Handbook for Delegates

ANNUAL HOUSE OF DELEGATES
MAY 14-15, 2021

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#TexMed2021
The TMA House of Delegates convened virtually April 29 in a prerecorded session, and live at 9 am, May 14, and at 9 am, May 15, 2021, virtually and in-person at the JW Marriott Hotel in Austin, Texas.

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 April 29, the Rev. Msgr. Louis L. Brum of McAllen gave the invocation.

Board of Trustees Chair Gary W. Floyd, MD, reported on association finances.

Dr. Weltge explained the business of the house.

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

TMA Alliance Outgoing President Martha Vijjeswarapu addressed the house.

TMA Alliance Incoming President Jennifer Lewis was installed and addressed the house.

Dr. Holland congratulated the following TMA section award recipients:

- **Young Physician Section Young at Heart Award** – Emily D. Briggs, MD
- **Medical Student Section C. Frank Webber, MD, Award** – Ashley Sturgeon, MD
- **Medical Student Section Student Member of the Year Award** – Whitney Stuard
- **Medical Student Section Chapter of the Year Award** – Texas Tech University Health Sciences Center School of Medicine
- **International Graduate Medical Section Outstanding Physician Award** – Gilberto Handal, MD

The following videos of TMA-established organizations were presented:

- Texas Medical Liability Trust
- Texas Medical Association Foundation
- Texas Medical Association Insurance Trust

During the live May 14-15 sessions of the house, Dr. Weltge presided over a technology orientation and explained the business of the house.

Credentials Committee Chair and Chief Teller Vani Vallabhaneni, MD, reported a majority of delegates present.

Minutes of the Sept. 2020 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 William H. Fleming III, MD.
Special recognition was given to TMA’s past presidents with an honorary slide show presentation.

Special recognition was given to outgoing council and committee chairs with an honorary slide show presentation.

The house observed a moment of silence to honor deceased physicians.

E. Linda Villarreal, MD, TMA’s 156th president, was installed and addressed the house.

**ELECTIONS:**
On Friday, May 14, the house elected the following council members:

**Constitution and Bylaws** – Christopher Sung Jin Chun, MD, Dallas; Samuel Mathis, MD, Galveston; Gerardo Ortega, MD, San Antonio.

**Health Care Quality** – Keith R. Eppich, MD, Plano; Marina C. George, MD, Houston; Ajay Gupta, MD, Austin.

**Health Promotion** – Louise Bethea, MD, Spring; Li-Yu Mitchell, MD, Tyler.

**Health Service Organizations** – Raymond L. Fowler, MD, Dallas; Doug Fullington, MD, Plano; Aakash Gajjar, MD, Houston; Faraz Khan, MD, Houston; Michelle Owens, DO, Austin.

**Legislation** – Michael Battista, MD, San Antonio; Tilden Childs, MD, Fort Worth; Troy Fiesinger, MD, Sugar Land; Martin Garza, MD, Edinburg; Linda M. Siy, MD, Fort Worth; Michelle Tarbox, MD, Lubbock.

**Medical Education** – James Byron Boone, MD, El Paso; Stephen Herrmann, MD, PhD, Houston; Joseph T. Martins, MD, Tyler; Ikemefuna C. Okwuwa, MD, Odessa; Stuart Pickell, MD, Fort Worth.

**Practice Management Services** – Lilette E. Daumas-Britsch, MD, Houston; Deborah Anne Fuller, MD, Dallas; Megan Kressin, MD, Austin; Lori A. Sedrak, DO, Plano; Jim Walton, DO, MBA, Dallas.

**Science and Public Health** – James Walter Castillo, II, MD, Edinburg; Hector Ocaranza, MD, Anthony; Jan Patterson, MD, San Antonio; Jeffrey Richards, MD, League City.

**Socioeconomics** – Jason L. Acevedo, MD, MBA, Abilene; Roel E. Cantu, MD, San Juan; Nefertiti duPont, MD, Spring; Lisa Ehrlich, MD, Houston; James P. Michaels, MD, Tyler; Lee Ann Pearse, MD, Dallas.

On Saturday, May 15, the following members were announced elected or reelected. The elections for these positions occurred April 29-May 3:

**President-Elect** – Gary W. Floyd, MD, Keller.

**Speaker, House of Delegates** – Bradford W. Holland, MD, Waco.

**Vice Speaker, House of Delegates** – John G. Flores, MD, Little Elm.
Trustees – Keith A. Bourgeois, MD, Houston; Lisa L. Ehrlich, MD, Houston; Jayesh “Jay” Shah, MD, San Antonio; Richard W. Snyder II, MD, Dallas; Joseph S. Valenti, MD, Denton.

Councilors – Three-year term: Gilbert A. Handal, MD, District 1; Vivek U. Rao, MD, District 2; Stuart L. Abramson, MD, District 4; Brenda M. Vozza, MD, District 11; Edward W. Tuthill, MD, District 14.

