Preventing, Identifying and Treating Violence and Abuse
Subject: Use of Human Tissue for Beneficial Applications

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Science and Public Health

Whereas, A vast amount of valuable human tissue is sent to incineration waste disposal instead of being applied in research and other efforts for the improvement of patient care and scientific investigation; and

Whereas, Current Texas Penal Code, Title 10, Chapter 48, Sec. 48.02, prohibits the purchase and sale of human tissue, even non-organ tissue; and

Whereas, Tissue that currently is being incinerated instead could be used to support the needs of independent laboratories that are innovating methods for enhanced treatment of patients in Texas; and

Whereas, Patients can benefit from the results of studies performed with excess non-whole-organ and nonfetal human tissue; and

Whereas, Many medical organizations in Texas require non-organ human tissue to validate studies and maintain high levels of quality control used in basic and translational medical research; and

Whereas, Some medical organizations in Texas purchase human tissue from other states because Texas does not permit such tissue to be bought within the state, even for research purposes that lead to advancements in patient care; therefore be it

RESOLVED, That the Texas Medical Association study and make active recommendations for a safe harbor in Texas allowing certified entities that have nonfetal tissue and non-whole-organ human tissue waste from a consenting adult patient to use the tissue strictly for research purposes and clinical diagnostics.

Related TMA Policy:
45.008 Blood, Organ, and Tissue Donations
45.011 County Contracts to Recover Tissue in Texas
280.010 Physician Role in Promoting Organ and Tissue Donation and Transplantation
280.012 Human Tissue

Related AMA Policy:
7.3.9 Commercial Use of Human Biological Materials
H-5.994 Use of Fetal Tissue for Legitimate Scientific Research
H-5.985 Fetal Tissue Research

Information:
From the Texas Penal Code, Title 10. Offenses Against Public Health, Safety. and Morals, Chapter 48. Conduct Affecting Public Health:
Sec. 48.02 PROHIBITION OF THE PURCHASE AND SALE OF HUMAN ORGANS.
(a) In this section, “human organ” means the human kidney, liver, heart, lung, pancreas, eye, bone, skin, or any other human organ or tissue, but does not include hair or blood, blood components (including
plasma), blood derivatives, or blood reagents. The term does not include human fetal tissue as defined by
Section 48.03.
(b) A person commits an offense if he or she knowingly or intentionally offers to buy, offers to sell,
acquires, receives, sells, or otherwise transfers any human organ for valuable consideration.
(c) It is an exception to the application of this section that the valuable consideration is: (1) a fee paid to
a physician or to other medical personnel for services rendered in the usual course of medical practice or a
fee paid for hospital or other clinical services; (2) reimbursement of legal or medical expenses incurred
for the benefit of the ultimate receiver of the organ; or (3) reimbursement of expenses of travel, housing,
and lost wages incurred by the donor of a human organ in connection with the donation of the organ.
(d) A violation of this section is a Class A misdemeanor.
ch. 900, Sec. 1.01, eff. Sept. 1, 1994.
Amended by: Acts 2017, 85th Leg., R.S., Ch. 441 (S.B. 8), Sec. 16, eff. September 1, 2017.

Sec. 48.03. PROHIBITION ON PURCHASE AND SALE OF HUMAN FETAL TISSUE.
(a) In this section, “human fetal tissue” has the meaning assigned by Section 173.001, Health and Safety
Code.
(b) A person commits an offense if the person knowingly offers to buy, offers to sell, acquires, receives,
sells, or otherwise transfers any human fetal tissue for economic benefit.
(c) An offense under this section is a state jail felony.
(d) It is a defense to prosecution under this section that the actor:
(1) is an employee of or under contract with an accredited public or private institution of higher
education; and
(2) acquires, receives, or transfers human fetal tissue solely for the purpose of fulfilling a donation
authorized by Section 173.005, Health and Safety Code.
(e) This section does not apply to:
(1) human fetal tissue acquired, received, or transferred solely for diagnostic or pathological testing;
(2) human fetal tissue acquired, received, or transferred solely for the purposes of a criminal
investigation;
(3) human fetal tissue acquired, received, or transferred solely for the purpose of disposing of the tissue
in accordance with state law or rules applicable to the disposition of human fetal tissue remains;
(4) human fetal tissue or human tissue acquired during pregnancy or at delivery of a child, provided the
tissue is acquired by an accredited public or private institution of higher education for use in research
approved by an institutional review board or another appropriate board, committee, or body charged with
oversight applicable to the research; or
(5) cell lines derived from human fetal tissue or human tissue existing on September 1, 2017, that are
used by an accredited public or private institution of higher education in research approved by an
institutional review board or another appropriate board, committee, or body charged with oversight
applicable to the research.
(f) With the consent of the appropriate local county or district attorney, the attorney general has
concurrent jurisdiction with that consenting local prosecutor to prosecute an offense under this section.
Added by Acts 2017, 85th Leg., R.S., Ch. 441 (S.B. 8), Sec. 17, eff. September 1, 2017.
TABLE

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 304
2020

Subject: Improving Physician Access to Immigrant Detention Facilities

Introduced by: Medical Student Section

Referred to: Reference Committee on Financial and Organizational Affairs

Whereas, There are 31 immigration enforcement detention facilities in Texas, with 12 located along the Texas-Mexico border; and

Whereas, As of 2018, the state of Texas detains the highest number of immigrants in the United States with close to 16,000 detained individuals – more than twice as many as California, which has the second highest number of immigration detainees (6,000); and

Whereas, The average length of stay in immigrant detention facilities has increased from 22 days in 2016 to 34 days in 2017; and

Whereas, Detention facilities are unsanitary and overcrowded, lacking basic supplies such as clean water, clean clothes, and facilities for bathing and handwashing; and

Whereas, Inadequate access to medical care within immigrant detention facilities has been well documented and found to be a contributing factor in several deaths in immigration detention centers; and

Whereas, The U.S. Department of Homeland Security Office of the Inspector General has reported that immigration enforcement detention facilities are failing to meet their obligation to employ sufficient medical staff to perform basic exams and treatments for all detainees; and

Whereas, The American Medical Association has cited substandard medical care as contributing to patient deaths, including children who have died from treatable illnesses like influenza infections; and

Whereas, In 2014, U.S. Customs and Border Protection allowed Texas physicians to provide medical care within immigrant detention facilities, but starting in 2018 physicians have been denied access to those same facilities to provide medical care; and

Whereas, U.S. District Judge Dolly Gee, supported by 80 physicians and lawyers, ordered the U.S. attorney general to allow physicians access to the U.S. Customs and Border Protection detention facilities in the El Paso and Rio Grande Valley regions, in response to findings that children were not receiving medical care because physicians being denied access to these facilities; and

Whereas, Detention centers deny community physicians access to patient medical information from the detention center for released detainees who then seek medical care in the community upon the patient’s release; and

Whereas, The World Health Organization advocates for incorporating health care services for refugees and immigrants, including prompt diagnosis and treatment, into regional and local political agendas; and
Whereas, The U.S. House of Representatives on July 24, 2019, passed HR 3239, the Humanitarian Standards for Individuals in Customs and Border Protection Custody Act, which outlines sanitation improvements for detention facilities but does not address improvements for medical care provision within detention facilities; and

Whereas, The American Academy of Pediatrics supports immediate access to medical care when a child enters a detention facility, and further, does not believe children should be held in immigration detention for any period due to the inability to provide appropriate health care; and

Whereas, Our Texas Medical Association has previously called for immigrant detention facilities to provide humane, compassionate treatment and basic necessities such as clean water, clean bedding, sufficient food, educational services, and health to those in the centers; and

Whereas, AMA has adopted new policy calling on detention center officials within U.S. Immigration Customs and Enforcement to revise medical standards governing the condition of housing facilities to meet standards set by the National Commission on Correctional Health Care; and

Whereas, AMA resolved to “advocate for access to health care for individuals in immigration detention” through the resolution its policy Improving Medical Care in Immigrant Detention Centers D-350.983; therefore be it

RESOLVED, That the Texas Medical Association advocate for community physician access to provide medical care in both U.S. Customs and Border Protection and U.S. Immigration and Customs Enforcement immigrant detention facilities; and be it further

RESOLVED, That TMA advocate for the right of community physicians to contact health care providers working in the immigrant detention facilities, in accordance with HIPAA, to ensure continuity of care for patients transferred to other health care facilities or released from custody.

Related TMA Policy:
260.005 Community and Migrant Health Centers

Related AMA Policy:
Health Care Payment for Undocumented Persons D-440.985
Improving Medical Care in Immigrant Detention Centers D-350.983
Medical Needs of Unaccompanied, Undocumented Immigrant Children D-65.992
Ensuring Access to Health Care, Mental Health Care, Legal and Social Services for Unaccompanied Minors and Other Recently Immigrated Children and Youth D-60.968

References:


Whereas, Suicide is a national public health concern and the 10th leading cause of death in the U.S.; and
Whereas, The suicide rate in Texas has risen by more than 18% since 1999; and
Whereas, Many individuals who died by suicide did not have a mental health diagnosis and were not regularly visiting specialized mental health professionals at the time of their death; and
Whereas, Stigma against persons with mental illness and suicidal ideation is still prevalent and can deter health care professionals from effectively treating these individuals; and
Whereas, Emergency department visits for suicidal ideation and/or self-directed violence increased by 25.5% overall in 2018 compared with 2017; and
Whereas, Universal screening tools for depression and suicidality such as the PHQ-9, while useful predictors, are not consistently used in primary care settings and do not identify all individuals who may be suicidal; and
Whereas, The Joint Commission has supported work demonstrating that current health care protocols miss signs of suicidal ideation and that more proactive measures can be used to identify suicide risk; and
Whereas, the White House, the U.S. Congress, and the U.S. Department of Health and Human Services all have financially supported efforts to expand suicide prevention education, such as through the Mental Health First Aid program, to health care professionals, educators, and other professionals who encounter individuals with suicidal ideation; and
Whereas, the Texas Suicide Prevention Council’s Suicide Prevention Plan supports implementing programs on suicide prevention and intervention based on recommendations from the U.S. Substance Use and Mental Health Services Administration, and the Suicide Prevention Resource Center; and
Whereas, the rate of suicide among U.S. veterans exceeded 6,000 each year from 2008 to 2017; and while the Association of American Medical Colleges reported in 2014-15 that 14 medical schools participated in veteran care curricula by case-based instructional method, fewer than four medical schools participated in clinical experience (e.g., ambulatory and inpatient) instructional methods; and
Whereas, medical students may not receive adequate or effective education on suicide prevention and intervention, impairing their ability to treat individuals with suicidal ideation; and
Whereas, only 15% of U.S. medical schools formally cover suicide prevention in their medical curriculum; and
Whereas, studies demonstrate that medical students who receive education on risk factors for suicide are more prepared to recognize and emergently respond to individuals experiencing suicidal ideation; and

Whereas, early patient interaction during the preclinical curriculum is becoming more common and has been associated with improved preparedness for clerkships, meaning students may encounter patients with suicidal ideation during their preclinical years; therefore be it

RESOLVED, That the Texas Medical Association support integrating validated suicide prevention training programs into the curriculum of preclinical students in Texas medical schools in accordance with Association of American Medical Colleges interpersonal, intrapersonal, and science competences for medical students, and Liaison Committee on Medical Education and Commission on Osteopathic College Accreditation standards; and be it further

RESOLVED, That our TMA recognize the importance of studying suicide identification and prevention training programs in order to develop the most efficacious method of training for Texas students.

Related TMA Policy:
200.030 Preventive Medicine Education

Related AMA Policy:
Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975
Awareness, Diagnosis and Treatment of Depression and other Mental Illnesses H-345.984

References:
3. Durkin M. Preventing Suicide in Primary Care. ACP Internist. October 2018.


16. Allexan S. Suicide Curriculum in Medical Education (undated).


TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 306
2020

Subject:   Facilitating Brain and Other Postmortem Tissue Donation for Research and Educational Purposes

Introduced by: Medical Student Section

Referred to: Reference Committee on Medical Education and Health Care Quality

Whereas, Postmortem tissue contains invaluable information that can be used for medical research and educational purposes to improve our understanding of human physiology and pathophysiology and thus enhance patient care; and

Whereas, Recent research using postmortem brain tissue has been critical to our understanding of the pathogenesis of neurological and psychiatric illnesses such as Parkinson’s disease, dementia, PTSD, autism, and major depression and builds upon advances from neuroimaging, genetic, biomarker, and animal studies; and

Whereas, States have taken efforts to raise awareness of and increase donation for organ transplant, including asking individuals if they would like to join transplant donor registries when applying for or renewing their driver’s licenses; and

Whereas, In Texas alone, nearly 7 million people have joined the Texas Donor Registry since a question regarding organ donation for transplantation was added to driver’s license applications; and

Whereas, Ninety-eight percent of organ donation registration occurs at motor vehicles departments, where promotional materials and clerk training have been shown to increase organ donation registration by up to 7.8%; and

Whereas, Although Texas offers an option for organ donation and/or tissue donation for research purposes on driver’s licenses and identification cards, brain tissue donation requires a separate consenting process that often occurs after death through the next of kin; and

Whereas, Recruitment for brain banks and willed body programs is not standardized across institutions and can create a large financial and logistic burden on institutions that potentially could be alleviated by standardized premortem consenting; and

Whereas, Widespread efforts to inform individuals of the importance of tissue donation for research and health professions education and to provide interested individuals with the opportunity to easily give informed consent have potential to increase donation rates, decrease costs, and eliminate the need for families to make decisions for their loved ones postmortem; and

Whereas, A study of public perceptions surrounding whole body donation found that 58.8% of participants reported insufficient understanding of the body and tissue donation process for research and educational purposes, 77.4% reported they did not know how to register to become a whole body donor, and 23.9% reported they did not know they could be registered as both a transplant organ donor and whole body donor or tissue donor; and
Whereas, Several studies have found that after receiving information about the tissue donation process, the majority of participants would be likely or somewhat likely to donate their brain tissue (>60%) for research; and

Whereas, While current TMA Policy 280.010 addresses increasing organ and tissue donation education and improving procurement processes for transplantation, TMA does not address education or procurement improvement for postmortem tissue donation for research or educational purposes; therefore be it

RESOLVED, That the Texas Medical Association support the production and distribution of educational materials regarding the importance of postmortem brain tissue donation for the purposes of medical research and education; and be it further

RESOLVED, That our TMA encourage the inclusion of additional information and consent options for brain tissue donation for research purposes on appropriate donor documents; and be it further

RESOLVED, That our TMA encourage all persons to consider consenting to brain and other tissue donation for research purposes; and be it further

RESOLVED, That our TMA encourage efforts to develop and improve logistical frameworks for the procurement and transit of postmortem tissue for research and educational purposes.

Related TMA Policy:
280.010 Physician Role in Promoting Organ and Tissue Donation and Transplantation
280.016 Human Subject Research – A Patients Bill of Rights
280.020 Science Coalition
205.005 Funding Levels for Research and Medical Education

Related AMA Policy:
H-460.930 Importance of Clinical Research
E-7.1.1 Physician Involvement in Research
D-370.985 Organ Donation
H-370.998 Organ Donation and Honoring Organ Donor Wishes
H-370.982 Ethical Considerations in the Allocation of Organs and Other Scarce Medical Resources Among Patients
H-370.983 Tissue and Organ Donation
H-370.995 Organ Donor Recruitment
H-370.996 Organ Donor Recruitment
H-85.954 Importance of Autopsies
H-370.984 Organ Donation Education
H-460.890 Improving Body Donation Regulation
E-6.1.2 Organ Donation After Cardiac Death
E-6.1.3 Studying Financial Incentives for Cadaveric Organ Donation
E-6.1.4 Presumed Consent & Mandated Choice for Organs from Deceased Donors
References:

Subject: Decommissioning Existing and Not Constructing New Wastewater Treatment Plants in or Near Flood Plains and Waterways

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Science and Public Health

Whereas, Recurrent flooding in Texas poses serious public health risks as homes are repeatedly inundated with sewage; and

Whereas, Wastewater treatment plants in flood plains and near waterways risk the dissemination of sewage into the homes of Texans; therefore be it

RESOLVED, That the Texas Medical Association support the need for local, county, and state governmental entities to decommission existing and not construct new wastewater treatment plants in or near flood plains and waterways.

Related TMA Policy:

None
Subject: Recurrent Flooding in Texas Must Be Resolved

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Science and Public Health

Whereas, Recurrent flooding in Texas poses serious public health risks as homes are repeatedly inundated with sewage; and

Whereas, Various attempts at flood control by local, county, and state governmental entities have failed to prevent recurrent flooding; therefore be it

RESOLVED, That the Texas Medical Association support the need for local, county, and state governmental entities to commit the necessary resources and responsibility to effectively eliminate recurrent flooding in Texas.

Related TMA Policy:

None
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 309
2020

Subject: Education and Action to Arrest the Effects of Climate Change on Health

Introduced by: Dallas County Medical Society

Referred to: Reference Committee on Science and Public Health

Whereas, Numerous scientific studies using different rigorous methods for measuring temperature and its many environmental consequences have demonstrated conclusively that the earth’s surface has been rapidly warming since the start of the Industrial Age, and the rate of warming has greatly accelerated since the 1980s. Consequently, the earth’s average temperature has warmed 1°C (1.8°F) since the start of the Industrial Age, while that of the Arctic region has warmed 3°C (5°F), both leading to profound threats to public health; and

Whereas, Numerous scientific studies using different rigorous methods have conclusively proved that the main cause of the earth’s warming is the emission of carbon dioxide (CO2) and methane (CH4) – “greenhouse gases” – from burning of fossil fuels including coal, oil, and natural gas; and

Whereas, In January 2020 the Texas Oil and Gas Association acknowledged that fossil fuels contribute to global warming, putting Texans’ health at risk, and that the oil and gas industry must find ways to reduce emissions and make progress in accomplishing it; and Blackrock, the world’s largest investment company, citing an impending fundamental reshaping of the financial markets, announced a significant reallocation of capital out of fossil fuels; and

Whereas, Methane, which commonly leaks from natural gas wells and pipelines, is 86 times more climate warming than CO2, and although it remains in the atmosphere for only 10-20 years, curtailing its release can buy time in the near term to implement longer-term solutions; and

Whereas, With only 1°C of warming we are already observing many predicted adverse effects that threaten public health, such as more powerful hurricanes and tornados, coastal flooding from sea level rise, decline of coastal fisheries from increasing ocean temperature and acidification, increases in vector-borne infectious diseases, water supplies threatened by disappearing glaciers, and unprecedented forest fires, which will intensify as climate warming continues; and

Whereas, Massive crop failures from droughts have precipitated regional threats to national security such as the 2011-14 Arab Spring, the Syrian civil war, and the recent onslaught of Central American immigrant caravans; climate change has long been a major consideration in U.S. defense planning; and

Whereas, Continued climate warming is starting to set off vicious cycles in nature that will result in runaway warming: For example, as ice cover melts, it exposes land or sea that absorbs more solar heat and accelerates ice cover melting; melting of the Arctic permafrost releases methane from putrefaction of long-frozen, mile-thick prehistoric strata of organic matter; and deforestation by fires, pests, and development allow carbon long sequestered in root systems of the trees to escape as methane; and
Whereas, Since added CO2 persists in the atmosphere for centuries, even if we stop adding more, the CO2 already released into the atmosphere will perpetuate the deterioration of our climate, unless we remove it; and.

Whereas, The private sector has developed economy-stimulating technologies capable of replacing fossil fuel burning with nonwarming alternatives such as solar, wind, geothermal, and safe nuclear power generation (e.g., traveling wave technology), as well as reforestation and technologies that can remove CO2 from the air and sequester it permanently or turn it into marketable products; and

Whereas, Since scientific projections give only 11 years before progression toward catastrophe becomes irreversible, the U.S. and other major industrial nations must immediately intensify research and development and scale-up of clean energy technologies in which Texas is a leader and stands to receive major economic stimulus; and

Whereas, Strong world leadership by the U.S. is required to bring other major CO2-producing countries into similar compliance; therefore be it

RESOLVED, That the Texas Medical Association educate its members, Texas and federal policymakers, and the public on the scientific evidence about the causes and the impact of climate change on the health of Texans, the seriousness of these threats, and nonpartisan evidence-based remedies; and be it further

RESOLVED, That TMA advocate for nonpartisan evidence-based remedies for climate change and include in its communications on budgetary priorities the future needs of state preparedness for the effects of climate change on human health, such as increased ferocity of natural disasters and more frequent infectious disease outbreaks by vector-borne diseases and dangerous new viruses; and be it further

RESOLVED, That the substance of the education and advocacy shall be managed through the established mechanisms of the TMA Council on Science and Public Health and the Council on Legislation.

Relevant TMA Policy:
260.077 Clean Air in Texas
260.098 Reduce Ozone-Causing Emissions From Three Antiquated Coal-Fired Power Plants
260.086 Retire Coal-Fired Power Plants and Replace With Cleaner Energy Sources

Relevant AMA Policy:
Global Climate Change and Human Health H-135.938
Climate Change Education Across the Medical Education Continuum H-135.919
Global Climate Change – The “Greenhouse Effect” H-135.977
AMA Advocacy for Environmental Sustainability and Climate H-135.923
Stewardship of the Environment H-135.973
Whereas, Hepatitis C virus (HCV) is a blood-borne pathogen that, left untreated, causes liver cirrhosis and hepatocellular carcinoma in the majority of those with chronic infection; and

Whereas, In Texas, 217,500-325,000 people are infected with HCV; and

Whereas, Texas has one of the highest hepatocellular cancer incidence rates in the country, and HCV is the second leading cause of this cancer; and

Whereas, As of 2017, HCV was a leading cause of liver transplants in the United States; and

Whereas, HCV is part of Healthy People 2020, an initiative to eradicate certain diseases; and

Whereas, Combined private and public funding has resulted in the development of direct-acting antiviral (DAA) therapies, which work to inhibit HCV cellular processes that result in liver disease; and

Whereas, DAA therapies have a greater than 90% cure rate and are an essential tool in eradicating this disease; and

Whereas, In Texas, more than 4 million people rely on Texas Medicaid for access to health care; and

Whereas, Texas Medicaid rules require that HCV-infected beneficiaries demonstrate irreparable, advanced liver fibrosis to be eligible for DAA therapy, a requirement that is the primary barrier to a beneficiary’s receiving the therapy; and

Whereas, Texas Medicaid beneficiaries are increasingly ineligible for patient-assistance programs, which provide DAA therapy free of charge only to certain low-income populations; and

Whereas, Withholding this cure results in a cycle of continued transmission, liver-cancer incidence, and thus demand for liver transplants statewide; and

Whereas, This is cost ineffective because not only is the average billing for a single liver transplant approximately $900,000 (more than 20 times the cost of DAA therapy) but also the human cost for not eradicating this curable disease is incalculable; therefore be it

RESOLVED, That the Texas Medical Association create policy using the following language:
The Texas Medical Association supports and will advocate for removing the requirement that a Texas Medicaid beneficiary infected with hepatitis C virus have liver fibrosis before being eligible to receive direct-acting antiviral therapy.

Relevant TMA Policy:

| 190.002 Medicaid Medications
| 190.011 Medicaid Benefits
| 190.023 Policy Principles for Medicaid and CHIP Legislative Initiatives
| 260.060 Hepatitis C

Relevant AMA Policy:

Advocacy for Hepatitis C Virus Education, Prevention, Screening and Treatment H-440.845

References:

Resolutions 311
2020

Subject: Advocating for the Improvement of Access to Mental Health Services Among Minority Teens

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, An estimated 10% to 20% of adolescents globally experience mental health conditions, yet these remain underdiagnosed and undertreated; and

Whereas, Adolescents with mental health conditions are more vulnerable to social exclusion, discrimination, stigma, educational difficulties, risk-taking behaviors, physical illness, and human rights violations; and

Whereas, A 2007 study conducted by the Youth Risk Behavior Survey of the Centers for Disease Control and Prevention found significantly higher prevalence rates of sad mood, suicidal ideation, and suicidal attempts among Latino and African American youth compared with non-Hispanic whites; and

Whereas, Only 1.5% of minority youth receive mental health care compared with 3.5% of ethnic majority youth; and

Whereas, Stigma and cultural norms regarding mental health represent significant barriers to mental health treatment in adolescents; and

Whereas, Culturally appropriate mental health services show the most promise for reducing major barriers to access and utilization, particularly language and ethnicity matching between patients and the mental health professionals who treat them; and

Whereas, Minority populations are underrepresented in health care professions, and those providing care are less likely to be board certified than physicians who treat white patients; and

Whereas, School-based mental health centers also have been shown to address many of the significant barriers that limit access to mental health services by providing services in a setting where students spend most of their time; and

Whereas, A 2018 meta-analysis suggests child psychiatrists and other mental health professionals are wise to recognize the important role that school personnel, who are naturally in children’s lives, can play in decreasing child mental health problems; and

Whereas, Only 34% of teachers felt they had the skills needed to support the mental health needs of students in their classrooms; and

Whereas, Students experiencing mental health challenges were more likely to be labeled as “bad students” in the classroom, and exclusionary discipline rates are significantly higher for students of color and students in special education classrooms; and
Whereas, Research indicates that individuals hold explicit biases that mentally ill individuals are helpless and bad but not blameworthy, which conflict with their implicit biases, which argue that mentally ill individuals are helpless, bad, and blameworthy; and

Whereas, Everyone harbors implicit biases, and these biases have an influence on every aspect of society; however, once implicit biases have been identified, they can be “unlearned”; and

Whereas, As we continue to address mental health disparities, identifying the best possible interventions to achieve the greatest positive effect per mental health outcome among minority teens remains an area of research that must be continually studied and evaluated; and

Whereas, The Texas Department of Health and Human Services supports the use of the Child and Adolescents Needs and Strength Assessment as an effective tool to provide metrics on trauma-informed behavioral and mental health needs within the state, yet few other assessment tools exist; and

Whereas, Using culturally appropriate methodology has been heralded as the most effective means to yield conclusive results for cross-cultural research; and

Whereas, Current Texas Medical Association policy advocates for school-based systems of mental health care that provide an integrated system of educator training, referral to treatment, and clear access to health care professionals; and

Whereas, Current American Medical Association policy recognizes the importance of developing and implementing school-based mental health programs that ensure at-risk youths access to appropriate mental health screening and treatment services, and supports efforts to accomplish these objectives; and

Whereas, Current AMA policy supports working with the U.S. Department of Education and state education boards and encourages them to adopt basic mental health education designed for preschool through high school students, as well as for their parents, caregivers, and teachers; therefore be it

RESOLVED, That the Texas Medical Association advocate for culturally informed mental health outreach and services to increase utilization by minority youths in schools, including advocating for an increase in the number of minority mental health professionals; and be it further

RESOLVED, That TMA advocate for school districts to incorporate best practices to reduce biases including those against minority students facing mental health and behavioral disorders; and be it further

RESOLVED, That TMA advocate for increased data collection of mental health intervention outcomes among minority adolescents.

Relevant TMA Policy:
215.023 Identifying Trauma and Mental Health Susceptibilities in Schools
55.033 Children's Mental and Behavioral Health
265.018 Evidence-Based Medicine and Practice

Relevant AMA Policy:
Improving Pediatric Mental Health Screening H-345.977
Increased Detection of Mental Illness and Encouraging Education D-345.994
Providing Medical Services through School-Based Health Program H-60.991
References:
Subject: Support for the Texas-CARES Program

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Science and Public Health

Whereas, Out-of-hospital cardiac arrest (OHCA), including or stemming from sudden cardiac death, drowning, and drug overdose, is a leading cause of death and a major public health problem with enormous impact across Texas; and

Whereas, Large and unacceptable geographic, racial, and socioeconomic disparities in access to basic life-saving care and OHCA survival rates exist; and

Whereas, A coordinated cardiac response system, including prompt bystander action; telecommunicator cardiopulmonary resuscitation (CPR); EMS high-performance CPR; and guideline-based, post-arrest care at hospitals can dramatically improve survival from OHCA; and

Whereas, The 2015 Institute of Medicine report, Strategies to Improve Cardiac Arrest Survival: A Time to Act, states that a centralized data registry is fundamental for measuring OHCA incidence and improving OHCA care and survival rates; and

Whereas, The Texas Cardiac Arrest Registry to Enhance Survival (Texas-CARES) Program, an institutional effort to measure OHCA incidence and improve OHCA care and outcomes statewide, was initiated in 2019; therefore be it

RESOLVED, That the Texas Medical Association shall investigate options, identify strategies, and support ongoing efforts to sustain the Texas Cardiac Arrest Registry to Enhance Survival (Texas-CARES) Program in order to collect data on out-of-hospital cardiac arrest (OHCA) incidence, 9-1-1 response, emergency medical services (EMS) treatment, and patient outcomes; and be it further

RESOLVED, That TMA work with state, regional, and local EMS organizations, universities, hospitals, public health entities, communities, and the Texas Legislature to support the Texas-CARES registry and quality improvement program in order to maximize survival after OHCA; and be it further

RESOLVED, That TMA work to ensure that the state of Texas shall own the data collected by the Texas-CARES registry; and be it further

RESOLVED, That TMA support adding sudden cardiac arrest as a reportable condition in Texas; and be it further

RESOLVED, That the Texas Delegation to the American Medical Association carry a similar resolution to the AMA House of Delegates for consideration.