Vice Councilors – Three-year term: Angel M. Rios, MD, District 1; James W. Huston, MD, District 2; Gina Mapes Jetter, MD, District 11; Steven R. Hays, MD, District 14. Two-year term (filling a vacancy): Steven E. Wolf, MD, District 8.

AMA Delegates – Two-year term: Roxanne M. Tyroch, MD, El Paso; Diana L. Fite, MD, Magnolia; Gary W. Floyd, MD, Keller; John T. Gill, MD, Dallas; John T. Carlo, MD, Dallas; David N. Henkes, MD, San Antonio; Jayesh Shah, MD, San Antonio; Elizabeth Torres, MD, Sugar Land.

AMA Alternate Delegates – Two-year term: Robert H. Emmick Jr., MD; Steven R. Hays, MD, Dallas; Jennifer R. Rushton, MD, Austin; Sherif Z. Zaafran, MD, Houston; Ezequiel “Zeke” Silva III, MD, San Antonio; Bryan G. Johnson, MD, Frisco; Kimberly Avila Edwards, MD, Austin; Mark A. Casanova, MD, Dallas; Angela Self, MD, Grapevine. Resident/fellow position: Matthew McGlennon, DO, Round Rock. Medical student position: Alwyn Mathew, San Antonio.

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

Lone Star Caucus Awards:
The Juan Fitz, MD, Memorial Award – Eric W. Baggerman, MD
Service Award – D. Allen Schultz, MD
Scholarship Awards:
Daniel Berry, Texas Tech University Health Sciences Center Paul L. Foster School of Medicine
Jordan Brown, Texas Tech University Health Sciences Center Paul L. Foster School of Medicine
Zachary Kennedy, The University of Texas Medical Branch School of Medicine
Malini Riddle, Texas Tech University Health Sciences Center Paul L. Foster School of Medicine
Clarence Sparks, Texas College of Osteopathic Medicine at the University of North Texas Health Science Center at Fort Worth

2020 50-Year Club Scholarship Fund Recipients:
Quinn Losefsky, Texas College of Osteopathic Medicine at the University of North Texas Health Science Center at Fort Worth
Ryan Wealther, Joe R. and Teresa Lozano Long School of Medicine at UT Health San Antonio
Michelle Zhang, The University of Texas at Austin Dell Medical School

Minority Scholarship Awards – TMA awarded 15 $10,000 scholarships to minority Texas college students entering medical school. TMA's 2021 Minority Scholarship Program is made possible with a grant from the TMA Foundation (TMAF) thanks to the TMAF Trust Fund of Dr. Roberto J. and Agniela (Annie) M. Bayardo; the TMAF Patrick Y. Leung, MD, Minority Scholarship Endowment; and generous gifts from H-E-B, and physicians and their families. Scholarship award recipients in 2021 were: Jamie
Provost, Baylor College of Medicine; Amanda Figueroa, Texas A&M University Health Science Center College of Medicine; Yaw Agyina, Texas Tech University Health Sciences Center School of Medicine in Lubbock; Gaspar Pina, John P. and Kathrine G. McGovern Medical School at UTHealth; Amy Beristain, Texas College of Osteopathic Medicine at the University of North Texas Health Science Center at Fort Worth; Fabiola Ramirez, Texas Tech University Health Sciences Center Paul L. Foster School of Medicine; Anuska Martinez, The University of Texas at Austin Dell Medical School; Felipe Diaz, The University of Texas Rio Grande Valley School of Medicine; Eryn Patin, UT Southwestern Medical School; Ndanzia "Paul" Mpunga, Joe R. and Teresa Lozano Long School of Medicine at UT Health San Antonio; Caitlin Aguirre, The University of Texas Medical Branch School of Medicine; Victoria Delano, University of the Incarnate Word School of Osteopathic Medicine; Alejandra Gutierrez, Texas College of Osteopathic Medicine at the University of North Texas Health Science Center at Fort Worth; Brooke Birks, Sam Houston State University College of Osteopathic Medicine; and Dominique Norris, University of Houston College of Medicine.

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

**Grand Prize Recipient** – Arlevia Davis, Legacy High School, Mansfield.

**Distinguished Award Recipients:**
- Elementary School Science Teacher – Valerie Valadez, Clara Love Elementary, Justin
- Middle School Science Teacher – Alejandra Martinez, Memorial Junior High School, Eagle Pass
- High School Science Teacher – Sergio Estrada, Riverside High School, El Paso

**Rookie Award Recipient** – Crystal Deville, Grand Oaks High School, Spring

ROLL CALL
May 14-15, 2021

**COUNTY MEDICAL SOCIETY DELEGATES AND ALTERNATE DELEGATES:**

**At-Large No CMS**
Oscar Garza, Pearsall

**Bell CMS**
Hongjing Cao, Temple; Patrick D. Crowley, Temple; A Keith Cryar, Temple; Christa C. DeFries, Temple; Robert Daniel Greenberg, Temple; Duren Michael Ready, Temple; Abirami Subramanian, Temple; Jenny Thomas Jacob, Round Rock; Sandra S. Vexler, Temple

**Bexar CMS**
Brian T. Boies, San Antonio; Dianna Mosley Burns-Banks, San Antonio; Stephen D. Gelfond, San Antonio; Prabhdeep Kaur Grewal, San Antonio; Pamela Ann Hall, San Antonio; David Anthony Hnatow, San Antonio; James Loyd Humphreys, Helotes; Leah Hanselka Jacobson, San Antonio; Margaret Ann Kelley, San Antonio; David Trueson Lam, San Antonio; William Cannon Lewis, San Antonio; Shazli Noorali Malik, San Antonio; Sekinat Kassim McCormick, San Antonio; Jesse Moss, Live Oak; Lubna Naeem, San Antonio; John Joseph Nava, San Antonio; Gerardo Ortega, San Antonio; Adam V. Ratner, San Antonio; Brent W. Sanderlin, Schertz; John Milton Shepherd, San Antonio; J. Marvin Smith, San Antonio; Rajeev Suri, San Antonio; Nora Linda Vasquez, Boerne; Verónica Marie Vasquez, San Antonio; Aruna Venkatesh, San Antonio; Alexis A. Wiesenthal, San Antonio
Big Country CMS
Indira C. Maharaj-Mikiel, Abilene; Daniel James Vaughan, Abilene

Bowie CMS
Cindy Renea Porter, Texarkana

Brazoria CMS
Mammen A. Sam, Pearland

Calhoun CMS
John B. Wright, Port Lavaca

Collin-Fannin CMS
Carrie E. De Moor, Frisco; Neha V. Dhudshia, Plano; Marlene Diaz, Plano; Aimee C. Garza, Dallas; Mei Melvin Hu, Frisco; Paul Daniel Kivela, Frisco; Sejal S. Mehta, Allen; Sherine E Boyd Reno, Dallas; Brent A. Spencer, Frisco

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

Concho Valley CMS
Bradly Bundrant, Ballinger

Dallas CMS
Akinwande A. Akinfolarin, Dallas; Drew Wilson Alexander, Dallas; Leyka M. Barbosa, Dallas; Christine Ann Becker, Dallas; Justin M. Bishop, Dallas; Adam C. Carter, Dallas; Samuel J. Chantilis, Dallas; Christopher Sung Jin Chun, Dallas; Christopher Ryan Cook, Garland; Stephanie M. Copeland, Irving; Cindy Lou Corpiere, Dallas; Rohit Rau Das, Dallas; Hina Dave, Dallas; Jennifer Ann Denning, Dallas; Shashi K. Dharma, Irving; Emma L. Dishner, Dallas; Shaina Marie Drummond, Dallas; John Stockton Early, Dallas; Jeremy Epstein, Carrollton; Walter Francis Evans, Dallas; Robert Lee Fine, Dallas; Juliana M. Fort, Dallas; Raymond L. Fowler, Dallas; Deborah Anne Fuller, Dallas; Angela Fulgham Gardner, Grapevine; John Russell Gilmore, Dallas; Victor Gonzalez, Dallas; Robert D. Gross, Dallas; Madeline Weinstein Harford, Dallas; Joseph Maxwell Hendrix, Irving; Zachary S. Jones, Frisco; Seth David Kaplan, Plano; R Elizabeth Kassanoff-Piper, Dallas; Rainer Anil Khetan, Dallas; Roger Sunil Khetan, Dallas; Yolanda R. Lawson, Dallas; Lauren Kylie Lazar, Dallas; Benjamin C. Lee, Dallas; C. Turner Lewis, Dallas; Warren E. Lichliter, Dallas; David Scott Miller, Dallas; Dawood Nasir, Dallas; Marcial Andres Oquendo Rincon, Dallas; Harveer Singh Parmar, Carrollton; Lee Ann Pearse, Dallas; Shawnta R. Pittman-Hobbs, Desoto; James E. Race, Dallas; Adnan Rafique, Southlake; Noah Munn Rosenberg, Dallas; Aurelia M. Schmalstieg, Dallas; F. David Schneider, Dallas; Elizabeth Ruth Seymour, Dallas; Austin D. Street, Dallas; Baran Devrim Sumer, Dallas; Robert Eduard Suter, Dallas; Laurie Jayne Sutor, Bedford; Lisa Louise Swanson, Dallas; John Morrow Truelson, Dallas; Michael Ian Vengrow, Prosper; Gabriela M. Zandomeni, Heath
Denton CMS
Folahan Kolawole Ayoola, Highland Village; Anil Nanda, Lewisville; Udaya Bhaskar Padakandla, Carrollton