Related TMA Policy:

100.028 Automated External Defibrillator Availability and Access

280.033 Hypothermia for Adult Out-of-Hospital Resuscitation
Related AMA Policy:

1. H-130.938 Cardiopulmonary Resuscitation (CPR) and Defibrillators
2. H-285.950 Managed Care Organizations’ Use of Physicians to Provide Second Opinions to Physicians Providing Emergency Services
3. D-295.972 Standardized Advanced Cardiac Life Support (ACLS) Training for Medical Students
4. H-300.945 Proficiency of Physicians in Basic and Advanced Cardiac Life Support
5. H-360.998 Cardiac Resuscitation by Nurses
6. D-470.992 Implementation of Automated External Defibrillators in High-School and College Sports Programs
Subject: Advocating for Increased Capacity of Local State Mental Health Facilities and Coordination of Behavioral Health Services

Introduced by: Dallas County Medical Society

Referred to: Reference Committee on Socioeconomics

Whereas, Studies show that the availability of local psychiatric beds can decrease the use of involuntary admissions and reliance on the criminal justice system for in-patient psychiatric care; and

Whereas, Texas ranks as the third highest state in prevalence of mental illness, yet 51st in access to mental health care, according to a report by Mental Health America in 2020; and

Whereas, The Parkland Health & Hospital System and the Dallas County Health and Human Services 2019 Community Health Needs Assessment found that Dallas County does not have enough behavioral health capacity to support the high demand for services, and as many as 22% of adults aged 18 and over report physical limitation of more than 14 days from poor mental health; and

Whereas, Many parts of the state, including North Texas, have little to no access to a local state mental health facility (SMHF), e.g., the nearest SMHF for Dallas and Tarrant county patients is in Terrell; and

Whereas, Patients with complex behavioral health care needs account for disproportionate percentages of health care costs that could be reduced with improved care coordination between in- and out-patient status as well as wrap-around services; and

Whereas, Availability of psychiatric in-patient treatment centers specializing in youth and adolescents is even worse than adult bed availability, with only about half of the state hospitals accepting patients under the age of 18; and

Whereas, As of July 2019, North Texas had only 580 licensed behavioral health beds, resulting in area hospital emergency departments serving as observation units until a psychiatric bed can be located, often hundreds of miles away; therefore be it

RESOLVED, That the Texas Medical Association advocate for increased funding and capacity for in-patient psychiatric beds throughout Texas with a priority emphasis in areas that lack local access to mental health facilities; and be it further

RESOLVED, That TMA Policy 215.019 Public Mental Health Care Funding be amended as follows:

Public Mental Health Care Funding: Despite increases in funding from the Texas Legislature for the mental health care system, Texas still struggles to provide optimal psychiatric care for those in need. The Texas Medical Association therefore supports: (1) state efforts to provide the public mental health system with funding sufficient to address common severe mental illness across the lifespan for all in need; (2) state efforts to ensure that appropriated funds are used to provide best practices for patients in a cost-efficient manner for taxpayers; (3) equity of
reimbursement for primary care providers offering behavioral health care in a primary care
setting as a way of improving access to mental health care; (4) innovative and evidence-based
approaches for the early detection and prevention of mental illness; and (5) comprehensive and
coordinated approaches that create more seamless transitions in psychiatric care, resulting in
fewer readmissions and better utilization of available resources.

and be it further

RESOLVED, That TMA Policy 55.033 Children’s Mental and Behavioral Health be amended as follows:

Children’s Mental and Behavioral Health: Texas has a relatively young population, with about
28 percent of Texans under the age of 18. TMA recognizes that many mental health disorders of
childhood are the basis of both physical and mental disease throughout an entire lifespan.
Childhood and adolescence are critical times for brain development; consequently, many mental
disorders develop during these periods.

Managing mental health disorders among children requires multiple strategies.

Physician Education. All physicians should have adequate information that enables them to
recognize common mental disorders. Primary care physicians should be provided educational
tools regarding the screening, diagnosis, and current available treatment modalities for mental
disorders such as attention deficit disorder, mild depression, and mild anxiety. TMA can provide
resources for physicians on national screening and treatment guidelines, and billing and coding
information.

Practice. Access to care remains a critical issue for children and adolescents with mental health
disorders, especially underserved children. A physician-led medical home, therefore, can play an
important role in recognizing, consulting, and treating children with mental health disorders by
following the United States Preventive Services Task Force (USPSTF) recommendations for
screening children and adolescents for mental health disorders.

All physicians who see and treat children should be able to recognize and either treat or refer
children with obvious mental illness including substance abuse disorder.

Because school is the "workplace of the child," primary care physicians should have knowledge
of the demands and resources of their local school districts.

Advocacy.

TMA should facilitate and advocate for:

a. Continuing mental health education programs for physicians and mental health care providers
regarding child and adolescent mental health and substance abuse,

b. Medical schools and graduate medical education programs that recognize the role of primary
care physicians and provide effective training and research in all aspects of child and
adolescent mental health and substance abuse,

c. Continuing dialogue and networking with the public mental health community on these
issues,
d. Minimizing youth exposure to advertisements for legal addicting substances,

e. Positive mental health messages that counteract tobacco and alcohol advertisements,

f. Strong children's mental health networks throughout the state,

g. Emphasizing pediatric mental health education for all physicians who see children,

h. Adequate numbers and quality of mental health professionals and behavioral health facilities throughout the state,

i. Coordinating with the educational system for mentally healthy schools, and

j. Public and private payment systems that fully integrate mental health care services into primary patient care and provide appropriate payment for mental health services.

Related TMA Policy:
215.019 Public Mental Health Care Funding
55.033 Children’s Mental and Behavioral Health
290.010 Improving Access to Care in Rural and Medically Underserved Areas

Related AMA Policy:
Access to Psychiatric Beds and Impact on Emergency Medicine H-345.978
Medicaid Coverage of Adults in Psychiatric Hospitals H-345.976
National Child Traumatic Stress Network H-60.929

References:

5. Mental Health America. State of Mental Health in America Ranking States.
TABLE

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 314
2020

Subject: Required Platelet Products at a Facility in Maternal Levels of Care Designation

Introduced by: Dallas County Medical Society

Referred to: Reference Committee on Science and Public Health

<table>
<thead>
<tr>
<th>Whereas, The Texas Legislature in 2013 passed a bill, modified slightly in 2015, with the Texas Department of State Health Services as the regulatory authority, mandating that health care facilities providing maternal care in Texas apply for and meet one of four defined standard levels of care by September 2020 to receive Medicaid funding for obstetrical care; and</th>
</tr>
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<tbody>
<tr>
<td>Whereas, The criteria for such levels of care were defined by a Perinatal Advisory Council consisting of 19 individuals who did not include a transfusion medicine specialist; and</td>
</tr>
<tr>
<td>Whereas, The criteria for levels II through IV require that all facilities providing such maternal care keep on site at all times a platelet product for possible transfusion; and</td>
</tr>
<tr>
<td>Whereas, Many such facilities have never stocked a platelet on site before and have rarely if ever transfused a platelet product; and</td>
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<tr>
<td>Whereas, The shelf life of a platelet product is only five to seven days total, with a three- to four-day time frame at the hospital in most cases after the logistics of delivery and required testing; and</td>
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<tr>
<td>Whereas, Platelets can be delivered to such facilities if needed for transfusion; and</td>
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<tr>
<td>Whereas, The collection of an apheresis platelet product requires approximately two hours of a volunteer donor’s time and is a valuable resource that should not be wasted; and</td>
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<tr>
<td>Whereas, The community inventory of platelets is already severely strained because of growing demands with increased cancer and transplant care, better trauma survival, and population growth in many areas; thus the requirement for stocking platelets at facilities that will not actually use them will put the entire community supply at risk for those patients who do need them; therefore be it</td>
</tr>
</tbody>
</table>

RESOLVED, That the Texas Medical Association work with appropriate authorities at the Texas Department of State Health Services in reevaluating the requirement for platelets on site at all facilities providing maternal care with a designation of level of care II through IV and remove this onerous requirement.

Related TMA Policy: None.

Related AMA Policy: None.
Subject: Designating Texas Hospitals as Sensitive Locations

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, There is concern by undocumented immigrants that they will face legal action, such as deportation, when visiting hospitals to receive care for themselves or their family members; and

Whereas, Fear of legal action against immigrants may lead to poor control of diseases that necessitate hospital emergency visits, thus increasing the financial burden of preventable hospitalizations; and

Whereas, Sensitive patient information is protected under the Health Insurance Portability and Accountability Act, which inhibits disclosure of such said information except in rare circumstances; and

Whereas, Our Texas Medical Association, in Policy 55.057 Health Care of Undocumented Children, advocates for children to be able to receive nonemergency and preventive care and supports health care professionals delivering medical care to children regardless of immigration status; and

Whereas, Latina women, regardless of immigration status, are less likely to use health services for both themselves and their children when immigration laws are enforced in health care facilities; and

Whereas, Undocumented parents are less likely to seek care for their children, even if their children have citizenship, when they fear they will be asked to provide documentation of citizenship; and

Whereas, U.S. Immigration and Customs Enforcement (ICE) designates hospitals as sensitive locations where enforcement actions are not to occur; and

Whereas, Undocumented immigrants receiving medical care have reported ICE activities at hospitals such as interrogations and arrests, despite ICE policy to not operate at hospitals; and

Whereas, The American Medical Association encourages hospitals to “promote their status as sensitive locations” and opposes the presence of ICE enforcement in the policy Presence and Enforcement Actions of Immigration and Customs Enforcement (ICE) in Healthcare D-160.921; and

Whereas, After the 2019 mass shooting in El Paso, authorities reported concern that some undocumented immigrants did not seek care at hospitals for traumatic injuries due to fear of deportation; therefore be it

RESOLVED, That the Texas Medical Association oppose U.S. Immigration and Customs Enforcement from operating in hospitals; and be it further

RESOLVED, That TMA advocate for state legislation that designates hospitals as sensitive locations where U.S. Immigration and Customs Enforcement cannot operate; and be it further,
RESOLVED, That TMA encourage hospitals to publicize their status as sensitive locations to interested parties.

Relevant TMA policy:
55.057 Health Care of Undocumented Children

Relevant AMA policy:
Presence and Enforcement Actions of Immigration and Customs Enforcement (ICE) in Healthcare

References:
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 316
2020

Subject: Concurrent Prescribing of Opioid Antagonists with Opioid Prescriptions

Introduced by: Magen Robinson, OMS I; Victoria Pierce, OMS II; Alexandra Stedke, OMS II, Texas College of Osteopathic Medicine

Referred to: Reference Committee on Science and Public Health

Whereas, According to the National Institutes of Health, prescription opioid deaths are increasing and are the No. 1 cause of opioid overdose deaths in Texas, ahead of synthetic opioids and heroin; and

Whereas, It is the current policy of the Texas Medical Association to support multidimensional strategies of opioid analgesia management that reduce the risk to patients and enhance public safety regarding opioid use, misuse, abuse, diversion, and nontherapeutic prescribing; and

Whereas, It is the current policy of TMA to endorse the education of health care workers and opioid users about the use of naloxone (and other opioid antagonists) in preventing opioid overdose fatalities, and to advocate for legislation that reduces barriers for medical professionals to prescribe and dispense naloxone (or other opioid antagonists) to family members and friends of an identified patient; and

Whereas, Patients who are or have been prescribed opioids are considered “persons at risk of opioid-related drug overdoses” under Texas Medical Board rules; and

Whereas, It has been shown that opioid antagonist and overdose education material made available to community members leads to overall overdose decrease in deaths in those communities; and

Whereas, The U.S. Department of Veterans Affairs (VA) has used the 15-item Risk Index for Overdose or Serious Opioid-Induced Respiratory Depression (RIOSORD) as a tool to further opioid overdose education and naloxone distribution programs and reported 172 overdose reversal events with the use of VA-dispensed naloxone; and

Whereas, The TMA Committee on Health Information Technology continues to advocate for electronic health record (EHR) vendors to create useable, safe, efficient, transportable, and cost-effective EHRs therefore be it

RESOLVED, That the Texas Medical Association support concurrent prescribing (coprescription) of naloxone (or other opioid antagonists) with prescriptions and refills of opioids in alignment with the Centers for Disease Control and Prevention naloxone coprescription guidelines; and further be it

RESOLVED, That TMA support the implementation of an automatic opioid-opioid antagonist coprescription risk index support tool within electronic health record (EHR) management systems; and further be it

RESOLVED, That the TMA Committee on Health Information Technology research and recommend pragmatic implementation of automatic opioid-opioid antagonist coprescription suggestions within EHR management systems to EHR vendors.
Relevant TMA Policy:

1. **260.092 Responsible Opioid Prescribing for Pain Management**
2. **95.040 Addressing Prescription Drug Abuse and Overdose**

References:

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 317
2020

Subject: Employee Rights to Lactation Accommodation

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, In Texas, lactation accommodation rights exclude nonexempt employees of private companies and employees of companies with fewer than 50 staff members; and

Whereas, Current Texas policy requires only the following lactation accommodations by public employers: “reasonable amount of break time for an employee to express breast milk” and “a place, other than a multiple user bathroom, shielded from view and free from intrusion;” and

Whereas, Nonpublic employees are covered under the Fair Labor Standards Act, which also only provides lactation accommodation rights to nonexempt employees of companies that employ more than 50 people; and

Whereas, These state and national laws fail to support new mothers classified as exempt employees or small business employees; and

Whereas, State legislation that supports lactation accommodation is associated with higher rates of breastfeeding; and

Whereas, Workplace barriers are a main contributor to low rates of breastfeeding; and

Whereas, Greater legislative support for lactation accommodation is associated with longer exclusive breastfeeding duration; and

Whereas, The Texas Medical Association already acknowledges and “supports breastfeeding and the provision of human milk as critical components of optimal infant and maternal health,” and “recommends that] every infant be exclusively breastfed or fed exclusively human milk for a minimum of six months”; therefore be it

RESOLVED, That the Texas Medical Association develop model legislation extending employee lactation accommodation rights to employees of private companies and companies of fewer than 50 staff members; and be it further

RESOLVED, That TMA amend Policy 140.008 as follows:

TMA supports the adoption of legislation and employer programs that allow breastfeeding mothers to express breast milk safely and privately at work or take time to feed their infants and encourages public facilities to provide designated areas for breastfeeding and breast milk expression.

and be it further
RESOLVED, That TMA develop model legislation extending employee lactation accommodation rights to employees of private companies and companies of fewer than 50 staff members.

Related TMA Policy:
TMA Policy 140.008 Breastfeeding and Human Milk

Related AMA Policy:
AMA Support for Breastfeeding H-245.982

References:
2. Right to Express Breast Milk In the Workplace, Chapter 619 H.B. No. 786, 84 Cong. (2015).
Subject: Updating Texas Medical Association Teenage Sexual Health Guidelines

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, The United States has one of the highest teen pregnancy rates among developed nations; and

Whereas, Texas has one of the highest teen pregnancy rates in the United States; and

Whereas, Rates for many sexually transmitted diseases have risen over the years in younger age groups in Texas; and

Whereas, Percentages of Texas high schoolers who have had sexual intercourse are equivalent to the national average; and

Whereas, The American Academy of Pediatrics supports “evidence-based education about human sexuality,” and states that sexuality education has been shown to reduce risk of pregnancy and sexually transmitted infections for adolescents; and

Whereas, The American Academy of Family Physicians explicitly opposes abstinence-only sexual education, instead promoting “an evidence-based approach to sexual health education,” “the need for more comprehensive and effective sex education programs in the community,” and “the importance of comprehensive sex education in reducing the incidence of unintended teenage pregnancies; preventing sexual assault; [and] increasing awareness of the risks and signs in adolescents regarding sex trafficking”; and

Whereas, The American Medical Association opposes “the sole use of abstinence only education” in its policy Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools H-170.968; therefore be it

RESOLVED, That the Texas Medical Association encourage its members to engage with their local communities and local school boards to develop comprehensive sexual education programs for adolescents that do not teach abstinence as the only effective practice to reduce the risk of unintended pregnancy or sexually transmitted infections; and be it further

RESOLVED, That TMA amend Policy 55.016 Sexuality Education to:

The Texas Medical Association supports age and developmentally appropriate comprehensive kindergarten through college sexuality education that is theory based, research based, and skills oriented. Effective curricula should focus on abstinence; avoidance of sexual risk-taking behaviors; availability of reproductive health choices; and information on responsible decision making, social influences, and peer pressures.
TMA should promote through visible and vocal leadership, to the state and other interested organizations and associations, its policy advocating comprehensive programs in sexuality education.

TMA will act as a resource and clearinghouse for scientific, medically accurate information on adolescent sexuality, dispelling medical misinformation, and for information on sexuality education programs.

TMA will continue to work with the Texas Education Agency and the state legislature to develop and implement curricula on sexuality education (e.g., education for self-responsibility).

TMA will monitor and encourage research on the effectiveness of different sexuality curricula. TMA will actively seek community, business, and corporate support for this policy.


**Related TMA Policy:**

55.016 Sexuality Education

**Relevant AMA Policy:**

H-170.968 Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in Schools

**References:**

WHEREAS, Texas employs an opt-in organ donation system where donors must actively register or agree to become a donor, while opt-out or presumed consent systems make organ donation automatic unless the individual specifically requests his or her organs are not donated; and

WHEREAS, Texans currently have the option to register voluntarily to become an organ, eye, and tissue donor through the online Donate Life Texas Registry, or opt in to the registry when applying for or renewing their driver’s license, hunting license, identification card, or vehicle registration, or use the MedID tab in the iPhone Health App (iOS 10 or later); and

WHEREAS, In the U.S., 95% of adults support organ donation, while only 58% are signed up to donate; and

WHEREAS, Texas has around 12 million registered donors despite having approximately 21.5 million individuals over the age of 18; and

WHEREAS, More than 113,000 men, women, and children are on the national transplant waiting list; and

WHEREAS, Nationally 20 people die each day waiting for a transplant; and

WHEREAS, Approximately 1,500 Texans are removed each year from the transplant waiting list due to death or becoming too ill; and

WHEREAS, Despite some opposition in Texas to an opt-out system due to concerns it would decrease current donor rates, countries with an opt-out system such as Spain, Croatia, and Belgium have higher actual donation rates than the United States; and

WHEREAS, During the 2017 Texas legislative session, our Texas Medical Association testified in favor of House Bill 1938 that would have changed Texas from an opt-in to an opt-out system; therefore be it

RESOLVED, The Texas Medical Association adopt new policy to support an opt-out organ, eye, and tissue donation system in Texas; and be it further

RESOLVED, That our TMA amend Policy 280.010 Physician Role in Promoting Organ and Tissue Donation and Transplantation to include this language.

**Related TMA Policy:**

[280.010 Physician Role in Promoting Organ and Tissue Donation and Transplantation](#)

[45.008 Blood Donations and Transfusions](#)
Related AMA Policy:

1. Removing Disincentives and Studying the Use of Incentives to Increase the National Organ Donor Pool
   H-370.958
2. Organ Donation and Honoring Organ Donor Wishes H-370.998
3. Methods to Increase the US Organ Donor Pool H-370.959
4. Organ Donor Recruitment H-370.995
5. Organ Donor Recruitment H-370.996
6. Organ Donation D-370.985

References:

1. National Conference of Commissioners on Uniform State Laws. Revised Uniform Anatomical Gift
5. Goard A. Texas bill aims to make organ donation opt-out, sparking debate. KXAN Austin. April 27,
   2017.
   https://tpwd.texas.gov/regulations/outdoor-annual/licenses/faqs.
8. International Registry in Organ Donation and Transplantation. Worldwide Actual Deceased Organ
Subject: Maternal Health and Postpartum Depression Screening

Introduced by: Medical Student Section

Whereas, A recent meta-analysis shows 12% of women who have given birth experience postpartum depression; and

Whereas, Women who participate in depression screenings, with or without treatment, show relevant reductions in postpartum depression; and

Whereas, Women with increased symptoms relatively early in the postpartum period are likely to develop postpartum depression over the first 18 months and may benefit significantly from early intervention; and

Whereas, Persistent and severe postpartum depressive symptoms in the mother are more likely to raise the risk of adverse child outcomes such as behavioral problems at age 3.5 years (OR, 4.84), lower mathematics grades at age 16 years (OR, 2.65), and higher prevalence of depression at age 18 years (OR, 7.44); and

Whereas, The American College of Obstetricians and Gynecologists (ACOG) recommends that obstetrician-gynecologists and obstetric care providers screen patients at least once during the perinatal period for depression and anxiety symptoms using a standardized tool, and also recognizes that screening alone can have clinical benefits, although initiation of treatment or referral to mental health care professionals offers maximum benefit; and

Whereas, It is AMA policy to work with stakeholders to encourage the implementation of a routine protocol for depression screening in pregnant and postpartum women during prenatal, postnatal, pediatric, or emergency department visits; and

Whereas, AMA encourages the development of training materials related to maternal depression to advise physicians on appropriate treatment and referral pathways; therefore be it RESOLVED, That the Texas Medical Association encourage implementation of postpartum depression screenings as routine protocol for perinatal and postnatal women in health care settings; and be it further RESOLVED, That TMA promote education regarding postpartum depression screenings to primary care physicians who are in contact with perinatal and postpartum women.

Related TMA Policy:
None.
Related AMA Policy:

1. Improving Treatment and Diagnosis of Maternal Depression Through Screening and State-Based Care
2. Coordination D-420.991
3. Improving Mental Health Services for Pregnant and Postpartum Mothers H-420.953

References:

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 321
2020

Subject: Saving Energy, Reducing Costs, and Increasing Efficiency in Medical Practices

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, A study by The Commonwealth Fund projected more than $5.4 billion in savings if all U.S. hospitals reduced energy consumption and waste, and gained efficiencies in operating room practices; and

Whereas, The U.S. health care industry contributes approximately 10% of the nation’s total carbon dioxide emissions; and

Whereas, Switching to ordering only copy paper with at least 30% recycled content and changing the default print option to double-sided printing for all networked printers reduced University of Wisconsin Hospital and Clinics’ paper use by 25% to 30%, lowering costs between $11,000 and $13,000 each month; and

Whereas, Dell Children’s Medical Center in Austin estimates that by installing fluorescent lights, automatic on and off switches, and high-efficiency air conditioning, among other initiatives, it has saved enough energy to power, heat, and cool nearly 300 average-sized homes daily; and

Whereas, The My Green Doctor initiative, which has been used in 58 countries and 38 U.S. states by hundreds of medical offices, clinics, and outpatient centers, requires adding only five minutes of Green Team business to each regular practice or clinic planning meeting; and

Whereas, My Green Doctor offers a Meeting-by-Meeting Guide that tells practices or clinics what to discuss and decide at each meeting, as well as 50 energy-efficiency action steps and education steps for physicians to consider for their office; and

Whereas, The Texas Medical Board adheres to a resource efficiency plan to promote energy savings in Texas; and

Whereas, The Texas Medical Association’s current policy is to promote energy conservation measures for homes, businesses, and public buildings to decrease Texas energy consumption (TMA Policy 260.077); and

Whereas, The American Medical Association’s current policy is to support physicians in adopting programs for environmental sustainability in their practices (AMA Policy H-135.923); and

Whereas, AMA’s guidelines work to support and educate physicians in adopting programs to help their medical practices save energy, reduce costs, and increase efficiencies; therefore be it

RESOLVED, That the Texas Medical Association adopt and recommend energy conservation guidelines for Texas medical practices; and be it further
RESOLVED, That TMA partner with the My Green Doctor initiative and promote its guidelines to physicians and health care providers in Texas; and be it further

RESOLVED, That TMA promote education for green practices for physicians and health care providers in Texas.

Related TMA Policy:
260.077 Clean Air in Texas

Related AMA Policy:
H-135.923 AMA Advocacy for Environmental Sustainability and Climate

References:
Subject: Recommendation for the Use of Low Titer Group O Whole Blood for Hemorrhagic Shock

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, Although hemorrhagic shock is the leading cause of potentially survivable death and efforts such as limb and junctional tourniquets have helped decrease mortality, noncompressible torso hemorrhage has a mortality rate of 44.6%; and

Whereas, The PROPPR study demonstrated that a component therapy of red blood cells, plasma, and platelets in a 1:1:1 ratio, which mimics whole blood with three times the anticoagulants and preservatives, resulted in better outcomes and potentially leads to increased derangement of the coagulation system; and

Whereas, The platelets in whole blood product provide improved hemostasis compared with component therapy; and

Whereas, Low titer group O whole blood (LTOWB) is a whole blood with a low but acceptable level of IgM anti-A and anti-B typically stored between 2° and 6°C, which studies demonstrate is potentially a better product for the hemorrhaging patient; and

Whereas, In 2017, AABB (formerly: American Association of Blood Banks) approved the use of LTOWB for non-group O recipients or for recipients whose ABO group is unknown; and

Whereas, Several Texas hospitals and the entire Southwest Texas Regional Advisory Council region currently use LTOWB in both the prehospital and the hospital settings; and

Whereas, Fewer than 34% of first responders are using blood products for prehospital resuscitation, in large part due to the logistic constraints of transporting and infusing component products from multiple bags; however, the use of LTOWB could reduce this burden while improving patient outcomes; and

Whereas, The use of LTOWB simplifies the logistics of the resuscitation and accelerates the provision of all blood components needed to treat hemorrhagic shock; and

Whereas, Studies have demonstrated the safety of LTOWB with more than 1 million units transfused in combat and civilian settings; and

Whereas, There is reduced risk of hemolysis from the low titer minor incompatible plasma compared with the risk from untitered minor incompatible plasma or platelets, and there is reduced risk of bacterial contamination compared with room-temperature stored platelets; and

Whereas, Evidence indicates that the use of LTOWB may reduce hospital costs, eliminating the need for fractionation of whole blood into components as well as bacterial testing for blood products that are typically stored at room temperature, at only the cost of IgM anti-A and anti-B titers for LTOWB; and
Whereas, Despite the shorter shelf-life of LTOWB at 35 days when stored between 2° and 6°C, units are still able to be spun down to obtain usable red blood cells past this date; therefore be it

RESOLVED, That the Texas Medical Association support the use of low titer group O whole blood as the optimal blood product in hemorrhagic shock for use in the prehospital setting; and be it further

RESOLVED, That TMA support the use of low titer group O whole blood as the optimal blood product in hemorrhagic shock for use in the hospital setting.

Related TMA Policy:
45.014 Blood Safety
45.008 Blood, Organ, and Tissue Donations

Related AMA Policy:
Safety of Blood Donations and Transfusions H-50.975
Blood for Medical Use H-50.996

Sources:
caued by the transfusion of blood or blood components containing ABO-incompatible plasma.
Transfusion. 2013;53 Suppl 1:114S-123S.
Subject: Recognizing the Effect of Climate Change on Public Health

Introduced by: Medical Student Section

Referred to: Reference Committee on Financial and Organizational Affairs

Whereas, The fifth assessment report of the Intergovernmental Panel on Climate Change concluded that “human influence on the climate system is clear” and “recent climate changes have had widespread impacts on human and natural systems”; and

Whereas, The World Health Organization estimates that climate change could cause approximately 250,000 additional deaths per year from 2030 to 2050 due to malnutrition, malaria, diarrhea, and heat stress; and

Whereas, A meta-analysis of global systemic risk associated with climate change found that 1,546 papers between 1989 and 2013 indicated a direct link between environmental change and negative health risks; and,

Whereas, According to the National Institute of Environmental Health, the most common noncommunicable chronic diseases – heart disease, stroke, cancer, diabetes, and respiratory diseases, which account for 60% of the 58 million global annual deaths – are significantly exacerbated by climate change, due to increased average temperatures, air pollution, chemical contaminants, and increased ultraviolet radiation exposure in urban communities; and

Whereas, A meta-analysis of 18 mortality publications representing 3,933,398 elderly mortality cases from 1980 to 2010 found that a 1°C temperature rise increased cardiovascular mortality by 3.44%, respiratory mortality by 3.60%, and cerebrovascular mortality by 1.40%; and

Whereas, The American Medical Association “[s]upports the findings of the Intergovernmental Panel on Climate Change’s fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant” and recognizes that “these climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor” (Global Climate Change and Human Health H-135.938); and

Whereas, Human-induced climate change likely increased the chances of the observed precipitation accumulations during Hurricane Harvey in the most affected areas of Houston by a factor of at least 3.59; and

Whereas, Climate change exacerbated the effects of the record-setting 2011 Texas drought, causing $5.2 billion dollars in agricultural losses, and similar bouts of extreme drought and heatwaves are predicted to increase in Texas; and
Whereas, The Clear Creek watershed in Houston will continue to experience larger periods of dry spells alternating with increasingly severe periods of concentrated precipitation, increasing the risks of droughts and flooding; and

Whereas, Parts of Texas have increased in average temperature more than 1.5°F between 1986 and 2016, and temperatures are projected to rise another 1°-6°F by 2100; therefore be it

RESOLVED, The Texas Medical Association concur with the scientific consensus that the Earth is undergoing adverse global climate change with anthropologic contributions, and acknowledge that climate change will increasingly affect public health, with disproportionate impacts on vulnerable populations such as the children, elderly, and people of low socioeconomic status.