Ector CMS
Olga Ovdyeyenko Dowell, Odessa; Sara Suzanne Dyrstad, Amarillo; Ikemefuna C. Okwuwa, Odessa; Jeffery Matthew Pinnow, Odessa; Vivek U. Rao, Odessa

El Paso CMS
James Byron Boone, El Paso; Richard W. McCallum, El Paso

Erath-Somervell-Comanche CMS
Matthew C. Maruska, Stephenville

Fort Bend CMS
Cedela Abdulla, Sugar Land; Jontel Dansby Pierce, Missouri City; Sapna Singh, Sugar Land

Galveston CMS
Abbey Belina Berenson, Houston; Ludwik Branski, Galveston; Carolyn Eaton, Galveston; Aakash H. Gajjar, Houston; Quratulanan Haroon Jan, League City; John George Knecht, League City; Samuel E. Mathis, Galveston; Bethany E. Powell, Galveston; Helen Colleen Silva, Galveston; Steven E. Wolf, Coppell

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

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

Harris CMS
Audrey E. Ahuero, Houston; Paul M. Allison, Houston; Janette K. Bateman, Pearland; Lindsay K. Botsford, Houston; Richard N. Bradley, Houston; Brian M. Bruel, Houston; Leanne Burnett, Fresno; Steven M. Croft, Houston; Anh Q. Dang, Houston; Daniel H. Darmadi, Houston; Rakhi C. Dimino, Houston; John D. Edwards, Kingwood; Lisa L. Ehrlich, Houston; Lewis E. Foxhall, Houston; Clare N. Gentry, Houston; Bernard M. Gerber, Bellaire; Angela M. Guerra, Baytown; James S. Guo, Houston; Shiva Gupta, Bellaire; Leslie M. Haber, Houston; Steven E. Haber, Houston; Alison J. Haddock, Houston; Ori Z. Hampel, Pasadena; Shannon B. Hancher-Hodges, Bellaire; Lindsey D. Harris, Houston; Hattie E. Henderson, Houston; Daniel L. Howell, Houston; David R. Hoyer, Houston; Nesreen S. Ibrahim, Houston; Terah C. Isaacson, Houston; Nora A. Janjan, Navasota; Laura P. Jimenez-Quintero, The Woodlands; Felicia L. Jordan, Richmond; Faraz A. Khan, Houston; Karl W. King, Sugar Land; Russell W. H. Kridel, Houston; Piotr A.
Kwater, Houston; Ana L. Leech, Houston; Arthur Lim, Missouri City; Shane M. Magee, Houston; Anna L. C. Mapp, Houston; Robert B. Morrow, Sugar Land; Clifford K. Moy, Houston; Lonzetta L. Newman, Houston; Mark L. Nichols, Houston; Stacy L. Norrell, Magnolia; Carla F. Ortique, Houston; Debra M. Osterman, Cypress; Uzondu C. Osuagwu, Houston; Bradford S. Patt, Houston; Emily Walker Petersen, Conroe; Kanchan A. Phalak, Houston; Evan G. Pivalizza, Houston; Christopher N. Prichard, Houston; Autumn L. Pruette, Houston; Syed A. Raza, Kingwood; Elizabeth M. Rebello, Houston; Manish Rungta, Webster; Amber D. Shambarger, Friendswood; Gary J. Sheppard, Houston; Mina K. Sinacori, Houston; Michael J. Snyder, Houston; Charles E. Soderstrom, Houston; Susanna C. Spence, Missouri City; Srikanth Sridhar, Houston; Charlotte M. Stelly-Seitz, Houston; Angela K. Sturm, Bellaire; Spencer H. Su, Houston; Irvin Sulapas, Houston; Rosa A. Tang, Houston; January Y. Tsai, Houston; Dexter G. Turnquest, Houston; Mohammad A. Ursani, The Woodlands; John R. Vanderzyl, Sugar Land; Baominh P. Vinh, Houston; David Vining, Sugar Land; Ronald S. Walters, Bellaire; Stephen E. Whitney, Missouri City; Thomas C. Wiener, Houston; George W. Williams, Bellaire; Wendell H. Williams, Houston; H. David Wills, The Woodlands; Kevin Scott Winfield, Houston; Karla E. K. Wyatt, Houston; Alisha Y. Young, Houston

**Harrison CMS**
Valarie Lee Allman, Marshall

**Hidalgo-Starr CMS**
Roel E. Cantu, San Juan; Lenore C. DePagter, McAllen; Sandra Esquivel, Weslaco; Marissa I. Gomez-Martinez, Edinburg; Audrey Lee Jones, Alamo; Rogelio Sergio Ramirez, Mission; Leticia Marie Volpe, Weslaco