Related TMA Policy:
265.018 Evidence-Based Medicine

Related AMA Policy:
Global Climate Change and Human Health H-135.938

References:
1. Intergovernmental Panel on Climate Change. AR5 synthesis report: Climate change 2014.
Subject: Mandatory Waiting Period for Firearm Purchases

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, Firearm violence is a public health issue in the United States, given that it is responsible for the death of 36,000 Americans each year (an average of 100 per day), continues to be one of the top three causes of death among American youth, and costs the U.S. at least $174 billion annually; and

Whereas, Current Texas Medical Association policy recognizes firearm violence as a public health issue requiring the promotion of evidence-based strategies in Texas (TMA Policy 260.015); and

Whereas, More than half of all suicides in Texas in 2016 (60%) were by firearm, and the firearm suicide rate in Texas increased 18% from 2006 to 2016; and

Whereas, Seventy-eight percent of veteran suicides in Texas in 2017 were by firearm; and

Whereas, Mass shootings are defined as those in which the perpetrator took the lives of at least four people, excluding the shooter; and

Whereas, There were more mass shootings than days in the year in 2019, totaling 417, including the shooting in El Paso, which was the deadliest of the year; and

Whereas, It is well established that accessibility to firearms increases the risk for completed suicide and being a victim of homicide; and

Whereas, Texas currently has no mandated waiting period for firearm purchases; and

Whereas, Waiting periods require a certain number of days to pass between the purchase of a firearm and when the buyer can actually take possession of that firearm; and

Whereas, Waiting periods can allow for a “cooling period” where visceral factors, such as anger or suicidal impulses, that otherwise could spur people to inflict harm on others or themselves can pass; and

Whereas, Current American Medical Association policy advocates a waiting period and encourages legislation that enforces a waiting period for all firearm purchasers (AMA Policy H-145.996); and

Whereas, States with mandatory waiting periods – no matter the total length – had on average 17% fewer homicides and 10% fewer suicides; therefore be it

RESOLVED, The Texas Medical Association advocate for mandatory waiting periods following the purchase of firearms to reduce firearm-related injuries and deaths.
Related TMA Policy:
260.015 Firearms

Related AMA Policy:
Firearm Availability H-145.996
Gun Violence as a Public Health Crisis D-145.995
Data on Firearm Deaths and Injuries H-145.984

References:
Subject: Promoting and Improving Health Literacy

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, The National Assessment of Adult Literacy found that 88% of American adults are “not proficient” in health literacy; and

Whereas, Texas has a lower rate of health literacy than many other states; and

Whereas, Those with limited health literacy often have difficulty or an inability to perform simple health-related tasks; and

Whereas, Poor health literacy is associated with physical inactivity, unhealthy diet, unhealthy weight, decreased engagement with health care professionals, and poorer health outcomes overall; and

Whereas, The direct cost of low health literacy in the U.S. is $105 billion to $238 billion every year; and

Whereas, Various Texas cities have begun initiatives to improve health literacy, such as the San Antonio Health Literacy Coalition; and

Whereas, Current American Medical Association policy recognizes and provides recommendations to alleviate the challenges of low community health literacy (H-160.931); and

Whereas, The Texas Medical Association has a webpage dedicated to community health literacy but as of yet does not have a comprehensive policy for it; therefore be it

RESOLVED, That the Texas Medical Association recognize that inadequate patient health literacy is a barrier to effective medical diagnosis and treatment; and be it further

RESOLVED, That TMA recommend the adoption of a health literacy policy at all health care institutions that should aim to improve physician and other health care professional communication and educational approaches to patient visits; and be it further

RESOLVED, That TMA encourage the allocation of public and private funds for research on health literacy as well as the development of low-cost community and health system resources focused on improving health literacy.

Related TMA Policy:

260.037 Essential Public Health Services
165.005 Public School Finance and Taxes

Related AMA Policy:

Health Literacy H-160.931
References:

1. White S. Assessing the Nation’s Health Literacy Key concepts and findings of the National Assessment of Adult Literacy (NAAL). 2008. AMA Foundation.


TABLE

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 326
2020

Subject: Pediatric Iron Deficiency Anemia Treatment and Diagnosis Guidelines

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, Texas lacks published guidelines on diagnosing and treating childhood iron deficiency anemia; and
Whereas, The American Academy of Family Physicians and American Center for Disease Control have not published treatment guidelines specifically for children; and
Whereas, The guidelines provided by the American Academy of Pediatrics only specify and cover children from birth to age 35 months; and
Whereas, Texas Health Steps has published guidelines for treatment and prevention of childhood iron deficiency anemia exclusively in children under age 35 months covered by Medicaid; and
Whereas, The Texas Medical Association recognizes the value and potential of evidence-based clinical guidelines to improve consistency, timeliness, and efficacy of clinical care; and
Whereas, Childhood iron deficiency anemia guidelines will empower general pediatricians and primary care physicians to exhaust treatment options within their scope before referring to subspecialty clinics; and
Whereas, A lack of guidelines on diagnosing and treating childhood iron deficiency anemia increases premature referrals to hematology without first attempting treatment with iron supplements; and
Whereas, Needless specialty referrals cause undue financial burdens on patients, particularly rural patients, by requiring them to pay for travel, potentially nonessential testing, and subspecialty physician visits; and
Whereas, Unnecessary referrals congest subspecialty practices and exacerbate the shortage of pediatric hematologists; and
Whereas, The subspecialist shortage creates a bottleneck in the overall health care system, prevents critical patients from receiving timely treatment, and ultimately passes medical costs to taxpayers; therefore be it

RESOLVED, That the Texas Medical Association support collaboration of qualified stakeholders to develop standard practice guidelines for diagnosis and treatment of childhood iron deficiency anemia that empower primary care physicians to exhaust treatment and care options within their scope before issuing subspecialty referrals.
Related TMA Policy:

180.003 Managed Care Referral Practices
265.018 Evidence-Based Medicine

Related AMA Policy:
H-410.980 Principles for the Implementation of clinical practice guidelines at the Local/State/Regional Level

References:

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 327
2020

Subject: Improving Access to Immediate Postpartum Long-Acting Reversible Contraception for Adolescents

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, The teenage birth rate in the United States remains among the highest in the developed world; and
Whereas, Approximately 19% of sexually active women aged 15 to 19 in the United States became pregnant; and
Whereas, A 2016 study conducted by the U.S. Department of Health and Human Services revealed that the adolescent birthrate in Texas is around 31.0 per 1,000 teenage females aged 15 to 19, which is nearly 11 points higher than the national average; and
Whereas, The same 2016 study found that 19% of adolescent pregnancies in the state of Texas were repeat births as compared to only 16% of adolescent pregnancies in the United States as a whole; and
Whereas, Of the approximately 574,000 adolescent pregnancies that occur each year in the United States, 75% are unintended; and
Whereas, A 2013 study revealed that approximately one in three adolescents reported using either a least effective contraceptive method (15.7%) such as the withdrawal method, condoms, or the contraceptive sponge, or no contraceptive method whatsoever (17.2%) following their first live birth; and
Whereas, Postpartum adolescents who participated in a comprehensive, multidisciplinary maternity program who were given a long-acting reversible contraceptive demonstrated markedly reduced repeat adolescent pregnancy rate than those who did not; and
Whereas, The American College of Obstetricians and Gynecologists and the American Academy of Pediatrics both recommend that clinicians counsel women (including adolescents) during prenatal care about birth spacing and postpartum contraceptive use, including the safety and effectiveness of long-acting reversible methods that can be initiated immediately postpartum; and
Whereas, Long-acting reversible contraceptives are proven to be an effective method for this chosen demographic partially because they do not require regular action on the part of the adolescent; and
Whereas, 84% of postpartum adolescent women demonstrate a high 12-month continuation of long-acting reversible contraceptive methods; and
Whereas, In Texas, the current age to consent to sexual intercourse is 17 years old, while the age to obtain prescriptive contraceptives and other sexual health services is 18 years old, thus creating a gap in adolescent sexual health care within the state; and
Whereas, Texas and Utah represent the only two states in the nation where adolescent mothers must receive parental consent in order to request prescriptive birth control, including long acting reversible contraceptives, from a provider; and

Whereas, 27 states and the District of Columbia explicitly allow all individuals, including minors, to consent to contraceptive services; and

Whereas, The state of Texas provides free and reduced-cost access to long acting reversible contraceptives, among other services, to low-income women through the Healthy Texas Women Program and Texas Family Planning Program, including minors who lose CHIP coverage; and

Whereas, Under federal laws, minors can receive confidential family planning services without parental consent through clinics that qualify for Title X funding and through Medicaid; and

Whereas, Across the nation, clinics receiving Title X funding have withdrawn from the program due to new regulations and stipulations, leaving a gap in family planning services, especially for low-income families; and

Whereas, For women and adolescents with little to no contraceptive coverage, the up-front cost of long-acting reversible contraceptives and the insertion procedure is often prohibitive; and

Whereas, Adolescent pregnancies cost the state of Texas approximately $1.1 billion each year due to loss of wages and increased reliance on social services; and

Whereas, Current American Medical Association (AMA) policy recognizes the efficacy of long-acting reversible contraceptives immediately postpartum; and

Whereas, Current Texas Medical Association (TMA) policy supports statewide efforts to improve access to family planning services for women in need, including long-acting reversible contraceptives; and

Whereas, Current TMA policy supports the right to confidential care for unemancipated minors; therefore be it

RESOLVED, That our Texas Medical Association supports increased funding for long-acting reversible contraceptives and other prescriptive contraceptives for women who do not qualify for services under the Healthy Texas Women Program and Texas Family Planning Program and who do not have reliable access to Title X funded clinics; and be it further

RESOLVED, That our TMA supports and advocates for the reduction of the age at which a minor can access prescriptive contraceptives, including long acting reversible contraceptives, without parental consent from either a) 18 to 17, to match the Texas age of consent, or b) from 18 to 15, to accommodate the entire age group of adolescents who are at increased risk of teenage pregnancy within the state of Texas; and be it further

RESOLVED, That our TMA advocates for the expansion of the Texas “mature minor” doctrine described in TMA Policy 55.004 Adolescent Sexual Activity to include access to contraceptive options, such as prescriptive birth control methods (i.e. oral contraceptives, shots, and intrauterine devices), and sexual health services (i.e. pap smears and treatment for urinary tract infections) without parental consent.
Related TMA Policy:

1. **55.004 Adolescent Sexual Activity**
2. **330.015 Physician-Led Initiatives to Address Maternal Mortality and Morbidity**
3. **260.075 Preventive Health Care for Texas Women**

Related AMA Policy:

1. **Increasing Availability and Coverage for Immediate Postpartum Long-Acting Reversible Contraceptive Placement H-75.984**
2. **Coverage of Contraceptives by Insurance H-180.958**
3. **Reducing Unintended Pregnancy H-75.987**

References:

Whereas, In Texas, the current age of consent to sexual acts is 17 years old, while the age to obtain contraceptives without required parental consent is 18 years old unless the minor receives Title X services or Medicaid; and

Whereas, As a result of revisions to Title X regulations, major organizations are opting out of Title X; for example, Planned Parenthood, the largest single provider of Title X services in the U.S., announced its decision to withdraw from the program, which will decrease minors’ access to contraceptive services; and

Whereas, In Texas, the teen birth rate in 2016 for mothers aged 15-17 was 15.1 births per 1,000 girls compared with the U.S. teen birth rate of 8.8 for that age range, making Texas the seventh highest state for teen pregnancies; and

Whereas, In Texas, 38% of high school females reported having had sexual intercourse in 2017; and

Whereas, Fourteen percent of high school students in Texas reported they or their partner used birth control pills before their last sexual intercourse, while 23% of high school students in Texas reported they or their partner did not use any method to prevent pregnancy during last sexual intercourse – compared with the U.S. averages of 21% and 14%, respectively; and

Whereas, Twenty-seven states and the District of Columbia adopted state laws that permit minors to consent to contraception without parental notification; and

Whereas, TMA policy states that requiring parental involvement in sexual and contraceptive health care reduces access to care without reducing sexual activity or increasing communication between parents and teens; and

Whereas, TMA legislative initiatives have advocated for adoption in state statute of the “mature minor” doctrine and elimination of other statutory barriers to adolescents accessing health care; and

Whereas, American Medical Association policy encourages medical societies to evaluate laws on consent and confidential care for adolescents and to help eliminate laws that restrict the availability of confidential care; therefore be it

RESOLVED, That the Texas Medical Association support lowering the legal age at which a minor can access contraceptives without a guardian or parental consent to at least the age of 17; and be it further

RESOLVED, That TMA continue to support initiatives, programs, and funding that eliminate barriers to adolescents accessing reproductive health care.
1 Related TMA Policy:
2 55.035 Right to Confidential Care
3 55.004 Adolescent Sexual Activity
4 55.016 Sexuality Education
5
6 Related AMA Policy:
7 Opposition to HHS Regulations on Contraceptive Services for Minors H-75.998:
8 Confidential Health Services for Adolescents H-60.965
9
10 References:
Subject: Flu Vaccinations in Immigrant Holding Facilities at the Border

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, Texas Medical Association policy supports the National Vaccine Plan by the U.S. government, including the “supply, distribution, and safety” of vaccines; and

Whereas, A major goal of the National Vaccine Plan is to “increase global prevention of death and disease” with interest in supporting programs that target “unvaccinated mobile populations” regardless of age; and

Whereas, TMA policy also supports the vaccination of children and adults in Texas through the Vaccines for Children Program and Adult Safety Net Program regardless of insurance or ability to pay as well as influenza vaccinations for all individuals 6 months and older; and

Whereas, TMA policy supports comprehensive primary care, access to care, and public health partnership through community and migrant health center programs; and

Whereas, Current living conditions in immigrant holding facilities pose a high risk for infectious disease outbreaks; and

Whereas, More than 2,000 immigrants are quarantined in U.S. Customs and Border Protection immigrant holding facilities across the U.S. for influenza, mumps, and chickenpox outbreaks, and since September 2018, seven children have died in these facilities, three from influenza; and

Whereas, U.S. Customs and Border Protection was unable to vaccinate detained migrants against influenza during winter 2019; and

Whereas, American Medical Association policy supports collaboration with partners on a state and national level to provide appropriately managed and timely redistribution of state and federally funded influenza vaccines to indigent or underserved populations; therefore be it

RESOLVED, That the Texas Medical Association support legislation increasing vaccine availability in immigrant holding facilities; and be it further

RESOLVED, That our TMA acknowledge the importance vaccinations for the health of immigrants in holding facilities on the border, which can also directly affect the health of Texas citizens.

Related TMA Policy:
135.005 National Vaccine Policy
135.012 Immunization Rates in Texas
260.088 United States-Mexico Border Health Commission
260.005 Community and Migrant Health Centers
135.013 Universal Influenza Vaccination

Related AMA Policy:
Influenza Vaccine Availability and Distribution H-440.851

References:
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 330
2020

Subject: Expanding Access to Regularly Scheduled Dialysis for All Individuals With ESRD

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, Despite near-universal coverage for end-stage renal disease (ESRD)-related dialysis under the 1972 Medicare ESRD entitlement program, as of 2017, around 6,500 dialysis-dependent individuals, namely undocumented immigrants, remain uninsured and ineligible for Medicare-covered, regularly scheduled dialysis; and

Whereas, 30% to 50% of these individuals receive treatment only in emergency situations, otherwise known as emergent dialysis; and

Whereas, The 1986 Emergency Medical Treatment and Labor Act mandates emergent dialysis for any individual who presents to the emergency department with indicated symptoms; and

Whereas, Dialysis-dependent undocumented immigrants are, on average, younger, able-bodied, and employed, but frequent unscheduled dialysis can quickly reduce quality of life; and

Whereas, Undocumented immigrants who receive emergency-only dialysis for five years have a 14 times higher relative hazard of mortality compared with those receiving regularly scheduled dialysis; and

Whereas, Emergent dialysis is a large cost to local health care systems – for example, in Houston, emergency dialysis costs $285,000 per patient annually; and

Whereas, A Harris County public hospital showed that restricting regularly scheduled dialysis for undocumented immigrants results, on average, in 152 more days inpatient per year, 25 more emergency department visits per year, and 3.7 times higher costs per patient per year; and

Whereas, A Dallas program that enrolls undocumented ESRD patients in off-exchange private health insurance plans afforded by charitable premium assistance resulted in a 14% mortality risk reduction, reductions in health care utilization, and estimated costs savings of $72,000 per person per year; and

Whereas, In Texas, only Harris Health System’s Riverside Dialysis Center and San Antonio’s University Health System provide regularly scheduled dialysis to undocumented immigrants; and

Whereas, Ten states allow undocumented patients with ESRD to receive scheduled dialysis through state, county, or municipal funds; charity; or other sources of nonfederal funds; and

Whereas, States that provide ESRD-related to care to undocumented immigrants have seen no increase in the number of undocumented immigrants; and

Whereas, Clinicians providing emergent dialysis experience professional burnout from the moral distress of providing substandard care and frustration over the inappropriate use of resources; and
Whereas, The American Medical Association Journal of Ethics acknowledges the challenges in access to regularly scheduled dialysis for undocumented immigrants with ESRD and supports continued advocacy for these patients to receive proper care; therefore be it

RESOLVED, That the Texas Medical Association support existing municipal, county, and state programs that allow undocumented immigrants with end-stage renal disease (ESRD) to receive regularly scheduled dialysis; and be it further

RESOLVED, That TMA support universal access to nonemergency, regularly scheduled dialysis as a humane and cost-effective standard of care for all individuals with ESRD, regardless of immigration status, for whom dialysis is appropriately indicated; and be it further

RESOLVED, That TMA collaborate with relevant stakeholders to identify and implement ways to achieve regularly scheduled dialysis as a standard of care for all individuals with ESRD in Texas.

Related TMA Policy:
55.057 Health Care of Undocumented Children
110.006 Health Plan

Related AMA Policy:
Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients H-440.876

References:
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 331
2020

Subject: Incorporating Helmet Safety Education Into Texas Elementary Schools

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, In 2018, a total of 857 bicyclists were killed in traffic accidents in the United States; and

Whereas, Children aged 5-14 years have the highest rates of bicycle injuries in the nation; and

Whereas, The greatest risk of death and disability to bicyclists is from head injuries; and

Whereas, Between 2007 and 2012, there were 12,789 crashes in Texas involving bicycles, which resulted in 12,132 injuries and 297 fatalities, with 27% of the victims under age 15; and

Whereas, The results of a meta-analysis of 55 studies between 1989 and 2017 determined that wearing helmets can reduce head injury by 48%, traumatic brain injury by 53%, face injury by 23%, and the total number of killed or seriously injured by 34%; and

Whereas, Children in states without helmet laws were 3.5 times more likely to not wear helmets consistently; and

Whereas, A survey of primary and secondary school children revealed the strongest correlates of not using a helmet were the belief of not needing a helmet and a wish to use a hat instead; and

Whereas, Children who receive bicycle safety instruction are more knowledgeable on safe bicycling behaviors than those who did not receive instruction, and they are less likely to be involved in a cycling accident; and

Whereas, Children living in suburbs that use a combination of helmet legislation and helmet education programs reported higher helmet use than children living in suburbs with helmet legislation alone and no helmet education programs; therefore be it

RESOLVED, That the Texas Medical Association amend Policy 55.021 Bicycle Helmets to encourage physicians to be informed about the safety of helmet use for elementary school children cyclists, promote awareness, and share with local school health and safety advisory committees evidence-based, best practices regarding helmet safety education for schoolchildren.

Related TMA Policy:

55.021 Bicycle Helmets

Related AMA Policy:

None.
References:
1. Board of Trustees Report 11 – Principles for Community-Based Accountable Care Organization
6. Committee on Health Information Technology Report 2 – Sunset Policy Review
7. Board of Trustees Report 13 – Compensation to Physicians for Activities Other Than Direct Patient Care

Agenda Items Tabled to 2021

The following items of business are tabled to the 2021 HOD meeting. However, one may make two motions: ‘Referral to the BOT for Action and report back’ (allowing TMA BOT to adopt policy and address the item and report back to the TMA 2021 HOD) or ‘Referral to the BOT and report back’ (allowing the BOT to consider the item and report back to the TMA 2021 HOD. Your Speakers strongly encourage the use of referral (of tabled items) be limited to urgent and essential items.

9. Patient-Physician Advocacy Committee Report 3 – Legislative Changes Regarding Vacating Orders
10. Resolution 401 – Insurance Coverage Transparency
11. Resolution 402 – Need for and Funding of Level I and II Trauma Centers
12. Resolution 403 – Taxes on Medical Billing Services
13. Resolution 404 – Individual Physicians Be Paid While Awaiting Credentialing Approval
14. Resolution 405 – Physicians to Retain Payment During Credentialing
15. Resolution 406 – Physicians’ Salary Survey
16. Resolution 407 – Compensation to Physicians for Activities Other Than Direct Patient Care
17. Resolution 408 – Contracted Health Plans Must Apply the Same Level of Benefits Concerning Patient Responsibility
18. Resolution 409 – School Physicals Should Be Conducted by Physicians or Their Supervised Designee
20. Resolution 411 – Prior Authorizations
21. Resolution 412 – Step-Edit Therapy Contributes to Denial of Care and Has Not Demonstrated Improved Patient Outcomes or Overall Cost Savings
22. Resolution 413 – Caps on Insulin Copayments with Insurance
24. Resolution 415 – Promotion of LGBTQ+ friendly and Gender-Neutral Options on Medical Documentation and Intake Forms
25. Resolution 416 – Interstate Medical Malpractice Tort Protection for Physicians Treating Patients in Neighboring States
26. Resolution 417 – Insurance Promotion of Preventive Care Services via Incentive-Based Programs
27. Resolution 418 – Paid Parental Leave
28. Resolution 419 – Placing Medicaid Expansion on a Statewide Voting Ballot
29. Resolution 420 – Training Requirements Imposed by Insurance Companies Preventing Patients’ Access to Quality Medical Care
30. Resolution 421 – Physician Societies to Create a Self-Funded, Balanced and Nonpartisan Center for the Study of Healthcare Reform
31. Resolution 422 – Develop Guidelines for Proper Oversight and Collaboration of Mid-Level Providers by Physicians
32. Resolution 423 – A Push for Mobile-First Design Principles within Medical IOT (Internet of Things) Interfaces
33. Resolution 424 – Adoption of Principles of Physician Value-Based Decision-Making in Medical Practice and Professionalism
34. Resolution 425 – Plastic Surgery Board-Certification
35. Resolution 426 – Results and Regulation of Freestanding Birthing Centers and at Home Birthing Services
36. Resolution 427 – Adjustments to Hospice Dementia Enrollment Criteria
Subject: Principles for Community-Based Accountable Care Organizations

Presented by: Linda Villarreal, MD, Chair, Board of Trustees

Referred to: Reference Committee on Socioeconomics

Background

In communities across Texas, a new approach to caring for vulnerable patients – Medicaid patients, uninsured, and seniors – and is gaining strong support among local physician leaders, hospitals, and patient advocates – the community-based accountable care organization (ACO). Other states, including Oregon, Washington, Colorado, and North Carolina, have paved the way for such programs, demonstrating that entities with strong physician leadership and integrated networks of physicians and providers can design, launch, and operate cost-effective health care delivery models that improve patient outcomes while slowing cost growth.

A community ACO model organizes a network of health care safety net physicians and providers, in both inpatient and outpatient settings, working under the direction of a single community-based board that uses value-based payment approaches to improve health outcomes for the population(s) served.

Why a community-based ACO? Texas’ state and local elected officials continue to struggle with how best to provide meaningful coverage to uninsured and underinsured Texans while constraining health care costs and improving patient outcomes. But top-down approaches to care delivery have not always yielded better health outcomes or lower costs. Community ACOs are predicated on developing a shared mission and vision among the physicians and providers within a community as well as shared accountability.

Moreover, Texas lawmakers, facing the withdrawal of billions of federal funds over the next few years as the state’s Medicaid 1115 Transformation Waiver winds down, will need to craft a novel strategy to replace or extend those dollars to prevent a potentially catastrophic financial impact on the state’s health care safety net. However, the Centers for Medicare & Medicaid Services has signaled that for it to approve any additional dollars, Texas must deploy a health care delivery model that will provide a return on investment.

Regardless of whether state lawmakers act, local communities will continue to test new health care delivery options. This mean even if Texas fails to find a statewide coverage solution, a local solution, or some combination, physicians must be at the table to design local patient-centered systems of care.

Given that TMA is the voice of Texas physicians and its mission is to improve the health of all Texans, TMA has an opportunity to promote the development of sustainable physician-led delivery systems. The TMA Workgroup on Value-Based Payment Initiatives and Physician-Led Community Health Care Delivery Models, formed at the behest of the Board of Trustees, believes TMA should advance the community ACO model by articulating key principles communities should consider when designing such models. Additionally, TMA should evaluate the development of physician education, training, and services to help prepare practices to participate in such models. When implemented with physician leadership, such models can provide a seamless network of physician practices, inclusive of the full spectrum of primary and specialty care, enabling greater access to health care for low-income and uninsured individuals.
To that end, the workgroup has developed policy principles to guide county medical societies and individual physician leaders on the formation of community-based ACOs.

**Workgroup on Value-Based Payment Initiatives and Physician-Led Community Health Care Delivery Models**

The board requested appointment of the workgroup in 2018 and charged it with the following goals:

- Support implementation of community-based health care delivery models and collaborate with county medical societies to advocate for the adoption of such models;
- Survey Texas' value-based payment landscape, particularly pertaining to models serving low-income, uninsured, or other vulnerable populations;
- Develop TMA policy, education, and toolkits not only to spur formation of physician-led, community-based organizations but also to help physicians who serve low-income populations successfully transition their practices to participate in new payment arrangements; and
- Advise the TMA-Texas Hospital Association Task Force on Medicaid Physician Payments and Accountable Care on formation of regional, risk-based, community-care collaboratives that may become the underpinnings of the state’s efforts to amend and extend the Medicaid 1115 waiver.

Per the board’s direction, the workgroup consisted of the chairs or designees of TMA councils and committees with overlapping interest in the workgroup’s charge and representatives from large county medical societies with an interest in advancing local community-based ACOs. TMA Trustee Sue Bornstein, MD, chaired the workgroup.

The workgroup met twice, with its work culminating in a report on the challenges facing physicians who care for vulnerable, uninsured Texans; an overview of Medicaid’s rapidly evolving value-based payment landscape; discussion of the benefits and drawbacks of Texas’ Medicaid 1115 Transformation Waiver; a high-level survey of existing community-based ACO activities; and a set of guiding principles for physicians seeking to develop or promote locally driven, community-based ACOs.

The workgroup went dormant for 11 months, largely due to the demands of the legislative session. However, in late 2019, the board revived the workgroup in response to the confluence of a number of advocacy, regulatory, and educational opportunities, including the impending cessation of Texas’ current Medicaid 1115 waiver and initiation of state planning for its replacement; proliferation of value-based payment models among Medicaid, Medicare, and commercial payers; increased interest in expanding use of value-based payment arrangements by policymakers and employers seeking constructive means to reduce health care costs; and a growing number of physicians participating in value-based payment arrangements.

Helping physicians transition successfully to and thrive within these models must be a priority for the association over the next several years.

The revived workgroup will continue where it left off:

- Survey Texas’ value-based payment landscape,
- Refine proposed community-based ACO principles to meet Texas’ diverse geographic and specialty needs,
- Develop a community-based ACO concept paper for consideration by the Texas Health and Human Services Commission (HHSC),
• Recommend potential educational, training, and technical assistance tools to help TMA members transition to and succeed in a value-based payment arena, and

• Identify potential value-based payment policy recommendations for consideration by the TMA House of Delegates.

Additionally, the workgroup will examine best practices for addressing social drivers of health within value-based payment arrangements. As health care costs continue to rise, there is considerable interest in whether better management of nonmedical factors, such as food security, safe housing, care coordination, and transportation, can help bend the cost curve while also improving health outcomes. As a result, community-based entities must evaluate how to incorporate such services into their models in a way meaningful to patients without creating undue burden or additional costs for physicians.

Caring for Vulnerable Patients – Texas’ Landscape

According to the September 2019 Census Bureau report, Texas’ overall poverty rate dropped modestly in 2018, from a two-year average of 14.3% (2015-16) to 13.7% (2017-18). The national average is 12.3%. For a family of four, this means living on an annual income of about $33,000. Yet, a growing body of evidence shows that living in poverty contributes to poorer health outcomes. Social drivers of health – access to safe, affordable housing; reliable transportation; and nutritious foods – play a major factor. So does the lack of health care coverage. From 2013 to 2016, Texas’ rate of uninsured dropped considerably, from 22.1% to 16.6%. But in 2017, the trend took an unfortunate U-turn. Today nearly 5 million Texans – 17.7% – lack coverage, double the national average. Some one-third of parents earning less than 138% of the federal poverty level ($46,575 for a family of four) lack health care coverage. One out of five uninsured children in the country live in Texas, though most are eligible for Medicaid or the Children’s Health Insurance Program. And among low-income women, 25% lack comprehensive health insurance coverage.

Going without health care coverage can have serious health consequences. Patients without coverage are less likely to receive cost-saving preventive, primary, and specialty care. Early identification and treatment of chronic illnesses like high blood pressure or diabetes can greatly reduce the likelihood of serious illness, yet without affordable health coverage, patients, particularly low-incomes ones, often forgo treatment. Uninsured people are up to four times more likely not to have a regular source of health care, often relying on overcrowded emergency departments for basic medical services. Moreover, being uninsured exposes individuals to the potential for catastrophic financial loss if unexpected medical care should arise, as in the case of a car accident or a cancer diagnosis.

By law, Texas counties must provide indigent health care. Yet the magnitude of uninsured Texans strains community resources, resulting in an overall economic impact felt by everyone. Large urban communities, with larger tax bases, fund hospitals and health systems to provide health care to the uninsured. But this also means taxpayers in these communities defray the rising costs of this care through increased property taxes. Business owners experience rising health insurance premiums to maintain health insurance benefits for their employees, thereby impacting their bottom line. Individuals who do not have access to health insurance from their employers find only unaffordable monthly premiums when shopping for health plans.

Federal dollars remain available to Texas to extend coverage to the working poor. To date, Texas has elected to forgo these funds, though 36 other states, including Arkansas, Indiana, Ohio, and Utah, have accepted the federal funds. However, in late January 2020, the Centers for Medicaid & Medicare Services announced a new initiative called the Healthy Adult Opportunities – a block grant for the so-called...
Medicaid expansion population – that might entice Texas to pursue coverage for this population. As of this writing, TMA is evaluating the implications of the program.

Regardless of whether Texas pursues coverage for low-income, uninsured adults, Texas counties must find new ways to deliver affordable, effective care at a more affordable cost.

**Future of the Texas Medicaid 1115 Transformation Waiver**

Texas’ Medicaid 1115 Transformation Waiver will expire September 2022, resulting in the loss of billions of needed federal dollars unless Texas obtains a new waiver. Under the waiver terms and conditions, the Texas Health and Human Service Commission must develop a waiver transition plan, including opportunities for future waiver proposals. TMA learned in a recent meeting with HHSC that the current waiver, as designed, will not continue. However, HHSC and CMS have begun exploring new waiver opportunities, including targeted coverage initiatives for certain low-income Texans, such as those with chronic diseases or severe behavioral health disorders. At the meeting TMA and specialty society leadership offered the community-based ACO concept as a potential framework for organizing any new waiver – an idea the agency liked. HHSC invited TMA to more fully design the concept and submit a concept paper to it by next summer.

TMA has strongly supported Texas’ waiver since its inception in 2011 and continues to do so. Undoubtedly, thousands of low-income Texans have benefitted from it. The waiver has:

- Stabilized financial solvency for safety net hospitals, particularly rural hospitals;
- Expanded availability of behavioral health care;
- Allowed Texas to test innovative health care delivery models to determine what models will work or not, such as medical home programs designed to increase use of prenatal care or to better serve children and adolescents with special health care needs; and
- Improved access to health and dental care services for low-income, uninsured Texans.

Yet, the current waiver design also has a fundamental flaw – namely, a hospital-centric approach to organizing health care delivery rather than a community-focused one. As HHSC evaluates the future of the waiver, TMA has strongly advocated for designing a new approach that will more fairly distribute funding throughout the health care delivery system, including to community-based physicians unaffiliated with hospitals or academic health systems. These physicians have no means to participate in innovative health care delivery models or funding despite also playing a vital role in the care of low-income patients.

Finding physicians who will care for Medicaid patients is a daily struggle across the state, though the situation is far worse in underserved communities. Most of Texas Medicaid’s physician fee-for-service payment rates – which are what most Medicaid managed care organizations pay physicians, too – have not received a meaningful, *enduring* increase in more than two decades.¹

For any future waiver, there must be an inclusive, community-based approach, such as establishment of a “medical neighborhood” or community-based ACO that will allow all physicians, hospitals, and providers who treat Medicaid and low-income, uninsured Texans to participate, regardless of their affiliation with a particular system.

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¹ In 2007, lawmakers allocated funds to increase payment rates for select preventive health services for children, including well-child visits. From 2013 to 2014, federal funding temporarily boosted select primary care physician payment rates to Medicare parity.
Primary care physicians, in particular, are the foundation of a robust, cost-effective health care delivery system. Studies show that systems built around a strong primary care model have better health care outcomes, higher patient satisfaction, and lower costs. If a future waiver request doesn’t benefit the array of primary care practices — hospital-affiliated or not — Texas’ primary care system will wither, impacting all Texans.

In addition to finding a fairer funding mechanism for any future waiver, TMA supports using any new waiver as a means to achieve two other vital goals: (1) reduce the number of Texans without health insurance and (2) implement innovative strategies to address the nonmedical factors that impact health care outcomes and costs.

Ultimately, all Texans benefit when their neighbors, colleagues, family, and friends have health care coverage. Insured children are healthier children, missing less school and contributing to their future socioeconomic success. Insured parents miss less work, increasing economic productivity, a win for employers and the state economy. Insured women have healthier pregnancies and maternal and infant health outcomes, reducing Medicaid costs. And more insured Texans contribute to lower health care premiums for everyone.

**Community Solutions**

Across Texas, physician leaders have devised or informed the creation of new health care delivery models organized to provide more efficient and effective health care for the uninsured. Several hospital associations and health-care foundations also have designed community-based initiatives. Examples of models include:

- **Project Access Dallas (discontinued):** This initiative connected physicians to low-income and uninsured patients to provide patient-centered care within an office setting. Important collaborations with local hospitals, businesses, and faith-based community organizations enabled Project Access to provide comprehensive primary care, access to specialists, hospital care, prescription drugs, and social services at minimal cost to eligible patients. In 2013, Dallas County Medical Society discontinued Project Access because of funding changes related to the Texas 1115 Medicaid waiver.

- **911 Telehealth Triage:** Developed with input from Harris County Medical Society, this program connects Harris County 911 callers with local clinics and physician services to reduce inappropriate ambulance dispatches and emergency department use for conditions better treated within a physician office.

- **Project Access Travis and Tarrant counties (extant):** Both models provide coordinated care for low-income residents by connecting patients with volunteer physicians from a range of specialties.

- **Travis County Community-Care Collaborative:** Operated by Central Health, the local hospital district, this program works through a network of clinics, system-affiliated physicians, and private physician practices to connect uninsured, underinsured, and low-income residents to high-quality, low-cost health care.

- Outside of organized medicine, several groups are also working on models to address the health care needs of low-income Texans. The Teaching Hospitals of Texas, with input from TMA and other physician organizations, modeled a new program called TCARE (Texas Community Access, Reform, and Engagement). This model sustains and redirects some federal funds into physician and community systems. It includes incentive payments to physicians and providers as well as per-member per-month care management fees, behavioral health care management, and performance sharing. The proposal embraces local innovation predicated on the involvement of public and private physicians.
There also is budding interest among the state’s executive leadership and rural lawmakers to revisit the dormant, but visionary, Rural Community Health System (RCHS) statute, which more than 20 years ago authorized formation of a community-led insurance entity. TMA, the Texas Academy of Family Physicians, and the Texas Organization of Rural and Community Hospitals helped design the model as a means for rural physicians and hospitals to better compete in a swiftly evolving Medicaid and commercial health care delivery landscape. Back then, RCHS was ahead of its time. Health plans refused to contract with it, and its community-led board eventually disbanded. But today it is a potential vehicle for rural physicians and hospitals to organize into community-led systems of care.

There is undeniable interest among community leaders and policymakers in developing local delivery systems for vulnerable patients. However, devising a single blueprint for the design and implementation of these models is challenging because of the variation in communities’ size, resources, and demographic characteristics. After reviewing extant, emerging, and discontinued community-based initiatives as well as out-of-state community-based ACOs, the workgroup identified key characteristics and principles critical to building and maintaining a successful community-based accountable care organization.

To succeed, community-based ACOs should adhere to the following principles:

- Ensure the establishment of a community-based board to govern the entity, comprising diverse representatives from primary care and specialty physicians, public and private hospitals, health care providers, social service agencies, faith-based and community organizations, and community members;
- Articulate a clear mission and vision and the ACO’s short-term and long-range community goals;
- Engage local physician leaders with a mix of practice size and employment status in the model’s design and implementation to ensure widespread support and participation;
- Foster transparent governance, decision-making processes, and operations to nurture and sustain trust among all stakeholders and funding entities;
- Foster initiatives to proactively address health disparities, including outreach and engagement of community leaders;
- Partner with local public health departments and social service organizations, such as food banks and affordable housing programs, to address social determinants of health that contribute to poorer health outcomes;
- Build and maintain robust physician and provider networks that include private practice physicians, employed physicians (e.g., those who work for federally qualified health centers or hospital systems), and other key partners – hospitals, post-acute care providers, and so forth;
- Establish competitive, fair, and reasonable payment rates for physicians and providers while also using population-health payment models that reward improved patient outcomes and practice transformation;
- Establish realistic, standardized, actionable, and validated performance measures;
- Leverage all available funding streams to support the ACO, including public and private payers as well as grants;
- Engage Medicaid managed care organizations serving Medicaid patients within the community to develop collaborative models; low-income patients frequently transition between having Medicaid coverage and being uninsured (e.g., Medicaid covers pregnancy for low-income women, but that coverage ends 60 days postpartum), so it is essential they have the opportunity to participate in an organized system of care regardless of insurance status;
- Establish a robust and meaningful health information exchange for both clinical and social service information exchange, using the latest technological tools to ensure seamless patient navigation.
across the network, reduce costs by eliminating redundant tests or procedures, and maintain a high
degree of population health metrics and evaluations;

- Ensure primary care is the cornerstone of each ACO network, and locate patient-centered primary
care sites in historically medically underserved areas to ensure ready access to services for eligible
patients;
- Ensure participating physicians retain their independence to advocate on behalf of their patients’
health needs;
- Incorporate patient risk assessment into the ACO’s essential activities to help participating physicians
more quickly identify and address patients’ medical and social needs that impact health quality,
outcomes, and costs;
- Ensure that care coordination is a core function of the ACO to ensure participating physicians can
quickly and easily facilitate referrals to medical, social, and supportive services based on a patient’s
individual needs;
- Build partnerships with state agencies and local social service entities, such as food banks, to allow
the ACO-participating physicians to easily and quickly obtain nonmedical interventions for patients; and
- Engage physician practices regardless of their degree of practice transformation, particularly in the
early stages of an ACO’s formation, while promoting activities that support practice evolution.

**Action**

Because TMA’s mission is to represent the voice of all Texas physicians, whose vision is health
improvement of all Texans, TMA is in a strategic position to introduce and advocate for the necessary
policy changes to promote sustainable health care financing and delivery systems for Texas. A
community ACO can reduce the “cost transfers” of uncompensated health care, address the health care
needs of historically marginalized populations, reduce the need for more complex and expensive health
care, and create a sustainable delivery and financing model for Texas.

Furthermore, as Texas explores options to transition from the current Medicaid 1115 Transformation
Waiver to a new one, Texas will need to submit a compelling, innovative health care delivery model to
CMS to gain approval. The community-ACO model fits that criteria by promoting a proactive, integrated,
transparent, and cost-effective approach to improving patient health outcomes.

**Recommendation 1:** That the Texas Medical Association adopt the following Principles for
Community-Based Accountable Care Organizations:

**Principles for Community-Based Accountable Care Organizations**

- Require establishment of a community-based board to govern the entity, composed of diverse
representatives from primary care and specialty physicians, public and private hospitals, health care
providers, social service agencies, faith-based and community organizations, and community
members.
- Articulate a clear mission and vision and the ACO’s short-term and long-range community goals.
- Engage local physician leaders with a mix of practice size and employment status in the model’s
design and implementation to ensure widespread support and participation.
- Foster transparent governance, decisionmaking processes, and operations to nurture and sustain trust
among all stakeholders and funding entities.
- Implement initiatives to proactively address health disparities, including outreach and engagement of
community leaders.
• Partner with local public health departments, state agencies, and social service organizations to address nonmedical factors, such as food and housing insecurity, that contribute to poorer health outcomes and to connect eligible low-income patients to available services.

• Build and maintain robust physician and provider networks that include private practice physicians, employed physicians (e.g., those who work for federally qualified health centers or hospital systems), and other key partners — hospitals, post-acute care providers, and so forth — with any interest in serving the population.

• Establish competitive, fair, and reasonable payment rates for physicians and providers while also using population-health payment models that reward improved patient outcomes and practice transformation.

• Establish realistic, standardized, actionable, and validated performance measures and ensure that measures are periodically reviewed to confirm their continued relevance and utility.

• Leverage all available funding streams to support the ACO, including funding from public and private payers as well as foundation and community grants.

• Engage Medicaid managed care organizations serving Medicaid patients within the community to develop collaborative models. Low-income patients frequently transition between having Medicaid coverage and being uninsured (e.g., Medicaid covers pregnancy for low-income women, but that coverage ends 60 days postpartum), so it is essential they have the opportunity to participate in an organized system of care regardless of insurance status.

• Establish a robust and meaningful health information exchange for both clinical and social service information exchange, using the latest technological tools to ensure seamless patient navigation across the network, reduce costs by eliminating redundant tests or procedures, and maintain a high degree of population health metrics and evaluations.

• Ensure primary care is the cornerstone of each ACO network, and locate patient-centered primary care sites in historically medically underserved areas to ensure ready access to services for eligible patients and to address health equity.

• Ensure participating physicians retain their independence to advocate on behalf of their patients’ health needs.

• Incorporate patient risk assessment into the ACO’s essential activities to help participating physicians more quickly identify and address the medical and social needs that impact a patient’s health quality, outcomes, and costs;

• Make care coordination a core function of the ACO to prevent gaps in care by allowing participating physicians and providers to quickly and easily obtain assistance in arranging and coordinating a patient’s medical, social and long-term care services.

• Engage physician practices regardless of their degree of practice transformation, particularly in the early stages of an ACO’s formation, while promoting activities that support practice evolution.

**Recommendation 2:** That the Texas Medical Association actively promote use of a community-based accountable care organization(s) as the foundation of any future Medicaid 1115 waiver.
REPORT OF COUNCIL ON HEALTH SERVICE ORGANIZATIONS

Subject: Sunset Policy Review

Presented by: Hattie E. Henderson, MD, Chair

Referred to: Reference Committee on Socioeconomics

The Texas Medical Association periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness.

The Council on Health Service Organizations recommends retention of the following policy:

**85.012 Advance Directives:** The Texas Medical Association encourages physicians who staff hospitals to attempt to obtain appropriate advance directives before discharging a patient (CM-EMS Rep. 4-A-00; reaffirmed CHSO Rep. 1-A-10).

**20.005 Long-Term Care Insurance:** The Texas Medical Association will develop an educational awareness program for physicians relevant to evolving federal laws and regulations on the benefits of long-term care insurance and the inadequacy of Medicare and Medicaid for that purpose (Substitute Committee on Aging and Long-Term Care, p 68, I-96; amended CHSO Rep. 1-A-10).

**260.001 Infectious Waste Management:** The Texas Medical Association, through the American Medical Association, supports the use of the Centers for Disease Control and Prevention’s standard precautions and the Environmental Protection Agency’s Model Guidelines for State Medical Waste Management as models for other federal agencies’ rules, and opposes adoption of rules that conflict with these generally accepted standards (Council on Health Facilities, p 105, A-90; amended CM-ID Rep. 2-I-00; reaffirmed CHSO Rep. 1-A-10).

**Recommendation 1:** Retain.

The Council on Health Service Organizations recommends amending of the following policy:

**115.010 Hospitalists:** The Texas Medical Association opposes the mandatory use of hospitalists proposed by health plans, institutions, or other entities, continues to support the voluntary use of hospitalists as deemed appropriate by physician-led policymaking bodies advising health plans, institutions, and other entities, and will continue to monitor hospitalist programs and assist members in dealing with the business and practice impacts associated with the use of hospitalists (Amended CSE Rep. 8-A-99; reaffirmed CSE Rep. 1-A-10).

**Recommendation 2:** Retain as amended.
The Council on Socioeconomics recommends retention of the following policies:

30.007 **Prescribing by Pharmacists**: The Texas Medical Association reaffirms its position in opposition to independent prescribing by pharmacists. TMA affirms its readiness to work with the Texas Pharmaceutical Association and the American Medical Association to review prescription drugs for appropriate transfers to “over the counter” status (Board of Councilors, p 44, A-93; reaffirmed BOC Rep. 5-A-10).

145.007 **Competitive Insurance Models**: A system of health care delivery free of burdensome and unnecessary government regulations is a goal which all patients and physicians should support. No national competitive health insurance model should be implemented irrevocable prior to pilot test studies which would identify and minimize problems of any new system. The Texas Department of Insurance should control the state’s insurance industry and its insurance policies and programs. Health care expenditures should remain tax deductible (Council on Socioeconomics, p 177, I-94; amended CSE Rep. 1-A-10).

145.011 **Plan Responsibility for Patient Education**: For the benefit of patient understanding, state health plans and insurers should use plain language in information on plan operating policies and procedures (Res. 411-A-99; reaffirmed CSE Rep. 1-A-10).

145.013 **Private Healthcare System Impact of Uninsured**: The Texas Medical Association supports continued efforts to address the issue of health care for the uninsured including input from all segments of the association with an emphasis on private sector solutions (Sub. Res. 403-A-99; reaffirmed CSE Rep. 1-A-10).

145.014 **Texas Department of Insurance**: The Texas Medical Association supports continued efforts to fund the Texas Department of Insurance (TDI) adequately and require that TDI resolve complaints and ensure insurance companies pay claims within the state-mandated statutory time frame (Amended Res. 406-I-00; amended CSE Rep. 1-A-10).

155.006 **Laboratory Personnel**: All clinical laboratory personnel should remain under the control and supervision of a physician (Council on Socioeconomics, p 179, I-94; reaffirmed CSE Rep. 1-A-10).

170.007 **Professional Liability**: To ensure access to medical care for Texans, the Texas Medical Association will continue efforts to (1) reduce or limit frivolous professional liability claims; (2) continue to examine the causes of claims frequency; (3) monitor claims data collected by the Texas Department of Insurance and the Texas Medical Board and make the aggregate data available to the membership; (4) advocate for judicial enforcement of current expert witness and cost bond provisions; and (5) allow the right to countersue (Substitute Res. 102, 103, 108-I-00; amended CSE Rep. 1-A-10).
Managed Care Truth in Advertising Standards: The Texas Medical Association favors legislation which would provide that managed health care plans in Texas meet high standards of truth in advertising and legal safeguards to assure that high quality medical care is not compromised by deceptive marketing activities, unsubstantiated claims about so-called “quality assurance” activities, and disruptive precertification and concurrent review practices (Resolution 27L, p 189, A-90; reaffirmed CSE Rep. 1-A-10).

Health Insurance Plans: The Texas Medical Association approves continued aggressive advocacy for members in dealing with health insurance plan issues and will expand where appropriate its cooperative, collaborative initiatives with health insurers to address issues and problems of mutual concern (BOT Rep. 22-A-99; amended CSE Rep. 1-A-10).

Prompt Payment of Claims: The Texas Medical Association reaffirms ongoing efforts through the TMA Hassle Factor Log initiative, carrier meetings, and regulatory advocacy to address the growing problems medical offices are encountering in obtaining prompt and appropriate payment and continues to support legislative initiatives directed towards streamlining and simplifying health plans' claims processing and administrative requirements (Sub. Res. 405-A-99; amended CSE Rep. 1-A-10).

Medicaid Reimbursement for Rehabilitation: The Medicaid program should provide payment for inpatient and outpatient rehabilitation services provided by community rehabilitation hospitals for treatment of persons aged 21 through 64 who suffer a major trauma or illness (CM-R Rep. 1-A-00; amended CSE Rep. 1-A-10).

Medicare Reform: Because the existing Medicare program has evolved into an overly complex, under-funded system, the Texas Medical Association agreed to seek an honest consensus to address current problems, explore ways to reduce the complexity of regulations, address the program’s “hassles,” develop a plan for future beneficiaries, explore funding alternatives, and examine long-term needs of the Medicare-eligible population (Res. 28U, p 167, A-91; reaffirmed CSE Rep. 1-A-10).

Medicare Payment Localities: The Texas Medical Association supports changes to Medicare payment locality boundaries so that they are defined to reflect measurable differences in local economic conditions and are updated at least every five years to reflect changes in those conditions. Reliance on Metropolitan Statistical Area boundaries and updates would meet this condition. TMA supports, where necessary, revision of federal administrative rules to accommodate locality boundary changes. When locality boundaries have not been updated for more than five years and the needed changes would result in significant fee cuts for some physicians, the Texas Medical Association favors locality revisions that include payment increases sufficient to assure that physicians in revised localities do not suffer fee cuts (CSE Rep. 2-A-10).

Health Savings Accounts for Medicare Beneficiaries: Medicare beneficiaries should be permitted to make tax-free contributions to health savings accounts (Res. 401-A-10).

Active Duty Physicians: The Texas Medical Association supports advocacy on the federal level for adequate compensation for both active duty and reserve physicians to ensure that medical care is available for our military forces (Resolution 27U, p 181B, I-90; amended CSE Rep. 1-A-10).
235.032 Payment for Services Provided to County Indigent Patients: When patients who have a payer, including all county indigent health care programs, are provided care, the payer should be responsible for paying for services (Res. 413-A-10).

240.019 Medicare’s Elimination of Payments for Consultation Codes: The Texas Medical Association opposes all public and private payer efforts to eliminate payments for inpatient and outpatient consultation service codes and supports legislation to overturn the Centers for Medicare and Medicaid Services action that eliminated payments for consultation codes (Res. 410-A-10).

240.020 Deactivation of Medicare Billing Privileges: Lack of Appeal Rights and Harsh Adverse Effects on Physicians: It is Texas Medical Association policy that (1) physicians who legitimately render services to Medicare patients be paid at their current practice’s geographic index without disruption, allowing for backdating the reactivation of the privilege to bill for Medicare and Medicaid covered services to eligible patients; (2) physicians be provided due process and appeals process in order to be compensated for care actually provided to Medicare or Medicaid patients when their billing privileges are deactivated such as for failure to notify the Medicare or Medicaid carrier of change of office address using the proper Centers for Medicare & Medicaid Services (CMS) form; and (3) access issues for Medicare beneficiaries be considered before similar CMS regulations are created (Res. 414-A-10).

265.010 Medical Care Guidelines: The Texas Medical Association opposes the use of so-called medical care guidelines (including, but not limited to, those published by Milliman & Robertson) that are based on economic data rather than evidence-based, scientifically sound medical data (Res. 402-A-00; reaffirmed CSE Rep. 1-A-10).

265.011 Medical Record Review: Health plans and insurance companies should be required to provide patients and physicians a minimum of two weeks’ notice of an impending review. Appropriate limits should be placed on such reviews (Amended Res. 402-I-00; reaffirmed CSE Rep. 1-A-10).

Recommendation 1: Retain.

The Council on Socioeconomics recommends amending of the following policies:

65.009 CMS Evaluation and Management Services Documentation Guidelines: The Texas Medical Association supports the following essential principles regarding the Center for Medicare & Medicaid Service’s (CMS’s) E & M documentation guidelines: (1) AMA Policy (H-330.920 and 921) should be strongly reaffirmed. That policy includes opposition to inappropriate “quantitative formulas” or assignment of “numeric values” to determine medical record keeping; unfair fraud and abuse penalties for disagreements in E & M code assignments; and repayment of “alleged Medicare overpayments” without fair due process; (2) CMS should not focus on counting methodologies or numerical formulas as the primary reason for medical record documentation. Documentation should serve the interests of good patient care and the integrity of the patient-physician relationship before any auditing or program integrity objectives are considered; (3) Focused medical review should be the sole focus of CMS audit and outlier review programs. Random audits, conducted in addition to medical reviews indicated by analysis of Medicare claims data, should not be the focus of CMS’s audit function. Such reviews are unnecessarily intrusive in physicians’ practices and are an inefficient use of taxpayer dollars; (4) Medical decision-making should be
emphasized much more than is presently the case in either the 1995 or 1997 “revised”
guidelines; and (5) Any proposed guideline that serves to criminalize the patient-physician
encounter should be vigorously and thoroughly opposed (Amended CSE Rep. 13-I-98;

110.007 **Cost Containment:** Members of the Texas Medical Association are encouraged to voluntarily
evaluate their practice patterns to further reduce and improve utilization of expensive hospital
and ambulatory services and to control costs. Insurance companies and fiscal intermediaries
are encouraged to support cost containment and cost-effective care by recommending use of
the least expensive setting in which a procedure can be performed safely and effectively.
Third-party payers should provide payment should cover not only for professional services,
but for also all other practice expenses costs incurred in physicians’ offices (such as surgical
trays, sterile draping, and necessary supplies). Duplicate laboratory procedures and tests
should be eliminated (Council on Socioeconomics, p 177, I-94; amended CSE Rep. 1-A-10).

145.012 **Health Insurance Individual Ownership:** The Texas Medical Association supports
operational strategies that provide control of health care purchasing and financing to
individual patients, efforts that focus on strategies that offer equal tax deductibility to persons
who purchase individual policies, the use of health savings accounts with tax-deductible
contributions, and consumer choice provisions as modeled by the Federal Employees Health
Benefits Program and believes that these efforts include a study of the issue of individually
chosen, individually purchased basic health insurance with a system of premium support for
the uninsured and lower income wage earners (Amended Res. 413-A-99; amended CSE Rep.
1-A-10).

190.019 **Medicaid and Medicaid Managed Care:** The Texas Medical Association (1) advocates for
Medicaid managed care reform including administrative simplification, protection of the
Primary Care Case Management model, and continuation of the moratorium on new Medicaid
managed care service areas until such time that current operational, administrative, and
payment problems can be resolved; and (2) continues to explore development of alternative
care delivery models for Medicaid managed care that incorporate the following principles: (a)
patient access to a medical home; (b) access to prescription drugs; (c) evidence-based health
and disease management for high-risk, chronically ill, patients and patients with disabilities
disabled patients; (d) a flexible delivery system design to accommodate Texas’ diverse care
delivery systems and geography; (e) physician-driven, clinically appropriate quality and
utilization management systems; (f) simplified administration and claims payment processes;
and (g) competitive payment that reflects the rapidly increasing practice costs of physicians
who care for this patient population (Amended CSE Rep. 3-I-00; amended CSE Rep. 1-A-10).

235.030 **Increase in Statewide Reimbursement Payment for After-Hours Care:** The Texas Medical
Association continues to propose that support payment revisions to the Texas HHSC Medicaid
fee schedule to allow Medicaid fee-for-service payments for CPT codes 99050 and 99051,
pay physicians for after-hours, non-emergency care codes, when physicians provide after-
hours care within their offices 99050 and 99051 (Res. 403-A-10).

**Recommendation 2:** Retain as amended.
At TexMed 2019, the House of Delegates adopted Resolution 414-A-19, Studying Financial Barriers of Rural Hospitals, from the Medical Student Section, calling on the Texas Medical Association to research the root causes of rural hospital closures in Texas. Resolution 414 identified financial barriers as a main reason for rural hospital closures, but asked TMA to identify these causes more specifically in addition to studying the impact hospital closures have on rural communities and economies. Testimony emphasized that a rural hospital’s closure impedes rural patients’ ability to obtain timely access to care; decreases the community’s ability to recruit and retain physicians, nurses, and other health professionals as well as other employers; and diminishes the ability for rural communities to sustain a tax base sufficient enough to support other community and social services.

Although TMA and the American Medical Association already support and advocate for initiatives to ensure the financial integrity of rural hospitals, testimony from the Medical Student Section expressed concerns regarding the record number of hospital closures in Texas and requested more detailed research and support from TMA to mitigate this problem. The students questioned why Texas is the state with the highest number of rural hospital closures since 2010, given that facilities are purportedly reimbursed “allowable costs.” Moreover, the testimony also pondered if rural hospitals’ inability to negotiate reasonable payment rates with health insurance plans partly explained the financial challenges of so many rural hospitals. Testimony specifically asked for TMA to further research the Texas Health and Human Services Commission definition of “allowable cost” and “rural hospitals,” and the minimum net revenue needed to keep rural hospitals’ doors open.