**Jasper-Newton CMS**
Ronnie A. McMurry, Jasper

**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; Luisa F. Florez, Lubbock; Cynthia Ann Jumper, Lubbock; Kalarickal J. Oommen, Lubbock; Karl G. Pankratz, Lubbock; Eldon Stevens Robinson, Lubbock; Melinda Garcia Schalow, Lubbock; Janice Ann Stachowiak, Lubbock; Michelle Babb Tarbox, Lubbock; Gerard A. Troutman, Lubbock; Davor Vugrin, Lubbock

**McLennan CMS**
Scott E. Blattman, Woodway; Clint W. McHenry, Woodway; Russell Scott Warren, Waco; Robert E. Wolf, Waco

**Nueces CMS**

Jack Locardi Cortese, Corpus Christi; Jerry Dean Hunsaker, Corpus Christi; Mary Dahlen Peterson, Corpus Christi; Karl Leon Serrao, Corpus Christi

**Potter-Randall CMS**

Evelyn D. Sbar, Amarillo

**Smith CMS**

Lisa E. Allen, Tyler; Joseph T. Martins, Tyler; Li-Yu H. Mitchell, Tyler; Evans S. Smith, Tyler; David L. Young, Tyler

**Tarrant CMS**

C. Mark Chassay, Fort Worth; Theresa V. Crouch, Arlington; David J. Donahue, Fort Worth; Tricia C. Elliott, Fort Worth; Ken C. Hopper, Fort Worth; Cheryl Lynn Hurd, Fort Worth; Nishant B. Jalandhara, Colleyville; R. Larry Marshall, Fort Worth; George Sealy Massingill, Fort Worth; Gregory J. Phillips, Fort Worth; Stuart C. Pickell, Fort Worth; Rebecca J. Rogers, Fort Worth; Robert J. Rogers, Fort Worth; Angela D. Self, Grapevine; Jason V. Terk, Keller; Melanie M. Vettimattam, Bedford; Veer D. Vithalani, Fort Worth

**Travis CMS**

Tony R. Aventa, Austin; Kimberly C. Avila Edwards, ; Ira Bell, Austin; Maya B. Bledsoe, Austin; Anna Buteau, Austin; Esther J. Cheung-Phillips, Austin; Elizabeth L. Chmelik, Austin; Scott W. Clitheroe, Austin; Goddy T. Corpuz, Round Rock; Colby C. Evans, Austin; Nancy Thorne Foster, Austin; Albert T. Gros, Buda; Katharina Hathaway, Austin; Grace L. Honles, Austin; Felix Hull, Austin; Anand Joshi, Austin; Craig Allen Kuhns, Austin; Parag Kumar, Austin; Daniel J. Leeman, Austin; Jonathan E. MacClements, Austin; Hillary Miller, Austin; Maria Claire Monge, Austin; Celia B. Neavel, Austin; Michelle C.M. Owens, Austin; Tina J. Philip, Round Rock; A. Melinda Rainey, Austin; Fara Ranjbaran, Austin; Roxana A. Rhodes, Austin; Holli T. Sadler, Austin; Dora L. Salazar, Austin; Arathi A. Shah, Austin; Sarah I. Smiley, Austin; Lynn N. Stewart, Austin; Brian W. Temple, Austin; David N. Tobey, Austin; Zoltan Trizna, Austin; Vani S. Vallabhaneni, Austin; John F. Villacis, Austin; Belda Zamora, Austin; Guadalupe Zamora, Austin

**Tri-County CMS**

Mark B. Randolph, New Braunfels; Alberto Santos, San Marcos

**Walker-Madison-Trinity CMS**

Lane Joseph Aiena, Huntsville

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

**Wichita CMS**

Allen B. Flack, Wichita Falls; T. David Greer, Henrietta; Bruce Lee Palmer, Wichita Falls; Susan M. Strate, Wichita Falls

**Williamson CMS**

James Michael Fay, Georgetown; Grace Patricia Tamesis, Round Rock

**EX OFFICIO MEMBERS PRESENT:**

**President, TMA Officers**

Diana L. Fite, Magnolia

**President-Elect, TMA Officers**

E. Linda Villarreal, Edinburg

**Secretary-Treasurer, TMA Officers**

Michelle A. Berger, Austin

**Chair, Council on Constitution and Bylaws**

William S. Gilmer, Houston

**Chair, Council on Health Care Quality**

Chelsea I. Clinton, San Antonio

**Chair, Council on Health Service Organizations**

Mark A. Casanova, Dallas

**Chair, Council on Medical Education**

Kevin Wayne Klein, Dallas

**Chair, Council on Science and Public Health**

Wendy M. Chung, Dallas

**Chair, Council on Socioeconomics**

Rodney B. Young, Amarillo
Councilor, TMA Board of Councilors

Stuart L. Abramson, San Angelo; James R. Eskew, Austin; Gilberto A. Handal, El Paso; Louis John Kirk, Longview; Kyle Gregory Krohn, Lufkin; David Christian Nickeson, Seabrook; Steven M. Petak, Houston; Vivek U. Rao, Odessa