National Policy Landscape

In the United States, more than 119 rural hospitals have closed since 2010. Texas leads the nation with 29 closures in this period.\(^1\) Although state and national policy leaders, lawmakers, and researchers have focused more attention on the issue in recent years, it is not new. According to the U.S. Department of Health and Human Services’ Office of Inspector General (OIG), the pattern began after the Prospective Payment System (PPS) was implemented in 1983.\(^2\) OIG conducted a study on closures annually from the late 1980s through the 1990s after this factor was identified.\(^3\)“As the rate of hospital closures increased throughout the 1990s, studies consistently found that smaller hospitals were more likely to close, putting rural hospitals at greater risk for closure.”\(^4\)To try to protect the smallest facilities, Congress established the Critical Access Hospital (CAH) program in 1997, ensuring hospitals meeting rural hospital criteria are paid on a reasonable cost basis for inpatient and outpatient services.\(^5\) These criteria include having 25 or fewer inpatient beds, providing 24/7 emergency services, meeting average length-of-stay requirements for acute care, and existing more than 25 miles from another hospital.\(^6\) Then, in the 2000s the rate of closure slowed, and interest waned until recently. The Affordable Care Act’s (ACA’s) replacement of disproportionate-share hospital (DSH) payments with Medicaid expansion coincided with an increase in rural hospital closure. However, the longevity of the issue is evidence that one piece of recent legislation cannot be the only problem.\(^7\)
A state’s decision whether to expand Medicaid to low-income, uninsured adults as authorized by the Affordable Care Act is highly correlated with rural hospital closure. In the context of the national rate of rural hospital closure, “the annual unadjusted hospital closure rate, measured as the number of closures per 100 hospitals, declined in both expansion and non-expansion states as the United States emerged from the 2008-09 Great Recession. Between 2010 and 2012, closure rates were nearly identical in the two groups of states.” However, beginning in July 2012, clear differences emerged between expansion and non-expansion states. Under the ACA, DSH payments were phased out in anticipation of hospitals having fewer uninsured patients. In 1981, DSH payments were implemented to offset the costs that hospitals incurred from a high payer mix of uninsured and Medicaid patients. Making matters worse, the 2% decrease in Medicare payments due to sequestration and the Budget Control Act of 2011 creates losses for public, rural hospitals that depended on federal dollars to make up a share of their revenue. Although some analysts attribute rural hospital closures to poor management, state and national policies can create difficult financial circumstances regardless of administrative choices.

National Financial and Market Statistics

A main question of this report is the financial circumstances that lead to closure. A study conducted in 2016 by the North Carolina Rural Health Research Program, Cecil G. Sheps Center for Health Services Research (a main source of information for this topic on a national scale), analyzed the financial performance and market statistics of rural hospitals that closed between 2010 and 2014 compared with those that remained open. Operating and total margin for hospitals that closed in this time frame was significantly lower (5% to 9%) in 2009 than for those that stayed open. “The median closed hospitals had a substantial negative operating and total margin, while the median open hospitals had a small positive operating and total margin.” Lower hospital liquidity is also associated with rural hospital closure, as closing CAHs and other rural hospitals (ORHs) had enough cash on hand to keep doors open for 14.67 and 8.33 days, respectively. Current ratio, or the number of times short-term liabilities can be paid with short-term assets, is also significantly lower for closed hospitals. Closed hospitals also had higher debt levels in 2009 than hospitals that stayed open during the 2010-14.

Hospitals can make more profit with procedures that keep the patient in the hospital longer, while outpatient dollars reap less benefit for the institution. Medical advances are increasing the number of outpatient procedures, thereby straining hospitals to find profits. This pattern is taking its toll on rural hospitals, as “outpatient to total revenue (the percentage of total revenues for outpatient services, including Rural Health Clinics, free-standing clinics, and home health clinics) was significantly lower in closed CAHs than in open CAHs.”

The daily census in ORHs that closed was also significantly lower, meaning more beds went empty and money was wasted on keeping lights on in larger facilities than necessary for daily use. The acute average daily census in these facilities was 8.5 patients. The number of full-time employees was also significantly lower in ORHs that closed than in open ones, as were workers’ salaries. Also, Medicare inpatient payer mix, or the percent of patients using Medicare, was significantly higher in ORHs that closed. Although the North Carolina Rural Health Research Program study focused on financial factors, it also acknowledges that “hospital factors associated with rural hospital closures include poor financial health, aging facilities, low occupancy rates, difficulty recruiting and retaining health care professionals, fewer medical services, and a small proportion of outpatient revenue.”

In addition to the financial data linked to closure, the committee studied the market that closing rural hospitals serve. The Medicare inpatient mix explains the populations that rural hospitals serve and the public policies regarding payment that affect these hospitals most. “Odds of unprofitability increase with proportion of residents over age 65, proportion of households in poverty, and decreased population density. An increase in total population of 10,000 reduces odds by 4%.” People living in rural areas are generally more expensive as patients because they experience higher rates of obesity, tobacco use, and
chronic disease, report fair to poor health, and/or have a greater number of potential years of life lost. Communities served by rural hospitals are more likely to be unemployed and uninsured, meaning a higher rate of poverty and a higher population of patients entering hospitals using Medicaid or having no insurance. This means rural hospitals proportionally accrue more debt caring for patients without insurance and by caring for patients with Medicare and only making 98 cents on the dollar due to Medicare payment reduction from sequestration efforts. The North Carolina Rural Health Research Program, discussed above, cites higher poverty rates in the South as a possible reason why this region experiences more hospital closures than other regions, at 64% of hospitals.

**Closure’s Impact on Patients**

Hospitals play a key role in rural economies as they can employ hundreds of residents and bring in significant revenue. Studies show that “if the 673 financially vulnerable hospitals [in the U.S.] closed, rural patients would need to seek alternatives for 11.7 million hospitals visits, 99,000 health care workers would need to find new jobs, and $277 billion in GDP would be lost.” High-paying jobs disappear, and it becomes more difficult for other local industries to recruit workers to a location without a hospital.

Emergency services would be significantly harder for rural patients to access as well. The time it would take to travel to the closest hospital can be detrimental to patients given the critical need for life-saving treatment for a “heart attack, stroke, anaphylactic allergic reaction, or complicated birth.” This may be why “60% of trauma deaths occur in rural America, even though only 20% of Americans live in rural areas.” The high, out-of-network costs of emergency helicopters also make the number of miles between a patient and the nearest emergency care essential to ensuring ambulances can bring a patient to care quickly.

Distance also hinders patients with chronic illnesses, like cancer, who must travel to hospitals for treatment on a regular, sometimes weekly basis. The cost of gasoline and car expenses to drive vast distances to the hospital and back in some cases makes care more inaccessible to rural patients.

Finally, the decreased profitability of rural hospitals due to the circumstances discussed makes it harder for these facilities to keep up technologically. Committee members agree that their patients often travel to larger, urban hospitals for care in order to access facilities that patients perceive as technologically savvy and of higher quality. Some patients would rather make a full-day trip across state lines to access more sophisticated treatments and equipment. These travel patterns are also caused by the physician shortage experienced in rural areas, as 125 of the 150 primary care health professional shortage areas (HPSAs) in Texas are rural or partially rural. Consequently, the Texas Organization of Rural & Community Hospitals acknowledges the low average daily census in Texas’s rural hospitals is a contributor to closure risk. Inaccessibility to care is a main reason why rural patients, especially in the South, lead in mortality rates for nearly all top-10 causes of death. According to the National Bureau of Economic Research, rural hospital closures contribute to mortality rates in surrounding areas rising nearly 6%.

**Addressing Physician Workforce Shortages**

Training rural physicians and expanding the workforce is critical to improving access to quality primary care and specialty care for rural patients. Infrastructure and health care cost affordability are also greatly influential, and a rural hospital cannot function without quality physicians, nurses, and other clinical staff. Texas needs an estimated 500 more primary care positions appropriately located in primary care HPSAs to remove all designations from the state. These physicians would need to be added to specific areas to meet the national shortage threshold for population-to-primary care physician ratio. The Texas Department of Health and Human Services estimates Texas could see a shortage of 3,375 primary care physicians by 2030, a 67% increase.
The committee determined that expanding efforts to recruit physicians to underserved areas should be further explored. TMA supports financial incentives for physicians who choose to practice in underserved areas, and medical schools’ development of programs increasing student exposure to primary care specialties, with state funding for such projects (Policy 185.001, Physician Workforce and Distribution).

Rural training tracks (RTT) are specifically designed to prepare physicians for the unique challenges of practicing in rural and isolated areas. These programs are a blend of the best of urban and rural training experiences and are structured to meet accreditation standards. Such programs in other states have demonstrated a high success rate, with 76% of participants in rural practice. Texas Tech University Health Sciences Center School of Medicine at the Permian Basin currently offers several family medicine rural training tracks. The University of Texas Health Science Center at Tyler also offers family medicine rural training tracks in East Texas.

Multiple state programs in Texas are designed to improve geographic distribution of physicians and enhance primary care access in underserved areas, but they are underfunded. Through House Bill 1065, a TMA bill, Texas established the Rural Resident Physician Grant Program in 2019 to encourage the creation of RTTs. A minimum of $1 million is necessary to start the program. In addition, the Texas Legislature reduced funding to the State Physician Educational Loan Repayment Program by a quarter in the 2018-19 budget. This funding cut prevents an estimated 94 physicians from receiving loan repayment funding each year. State funding for the Family Medicine Residency Program was cut 40% in the 2016-17 budget. In the 2019 legislative session, the Texas Higher Education Coordinating Board requested a partial restoration of $2 million, which TMA supported. The Texas Academy of Family Physicians sought $10 million in additional funding. No additional state funding was provided.

Discussion

Patients’ access to quality health care is of top concern to physicians. Ensuring rural hospitals stay open is integral to this issue, especially in the case of emergency, maternal, and chronic care. Part of the reason rural hospitals are struggling is a payment system causing them to take on bad debt to treat uninsured or underinsured patients instead of paying physicians for the care they provide to patients in the United States.

Texas is especially hard hit by the policies discussed above because it is a large, southern state, with numerous rural communities, and to date has chosen not to expand Medicaid. This means a large population of uninsured and underinsured patients increasing debt in rural hospitals. However, given that Medicaid expansion remains politically unpalatable for the state’s legislative leadership, it is important to discuss the numerous other national and state policy recommendations and community-driven initiatives that can help alleviate this issue.

Telehealth and broadband expansion are legislative priorities for Texas physicians hoping to bring health care access to patients in communities far from hospitals without asking them to sacrifice a day of work or the cost of driving significant distances to see a doctor. This is a major priority for the state, as eight bills passed in the 2019 legislative session regarding telemedicine, including measures to expand telemedicine coverage, allow telehealth to count towards hospitals’ neonatal and maternal level of care designations, and repeal outdated regulations. Telehealth training and capabilities for physicians are important in order to implement these initiatives on a local level. It is vital to note that these services can supplement, but do not replace, person-to-person health care. Many health systems mandate that a patient see a physician in person first to establish a relationship before moving to telemedicine communications. This solution, and the way health care systems and states around the country are using telemedicine, should be further explored. Ensuring the doctor-patient relationship is maintained and doctors are paid fairly for these services is essential.
Physician advocacy to promote fair payment for Medicaid services and Medicaid expansion can help prevent further rural hospital closures in Texas. The involvement of doctors in the implementation of programs that can alleviate the pressure hospital closure puts on communities can help keep care accessible and lessen the blow these changes have on rural economies.

**Conclusion**

There are two schools of thought when approaching the rural hospital closure crisis. The first is to find ways to save the local hospital, while another is to implement a sustainable alternative. This report takes the position that these approaches are not mutually exclusive. Recommendations discussed are intended to put hospitals in a better financial position, examine common hospital alternatives, and explore ways to reform the definition of a hospital to serve rural communities in a cost-effective manner.

Due to the demographic composition of many southern rural communities, with increasing levels of unemployment and poverty, the committee’s research showed that the percent of uninsured patients is higher in rural hospitals. As is well known, when patients come to the hospital for emergency care, federal law obligates the hospital to treat them regardless of their ability to pay, often resulting in bad debt for the hospital. Expanding Medicaid to increase health care coverage for those too poor to pay and who do not qualify for Texas Medicaid could decrease the debt taken on by rural hospitals and prevent closure. Multiple studies reviewed in this report showed that rural hospital closure in expansion states is significantly less frequent than in nonexpansion states. A 2016 study from the *Journal on Rural Health* states, “We posit that the primary mechanism that underlies the relationship between hospital closures and Medicaid expansions is the substitution of utilization by patients with Medicaid coverage for utilization by uninsured patients. The financial benefit from this shift in utilization improved hospitals’ financial margins and enabled them to remain in business. We also found that the financial benefits of the ACA’s Medicaid expansion, and corresponding decreased risk of closure, were greater for hospitals in areas with higher uninsurance rates. This result was more pronounced for hospitals in rural areas. The finding that the relationship was stronger at hospitals in areas with higher uninsurance rates strongly supports the link between hospitals’ financial viability and increased rates of health insurance coverage because of the ACA’s Medicaid expansion.”

To date, 37 states, including Republican-led ones such as Arkansas, Indiana, Ohio, and Utah, have implemented such coverage. Under the ACA, states have considerable flexibility to implement expansion in a manner best suited for their populations and needs. Existing TMA policy supports pursuing a strategy to draw down all available federal funds to increase health care coverage to low-income Texans using private-sector solutions (Policy 190.032, Medicaid Coverage and Reform). The Texas Legislature introduced multiple bills in the 2019 session to reduce the state’s rate of uninsured – the highest in the country. The Episcopal Health Foundation’s 2019 Health Policy Poll found that two-thirds of Texans support Medicaid expansion. None of the bills gained traction last legislative session.

The 2016 *Journal of Rural Health* study also recorded common options for health care facilities in rural communities where hospitals close. About half of the closed hospitals no longer provided any type of care, while the other half converted into emergency or urgent care, outpatient or primary care, and skilled nursing and rehabilitation services. The study notes, “These models may mitigate the negative impact of hospital closure on rural communities by improving access to health services, providing employment, and reconceiving the rural health paradigm.”

There is also a middle ground to be explored between keeping conventional rural hospitals open in areas where they struggle financially and moving away from a hospital completely. Multiple federal bills and the Texas Organization of Rural and Community Hospital’s legislative priorities support a step-down hospital model. Step-down hospitals could make hospitals less expensive by decreasing size and capacity or providing only emergency services, while keeping some health care access in places where hospitals
would otherwise close. Creating the step-down hospital model by reforming the federal and state
definitions of a hospital are essential to retaining Medicaid payments in these facilities.

The federal government would have to take the first step to establish step-down hospitals, then Texas
should enact mirror legislation to affirm recognition from the Centers for Medicare & Medicaid Services.
In 2018 there were three bills in Congress that would establish step-down hospital variations:

- **HR 578 (Rural Emergency Medical Center Act of 2018 – Jenkins/Kind):** CAHs and rural hospitals of
50 beds or less could convert to a 24-hour emergency department and outpatient clinic. Patients could
be held for up to 24 hours, and the hospital would not participate in traditional inpatient care. After 24
hours, the patient would be discharged or transferred to a full-scale hospital.

- **S. 1130 (Rural Emergency Acute Care Hospital [REACH] Act – Grassley/Klobuchar):** Small rural
hospitals with 50 or fewer beds could convert to emergency hospitals, with necessary emergency and
observation services, while receiving Medicare payment rates of 110% of reasonable costs.

- **HR 2957 (Save Rural Hospitals Act – Graves/Loebsack):** Establishes a step-down hospital option
with emergency, outpatient services, and one-night inpatient stay. These facilities would be paid
105% of eligible costs on Medicare patients.38

In addition, the Texas Organization of Rural and Community Hospitals, a consultant to this committee,
explicitly states one of its legislative priorities is that “congress must create a step-down rural hospital to
address the closure crisis and gives rural communities an option for sustainable care that are about to lose
their hospital. Without this option, rural communities with a closed hospital will continue to find
themselves with little or no emergency or other care.” These are just a few of the many examples of step-
down hospital alternatives to keep some health care options in rural communities, both for the people who
live there and those traveling through who may need emergency care.

In addition, the state legislature took initiative to address the technology and infrastructure challenges
faced by rural hospitals numerous times and should consider doing so again. House Bill 7 of the 2001
Texas Legislature created the Rural Health Facility Capital Improvement Program. A total of $2 million
in grant funds was available for projects costing up to $50,000 in counties with populations less than
150,000 people for “improvements to existing facilities, construction of new facilities, and the purchase
of capital equipment, including information systems hardware and software”39 Replenishing this funding
to provide more grants to rural hospitals could help retain facilities and improve quality of care.

The National Rural Health Association also lists several policy options to bring rural hospitals financial
relief. These include the elimination of Medicare sequestration for rural hospitals and of the CAH 96-hour
condition of payment regulation, which causes CAHs to lose payment if a patient is not discharged or
transferred within 96 hours.

Overall, expanding options to keep rural hospitals financially healthy and reducing the amount of bad
debt they take on is a primary step towards reducing rural hospital closure. Medicine should also continue
to research and advocate for reformed health care options in rural communities, so patients are not left in
the dust in the case of closure.

**Recommendation 1:** That the Texas Medical Association reaffirm support for existing TMA policy
190.032 Medicaid Coverage and Reform and redouble its efforts to reduce Texas’ rate of uninsured
during the 2021 legislative session.

**Recommendation 2:** That TMA highly prioritize replenishing funding for the State Physician Education
Loan Repayment Program, as 2018-19 budget cuts to this program prevent an estimated 94 physicians
from receiving loan repayment funding each year and prevent many underserved communities from
benefiting from increased access to physician services.

**Recommendation 3**: That TMA make a high priority adding $1 million to the state budget for 2022-23 to
start the Rural Resident Physician Grant Program, HB 1065.

**Recommendation 4**: That TMA support step-down hospital formation by expanding the bed capacity and
service requirements used to qualify a hospital for Medicaid and Medicare payments.

**Recommendation 5**: That TMA support elimination of the Medicare physician payment reductions
because of sequestration.

**Recommendation 6**: That TMA support elimination of the Medicare critical access hospital 96-hour
condition of payment regulation.

**Recommendation 7**: That TMA support expansion of Medicare critical access hospital (CAH)
designation requirements, increase funding for CAHs, and/or study why CAH designation doesn’t always
save rural hospitals.

**Recommendation 8**: That TMA support increasing funding for Prospective Payment System rural
hospitals under Medicare.

**Related TMA Policy:**
- 100.016 Texas Department of State Health Services Emergency Medical Services Local Projects Grant
- 190.032 Medicaid Coverage and Reform
- 190.015 Medicaid and Rural Physicians
- 235.031 Equal Payment for Rural Health Clinics Regardless of Type of Ownership
- 275.003 Rural Health Clinic Regulations
- 275.006 Broadband Internet Access to Rural Texas
- 290.010 Improving Access to Care in Rural and Medically Underserved Areas
- 185.006 Physician Workforce and Distribution
- 185.019 Rural Physician Workforce Policy

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Resolution 411-A-19, introduced by the Medical Student Section, was referred to the Committee on Health Information Technology and the Office of the General Counsel. The resolution addresses the transfer and ownership of data when physicians change electronic health records.

The resolution recommends that (1) the Texas Medical Association work with the American Medical Association and other state medical societies to develop model contract and business associate agreement (BAA) language that ensures electronic health record (EHR) vendors are required to deliver the patient’s complete medical record in a discrete, industry-recognized, nonproprietary format that can be imported into the new EHR at no cost to the physicians; and (2) our TMA seek legislative and/or regulatory relief to require that physicians have access to their former EHR data while transitioning EHRs to ensure continuity of patient care, limit gaps in information exchange, and ensure physician ownership of data.

Status
Testimony during the reference committee indicated support of this resolution. Physicians have few options to transfer data from proprietary EHR vendors when trying to switch systems. Physicians who adopted EHRs, many with federal incentives, expected the benefits of EHR use to include the promotion of safer care, higher quality care, practice efficiency, and medical record accessibility. It has been more than a decade since the passage of the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, and many EHRs still fall short. Physicians, with limited knowledge and experience of EHRs, made purchases in good faith, with the understanding that certified EHRs had the government’s “stamp of approval” and should meet the four previously listed benefits. Physicians adapted their practices and used EHRs as effectively as possible, yet, for many, switching to another product was inevitable. This could be for reasons including, but not limited to, poor service, limited usability, vendors going out of business, vendors being acquired, or the product being discontinued. In these circumstances, physicians were left with limited options for transitioning patient data from one EHR to the next.

The HIT Committee has heard testimony of members who have been cut off from their EHR data or forced to sign contracts without the ability to review or negotiate them in order to continue to receive access to their patient data.

There are multiple reasons to require data availability, including patient safety, medical record retention requirements, HIPAA regulations, and data blocking regulations. Each of these is explored below.

1. **Patient Safety**
When important information, such as allergies, key studies, and other information, is not available electronically in the new record, the clinical decision support systems of the new EHR cannot function as designed. Transferring information by putting it in a document (e.g., a .pdf) defeats the purposes of EHRs. Of course, one can argue that the physician can reinterview the patient during the first visit with the new EHR, but important information can be missed. One could also argue that the physician could employ a
scribe to review the old EHR for important information and reenter it, but again, this is fraught with risk of omission and error. Both choices are also expensive. It is also well known that when data are not available in the workflow of the physician, they often are overlooked.

Based on the above, electronic transfer of at least selected important information (e.g., problems, medications, allergies, immunizations, demographics, growth parameters, visit history, key notes, and key imaging/lab/procedure reports) in a manner that can be used by the new EHR for computer-aided decisionmaking is vitally important to fulfilling the promise of EHRs improving patient safety.

2. Legal Medical Record Requirements

Although each state has specific medical record requirements, EHR vendors generally have not sufficiently addressed them, leaving physicians to figure out how to meet them. When physicians don’t change their EHR, it’s relatively easy; the system retains all the old records, and many systems have tools for producing a legal medical record. But for physicians who change EHR, few, if any, systems provide mechanisms for making records available when the physician no longer is using the old EHR.

In Texas, the Texas Medical Board (TMB) rules require physicians to maintain adequate medical records of a patient for a minimum of seven years from the anniversary date of last treatment by the physician. If a patient was younger than 18 years of age when last treated by the physician, the physician is required to maintain the patient’s medical records until the patient reaches age 21 or for seven years from the date of last treatment, whichever is longer. Physicians must retain medical records for longer lengths of time than imposed by the TMB regulations when mandated by federal or by other state statute or regulation. A physician also may not destroy medical records that relate to any civil, criminal, or administrative proceeding if the physician knows the proceeding has not been finally resolved.

The specific TMB requirements related to the contents, release, and maintenance of a medical record, found in 22 Texas Administrative Code§§165.1-165.6, are extensive. Some of these are listed below:

**Contents of Medical Record**

Each licensed physician of the board shall maintain an adequate medical record for each patient that is complete, contemporaneous and legible. An “adequate medical record” should meet the following standards:

1. The documentation of each patient encounter should include:
   
   (A) reason for the encounter and relevant history, physical examination findings and prior diagnostic test results;
   (B) an assessment, clinical impression, or diagnosis;
   (C) plan for care (including discharge plan if appropriate); and
   (D) the date and legible identity of the observer.

2. Past and present diagnoses should be accessible to the treating and/or consulting physician.

3. The rationale for and results of diagnostic and other ancillary services should be included in the medical record.

4. The patient’s progress, including response to treatment, change in diagnosis, and patient’s noncompliance should be documented.

5. Relevant risk factors should be identified.

6. The written plan for care should include when appropriate:
   
   (A) treatments and medications (prescriptions and samples) specifying amount, frequency, number of refills, and dosage;
   (B) any referrals and consultations;
   (C) patient/family education; and,
   (D) specific instructions for follow up.
(7) Include any written consents for treatment or surgery requested from the patient/family by the physician.

(8) Include a summary or documentation memorializing communications transmitted or received by the physician about which a medical decision is made regarding the patient.

(9) Billing codes, including CPT and ICD-9-CM codes, reported on health insurance claim forms or billing statements should be supported by the documentation in the medical record.

(10) All non-biographical populated fields, contained in a patient’s electronic medical record, must contain accurate data and information pertaining to the patient based on actual findings, assessments, evaluations, diagnostics or assessments as documented by the physician.

(11) Any amendment, supplementation, change, or correction in a medical record not made contemporaneously with the act or observation shall be noted by indicating the time and date of the amendment, supplementation, change, or correction, and clearly indicating that there has been an amendment, supplementation, change, or correction.

(12) Salient records received from another physician or health care provider involved in the care or treatment of the patient shall be maintained as part of the patient's medical records.

Maintenance of Medical Records

(1) A licensed physician shall maintain adequate medical records of a patient for a minimum of seven years from the anniversary date of the date of last treatment by the physician.

(2) If a patient was younger than 18 years of age when last treated by the physician, the medical records of the patient shall be maintained by the physician until the patient reaches age 21 or for seven years from the date of last treatment, whichever is longer.

(3) A licensed physician is required to retain records from a forensic medical examination in accordance with Section 153.003 of the Medical Practice Act.

(4) A physician may destroy medical records that relate to any civil, criminal or administrative proceeding only if the physician knows the proceeding has been finally resolved.

(5) Physicians shall retain medical records for such longer length of time than that imposed herein when mandated by other federal or state statute or regulation.

(6) Physicians may transfer ownership of records to another licensed physician or group of physicians only if the physician provides notice consistent with §165.5 of this title (relating to Transfer and Disposal of Medical Records) and the physician who assumes ownership of the records maintains the records consistent with this chapter.

(7) Medical records may be owned by a physician’s employer, to include group practices, professional association, and non-profit health organizations, provided records are maintained by these entities consistent with this chapter.

(8) Destruction of medical records shall be done in a manner that ensure continued confidentiality.

EHRs used by Texas physicians should meet all the above content and maintenance requirements if the physician uses the EHR as his or her medical record system.

3. HIPAA Regulations

In September 2016, the Department of Health and Human Services Office of Civil Rights (OCR) made it clear that physician-covered entities must be able to access the protected health information (PHI) of their patients when that PHI is maintained on their behalf by a business associate. This was addressed in an FAQ regarding the issue of a business associate blocking or terminating access by a covered entity to the PHI maintained for or on behalf of the covered entity.

Question: “May a business associate of a HIPAA covered entity block or terminate access by the covered entity to the protected health information (PHI) maintained by the business associate for or on behalf of the covered entity?”
Answer: “No.”

“First, a business associate may not use PHI in a manner or to accomplish a purpose or result that would violate the HIPAA Privacy Rule. See 45 CFR § 164.502(a)(3).

Generally, if a business associate blocks access to the PHI it maintains on behalf of a covered entity, including terminating access privileges of the covered entity, the business associate has engaged in an act that is an impermissible use under the Privacy Rule. For example, a business associate blocking access by a covered entity to PHI (such as where an Electronic Health Record (EHR) developer activates a “kill switch” embedded in its software that renders the data inaccessible to its provider client) to resolve a payment dispute with the covered entity is an impermissible use of PHI. Similarly, in the event of termination of the agreement by either party, a business associate must return PHI as provided for by the business associate agreement. If a business associate fails to do so, it has impermissibly used PHI.

“Second, a business associate is required by the HIPAA Security Rule to ensure the confidentiality, integrity, and availability of all electronic PHI (ePHI) that it creates, receives, maintains, or transmits on behalf of a covered entity. See 45 CFR § 164.306(a)(1). Maintaining the availability of the ePHI means ensuring the PHI is accessible and usable upon demand by the covered entity, whether the PHI is maintained in an EHR, cloud, data backup system, database, or other system. 45 CFR § 164.304. This also includes, in cases where the business associate agreement specifies that PHI is to be returned at termination of the agreement, returning the PHI to the covered entity in a format that is reasonable in light of the agreement to preserve its accessibility and usability. A business associate that terminates access privileges of a covered entity, or otherwise denies a covered entity’s access to the ePHI it holds on behalf of the covered entity, is violating the Security Rule.

“Third, a business associate is required by the HIPAA Privacy Rule and its business associate agreement to make PHI available to a covered entity as necessary to satisfy the covered entity’s obligations to provide access to individuals under 45 CFR § 164.524. See 45 CFR §§ 164.502(a)(4)(ii), 164.504(e)(2)(ii)(E). Therefore, a business associate may not deny a covered entity access to the PHI the business associate maintains on behalf of the covered entity if the covered entity needs the PHI to satisfy its obligations under 45 CFR § 164.524.

“OCR recognizes, however, that there may be certain arrangements that authorize the business associate to destroy or dispose of PHI, or perform data aggregation or otherwise combine data from multiple sources, and where, because of the nature of the services to be performed by the business associate with the PHI as specified in the contractual arrangements between the parties, the covered entity and business associate agree that the business associate will not provide the covered entity access to the PHI. For example, a covered entity may engage a business associate to perform data aggregation of information from multiple sources that renders the disaggregated original source data unreturnable to the covered entity. OCR does not consider these contractual arrangements to constitute the types of impermissible data blocking or access termination described above.

“Finally, OCR notes that a covered entity is responsible for ensuring the availability of its own PHI. To the extent that a covered entity has agreed to terms in a business associate
agreement that prevent the covered entity from ensuring the availability of its own PHI,
whether in paper or electronic form, the covered entity is not in compliance with 45 CFR
§§ 164.308(b)(3), 164.502(e)(2), and 164.504(e)(1)."

In the scenario described in this OCR FAQ, the EHR vendor would be the business associate of the
physician-covered entity.

4. Data Blocking (21st Century Cures Act)

In the 21st Century Cures Act, Congress adopted language designed to promote EHR interoperability.
As part of that language, Congress authorized civil penalties for certain information blocking activities.
Congress included a definition of “information blocking” in Sec. 4004. Information Blocking and
required the secretary “through rulemaking, … [to] identify reasonable and necessary activities that do
not constitute information blocking.”

On March 4, 2019, addressing the 21st Century Cures Act, the Office of the National Coordinator (ONC)
posted to the Federal Register proposed rules related to interoperability and information blocking. In the
proposed rule, ONC gave examples of restricted access to information that included physicians switching
EHRs.

The final rule is not yet posted, but TMA did comment indicating agreement that a new export criterion is
needed so physicians can receive complete data exports when transitioning EHRs. TMA went on to
implore ONC to not allow vendors to use transitioning as an opportunity to create another revenue stream.
Physicians already pay hefty fees to purchase or lease the software, in addition to annual licensing fees.
TMA further recommended that ONC should hold vendors responsible for standardized export practices
that do not punish the EHR purchasers and users. The final rules will be analyzed once posted, and TMA
will educate physicians as to any regulatory relief for data transition.

Considerations in Transition of EHR Data

Because EHR databases are not standardized, it usually is difficult to move data when physicians
transition from one EHR vendor to another. Physicians trying to meet the patient safety goals and the
legal medical record requirements above have few options without spending enormous amounts of
money.

Current options, while not optimal, include these:

1. If the vendor permits this, maintain an active read-only license with the old EHR, allowing read-only
access to view old patient records.

2. Save each patient’s full record to an electronic file (e.g., .pdf) and (optimally) save the file as an
attachment to each patient’s record in the new EHR. Depending on the number of patients, this can
take a dedicated staff person days, if not weeks, to complete. A best practice is to archive inactive
patients, and only move the records of active patients to the new EHR. A practice also can print
everything and make the paper records accessible to clinicians after the go-live for the new EHR.

3. Depending on the vendor database, archive and maintain the read-only version of the old EHR
without paying for a read-only license. This also can be done with some third-party vendors, who
provide electronic read-only access to the old EHR information that is stored using the third-party
vendor’s software and database.

4. Migrate data from the old EHR to the new one. While this sounds simple, it is not, and it rarely works
well. Most vendor databases do not map their data with metadata or “tags.” As a result, when
migrating data, vendors attempt to map as much as possible of the old data so that when the data are
extracted from the old EHR, they are correctly imported into the new EHR. This often is done on a
most basic level using a Continuity of Care Document (CCD), where predefined, standardized extensible markup language (XML) tags exist. Unfortunately, the accuracy and completeness of CCDs are variable. It is worth having a conversation with both vendors to understand their experience and success with exporting and importing patient data. Even when it works well, it is unlikely the full record will transfer easily, as attachments, free text notes, and custom fields rarely get placed correctly within the new EHR and may require manual manipulation. Sometimes even small incompatibilities such as date formats cause problems (e.g., 02/18/1952 versus Feb-18-52). Also, this option is usually the most expensive approach.

5. Hire a conversion team that will enter key data (e.g., problems, allergies, medications, immunizations, and more) from the old system into the new system for patients who on the schedule for the next day. This solution is costly and incomplete, but it targets only those patients for whom the data are needed.

Some combinations of all the options are often used. For most, the experience is costly and difficult. The process also can be potentially harmful to patient safety. To better understand all the risks and challenges of the options above, it is advisable to discuss the situation with a privately retained attorney.

TMA Advocacy
TMA has long advocated for the ability to transition data from one EHR to another and maintain the full electronic patient records. TMA has urged federal agencies to require the universal (i.e., all EHR data) use of XML or a similar standard (e.g., FHIR – Fast Healthcare Interoperability Resources) as a way of exchanging health data, as is used in accounting and other industries. Universal common encoding of all data elements would allow physicians to change their EHR quickly with very little cost. Data consumed by a receiving EHR could be placed correctly within the new system to give them meaning and make them immediately useful. It is important that physicians have the ability to export and import tagged patient data from one EHR to another, especially when changing vendors. Unless EHR vendors are required to tag all data fields, allowing complete mapping between disparate systems, this problem will continue to exist.

TMA Resources
To help Texas physicians navigate the potential problems related to data migration and contracting, TMA has developed numerous resources that are available on the TMA website. They include:

- **EHR to EHR Conversions – When, Why and How** is a free (for members) webinar that provides expert insight on strategies and best practices for EHR system conversions, distinguishing risks within vendor contracts and ways to avoid those risks, and how to properly notify the current EHR vendor and promote a smooth transition.

- **Switching EHR Systems** is a free (for members) publication designed to help physicians think through all aspects of the EHR transition process and minimize disruption and risk as much as possible.

- “**EHR Buyer Beware: Issues to Consider When Contracting with EHR Vendors**” is a white paper that discusses eight important EHR contract terms a medical practice should consider before signing an EHR contract.

- **Guide to Licensing and Service Agreements** is a free guide that includes an assessment of things to consider before signing a technology-related product contract.

- “**Before You Sign: 10 Tips for Tech Contracts**” is a *Texas Medicine Today* article that lists 10 items to consider before signing a technology contract.

- “**Get the Know-How You Need When Upgrading Your EHR**” is a *Texas Medicine Today* article that lists resources and services that members can use when changing EHRs.

- “**EHR Vendors Behaving Badly: What Can You Do?**” is a *Texas Medicine Today* article that lists some things to consider and how to report EHR vendors if the physician can’t access data or transfer patient records to a new EHR.
• “Glitch in the Switch: Changing EHR Vendors Can Present Major Problems” is an article from *Texas Medicine* magazine that shows the difficulties of migrating patient records from one EHR system to another and how to minimize risk.

• “Switching EHRs? Transferring Data Can Be a Hurdle” is an e-tip article available on the TMA website that lists some resources and tips related to data transition.

• The Coker Group is a TMA group discount program vendor that offers TMA members free technology contract reviews. It looks for terms and conditions that may be unfavorable to TMA members. After reviewing the contract, Coker Group consultants will discuss it with the physician, including suggestions on how to address any unfavorable terms. TMA members who want help negotiating the contract are eligible for a 5% discount on Coker’s fees, which will be capped.

Additionally, TMA has a general model business associate agreement that physicians can use in consultation with their privately retained attorneys and modify specific to their practice.

**External Resources**
The Office of the National Coordinator has a good resource on the subject of switching EMRs on its website at [www.healthit.gov](http://www.healthit.gov).

**Recommendation:** That the Texas Delegation to the American Medical Association take a resolution to AMA formally requesting AMA assistance with model contract language and regulatory relief through electronic health record (EHR) vendor certification that ensures EHR vendors are contractually required to deliver the patient’s complete medical record in a discrete, industry-standardized, nonproprietary format that can be imported into the new EHR at no cost to the physicians by:

A. The development of an exportable AMA-endorsed standard-format database that all EHRs must be able to create electronically for all patients that would be suitable for importing the old EHR data into a new EHR. This must operate at no cost and with minimal effort by physicians and their practices. A Continuity of Care Document (CCD) format, Fast Healthcare Interoperability Resources (FHIR) (as this standard increases in use), or other methodology could be used for discrete data and a document repository for all other information.

B. Regulatory relief that requires EHR vendors to be contractually required to have such a medical-record transfer capability within 18 months of a final rule.

C. Regulatory relief that requires vendors to be contractually required to provide physicians and patients read-only access to and data extraction from (through .pdf, CCD, and FHIR) the old EHR system for the length of time required to meet state legal medical record retention requirements after contract termination or vendor bankruptcy. This should provide time to make electronic transfers and develop alternative methods of accessing information that is not transferred electronically under (A), above. Vendors should be able to transfer fulfillment of this requirement to a third party that can provide the same service. This must operate at no cost and with minimal effort by physicians and their practices.
REPORT OF COMMITTEE ON HEALTH INFORMATION TECHNOLOGY

CM-HIT Report 2 2020

Subject: Sunset Policy Review

Presented by: Joseph H. Schneider, MD, MBA, Chair

Referred to: Reference Committee on Socioeconomics

The Texas Medical Association periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness.

The Committee on Health Information Technology recommends amending the following policy:

155.009 Laboratory and Radiology Reports Database: The Texas Medical Association supports immediate implementation of an effective method for helping physicians who did not order the patients’ lab, radiology, and other tests to access those results whether directly or through a health information exchange (Res. 409-A-10).

Recommendation: Retain as amended.
Subject: Compensation to Physicians for Activities Other Than Direct Patient Care

Presented by: E. Linda Villareal, MD, Chair

Referred to: Reference Committee on Socioeconomics

At TexMed 2019, the House of Delegates amended Resolution 401-A-19 Compensation to Physicians for Activities Other Than Direct Patient Care, submitted by Harris County Medical Society, and adopted it as follows:

RESOLVED, That the Texas Medical Association form a task force including members of the Council on Legislation, Council on Socioeconomics, Council on Health Care Quality and interested county medical societies to strategically prepare solutions for advocacy that address and mitigate the burden of prior authorization and that the task force bring a report back to the House of Delegates in 2020.

Resolution 401-A-19, as adopted, was referred to the Board of Trustees. Accordingly, the Board of Trustees voted at its 2019 Winter Conference meeting to create a task force to address the charge of the resolution. As a result, the TMA Prior Authorization Task Force was formed.

Debra Patt, MD, chair of the TMA Council on Legislation, was selected to chair the Prior Authorization Task Force. Under her leadership, TMA efforts to advocate for reforms of prior authorization processes and requirements were streamlined and unified by combining the task force’s membership with the Council on Legislation’s existing Workgroup on Prior Authorizations.

Dr. Patt called the task force’s first meeting in February 2020. During that meeting, the task force engaged in a robust discussion regarding the need for a wide variety of prior authorization reforms. More specifically, the taskforce discussed:

- TMA legislative efforts related to prior authorization during the 2019 session of the Texas Legislature;
- Interim legislative committees, including the Select Committee on Prior Authorization Reform and the Committee on Health Care Cost and Efficiency;
- Current regulatory efforts related to prior authorizations; and
- Strategies and support needed for success with prior authorization reforms.

The task force has been evaluating (and will continue to evaluate) physician survey data collected by TMA and other sources regarding the burden of prior authorization requirements and the impact these requirements have on patients. Furthermore, the task force is asking for physician testimonials to demonstrate the need for significant prior authorization reform. These testimonials will be helpful in preparing for interim hearing testimony. The task force also is working towards securing physician volunteers to provide oral testimony, when needed.

The task force has created a list of potential legislative and regulatory priorities for prior authorization reform. That working list may be modified and expanded as the task force continues its work. The task force has scheduled its next meeting for late March.
TMA and the task force are also working closely with the American Medical Association and other states in evaluating legislative initiatives.

**Recommendation:** That the Texas Medical Association advocate for significant legislative and/or regulatory reforms to lessen (1) the negative impact of state-regulated health plan prior authorization requirements on patients and (2) the burden of state-regulated health plan prior authorization requirements on physician practices.
Background

In August 2019, the U.S. Department of Homeland Security adopted new rules revising the definition of “public charge” – the standard used by federal immigration officials to determine if a person seeking legal permanent residency (commonly known as a green card) is a risk for becoming reliant on public assistance. Per the new rules, immigration officers may consider whether a person lawfully immigrating to the U.S. is at risk of using Medicaid, Supplemental Nutrition Assistance Services (SNAP), housing, and other social services in the future. Heretofore, immigration officials only considered use of public cash assistance or government-sponsored long-term care institutionalization in making a public charge determination. Health care services were not, recognizing that health care coverage is an essential aspect of improving the health and well-being of individuals and the broader public.

Indeed, in 1999, the federal government issued guidance clarifying that immigration officials do not consider enrollment in Medicaid (except for long-term care services) or the Children’s Health Insurance Program (CHIP) in public charge determinations in order to quell fear among immigrants that if they or their children, the vast majority of whom are U.S.-born citizens, are so enrolled, it would count against them. At that time, immigration officials noted that enrollment in Medicaid or CHIP by lawfully present immigrants would benefit not only them and their families but also the communities in which they lived.

From the outset, TMA opposed the rules. While the association has historically not taken a position on federal immigration issues, the rules will undoubtedly have significant implications for the health of Texans and physician practices. As noted in TMA’s comment letter, “when proposed changes to federal immigration policy intersect with the state’s health care delivery system, it is incumbent on TMA to provide input on how the changes will affect our members’ ability to care for their patients.”

Implications to the Health of Texans and State’s Health Care Delivery System

Federal law already restricts the use of Medicaid, CHIP, and other publicly financed health care services by legal immigrants. Temporary visa holders are ineligible for enrollment in these programs. And for five years following immigration to the United States, green card holders cannot enroll in Medicaid or CHIP. But there are important exceptions to the five-year waiting period for pregnant women and children. States have the option to allow these populations to enroll in Medicaid or CHIP prior to the expiration of the five-year bar because doing so will ensure children and pregnant women receive the preventive, primary, and specialty care services they need to thrive. By receiving coverage, pregnant immigrants are more likely to obtain early prenatal care, a key factor in addressing Texas’ concerningly high rate of maternal mortality and morbidity. Additionally, a healthy pregnancy is vital to giving the unborn child — a future U.S. citizen — a head start on healthy development. If nothing else, such coverage is also just good business because healthy pregnancies and healthy babies result in lower future federal and state Medicaid costs.

According to the federal government, fewer than 400,000 legal immigrants nationwide will be directly impacted. However, the indirect impact of rules already has been widely felt. Nationwide, 13.5 million
Medicaid/CHIP enrollees, including 7.6 million children, live in a household with a noncitizen or are noncitizens themselves. Some 100,000 Texans receive a green card annually, though at any given time, many more legal immigrants are in the process of obtaining their green card. Misunderstanding and confusion about the rules has resulted in a “chilling effect” on Medicaid and CHIP enrollment, with immigrant parents skipping preventive care for their children, including immunizations, and forgoing Medicaid or CHIP coverage renewal for their children or themselves. Since adoption of the rules, Texas physicians, hospitals, community clinics, food banks and other social service agencies across the state have reported sharp decreases in use of health care and SNAP services by immigrant families and their children. Similarly, anecdotal information from physicians indicates fewer use of prenatal care services, including CHIP Perinatal, by immigrant pregnant women.

Unfortunately, as fewer immigrants enroll in Medicaid or CHIP, many of these patients resort to costly, taxpayer-supported emergency departments instead, increasing uncompensated care costs for the physicians and hospitals that are required to provide this care and ultimately contributing to higher costs and property taxes for Texans. Along the border, physicians report large increases in the number of immigrant families seeking care in emergency departments for conditions treatable in a primary care setting. Obstetricians and family physicians report an increase in immigrant women coming to their hospitals in labor with no prior prenatal care.

The anecdotal evidence corresponds to research conducted by the Urban Institute prior to the rules’ adoption. According to a survey it conducted, “one in seven adults in immigrant families reported avoiding public benefit programs for fear of risking future green card status.” Furthermore, from late 2017 until today, enrollment in Texas Medicaid among children dropped by more than 225,000. While multiple factors contributed to the decline, the public charge rules are one.

Furthermore, the rule also will invariably harm the state’s public health by contributing to the spread of communicable diseases. Though the rule explicitly excludes public preventive health services from the public charge definition, vaccine coverage among immigrants and their family members most certainly will decline as a result of people dropping Medicaid or CHIP coverage because they likely will forgo use of public vaccine clinics out of fear or misunderstanding about the rule.

Moreover, when the federal government published the proposed rule, the agency itself acknowledged the many negative consequences the rule will have on people and communities, including an increase in emergency department use, an increase in the prevalence of communicable diseases, an increase in uncompensated care, and worse health outcomes among immigrants and their families.

Already, the rules have worsened the state’s sky-high rate of uninsured – the highest in the country – and will immeasurably harm the health and well-being of Texas and Texans by:

- Undercutting efforts to improve maternal and infant health by deterring use of prenatal care among immigrant mothers in our country;
- Harming the health of children by deterring immigrant parents from enrolling their children in Medicaid or CHIP, which provides children important preventive, primary, and specialty care;
- Weakening efforts to address Texas’ opioid and substance use disorder crises by deterring pregnant and postpartum immigrant women from obtaining treatment; and
- Increasing uncompensated care by physicians, health care providers, and hospitals, a potentially devastating blow to rural communities where physician practices and hospitals already operate on razor-thin margins.
Status of Federal Rules

Quickly following adoption of the rules, multiple state attorneys general and advocacy organizations filed lawsuits seeking to halt enforcement, arguing the rules would negatively impact public health and increase indigent health care costs for state and local governments. Last October, federal courts in California, New York, and Washington issued injunctions preventing nationwide implementation of the rules, but the U.S. 4th Circuit Court of Appeals in a 2-1 ruling lifted the injunction in December. However, on Jan. 8, 2020, the U.S. Court of Appeals for the 2nd Circuit unanimously upheld the injunction. The week following that decision, the U.S. solicitor general filed an emergency application asking the U.S. Supreme Court to stay the injunctions and allow implementation of the new rule. As of this writing, the Supreme Court has not responded to the request. On January 27, the Supreme Court lifted the injunction. Enforcement of the rules began Feb. 24, 2020.

Recommendation 1: That the Texas Medical Association adopt new policy opposing revisions to the federal definition of public charge that prevent legal immigrants or their children from using local, state or national health, nutrition, and housing services, including Medicaid or the Children’s Health Insurance Program.

Recommendation 2: That the Texas Medical Association continue to advocate that the new federal rules be rescinded to protect the health of all Texans.

Recommendation 3: That the Texas Medical Association develop resources to help physicians accurately and concisely convey to their patients what the federal rules relating to public charge do and do not say.
The Texas Medical Board (TMB) is authorized to temporarily suspend or restrict a physician’s license if a panel of board members determines the physician’s practice constitutes a continuing threat to the public welfare. No minimum requirement of evidence must be satisfied for the temporary suspension or restriction.

Following a temporary suspension or restriction, TMB undergoes a full investigation and attempts informal settlement. In some cases, the physician refutes the allegations forming the basis of the suspension or restriction and does not wish to settle, preferring instead to have the alleged violations decided before the State Office of Administrative Hearings (SOAH).

In the end, SOAH issues findings of fact and conclusions of law on the case, determining either that the physician violated applicable law or regulation, or that there was no violation. TMB determines any penalty based on SOAH’s findings.

One particular recent case indicated a significant flaw with this process: Even if, following a temporary suspension or restriction, SOAH determines there was no violation of law or regulation, TMB does not void the initial suspension or restriction, and it stays as a permanent mark on the physician’s record.

When TMB imposes a temporary suspension or restriction, it is required by law to notify several different entities, including hospitals, professional societies, and government payers and other entities (Texas Occupations Code, Section 164.060). Additionally, this board action shows up on the National Practitioner Data Bank (NPDB) – a national database containing negative actions against a physician – and in TMB’s profile for the physician on its website.

Yet, when SOAH determines there has been no violation, and TMB affirms SOAH’s findings of fact and conclusions of law that there was no violation by dismissing all allegations against the physician, TMB merely revises, rather than voids and vacates, the earlier temporary suspension in its report to the NPDB. The NPDB maintains reference to the report of the earlier unproven and superseded temporary suspension or restriction.

Though TMB has an obligation to alert relevant parties when it imposes a temporary suspension or restriction, TMB believes it has no equivalent duty to inform those parties other than the NPDB that the temporary suspension or restriction was “superseded” (voided). TMB maintains that the temporary suspension or restriction should stay on the physicians’ profile even though, ultimately, the allegations were unproven. Both the charges and the earlier (later unproven) allegations remain on the TMB website and are referenced in the revised TMB report to the NPDB.

The Patient-Physician Advocacy Committee contends this is an unfair and unjust result. To address these issues, the Patient-Physician Advocacy makes the following recommendations:
**Recommendation:** That the Texas Medical Association seek legislation that would provide that: (1) should an administrative law judge find that the Texas Medical Board (TMB) failed to meet its burden of proof on charges that served as the basis for a temporary suspension or restriction of a physician’s license, TMB shall overturn and vacate the temporary suspension or restriction as soon as practicable and dismiss the case; (2) the effect of an overturned and vacated temporary suspension or restriction, unless specifically appealed by TMB to district court, shall be that the suspension or restriction never happened and never should have happened; and (3) any mention of charges against a physician related to the temporary suspension or restriction shall be removed from the physician’s TMB profile, any related report to the National Practitioner Data Bank voided, and the case dismissed, unless and until a court of law reverses the administrative law judge’s findings of facts and conclusion of law.
Subject: Insurance Coverage Transparency

Introduced by: Lone Star Caucus

Referred to: Reference Committee on Socioeconomics

Whereas, Medical offices and facilities want to provide accurate estimates to patients of their cost-sharing liability prior to office visits, procedures, and tests; and

Whereas, They are often unable to do so because each commercial health insurance plan has its own set of rules regarding whether the patient is responsible for meeting the deductible or paying a copay or coinsurance for a particular type of visit, procedure, or test; and

Whereas, Medical offices and facilities typically call the commercial insurance carrier directly or go online to verify coverage but are frequently given inaccurate information regarding the patient’s cost-sharing liability; and

Whereas, This inaccurate information can harm the patient-physician relationship if the insurance carrier underestimates the patient’s liability; and

Whereas, This inaccurate information can delay needed medical care if the insurance carrier overestimates the patient’s liability, thereby making the patient reluctant to proceed with recommended tests or procedures; and

Whereas, Commercial insurance carriers have the technology to input the diagnosis codes and Current Procedural Terminology codes and know immediately the patient’s liability but rarely provide this information; therefore be it

RESOLVED, That the Texas Medical Association advocate for legislation requiring commercial insurance carriers to provide accurate information regarding the patient’s cost-sharing liability and the insurance plan’s liability when a medical office or facility provides the diagnosis codes and Current Procedural Terminology codes via phone or the internet; and be it further

RESOLVED, That TMA advocate for legislation requiring commercial insurance carriers to provide updated information at the time of insurance eligibility verification regarding factors that may result in the claim being denied (e.g. the insurance carrier is waiting for the primary policyholder to verify that he or she does not have other health insurance coverage); and be it further

RESOLVED, That TMA advocate for legislation requiring commercial insurance carriers to respond to telephone inquiries regarding the patient’s cost-sharing liability by providing accurate information both verbally and via a fax confirmation; and be it further

RESOLVED, That TMA advocate for legislation penalizing commercial insurance carriers (via fines and the publication of statistics showing the number of complaints regarding noncompliance by each
insurance carrier) for instances where the above information is inaccurate or not provided in a timely
manner; and be it further

RESOLVED, That the Texas Delegation to the American Medical Association carry a similar resolution
to the AMA House of Delegates.

Related TMA Policy:
- **145.031 Requirement for Medical Insurance Companies to Provide Online Real-Time Insurance
  Claim Adjudication**
- **180.027 Prompt Payment of Claims**
- **145.020 Insurer Liability for Unpaid Claims**

Related AMA Policy:
- **H-185.981 Third Party Responsibility for Payment**
- **H-185.938 Health Insurance Exchange and 90-Day Grace Period**
Subject: Need for and Funding of Level I and Level II Trauma Centers

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Socioeconomics

Whereas, A shortage of Level I and Level II trauma centers exists in many communities in Texas; and

Whereas, The recent closing of Memorial Hermann Southwest Level II Trauma Center in Houston has created additional demand at the two Level I trauma centers in the area; and

Whereas, The Texas Legislature has not adequately funded trauma centers through the Drivers Responsibility Program funds and other funding; and

Whereas, A recently enacted law eliminated the Drivers Responsibility Program and reduced current funding to hospital trauma centers by 2%; therefore be it

RESOLVED, That the Texas Medical Association work with state officials to determine the number of Level I and Level II trauma centers necessary to support communities of various sizes throughout Texas and to provide necessary funding to make Level I and Level II trauma centers viable with adequate funding for all other service lines.

Related TMA Policy:
100.011 Trauma Care Funding
100.013 Trauma Funding
100.018 Emergency Medical Resources
100.025 Access to Emergency Care in Texas
120.010 Principles for Evaluating Health System Reform
Subject: Taxes on Medical Billing Services

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Socioeconomics

Whereas, In 2019, the Texas comptroller’s office announced that medical billing services by an outside company would be subject to sales and use taxes; and

Whereas, The comptroller’s opinion to tax medical billing services is based on an attorney general’s opinion that preparing an insurance claim is an “inherent part of the insurance claim process”; and

Whereas, In 2002, the comptroller had reasonably determined that merely completing a form for the insured did not rise to the level of claim processing, and thus, medical billing services performed before the claim was submitted were not taxable; and

Whereas, Physicians likely will be unable to pass along any of this tax, which could amount to 8.25%, to patients because payment rates would already have been set by insurance companies or the federal government; and

Whereas, Such a policy will further diminish the value of insurance payments, including those of Medicare and Medicaid, which already struggle to lure physician participation; and

Whereas, This policy potentially creates an even greater uneven playing field for the health care arena between nonprofit and for-profit entities; therefore be it

RESOLVED, That the Texas Medical Association oppose the imposition of service and use taxes on processes that are not actually part of delivering a medical service; and be it further

RESOLVED, That TMA work with the Texas Comptroller of Public Accounts and state legislators to resolve and clarify that medical billing, including outsourced billing services, is not the adjudication or practice of insurance, and thus should not be subject to insurance-related sales taxes.

Related TMA Policy:

235.028 Texas Revised Franchise Tax
235.029 Franchise Tax Issues
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 404
2020

Subject: Individual Physicians Be Paid While Awaiting Credentialing Approval

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Socioeconomics

Whereas, In addition to signing a contract, physicians must be credentialled by a health plan to get paid for the services they provide; and

Whereas, Waiting several months to a year for their credentials to be approved can have drastic consequences on physicians’ livelihoods and the viability of their practices; and

Whereas, While physicians are out of network, patients are likely to be balance billed or receive a surprise bill; and

Whereas, Health plan network adequacy is frequently insufficient; and

Whereas, Due to the magnitude of this issue, the 2007 Texas Legislature passed legislation (Texas Insurance Code, Title 8, Subtitle F, Chapter 1452, Secs. 1452.101-1452.108) allowing for physicians in group practices to be paid the contracted rate while waiting for their credentials to be approved; and

Whereas, That legislation did not address the issue for individual physicians, who have the same concerns as their group practice colleagues; therefore be it

RESOLVED, That the Texas Medical Association adopt as policy that individual physicians should be paid the contracted rate while awaiting approval of their credentials by a health plan; and be it further

RESOLVED, That TMA advocate for legislation that individual physicians be paid by health plans for their services while they are awaiting formal approval of their credentials.

Related TMA Policy:
80.003 Universal Credentialing Form
190.014 Medicaid Managed Care Guiding Principles

Information:
From the Texas Insurance Code, Title 8. Health Insurance and Other Health Coverages, Subtitle F. Physicians and Health Care Providers, Chapter 1452. Physician and Provider Credentials:
Sec. 1452.101. DEFINITIONS. In this subchapter:
(1) “Applicant physician” means a physician applying for expedited credentialing under this subchapter.
(2) “Enrollee” means an individual who is eligible to receive health care services under a managed care plan.
(3) “Health care provider” means:
(A) an individual who is licensed, certified, or otherwise authorized to provide health care services in this state; or
(B) a hospital, emergency clinic, outpatient clinic, or other facility providing health care services.
(4) “Managed care plan” means a health benefit plan under which health care services are provided to enrollees through contracts with health care providers and that requires enrollees to use participating providers or that provides a different level of coverage for enrollees who use participating providers. The term includes a health benefit plan issued by:
(A) a health maintenance organization;
(B) a preferred provider benefit plan issuer; or
(C) any other entity that issues a health benefit plan, including an insurance company.

(5) “Medical group” means:
(A) a single legal entity owned by two or more physicians;
(B) a professional association composed of licensed physicians;
(C) any other business entity composed of licensed physicians as permitted under Subchapter B, Chapter 162, Occupations Code; or
(D) two or more physicians on the medical staff of, or teaching at, a medical school or medical and dental unit, as defined or described by Section 61.003, 61.501, or 74.601, Education Code.

(6) “Participating provider” means a health care provider who has contracted with a health benefit plan issuer to provide services to enrollees.

Added by Acts 2007, 80th Leg., R.S., Ch. 1203 (H.B. 1594), Sec. 1, eff. September 1, 2007.
Amended by:
Acts 2009, 81st Leg., R.S., Ch. 296 (H.B. 389), Sec. 1, eff. September 1, 2009.
Acts 2011, 82nd Leg., R.S., Ch. 414 (S.B. 822), Sec. 1, eff. September 1, 2011.

Sec. 1452.102. APPLICABILITY. This subchapter applies only to a physician who joins an established medical group that has a current contract in force with a managed care plan.

Added by Acts 2007, 80th Leg., R.S., Ch. 1203 (H.B. 1594), Sec. 1, eff. September 1, 2007.

Sec. 1452.103. ELIGIBILITY REQUIREMENTS. To qualify for expedited credentialing under this subchapter and payment under Section 1452.104, an applicant physician must:
(1) be licensed in this state by, and in good standing with, the Texas Medical Board;
(2) submit all documentation and other information required by the issuer of the managed care plan as necessary to enable the issuer to begin the credentialing process required by the issuer to include a physician in the issuer’s health benefit plan network; and
(3) agree to comply with the terms of the managed care plan’s participating provider contract currently in force with the applicant physician’s established medical group.

Added by Acts 2007, 80th Leg., R.S., Ch. 1203 (H.B. 1594), Sec. 1, eff. September 1, 2007.