Texas Delegate, Texas Delegation toAMA

William H. Fleming, Houston; Gregory M. Fuller, Keller; David Norman Henkes, San Antonio; Asa C. Lockhart, Tyler; Kevin Hood McKinney, Galveston; Leslie Harold Secrest, Dallas; Lyle Sheldon Thorstenson, Farmers Branch; Roxanne Marie Tyroch, El Paso

Texas Alternate Delegate, Texas Delegation to AMA

John T. Carlo, Dallas; Shanna Marie Combs, Fort Worth; Robert Harold Emmick, Austin; John Gerard Flores, Carrollton; Steven Ray Hays, Dallas; Bryan G. Johnson, Frisco; Eddie L. Patton, Houston; Jennifer R. Rushton, Austin; Ezequiel Silva, San Antonio; Elizabeth Torres, Sugar Land; Sherif Z. Zaafran, Houston

Member, Council on Legislation

Tilden L. Childs, Fort Worth; Victor Hugo Gonzalez, McAllen; Robert E. Jackson, Houston; Yvonne Kew, Houston; Thomas J. Kim, Austin; J. Timothy Parker, Denison; Victor A. Simms, Pearland; Linda M. Siy, Fort Worth; Michelle Babb Tarbox, Lubbock; Gerad A. Troutman, Lubbock

Member At-Large, TMA Board of Trustees

Sue Scher Bornstein, Dallas; Keith A. Bourgeois, Houston; Gerald R. Callas, Beaumont; Gary W. Floyd, Roanoke; Cynthia Ann Jumper, Lubbock; Kimberly E. Monday, Pearland; Jayesh B. Shah, San Antonio; Richard Wesley Snyder, Dallas

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 Association of Neurological Surgeons: Ramsey R. Ashour, Austin
Texas Association of Otolaryngology: Jeffrey B. Kahn, Austin
Texas College of Emergency Physicians: Heidi C. Knowles, Forney
Texas Dermatological Society: Ryan Walter Hick, Dallas
Texas Orthopaedic Association: Robert E. Wolf, Waco
Texas Pain Society: Allen L. Dennis, Round Rock
Texas Pediatric Society: Valerie Borum Smith, Tyler
Texas Radiological Society: Tilden L. Childs, Fort Worth
Texas Society of Anesthesiologists: Stacy L. Norrell, Magnolia
Texas Society of Anesthesiologists: Elizabeth M. Rebello, Houston
Texas Society of Pathologists: Allen B. Flack, Wichita Falls
Texas Society of Plastic Surgeons: Susan M. Pike, Georgetown
Texas Society of Psychiatric Physicians: Richard L. Noel, Houston
Texas Society of Psychiatric Physicians: J. Clay Sawyer, Waco

SECTION DELEGATES AND ALTERNATE DELEGATES PRESENT:
Andrew Gabriel Alfaro, Katy, SCMSS, Texas Tech University Health Sciences Center
Joshua Baker, Fort Worth, SCMSS, University of North Texas Health Science Center
Hannah Coco, SCMSS, McGovern Medical School at UT Health Houston
Canaan James Hancock, Austin, SCMSS, Dell Medical School at UT Austin
Grayson Richard Jackson, Galveston, SCMSS, UT Medical Branch
Meagan Adiva Khan, San Antonio, SCMSS, UIW School of Osteopathic Medicine
Kireet Koganti, Southlake, SCMSS, Texas A&M University-Medical School
Aman Narayan, Dallas, SCMSS, UT Southwestern Medical Center
Sarah Person, Fort Worth, SCMSS, TCU and UTHSC School of Medicine
Cyrena Dawn Petersen, , SCMSS, Paul L. Foster School of Medicine [TTUHSC El Paso]
Rajadhar T. Reddy, Houston, SCMSS, Baylor College of Medicine
Ammie Rupani, Richmond, SCMSS, Sam Houston State University College of Osteopathic Medicine
Billal Siddiq, Robinson, SCMSS, Paul L. Foster School of Medicine [TTUHSC El Paso]
Whitney Leigh Stuard, Irving, SCMSS, UT Southwestern Medical Center
Nikki Verma, San Antonio, SCMSS, Long School of Medicine at UT Health San Antonio
Shail Vyas, San Antonio, SCMSS, Long School of Medicine at UT Health San Antonio
Sonia Wadekar, Harlingen, SCMSS, UTRGV School of Medicine
Tina Zhu, Lubbock, SCMSS, Texas Tech University Health Sciences Center
Apeksha Nitendra Agarwal, MD, San Antonio, SCRFS
Zahra Ali, MD, Odessa, SCRFS
Pruthali Kulkarni, DO, Katy, SCRFS
Myphuong T. Phan, MD, Houston, SCRFS
Gates B. Colbert, MD, Richardson, SCYPS
Stephen A. Herrmann, MD, Houston, SCYPS
Ann C. Hughes Bass, MD, Littlefield, SCYPS
Angelica Melillo Knickerbocker, MD, Dallas, SCYPS
Kanchan A. Phalak, MD, Houston, SCYPS
Colleen C. Yard, MD, Austin, SCYPS
PAST PRESIDENTS PRESENT:

Susan Rudd Bailey, Fort Worth; Mark J. Kubala, Beaumont; J. James Rohack, Kemah; Michael E. Speer, Houston

Members Present (Quorum: 274)

May 14  364 (331 voting + 33 nonvoting)

May 15  372 (341 voting + 31 nonvoting)

Total unique members:

Both days 450 (401 voting + 49 nonvoting)
At the second live virtual convention of the Texas Medical Association House of Delegates, physicians carried out their policymaking duties to improve the health of all Texans despite being scattered across the state.

Delegates made headway on policies to address vaccine rollouts and nonmedical exemptions; emergency preparedness; postpartum depression screenings; prevention of suicide and physician burnout; health care reform; Medicaid payments; and red tape reductions and transparency in health plan practices, among others.

The first item of business resulted in a vote in favor of TMA evaluating “the feasibility of a virtual or hybrid option during the House of Delegates session for delegates to give testimony and vote on resolutions if unable to attend the meeting in person.”

The house also considered 50% more business this year as delegates took on numerous items tabled during the 2020 annual meeting, Dr. Weltge said. Because that first virtual meeting of the house took place later than usual in September 2020 under more restrictive pandemic conditions, delegates at the time only took on a limited calendar of “essential” house business.

This year, nearly 400 voting delegates – and even more attendees – participated in the meeting, which was conducted live online and from the JW Marriott in Austin with limited in-person participation.

Once again using technology that allowed for remote voting, delegates overwhelmingly approved recommendations from four reference committees that collected and considered physician testimony on nearly 200 proposed recommendations and resolutions in the weeks leading up to the annual meeting on May 14-15.

Below is a short list of some of the top actions the house voted on this weekend in the four reference committees. Read Texas Medicine Today throughout the week for details on these and other TMA policy items.

In the Reference Committee on Science and Public Health, delegates voted to:

- Encourage routine postpartum depression screenings; and
- Advocate for the removal of nonmedical vaccine exemptions.

In the Reference Committee on Medical Education and Health Care Quality, delegates voted to:

- Adopt policy supporting post-pandemic research to inform state emergency preparedness agencies when it comes to hospital surges; and
• Study ways to address, screen, and provide healthy coping mechanisms for burnout.

In the Reference Committee on Socioeconomics, delegates voted to:

• Create a physician-led think tank on health care reform; and
• Advocate to increase Texas Medicaid physician payment rates to at least Medicare rates.

In the Reference Committee on Financial and Organizational Affairs, delegates voted to:

• Study noncompete agreements in physician employment contracts with a report back to the house no later than TexMed 2022; and
• Study a measure that would give physicians a way “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.”

Also at TMA’s 2021 annual meeting, Edinburg internist E. Linda Villarreal, MD, was installed as TMA’s 156th president; Keller pediatrician Gary W. Floyd, MD, was elected as TMA president-elect; and Houston neurologist William H. Fleming III, MD – a TMA past president – was honored with TMA’s Distinguished Service Award.

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

**Reference Committee on Financial and Organizational Affairs**

**SPKR Report 1 2021 – Amending Policy 295.013 Election Process.** That TMA amend policy 295.013 Election Process to allow for virtual elections. **Adopted.**

**SPKR Report 2 2021 – Amending TMA Constitution Article V House of Delegates and TMA Bylaws Chapter 3 House of Delegates.** That TMA (1) amend TMA Constitution Article V. House of Delegates by adding the words “and past speakers” to item (i); and (2) amend TMA Bylaws, Chapter 3. House of Delegates by adding the words “and past speakers” to 3.12 Voting Rights and 3.45 Quorum. **Adopted.**

**BOC Report 1 – Emeritus Nominations.** That the House of Delegates approve the nominations of Drs. Kronberg and Thorstenson to Emeritus member status. **Adopted.**

**BOC Report 2 – Honorary Nominations.** That the House of Delegates approve Drs. Greenberg, Haufrect, Poonawala, and Ruiz’s nominations to honorary member status. **Adopted.**


**C-CB Report 1 – Amendment to Bylaws to Remove “Spring” Requirement for the Annual Session.** That TMA amend Chapter 8, Section 10 of the Texas Medical Association Bylaws to remove “spring” as a requirement for the Annual Session. **Adopted.**