Sec. 1452.104. PAYMENT OF APPLICANT PHYSICIAN DURING CREDENTIALING PROCESS. On submission by the applicant physician of the information required by the managed care plan issuer under Section 1452.103(2), and for payment purposes only, the issuer shall treat the applicant physician as if the physician were a participating provider in the health benefit plan network when the applicant physician provides services to the managed care plan’s enrollees, including:
(1) authorizing the applicant physician to collect copayments from the enrollees; and
(2) making payments to the applicant physician.

Added by Acts 2007, 80th Leg., R.S., Ch. 1203 (H.B. 1594), Sec. 1, eff. September 1, 2007.

Sec. 1452.104. PAYMENT OF APPLICANT PHYSICIAN DURING CREDENTIALING PROCESS. On submission by the applicant physician of the information required by the managed care plan issuer under Section 1452.103(2), and for payment purposes only, the issuer shall treat the applicant physician as if the physician were a participating provider in the health benefit plan network when the applicant physician provides services to the managed care plan's enrollees, including:
(1) authorizing the applicant physician to collect copayments from the enrollees; and
(2) making payments to the applicant physician.
Added by Acts 2007, 80th Leg., R.S., Ch. 1203 (H.B. 1594), Sec. 1, eff. September 1, 2007.
TABLE

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 405
2020

Subject: Physicians to Retain Payment During Credentialing

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Socioeconomics

Whereas, In addition to signing a contract, physicians must be credentialled by a health plan to get paid for the services they provide; and

Whereas, Waiting several months to a year for a physician’s credentials to be approved can have dire consequences on the physician’s livelihood and the viability of the practice; and

Whereas, While the physician is out of network, patients are likely to be balance billed or receive a surprise bill; and

Whereas, Health plan network adequacy is frequently insufficient; and

Whereas, Physicians are providing a service and should be compensated for that service; and

Whereas, Due to the magnitude of this issue, the 2017 Texas Legislature passed legislation (Texas Insurance Code, Title 8, Subtitle F, Chapter 1452, Secs. 1452.101-1452.108) allowing for physicians in group practices to be paid the contracted rate while waiting for their credentials to be approved; and

Whereas, This law states:

If, on completion of the credentialing process, the managed care plan issuer determines that the applicant physician does not meet the issuer’s credentialing requirements:

(1) the managed care plan issuer may recover from the applicant physician or the physician’s medical group an amount equal to the difference between payments for in-network benefits and out-of-network benefits; and

(2) the applicant physician or the physician’s medical group may retain any copayments collected or in the process of being collected as of the date of the issuer’s determination;

(Sec. 1452.106 Effect of Failure to Meet Credentialing Requirements); and

Whereas, No out-of-network benefit exists for HMO plans; thus physicians would be providing a service with only a copayment for compensation; therefore be it

RESOLVED, That the Texas Medical Association adopt as policy that physicians should not be required to refund the contracted rate should credentialing be denied by a health plan; and be it further

RESOLVED, That TMA advocate to amend, by changing “may recover” to “may not cover,” Texas Insurance Code, Title 8, Health Insurance and Other Health Coverages, Subtitle F. Physicians and Health Care Providers, Chapter 1452 Physician and Provider Credentials, Sect. 1452.106 Effect of Failure to Meet Credentialing Requirements, to state that “the managed care plan issuer may not recover from the
applicant physician or the physician’s medical group an amount equal to the difference between payments
for in-network benefits and out-of-network benefits.”

Information:
From the Texas Insurance Code, Title 8. Health Insurance and Other Health Coverages, Subtitle F.
Physicians and Health Care Providers, Chapter 1452. Physician and Provider Credentials:
Sec. 1452.106. EFFECT OF FAILURE TO MEET CREDENTIALING REQUIREMENTS. If, on
completion of the credentialing process, the managed care plan issuer determines that the applicant
physician does not meet the issuer's credentialing requirements:
(1) the managed care plan issuer may recover from the applicant physician or the physician's medical
group an amount equal to the difference between payments for in-network benefits and out-of-network
benefits; and
(2) the applicant physician or the physician's medical group may retain any copayments collected or in
the process of being collected as of the date of the issuer's determination.
Added by Acts 2007, 80th Leg., R.S., Ch. 1203 (H.B. 1594), Sec. 1, eff. September 1, 2007.
Subject: Physicians’ Salary Survey

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Socioeconomics

Whereas, Physicians now have a variety of contractual arrangements to consider when deciding where to practice; and

Whereas, More physicians are choosing to become employed, by either a hospital, an academic institution, or a large or small physician practice; and

Whereas, Physicians who wish to be employed need the proper tools to help them negotiate a fair salary when seeking employment; and

Whereas, The Texas Medical Association has available a book to assist employed physicians with contract terms; and

Whereas, Individual physician placement firms have salary data on the limited number of their placements; however, an overall survey of all physicians conducted by a respected physician association would provide much more robust, statistically valid results; and

Whereas, As in negotiations with health plans, a physician’s medical association should provide a tool that helps physicians stand up for themselves in employment negotiations; therefore be it

RESOLVED, That the Texas Medical Association work with an established and credible human resources or placement firm to develop, implement, and publish a physicians’ salary survey available to TMA members only that takes into account a variety of factors that affect salary including, but not limited to, specialty, demographics, practice type and size, geographic location, and different types of contractual payment arrangements.

Related TMA Policy:

None found
Whereas, Traditionally, physicians get paid for direct patient care, such as evaluation and management and procedures; and

Whereas, Insurance and managed care companies (payers) demand and require physicians and their staff to perform services outside of direct patient care (noncare services) without any payment. Examples of such noncare services are obtaining authorization and preauthorization for coverage and payment for prescriptions, laboratory tests, radiology tests, procedures, surgeries, hospitalizations, and physician visits; and gathering, compiling, and submitting medical records and data that benefit payers as they delay and deny care, meet requirements for outside commercial and governmental auditors, and enhance their ability to compile and use actuarial data for their pricing and profitability. Noncare services (1) have greatly increased expenses for physicians, (2) have endangered the ability of physician practices to survive economically, and (3) have caused the demise of independent physician practices; and

Whereas, The purpose of such noncare services is to delay and deny care, thus allowing payers to save, keep, and invest money that otherwise would pay for patient care, thus increasing their profits; and

Whereas, The overwhelming majority of authorization and preauthorization requests eventually are authorized by payers; and

Whereas, Such noncare services harm patients by delaying diagnosis and treatment, thus causing pain, suffering, morbidity, and mortality. The time spent by physicians and their staff in performing noncare services decreases their availability to provide direct patient care for other patients, thus exacerbating physician shortages; and

Whereas, Other professionals, such as attorneys, accountants, and their staff bill and get paid for all services they provide to their clients. The payers’ demands and requirements for physicians and their staff to provide noncare services without compensation is theft, extortion, and indentured servitude; and

Whereas, Despite existing Texas Medical Association policy, such noncare services and their direct and indirect costs have continued to increase and are endangering the viability of the private practice of medicine. As payers continue to disregard existing TMA policy, physicians currently are not compensated for such noncare services that benefit only payers, to the detriment of patients and physicians. The dire need for relief from payers’ demands and requirements for physicians to provide noncare services necessitates the reiteration and strengthening of existing TMA policy; therefore it be

RESOLVED, That the Texas Medical Association adopt policy that payers – insurance companies and managed care companies, including companies managing governmental insurance plans – must compensate physicians for the time physicians and their staff spend on services outside of direct patient care (noncare services) such as authorization and preauthorization for coverage and payment for prescriptions, laboratory tests, radiology tests, procedures, surgeries, hospitalizations, and physician
visits, as well gathering, compiling, and submitting medical records and data. Such compensation shall be promptly paid in full by payers to physicians at a level commensurate with the education, training, and expertise of the physician and at a rate comparable to that of the most highly trained professionals. The physician shall bill the payers for time spent by the physician and his or her staff in performing noncare services including, but is not limited to, time spent filling out forms, reviewing the patient’s medical record, gathering patient-related data, making telephone calls (including time spent negotiating “phone trees” and hold time), documenting in the patient’s medical record, communicating with the patient, altering treatment plans (such as changing medications to comply with formularies), printing, copying, and faxing. Upon receiving such a bill, the payers shall pay the physician promptly, with significant interest penalties assessed for delay in payment. Because noncare services benefit the payers, compensation owed to physicians for these services should not be billable to patients.

Related TMA Policy:

115.016 “A Modest Proposal” to Save our Health Care System
120.003 Health System Reform Managed Care
155.012 Laboratory Benefit Managers
180.031 Pharmacy Benefit Managers
235.027 Payment for Physician Work Product
235.034 Authorizations Initiated by Third-Party Payers, Benefit Managers, and Utilization Review Entities
235.038 Standardized Electronic Prior Authorization Transactions
235.040 Prior Authorization Approval
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 408
2020

Subject: Contracted Health Plans Must Apply the Same Level of Benefits Concerning Patient Responsibility

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Socioeconomics

Whereas, The purpose of contracts between physicians and health plans is to arrange for physicians to provide medical services to health plan policy holders; and

Whereas, Health plans encourage patients to find a medical home through these contracts, which helps keep down medical costs; and

Whereas, Many physicians have adopted telemedicine as another way to care for patients and reduce costs; and

Whereas, Health plans have been reluctant to adopt telemedicine as a covered benefit, thus refusing to pay physicians who use telemedicine; and

Whereas, Health plans recently have begun to offer telemedicine as a covered benefit, waiving any patient responsibility if the patient uses the plan’s preferred vendor (such as Teledoc), but charging a copay or coinsurance for a telemedicine encounter with a contracted physician, thereby offering a separate set of benefits for the same service based on who renders the service; therefore be it

RESOLVED, That the Texas Medical Association create policy that health plans in a binding contract with a physician must apply the same level of benefits concerning patient responsibility (copay, coinsurance) regardless of the contracted physician or provider rendering the service; and be it further

RESOLVED, That TMA take this issue to the state legislature for potential statutory action; and be it further

RESOLVED, That the Texas Delegation to the American Medical Association carry a similar resolution to the AMA House of Delegates for policy development and legislative action.

Related TMA Policy:
145.028 Unequal Insurance Contract Reimbursement for Solo Practitioners
180.024 Conflict Between Physician Ethics and Health Plan Business Practices
180.026 Health Insurance Plans
180.032 Advocacy Efforts Regarding Health Care Payment Plans

Related AMA Policy:
D-285.972 Tiered, Narrow, or Restricted Physician Networks
H-450.941 Pay-For-Performance, Physician Economic Profiling, and Tiered and Narrow Networks
TABLE

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 409
2020

Subject: School Physicals Should Be Conducted by Physicians or Their Supervised Designee

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Science and Public Health

Whereas, The University Interscholastic League already has established the importance of athletic
preparticipation physical examinations by requiring them for school-based athletics; and

Whereas, Children and adolescents are developmentally different from the adult population and have very
different physical attributes depending on age and different nutritional, psychological, physical,
emotional, and developmental needs; and

Whereas, Because of their extensive training, physicians are best qualified to conduct athletic
preparticipation physical examinations; and

Whereas, The Texas Medical Association has established policy (55.056) supporting changes to the Texas
Education Code requiring that athletic preparticipation physicals for school-age children be conducted
only by licensed physicians or appropriately supervised physician assistants or advanced practice nurses
licensed in Texas; and

Whereas, Some school districts in Texas allow nonphysician practitioners to conduct athletic
preparticipation physicals; therefore be it

RESOLVED, That the Texas Medical Association advocate for legislative changes to the Texas
Education Code as described in TMA Policy 55.056 requiring that athletic preparticipation physical
examinations for school-age children be conducted only by licensed allopathic or osteopathic physicians,
or appropriately supervised physician assistants or advanced practice nurses licensed in Texas.

Related TMA Policy:
55.056 Physician Examinations for Young Athletes
55.046 Recommendations for Ensuring the Health of the Adolescent Athlete
30.004 Allied Health
30.012 Nursing and Nurses with Advanced Training
30.015 Nurses in Advanced Practice
30.016 Physician Assistants and Allied Health Personnel
30.025 Allied Health Care Professionals
30.029 Physician Extenders in Rural Health Clinics
30.035 Federal Prohibition of the Independent Practice of Medicine by Nurse Practitioners
30.036 Opposition to New State Licensing Category for Physicians Who Do Not Complete Residency
Training
55.006 School-Based Health Care Centers

Information:
From the Texas Education Code, Title 2. Public Education, Subtitle F. Curriculum, Programs and
Services, Chapter 33. Service Programs and Extracurricular Activities:
Sec. 33.096. CARDIAC ASSESSMENTS OF HIGH SCHOOL PARTICIPANTS IN EXTRACURRICULAR ATHLETIC ACTIVITIES. (a) A school district must provide a district student, who is required under University Interscholastic League rule or policy to receive a physical examination before being allowed to participate in an athletic activity sponsored or sanctioned by the University Interscholastic League, the following:

1. information about sudden cardiac arrest and electrocardiogram testing; and
2. notification of the option of the student to request the administration of an electrocardiogram, in addition to the physical examination.

(b) A student may request an electrocardiogram from any health care professional, including a health care professional provided through the student’s patient-centered medical home, as defined by Section 533.0029, Government Code, a health care professional provided through a school district program, or another health care professional chosen by the parent or person standing in parental relation to the student, provided that the health care professional is:

1. appropriately licensed in this state; and
2. authorized to administer and interpret electrocardiograms under the health care professional’s scope of practice, as established by the health care professional’s Texas licensing act.

(c) The University Interscholastic League shall adopt rules as necessary to administer this section.

(d) The rules adopted under Subsection (c) must include:

1. criteria under which a school district may request an exemption from the requirements of Subsection (a);
2. variances that allow for a delay of the implementation of the requirement to notify students of the option to request an electrocardiogram under this section;
3. procedures to ensure students receiving the required annual physical examination are notified of the option to request an electrocardiogram; and
4. provisions to ensure that the requirements under this section are minimum standards that provide a school district with the option to implement a program that exceeds the standards required by this section.

(e) This section does not create a cause of action or liability or a standard of care, obligation, or duty that provides a basis for a cause of action or liability against a health care professional described by Subsection (b), the University Interscholastic League, a school district, or a district officer or employee for:

1. the injury or death of a student participating in or practicing for an athletic activity sponsored or sanctioned by the University Interscholastic League based on or in connection with the administration or interpretation of or reliance on an electrocardiogram; or
2. the content or distribution of the information required under Subsection (a) or the failure to distribute the required information under this section.

Added by Acts 2019, 86th Leg., R.S., Ch. 1023 (H.B. 76), Sec. 1, eff. September 1, 2019.
Subject: Utilization Review, Medical Necessity Determination, Prior Authorization Decisions

Introduced by: Bexar County Medical Society

Referred to: Reference Committee on Financial and Organizational Affairs

Whereas, Prior authorization requirements are increasing in number yearly, and this burden is driving administrative costs higher to an estimated $68,274 per physician per year, which equates to $31 billion annually, according to Health Affairs; and

Whereas, Prior authorizations delay care and are obstacles to patients receiving optimal care. A recent American Medical Association survey reported that 91% of physicians said prior authorization had a significant or somewhat negative impact on their patients’ clinical outcome, and 28% said prior authorization intrusion led to a serious adverse event for a patient under their care; and

Whereas, The Texas Medical Association Board of Councilors’ current opinions state that medical necessity determination “is the practice of medicine; it is not a benefit determination”; and

Whereas, The TMA Board of Councilors also opined that physicians who perform prospective and/or concurrent utilization review are “obligated to review the request for treatment with the same standard of care as would be required by the profession in the community in which the patient is being treated”; and

Whereas, Decisions made by insurance medical directors, physicians conducting utilization reviews, and physicians providing peer-to-peer reviews on behalf of insurance companies affect patient care and can lead to adverse outcomes; therefore be it

RESOLVED, That the Texas Medical Association urge physicians to bring their concerns regarding decisions made by physicians working for insurance companies to the attention of the Texas Medical Board and Texas Department of Insurance, as these decisions affect patient outcome, and that TMA create a clearinghouse of all complaints against insurance companies and insurance doctors and aggregate this data; and be it further

RESOLVED, That the Texas Delegation to the American Medical Association take this resolution to the AMA House of Delegates, urge the AMA House of Delegates to adopt similar policy, and urge the AMA Council on Ethical and Judicial Affairs to devise ethical opinions similar to the TMA Board of Councilors’ opinions on medical necessity determination and utilization review.

Related TMA Policy:

235.034 Authorizations Initiated by Third-Party Payers
235.040 Prior Authorization Approval
235.038 Standardized Electronic Prior Authorization Transactions
160.017 Utilization Review
145.024 Medical Decision Makers Licensed in Texas
Related AMA Policy:
1 Utilization Review by Physicians H-320.973
2 Principles of Drug Utilization Review H-120.978
3 Medical Necessity and Utilization Review H-320.942
Subject: Prior Authorizations

Introduced by: Bexar County Medical Society

Referred to: Reference Committee on Socioeconomics

Whereas, Prior authorizations are increasing in number and driving administrative costs higher – by an estimated $68,274 per physician per year, which equates to $31 billion annually, according to Health Affairs; and

Whereas, When a prior authorization is required, only 29% of patients end up with the originally prescribed product, and 40% abandon therapy altogether; and

Whereas, In one study of more than 4,000 type 2 diabetics patients, those denied their diabetic drugs had higher overall medical costs the following year; and

Whereas, Although the purpose of prior authorizations was to save money, they have not lowered insurance premiums; in fact, health care insurance premiums increased more than wages in 2019, with the average premium for family coverage having increased 22% over the past five years and 54% over the past 10 years; and

Whereas, prior authorizations have neither saved money for the patient nor improved patient outcomes, but rather have increased the financial burden on physicians while delaying or denying needed care for patients; therefore be it

RESOLVED, That the Texas Medical Association work to limit the use of prior authorizations to only treatments not supported by the medical literature.

Related TMA Policy:
235.034 Authorizations Initiated by Third-Party Payers
235.040 Prior Authorization Approval
235.038 Standardized Electronic Prior Authorization Transactions

Related AMA Policy:
Prior Authorization and Utilization Management Reform H-320.939
Prior Authorization Reform D-320.982
Promoting Accountability in Prior Authorization D-320.983
Preauthorization D-320.988
Opposition to Prescription Prior Approval D-125.992
The Impact of Pharmacy Benefit Managers on Patients and Physicians D-110.987
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 412
2020

Subject: Step-Edit Therapy Contributes to Denial of Care and Has Not Demonstrated Improved Patient Outcomes or Overall Cost Savings

Introduced by: Bexar County Medical Society

Referred to: Reference Committee on Socioeconomics

Whereas, step-edit therapy – also known as a “fail first” policy – is used by insurance companies as a form of prior authorization that dictates a required first line of drug therapy for a patient, and defines first-line drugs as preferred and designated as Tier 1, while nonpreferred drugs are designated as Tier 2 or Tier 3, with copays for nonpreferred drugs in Tier 2 higher than in Tier 1 and highest in Tier 3; and

Whereas, Studies have shown patients underutilize therapeutic drugs when a copay is higher, with a nonadherence rate as high as 52% for antihypertensive drugs and with similar results of nonadherence for antidepressants, nonsteroidal anti-inflammatory drugs, and antidiabetic drugs; and

Whereas, Although the underutilized drugs have demonstrated a cost savings on drugs, studies have shown an increase in medical cost; however, overall costs savings have been shown to occur when medicines were affordable without a tier system; therefore be it

RESOLVED, That the Texas Medical Association (TMA) urge our legislators to review and make transparent the “fail-first” policy of step-edit therapy and study how it affects patient outcomes; and be it further

RESOLVED, That the TMA ask the American Medical Association to review the ethical implication of step-edit therapy and make further recommendations on its use.

Related TMA Policy:
235.034 Authorizations Initiated by Third-Party Payers
235.040 Prior Authorization Approval
235.038 Standardized Electronic Prior Authorization Transactions
95.012 Drugs Antisubstitution Laws and Generic Prescriptions
245.020 Physicians Retaining Autonomous Clinical Decision-Making Authority
95.043 Prescription Drug Value Based Contracting

Related AMA Policy:
Step Therapy D-320.981
Step Therapy H-320.937
Subject: Caps on Insulin Copayments With Insurance

Introduced by: Medical Student Section

Referred to: Reference Committee on Socioeconomics

Whereas, Diabetes affects approximately 11.2% of the population in Texas and is the seventh leading cause of death nationally and in Texas; and

Whereas, The direct medical cost for diagnosed diabetes in Texas was estimated at $18.9 billion in 2017, with an additional $6.7 billion spent on indirect costs from lost productivity due to diabetes; and

Whereas, The annual average medical cost per diabetic patient is $13,240 with approximately 44% of expenditures stemming from prescription medications, including insulin; and

Whereas, Our Texas Medical Association advocates reducing the higher cost of medications by supporting the negotiation of drug prices for Medicare and Medicaid; and

Whereas, From 2012 to 2016, the average point-of-sale price of insulin nearly doubled from 13 cents per unit to 25 cents per unit, translating to a daily cost increase from $7.80 to $15 for a type 1 diabetic patient using an average amount of insulin (60 units per day); and

Whereas, One in four patients reported cost-related insulin underuse, including taking smaller doses and skipping doses, which was independent of the patient’s prescription drug coverage plan; and

Whereas, Patients who report cost-related underuse were more likely to have poor glycemic control, increasing their risk for complications such as hypertension, chronic kidney disease, neuropathy, lower limb amputations, retinopathy, stroke, coronary heart disease, depression, and cancer; and

Whereas, Our TMA has an existing policy that all patients must have access to medically indicated prescription drugs necessary to treat their illnesses; and

Whereas, Our TMA currently does not have an explicit policy regarding insulin pricing for patients; and

Whereas, The Texas Diabetes Council supports insulin caps in its State Plan for Diabetes; and

Whereas, The American Medical Association has policy consistent with the principle of increasing access to prescription medications including insulin for patients; and

Whereas, Some private insurance programs have shown the capability to offer a capped copayment on insulin for their customers; therefore be it

RESOLVED, That the Texas Medical Association support limiting the copayments insured patients pay per month for prescribed insulin.
Related TMA Policy:
1. 195.039 Lower Drug Costs
2. 195.037 Prescription Drug Negotiation in the Medicare Program
3. 95.043 Prescription Drug Value Based Contracting
4. 95.041 Ensuring Patient Access to Affordable Prescription Medications

Related AMA Policy:
5. Additional Mechanisms to Address High and Escalating Pharmaceutical Prices H-110.980
6. Insulin Affordability H-110.984
7. Pharmaceutical Costs H-110.987
8. Controlling the Skyrocketing Costs of Generic Prescription Drugs H-110.988
9. Cost of Prescription Drugs H-110.997
10. Reducing Prescription Drug Prices D-110.993
11. Prescription Drug Prices and Medicare D-330.954

References:
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 414
2020

Subject: Postpartum Maternal Healthcare Coverage Under Children’s Insurance

Introduced by: Medical Student Section

Referred to: Reference Committee on Socioeconomics

Whereas, Perinatal depression is defined as a major or minor depressive disorder with a depressive episode occurring during pregnancy or within the first year after childbirth; and

Whereas, One in seven women suffer from perinatal depression within the first year of motherhood; and

Whereas, Estimated rates of depression among pregnant and postpartum women range from 10% to 25% depending on socioeconomic status and additional risk factors; and

Whereas, Postpartum screening is important to maximize the health of mothers with newborns as it provides a significant opportunity to identify possible factors that can affect maternal health, such as breastfeeding practices, family planning, and depression, among others; and

Whereas, Untreated postpartum depression interferes with the mother’s ability to care for her newborn child and can lead to problems with the child’s physical, cognitive, and behavioral development; and

Whereas, Regular monitoring and support during the first three months postpartum should be required to optimize maternal mental health care and reduce the risk of suicide, especially among mothers with a history of psychiatric disorders; and

Whereas, Barriers prevent peripartum women from accessing postpartum depression screening and care, such as financial and geographic barriers that limit access to health care, societal and familial stigma, and lack of postpartum depression education and awareness; and

Whereas, The World Health Organization recommends all mothers receive at minimum three postpartum visits from time of delivery to six weeks postpartum, where each visit includes psychosocial support to prevent postpartum depression; and

Whereas, The American Academy of Pediatrics recommends screening for maternal-perinatal depression during pediatric visits; and

Whereas, In 2016, the Centers for Medicare & Medicaid Services published best practices for state Medicaid programs to cover maternal depression screening as part of the pediatric well-child visit; and

Whereas, As of 2018, screening for perinatal depression during the pediatric well-child visit is a covered benefit under state Medicaid programs for 25 states; and

Whereas, In 2018, Texas added a one-time postpartum depression screening per eligible child as a covered benefit under Children’s Medicaid and the Children’s Health Insurance Program; and
Whereas, Insurance coverage greatly improves health outcomes for individuals and families because they have access to preventive and screening services; therefore be it

RESOLVED, That the Texas Medical Association will work with relevant stakeholders to support coverage of and payment for postpartum maternal health care for at least 12 months postpartum under the newborn child’s health insurance plan, including Children’s Medicaid and Children’s Health Insurance Program plans for women who are otherwise uninsured or ineligible for Medicaid.

Related TMA Policy:
330.015 Physician-Led Initiatives to Address Maternal Mortality and Morbidity

Related AMA Policy:
Improving Mental Health Services for Pregnant and Postpartum Mothers H-420.953
Extending Medicaid Coverage for One Year Postpartum D-290.974

References:
Subject: Promotion of LGBTQ+ Friendly and Gender-Neutral Options on Medical Documentation and Intake Forms

Introduced by: Neil Gupta, MSS Delegate

Referred to: Reference Committee on Socioeconomics

Whereas, The visibility of lesbian, gay, bisexual, transgender, queer, and questioning (LGBTQ+) individuals is increasing with more social acknowledgment, social movements, and legal precedents; and

Whereas, The Center for American Progress (CAP) has documented that the discrimination faced by the LGBTQ+ population discourages members of the community from seeking health care; and

Whereas, A 2017 CAP survey indicated 8% of all LGBTQ+ people, 22% of transgender people, and 14% of LGBTQ+ people who had experienced discrimination based on their sexual orientation and gender identity in the past year avoided or postponed medical care because of disrespect or discrimination from medical staff; and

Whereas, The 2017 Texas Pride Impact Funds report indicates that roughly 740,000, or 3.6%, of Texas residents identify as LGBTQ+, and the 854 survey respondents universally ranked routine health care as their No. 1 priority need, followed by health care provider LGBTQ+ competency; and

Whereas, While almost 100% of Texas Pride Impact Funds survey respondents reported being out to close friends, more than 30% of respondents reported not being out or open to their health care providers, with many experiencing biased and discourteous encounters with medical professionals as patients when they were open about their gender identity and/or sexual orientation; and

Whereas, Physicians and researchers leading the charge in understanding the gaps in LGBTQ+ health needs have voiced an urgent need to collect and standardize demographic data of these populations in federally and privately funded surveys and electronic health records; and

Whereas, Increased medical documentation of sexual identity and gender preferences can help researchers better understand the specific health needs of each distinct population group under the LGBTQ+ umbrella; and

Whereas, The National LGBT Health Education Center states that using LGBTQ+ friendly and gender-neutral options on forms will help ensure LGBTQ+ people are comfortable sharing information relevant to their care with physicians and staff, and by taking this step, health centers can ensure all their patients, including their LGBTQ+ patients, attain the highest possible level of health; and

Whereas, The National LGBT Health Education Center states a best practice as the following: document patient name, pronoun(s), a process for ensuring staff compliance of those names and pronouns, answers to questions about sexual orientation and gender identity in the demographics section of registration forms, current gender identity, and sex assigned at birth; and
Whereas, The National LGBT Health Education Center advocates for the avoidance of gender-specific terms on forms, such as “husband/wife” or “mother/father,” and should reflect the reality of LGBT families by asking about “relationships,” “partners,” and “parent(s);” and

Whereas, The American Medical Association has adopted policies H-315.967, Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation, and D-315.974, Promotion of LGBTQ-Friendly and Gender-Neutral Intake Forms (including in electronic health records and other health information technology); and

Whereas, Current TMA Policy 265.028 supports increasing educational opportunities for physicians on LGBTQ+ issues to improve health outcomes and increase gender identity and sexual orientation reporting of LGBTQ+ patients; and

Whereas, TMA has established a LBGTQ+ Health Workgroup to “raise awareness among physicians’ colleagues” so LGBTQ+ health needs are adequately met; and

Whereas, Current TMA policy supports the use of standardized, free-of-charge, personal health records (PHRs) and supports the “interoperability of PHRs in allowing access to patient health information in patient care settings”; therefore be it

RESOLVED, That the Texas Medical Association amend the wording of TMA Policy 265.028 to support inclusion of a patient’s biological sex; current gender identity; sexual orientation; preferred gender pronoun(s); preferred name; and clinically relevant, sex-specific anatomy in medical documentation and related forms, including in electronic health records, in a culturally sensitive and voluntary manner; and be it further

RESOLVED, That TMA amend the wording for TMA Policy 265.028 to advocate for the incorporation of recommended best practices of LGBTQ+ friendly and gender-neutral medical documentation into electronic health records and other health information technology products at no additional cost to physicians; and be it further

RESOLVED, That TMA, with input from the TMA LGBTQ+ Health Workgroup and appropriate medical and community-based organizations, promote among our membership these recommendations pertaining to medical documentation and related forms, including in electronic health records.

Related TMA Policy:

265.028 Improving LGBTQ Health Care Access
118.004 Health Information Technology – Health Information Exchange
118.002 Health Information Technology – Electronic Health Records and Personal Health Records
265.027 Costs to Update Health Information Technology Products to Address Issues of Sex and Gender

Related AMA Policy:

D-315.974 Promotion of LGBTQ-Friendly and Gender-Neutral Intake Forms
H-315.967 Promoting Inclusive Gender, Sex, and Sexual Orientation Options on Medical Documentation

Sources:


Subject: Interstate Medical Liability Tort Protection for Physicians Treating Patients in Neighboring States

Introduced by: Medical Student Section

Referred to: Reference Committee on Socioeconomics

Whereas, In 2015, a citizen of New Mexico filed a medical malpractice suit against a Texas physician in the New Mexico District Court System for care rendered in Lubbock, Texas; and

Whereas, Texas law would have required that the lawsuit be dismissed under Texas Tort Claims Act §101.106(f) (sovereign immunity) because the physician was a Texas governmental employee and the plaintiff failed to timely substitute the governmental entity as the defendant; and

Whereas, Texas physicians threatened to stop seeing New Mexico patients as a result of this lawsuit; and

Whereas, Texas physicians ultimately provide care for more than 22% of hospitalized patients in southern and eastern New Mexico; and

Whereas, The American Medical Association Litigation Center, along with TMA and the New Mexico Medical Society (NMMS), filed an amicus brief supporting the enforcement of Texas law in solidarity with Texas physicians; and

Whereas, In 2017, the New Mexico Supreme Court dismissed the case in favor of the defendant (Texas physician) based upon the legal principle of comity; and

Whereas, Comity is defined as “the legal principle that political entities (such as states, nations, or courts from different jurisdictions) will mutually recognize each other’s legislative, executive, and judicial acts. The underlying notion is that different jurisdictions will reciprocate each other’s judgments out of deference, mutuality, and respect”; and

Whereas, In 2016, the New Mexico Legislature responded by passing New Mexico House Bill 270 clarifying that New Mexico courts would honor choice-of-law and exclusive-forum-selection clauses in contracts between New Mexico patients and out-of-state caregivers; and

Whereas, A legal forum is defined as “a place where disputes are heard and decided, such as a tribunal or court”; and

Whereas, NMMS, in solidarity with Texas physicians, provided a “summary of HB 270 and sample forms for physicians to use in Texas (or other states) when accepting patients from New Mexico”; and

Whereas, House Bill 270 was repealed effective July 01, 2019, per its original language, which poses a recurrence of risk for physicians to be litigated under New Mexico tort law for care rendered in Texas; and
Whereas, In the case described above, the New Mexico Supreme Court ruling was in favor of the Texas defendant, but in absence of clarifying legislation, the original question of whether New Mexico will exert jurisdiction in out-of-state care litigation is once again relevant, creating uncertainty for our Texas physicians; therefore be it

RESOLVED, The Texas Medical Association recognize that the appropriate forum for medical liability suits against physicians is the state in which care is rendered; and be it further

RESOLVED, The Texas Delegation to the AMA take this resolution with the added language below to AMA:

That our AMA recognize that access to care for patients seen by out-of-state physicians may be diminished when there is uncertainty about the appropriate legal forum for medical liability claims.

Related TMA Policy:
Professional Liability 170.007

Related AMA Policy:
Health System and Litigation Reform D-435.974
Support of Campaigns Against Lawsuit Abuse H-435.974
Insurance Coverage Parity for Telemedicine Service D-480.969
Established Patient Relationships and Telemedicine D-480.964

References:
Texas Medical Association House of Delegates

Resolution 417
2020

Subject: Insurance Promotion of Preventive Care Services via Incentive-Based Programs

Introduced by: Medical Student Section

Referred to: Reference Committee on Socioeconomics

Whereas, Approximately 45% of all Americans suffer from at least one chronic disease; and

Whereas, 34% of heart disease deaths, 21% of cancer deaths, and 39% of chronic lower respiratory deaths from 2008 to 2011 were preventable; and

Whereas, In 2015, only 8% of U.S. adults aged 35 and older had received all the high-priority, appropriate clinical preventive services recommended for them; and

Whereas, Small cash incentives to patients have been shown to improve visits to primary care and as a result help with screening for preventable health conditions; and

Whereas, 79% of commercially available health insurance plans had offered positive incentives to members for receiving specific clinical preventive services; and

Whereas, 49% of commercial health insurance plans found incentives very useful for uptake of preventive health care services; and

Whereas, Texas created the Wellness Incentives and Navigation (WIN) project funded by the Medicare Incentives for Prevention of Chronic Disease (MIPCD) program from 2011 to 2015 to monetarily incentivize usage of health promotion programs to prevent diseases such as diabetes prevention, heart disease and hyperlipidemia; and

Whereas, 76% of the beneficiaries of the MIPCD program nationwide reported the program had encouraged lifestyle changes such as setting goals and working towards improving improve their health; therefore be it

RESOLVED, That the Texas Medical Association advocate for health insurance companies to adopt cash-based incentive programs like the Medicare Incentives for Prevention of Chronic Disease program to promote usage of preventive care services; and be it further

RESOLVED, That TMA support further research on health care initiatives that can increase usage of preventive care services by individuals.

Related TMA Policy:

145.027 Transparency of Preventive Care Services
260.029 Preventive Medicine
Related AMA Policy:

None.

References:


2. McCarthy M. Up to 40% of premature deaths in the US are preventable, says CDC. BMJ 2014; 348:g3122.


Subject: Paid Parental Leave

Introduced by: Women Physicians Section

Referred to: Reference Committee on Socioeconomics

Whereas, Beginning on Oct. 1, 2020, federal workers employed by the government for at least one year will be guaranteed 12 weeks of paid parental leave upon the birth or adoption of a child; and

Whereas, Six states and the District of Columbia have enacted paid parental leave policies set to take effect in 2020 or 2021; and

Whereas, Numerous studies have confirmed the benefits of paid parental leave on health outcomes for children and families, such as fewer low birthweight and preterm births, increased breastfeeding, fewer hospitalizations among infants, and improved maternal health; and

Whereas, Paid parental leave increases long-term employment and job continuity for mothers, and

Whereas, Research suggests more low-income and disadvantaged families used the time for parental leave more when this leave was paid than when it was not a paid leave policy; and

Whereas, Approximately 38% of employers currently offer paid parental leave for employees who are new parents; and

Whereas, Currently under the Family Medical Leave Act, all eligible parents are guaranteed up to 12 weeks of unpaid leave if they are employed by an organization with at least 50 employees; therefore be it

RESOLVED, That the Texas Medical Association promote awareness and education for physicians, legislators, and the public on the importance of adequate parental leave, especially paid leave, in ensuring good maternal and infant health outcomes and promoting the health and well-being of the family; and be it further

RESOLVED, That TMA support federal, state, local, and private parental leave policies that provide adequate time to give birth, recover, and breastfeed, and allow for parental bonding following the birth or adoption of a child; and be it further

RESOLVED, That TMA support policies that provide at least 12 weeks of paid parental leave following the birth or adoption of a child; and be it further

RESOLVED, That TMA support that paid parental leave policies incorporate funding mechanisms that do not put an undue burden on solo or small business owners; and be it further

RESOLVED, That TMA evaluate how internal policies for employees should be updated to provide paid parental leave following the birth or adoption of a child.
Subject: Placing Medicaid Expansion on a Statewide Voting Ballot

Introduced by: Medical Student Section

Referred to: Reference Committee on Financial and Organizational Affairs

Whereas, Texas declined to expand Medicaid to cover individuals with incomes up to 138% of the federal poverty level following the passage of the Affordable Care Act (ACA); and

Whereas, Texas has 5 million uninsured residents, or 17.7% of the total population; and

Whereas, Texas has the highest rate of uninsured individuals of all 50 states and is above the national average of 8.5%; and

Whereas, If Texas opted to expand its program through the ACA, 1.5 million Texans would become eligible for Medicaid; and

Whereas, The American Medical Association endorsed state Medicaid expansion to 138% of the federal poverty level in its policy Medicaid Expansion D-290.979; and

Whereas, States that expanded Medicaid to 138% of the federal poverty level experienced significant drops in their rates of uninsured individuals, particularly among those in small towns and rural areas; and

Whereas, The value of lost earnings and poor health for uninsured Texans was estimated to be $57 billion in 2016; and

Whereas, The cost of lost earnings and poor health for uninsured Texans is estimated to rise to $174 billion by 2040 unless action is taken to reduce the number of uninsured Texans; and

Whereas, Medicaid expansion to 138% of the federal poverty level has been correlated to increased economic gains among newly covered individuals; and

Whereas, Rural community health centers in states that expanded Medicaid experienced consistent improvements in quality and volume of care; and

Whereas, States that opted to expand Medicaid experienced fewer closures of rural hospitals; and

Whereas, From 2010 to 2018, Texas experienced the highest number of rural hospital closures of all 50 states with 15 closures; and

Whereas, Texas hospitals and physicians spent $3.5 billion in 2016 on uncompensated care; and

Whereas, The cost of uncompensated care in Texas is expected to rise to $12.4 billion in 2040 unless action is taken to reduce the number of uninsured; and
Whereas, Maine expanded Medicaid in January 2019 after the state’s voters approved a ballot initiative in November 2017 to expand; and

Whereas, The states of Utah, Idaho, and Nebraska opted to expand Medicaid following approval of a ballot initiative by each states’ voters in November 2020; and

Whereas, Sixty-four percent of Texans support Medicaid expansion; therefore be it

RESOLVED, That the Texas Medical Association advocate for the inclusion of Medicaid expansion initiatives on a statewide ballot to allow eligible Texas voters to decide; and be it further

RESOLVED, That TMA encourage a reopened dialogue on the topic of Medicaid expansion as an avenue to reduce the high rate of uninsured individuals in Texas.

Related TMA Policy:
None.

Related AMA Policy:
Medicaid Expansion D-290.979

References:
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 420
2020

Subject: Training Requirements Imposed by Insurance Companies Preventing Patients’ Access to Quality Medical Care

Introduced by: Lone Star Caucus

Referred to: Reference Committee on Medical Education and Health Care Quality

Whereas, Physicians undergo rigorous education in medical schools, extensive training in their residencies, and in some cases intensive training in subspecialties (fellowships) prior to entering clinical practice; and

Whereas, Physicians are licensed by state medical boards after initial review of their training and credentials; and

Whereas, Physicians face rigorous and stringent license renewal criteria in the form of continuing education credits annually or biannually; and

Whereas, In some cases, physicians are required to obtain periodic recertifications by their specialty boards; and

Whereas, A physician’s primary obligation is attending to a patient’s well-being by applying his or her medical knowledge and experience and not learning the various and sundry business practices of insurance companies; therefore be it

RESOLVED, That the Texas Medical Association urge insurance companies to cease and desist from requiring physicians to spend time – in addition to their extensive professional training – in training in each companies’ requirements for patient care; and be it further

RESOLVED, That the Texas Medical Association urge the Texas Medical Board to condemn such practice by insurance companies as beyond the companies’ purview of physician training responsibilities; and be it further

RESOLVED, That the Texas Medical Association urge the Texas insurance commissioner to investigate the appropriateness of insurance companies imposing on physicians the onerous and unnecessary burden of web-based or otherwise administered training; and be it further

RESOLVED, That the Texas Medical Association urge the Texas Legislature to take adequate measures to prevent insurance companies from interfering with the education of physicians by engaging in the wasteful exercise of requiring physicians to train in the companies’ preferences, objectives, and/or goals.

Related TMA Policy:
None.

Related AMA Policy:
None.
Texas Medical Association House of Delegates

Resolution 421
2020

Subject: Physician Societies to Create a Self-Funded, Balanced, and Nonpartisan Center for the Study of Health Care Reform

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Science and Public Health

Whereas, Evidence suggests growing support among national politicians and the general public for expansive health care reform, and it is feasible that national legislation creating a universal Medicare or single-payer system will be proposed soon; and

Whereas, In the absence of clear and accessible evidence derived from the scientific method and rational skepticism, such reform is driven by anecdotes, assumptions, emotion, and politics; and

Whereas, Health care reform legislation is often massive, opaque, and unproven, and without the benefit of pilot studies or existing models, the downstream consequences of such legislation are unpredictable and riddled with unintended consequences; and

Whereas, Despite the support for significant change to our health care system, the implications for patient choice, physician autonomy, and the “rationing of care” are often poorly understood; and

Whereas, Some of the proposed reforms directly conflict with Texas Medical Association and American Medical Association policy – that health care reform should be evidence-based, responsible, sustainable, and incremental, and preserve patient and physician choice, as described in TMA policy 120.010; and

Whereas, To promote greater public awareness and elevate the current partisan political discourse, a physician-led, balanced, and nonpartisan entity would provide a more effective and trusted platform for the collection, study, and distribution of information regarding the potential effects of proposed health care reform; and

Whereas, The startup investment provided by medical societies for the creation of the proposed entity can be structured in the form of a loan to be repaid at a future date. The initial phase of development could include the minimum personnel and resources necessary to create a website, solicit additional sources of funding from individuals and organizations, and recruit essential staff; therefore be it

RESOLVED, That the Texas Medical Association, in collaboration with other medical societies, create and support a permanent, physician-led, independently funded “center” for the balanced, nonpartisan study of health care reform. This entity will maintain and advertise for an online platform to provide a balanced critique upon the strengths and limitations of general and specific policy proposals, health care reports, and national health care systems for the benefit of the general public; and be it further

RESOLVED, That the Texas Delegation to the American Medical Association carry a similar resolution to the AMA House of Delegates, calling upon AMA to support the aforementioned permanent, physician-led, independently funded center for balanced, nonpartisan study of health care reform.
Related TMA Policy:

1. 60.004 Freedom of Choice
2. 110.003 Private Individualized Medical Care
3. 110.009 Health Care Coverage
4. 120.001 Health Care Reform
5. 120.002 Health System Reform Cost Control
6. 120.003 Health System Reform Managed Care
7. 120.010 Principles for Evaluating Health System Reform
8. 145.005 Single Payer Systems
9. 145.007 Competitive Insurance Models
10. 145.009 Individual Responsibility for Health Care
11. 145.012 Health Insurance Individual Ownership
12. 145.013 Private Healthcare System, Impact of Uninsured
13. 190.032 Medicaid Coverage and Reform

Related AMA Policy:

1. 165.838 Health System Reform Legislation
2. H-165.844 Educating the American People About Health System Reform
3. H-165.888 Evaluating Health System Reform Proposals
4. H-165.904 Universal Health Coverage
5. D-165.935 Protecting Patient Access to Health Insurance Coverage, Physicians, and Quality Health Care
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 422
2020

Subject: Develop Guidelines for Proper Oversight and Collaboration of Midlevel Practitioner by Physicians

Introduced by: Bexar County Medical Society

Referred to: Reference Committee on Socioeconomics

Whereas, Patients deserve care led by physicians, as four out of five patients prefer having physicians lead their health care team; and
Whereas, Many states like Texas require physician supervision of midlevel practitioners, and TMA has published a resource guide on midlevel supervision; and
Whereas, Physician supervision of midlevel practitioners is enforced by the Texas Medical Board; therefore be it
RESOLVED, That the Texas Medical Association (TMA) educate physicians and disseminate to them information on basic tenets of proper physician oversight and supervision of midlevel practitioners and encourage physicians to bring to the attention of the Texas Medical Board physicians who are not providing supervision as required per the delegation of duties; and be it further
RESOLVED, That the Texas Delegation to the American Medical Association take this resolution to the AMA House of Delegates, urging it to develop national guidelines for proper oversight and collaboration of midlevel practitioners by a physician.

Related TMA Policy:
100.032 Appropriate Physician Oversight of Emergency Medical Service Medical Practices
30.035 Federal Prohibition of the Independent Practice of Medicine by Nurse Practitioners
30.025 Allied Health Care Professionals
30.029 Physician Extenders in Rural Health Clinics
Subject: A Push for Mobile-First Design Principles Within Medical IOT (Internet of Things) Interfaces

Introduced by: Medical Student Section

Referred to: Reference Committee on Socioeconomics

Whereas, Eighty-one percent of Americans own a smartphone, and at least 96% own a cellphone; and

Whereas, Sixty-seven percent of web traffic is mobile device-oriented and continues to rise; and

Whereas, Lower-income adults are more likely than those in higher-earning households to be smartphone-only internet users; and

Whereas, One-quarter of Hispanic and black Americans are smartphone-only internet users compared with about one in 10 white Americans; and

Whereas, Studies of rural America report greater ownership of smartphones compared with broadband access; and

Whereas, Broadband access is a primary concern for the Texas Medical Association, as shown by Policy 275.06, in part due to informational accessibility concerns as shown by Policy 118.002; and

Whereas, American Medical Association Policy H-478.981 promotes mobile engagement in health information technology; and

Whereas, Broadband coverage for desktop computers has improved only slightly, while smartphone web traffic has risen dramatically to 58% in 2018, with a predicted 72% of web users being mobile-only by 2025, according to industry research; and

Whereas, Smartphone users are five times more likely to abandon a task if the site isn’t optimized for mobile use; and

Whereas, “Ninety-six percent of organizations using smartphones, tablets and other mobile devices see an increase in patient experience scores. Of those, 32 percent say their scores have risen drastically.” (Jamf 2018 survey); and

Whereas, In a hospital setting, stationary terminals do not provide the mobility health care requires; and

Whereas, Physicians worldwide show an increased usage of mobile devices in their daily practice and patient interactions; and

Whereas, Feasibility reports predict that transitioning from web to mobile is not expected to significantly increase cost and that mobile-oriented care can overcome rural disparities; therefore be it
RESOLVED, That the Texas Medical Association recognize and encourage mobile-first designs within our health care systems IOT (internet of things) vendors; and be it further

RESOLVED, That our TMA encourage a mobile-first design goal among hospital administrations within their own local scope of health care systems; and be it further

RESOLVED, That our TMA be aware of rising trends in patient informational technology and adjust future legislation accordingly with respect to previously written TMA policy and future technological trends.

Relevant TMA Policy:
275.006 Broadband Internet Access to Rural Texas
118.002 Health Information Technology – Electronic Health Records and Personal Health Records

Relevant AMA policy:
Health Information Technology Principles H-478.981

References:
study?zd_source=mta&zd_campaign=14105&zd_term=praveenkanyadi
Subject: Adoption of Principles of Physician Value-Based Decisionmaking in Medical Practice and Professionalism

Introduced by: Medical Student Section

Referred to: Reference Committee on Socioeconomics

Whereas, Value-based medicine is the practice of medicine that emphasizes the patient’s improvement in quality of life, outcomes, safety, and service, divided by the total cost of patient care over time to minimize unnecessary interventions; and

Whereas, The National Academy of Medicine developed a STEEP framework that describes value-based medicine as safe, timely, effective, efficient, equitable, and patient-centered; and

Whereas, The Institute for Healthcare Improvement developed the widely used Triple Aim framework to measure value in the health care system: (1) improve the quality, satisfaction, and patient experience of care; (2) improve the health of populations; and (3) reduce the per-capita cost of health care; and

Whereas, Improvements in technology, advances in research on cost-effective clinical decisionmaking cascades of care, and initiatives like Choosing Wisely are equipping physicians with tools to make better value-based decisions by providing ready access to current data and value frameworks; and

Whereas, In 2002, in the Annals of Internal Medicine, the Charter on Medical Professionalism was published through collaboration of the ABIM Foundation, ACP Foundation, and European Federation of Internal Medicine consisting of three principles and 10 commitments recognized by many physicians as the bedrock of their professional relationships with their patients and the public; and

Whereas, The charter explicitly states the importance of “minimiz[ing] overuse of health care resources, and optimiz[ing] the outcomes of care,” “scrupulous avoidance of superfluous tests and procedures,” and “cost-effective management of limited clinical resources,” all of which align with the principles of value-based decisionmaking in medical practice; and

Whereas, Medical professionals have further championed the need to adopt value-based medicine principles as the core of physician professionalism; and

Whereas, Multiple professional societies have adopted value-based medicine principles such as the American Medical Association’s STEPS Forward practice improvement strategies and the American College of Physician’s High Value Care initiative; and

Whereas, The evidence-based medicine policy previously adopted by the Texas Medical Association (265.018), although addressing an important component of value-based medicine, cannot fully account for the principles of value-based medicine and decisionmaking, such as emphasizing patients’ values in clinical decisionmaking and prioritizing quality-of-life improvements; and
Whereas, TMA Board of Councilors recognizes physician professionalism as described in the Principles of Medical Ethics of the American Medical Association; and

Whereas, Current TMA policy recognizes the need to advocate for inclusion and integration of topics of health care value in undergraduate and graduate medical education (200.054) and the adoption the Choosing Wisely campaign (265.023); therefore be it

RESOLVED, That the Texas Medical Association adopt the American Medical Association policy Value-Based Decision-Making in the Health Care System H-450.938:

Principles to guide physician value-based decision-making

1. Physicians should encourage their patients to participate in making value-based health care decisions.

2. Physicians should have easy access to and consider the best available evidence at the point of decision-making, to ensure that the chosen intervention is maximally effective in reducing morbidity and mortality.

3. Physicians should have easy access to and review the best available data associated with costs at the point of decision-making. This necessitates cost data to be delivered in a reasonable and useable manner by third-party payers and purchasers. The cost of each alternate intervention, in addition to patient insurance coverage and cost-sharing requirements, should be evaluated.

4. Physicians can enhance value by balancing the potential benefits and costs in their decision-making related to maximizing health outcomes and quality of care for patients.

5. Physicians should seek opportunities to improve their information technology infrastructures to include new and innovative technologies, such as personal health records and other health information technology initiatives, to facilitate increased access to needed and useable evidence and information at the point of decision-making.

6. Physicians should seek opportunities to integrate prevention, including screening, testing and lifestyle counseling, into office visits by patients who may be at risk of developing a preventable chronic disease later in life.

RESOLVED, That TMA adopt policy encouraging physicians to practice value-based decisionmaking, to the best of their ability, as a core tenet of physician professionalism.

Relevant TMA Policy:
265.023 Choosing Wisely® Campaign
200.054 High-Value Care in Undergraduate and Graduate Medical Education
110.002 Cost Effectiveness
110.007 Cost Containment
265.018 Evidence-Based Medicine and Practice

Relevant AMA Policy:
Value-Based Decision-Making in the Health Care System H-450.938
Strategies to Address Rising Health Care Costs H-155.960
Professionalism in Health Care Systems 11.2.1

References:


Subject: Plastic Surgery Board-Certification

Introduced by: Medical Student Section

Referred to: Reference Committee on Socioeconomics

Whereas, The Texas Medical Association endorses physicians having a social contract to maintain professional competency and ensure patient safety and quality care is provided; and

Whereas, The Texas Medical Board does not allow the performance of surgical cosmetic procedures by an individual or the delegation of such to an individual who is not an appropriately licensed surgeon practicing within the scope of practice provided by such a license; and

Whereas, The American Board of Plastic Surgery is the only board accredited by the American Board of Medical Specialities that certifies physicians to practice cosmetic surgery; and

Whereas, Multiple self-designated medical boards claim to certify physicians who have not completed a plastic surgery residency in cosmetic surgical procedures accredited by the Accreditation Council for Graduate Medical Education, allowing these physicians to advertise themselves as “board certified” with as little as one year of training in cosmetic surgery and provide patients with a false sense of trust in their surgical competence; and

Whereas, The Medical Practice Act states that an individual commits a prohibited practice if that person advertises himself or herself in a way that could be considered false, misleading, or deceptive; and

Whereas, The American Medical Association Truth in Advertising Campaign encourages state medical societies to advocate for physicians and health care practitioners to clearly and honestly state their level of training, education, and licensing to patients; and

Whereas, TMA adopts the standard that patient safety and quality are paramount, and thus patients should be assured that individuals who perform surgical procedures are appropriately trained physicians; and

Whereas, A 2017 study from Plastic and Reconstructive Surgery indicated that 70.8% of cosmetic surgery patients (n= 5,239) are unaware of the differences in training requirements between ABPS diplomates and diplomates from self-designated boards; and

Whereas, A 2018 study from Aesthetic Surgery Journal indicated that only 17.8% of the top 163 plastic surgery posts on Instagram were from plastic surgeons certified by ABPS and that 67.1% of these posts were self-promotional as opposed to educational; and

Whereas, The American Society of Plastic Surgeons’ Do Your Homework campaign endeavors to help educate the public on how to correctly identify an ABPS board-certified plastic surgeon, but misperceptions among the patient populace still remain regarding who can safely perform plastic surgery; therefore be it

therefore be it
RESOLVED, That the Texas Medical Association support efforts to inform patients of the difference in training requirements between American Board of Plastic Surgery (ABPS) board-certified plastic surgeons and individuals board certified through self-designated medical boards; and be it further resolved,

RESOLVED, That TMA reaffirm its commitment to advocate for appropriate scope of practice by discouraging non-ABPS-certified individuals from advertising themselves as board-certified plastic surgeons and performing plastic surgery procedures.

**Related TMA Policy:**

175.023 Initial Guiding Principles on Maintenance of Certification
280.032 Definition of Surgery

**Related AMA Policy:**

Truth in Advertising H-405.964

**References:**

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 426
2020

Subject: Results and Regulation of Freestanding Birthing Centers and at Home Birthing Services

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Socioeconomics

Whereas, Texas maternal mortality rates are higher than the U.S. average; and
Whereas, Many mothers are opting to deliver their babies at birthing centers and at home; and
Whereas, Adequate regulation of individuals assisting with the deliveries appears not to exist; and
Whereas, Clarity is needed to determine if the delivery of a baby is the practice of medicine; and
Whereas, Studies show worse outcomes for mother and child when complications arise during deliveries at home or in freestanding birthing centers; and
Whereas, Reducing maternal mortality is already Texas Medical Association policy; therefore be it
RESOLVED, That the Texas Medical Association work with state agencies to study the results, regulation, and quality review mechanisms of freestanding birthing centers and at-home birthing services; and be it further
RESOLVED, That TMA determine if additional regulations and public education are needed.

Related TMA Policy:
30.005 Midwifery
330.011 Home Deliveries
330.012 Obstetrical Delivery in the Home or Outpatient Facility
330.013 Maternal Mortality Review
330.015 Physician-Led Initiatives to Address Maternal Mortality and Morbidity
Subject: Adjustments to Hospice Dementia Enrollment Criteria

Introduced by: Dallas County Medical Society

Referred to: Reference Committee on Socioeconomics

Whereas, The enrollment criteria for hospice established in the early 1980s were based on a six-month life expectancy if the “underlying disease were to run its natural course.” At the time of the development of six-month criteria, most hospice patients were cancer patients; and

Whereas, It has since been appreciated that the six-month expectancy is more accurate in the cancer setting than for other medical conditions, namely dementia; and

Whereas, The admission criteria for hospice enrollment for dementia patients rely on the Functional Assessment Staging Test (FAST) scoring mechanism, which measures activities of daily living and rates appetite, nourishment, and mobility, based on the presumption of a linear progression (ordinal) of decline; and

Whereas, FAST Stage 7c is used as the cut-off point for acceptable, primary dementia criteria for hospice enrollment and provides accurate prognostication for dementia patients who follow ordinal degradation through FAST stages of decline; and

Whereas, A full 41% of dementia patients are either unable to be scored accurately using FAST or do not follow ordinal patterns of degradation, and of these patients who did not follow ordinal degradation or were unable to be accurately scored via FAST, 42% died within six months; and

Whereas, For patients who follow nonordinal decline, there is a three-fold difference in survival between those who did and did not receive medications for acute illness: 14.9 months for receivers and 5.2 months for nonreceivers; and

Whereas, This effect of treatment suggests that nonordinal patients with impaired mobility and better-preserved language might be suitable for hospice if their palliative care plans were conservative but not suitable if more life-prolonging care was anticipated; therefore be it

RESOLVED, That the Texas Medical Association collaborate with the American Medical Association in advocating for the Centers for Medicare & Medicaid Services (CMS) to adjust the secondary hospice enrollment criteria for dementia. Specifically, CMS should incorporate dementia patients who are Functional Assessment Staging Test Stage 6e, who, or their families on their behalf, have chosen not to receive medications or interventions for acute illnesses; and be it further

RESOLVED, That TMA collaborate with AMA in advocating for CMS to expand the coverage and availability of other, novel provisions of care for dementia patients, such as expanding the Medicare Care Choices model that allows palliative services to be provided in the home setting, as a bridge to hospice care.
Relevant TMA Policy:
20.006 Alzheimer’s Disease and Other Dementia: The Texas Medical Association
85.018 Supportive Palliative Care
125.003 Home Health and Hospice

Relevant AMA Policy:
Alzheimer’s Disease H-25.991
Payment for Dementia Treatment in Hospitals and Other Psychiatric Facilities D-345.985
Physicians and Family Caregivers: Shared Responsibility H-210.980