**C-CB Report 2 – Amendments to Bylaws to Establish an Application and Appeal Process for At-Large Members, and to Clarify the Disciplinary Process for Small County Medical Societies.** That TMA amend Chapters 1, 3, 5, and 12 of the TMA Bylaws, and renumbering them accordingly, to (1) add an application, discipline, and appeal process, as well as the operating requirements for at-large members, and (2) add a disciplinary process for small county medical societies. **Adopted as amended.**
C-CB Report 3 – Amendments to Bylaws to Allow Two-Year Terms for County Medical Society Officers. That TMA amend Chapter 12 of the TMA Bylaws to allow two-year terms for county medical society officers. **Adopted.**

C-CB Report 4 – Amendment to Bylaws to Tie Council Meeting Requirements to the TMA Session Year. That TMA amend Chapter 9, Section 40 of the TMA Bylaws to tie council meeting requirements to the TMA session year. **Adopted.**

C-CB Report 5 – Amendments to Bylaws to Allow Sections to Determine Members’ Right to Vote and Hold Office. That TMA Chapter 1 of the TMA Bylaws to allow sections to determine members’ right to vote and hold office. **Adopted.**

C-CB Report 6 – Amendments to Bylaws to Update and Clarify Existing Language. That TMA amend TMA Bylaws to update and clarify existing language. **Adopted as amended.**

C-CB Report 7 – Amendments to Bylaws to Allow Use of Virtual Platforms, In-Person Voting. That TMA amend TMA Bylaws to allow use of virtual platforms and in-person voting. **Adopted.**

C-CB Report 8 – Amendments to Article V of the TMA Constitution. That TMA amend the TMA Constitution to include delegates from the LGBTQ Health Section and Women Physicians Section, and delegates representing at-large members in Article V, “House of Delegates” for representation in the TMA House of Delegates. **Adopted.**

C-PMS Report 1 – Sunset Policy Review. That TMA policy 105.019 Principles for Protection of Medical Record Privacy be retained as amended. **Adopted.**

PPAC Report 2 – Sunset Policy Review. That (1) policies 160.013 Medical Expert Witness Standards, 225.001 Peer Review Notices of Final Determination, 225.007 Peer Review Regulation of Private Review Organizations, and 225.019 Criteria for Physicians Conducting Peer Review be retained; (2) policy 95.035 Distribution of Donated Medications be deleted; and (3) policy 170.001 Good Samaritan and Charitable Immunity Laws be retained as amended. **Adopted.**

BOT Report 10 – Sunset Review of TMA Standing Committees. That TMA (1) continue the Interspecialty Society Committee and Committee on Membership for three years; (2) continue the Committee on Physician Health and Wellness for three years; (3) continue the Committee on Continuing Education and Committee on Physician Distribution and Health Care Access for three years; (4) continue the Committee on Health Information Technology for three years; (5) amend the TMA Bylaws to reassign the Committee on Health Information Technology from the parent Council on Practice Management Services to the parent Council on Socioeconomics and renumber the bylaws accordingly; (6) continue the Committee on Cancer; Committee on Child and Adolescent Health; Committee on Emergency Medical Services and Trauma; Committee on Infectious Diseases; and Committee on Reproductive, Women’s, and Perinatal Health for three years; and (7) continue the Committee on Medical Home and Primary Care, the Committee on Rural Health, and the Patient-Physician Advocacy Committee for three years. **Adopted.**


BOT Report 17 – Physicians in Employed Settings (Tabled BOT Report 12 2020). That (1) the Texas Medical Association pilot a forum for physicians in employed settings, combining virtual
communications with in-person programming at TexMed 2022, and (2) that TMA approve the evaluation and implementation of these priorities and services. **Adopted.**

**BOT 20 – Nominations for Board of Governors, Texas Medical Liability Trust.** That TMA approve Leah Jacobson, MD; Sarah Way, MD, JD; and Tim West, MD; nominees of the TMLT Governing Board, to be placed before TMLT policyholders for election. **Adopted.**

**CM-M Report 1 – New Telemedicine TMA Dues Category (Tabled CM-M Report 2 2020).** That (1) the Texas Medical Association create a new telemedicine membership category at one-half of TMA full active dues, and (2) if approved, that the Board of Trustees direct the Council on Constitution and Bylaws to recommend the necessary bylaw amendments. **Adopted.**

**LGBTQ HS Report 1 – LGBTQ Health Section Update.** That TMA adopt the LGBTQ Health Section’s operating procedures. **Adopted.**

**Resolution 101 – The Creation of an Independent Physician Section (Tabled Res 101 2020).** That TMA take steps to create a section dedicated to help meet the unique needs of physicians in private practice who reside in this state. **Referred for action with report back.**

**Resolution 102 – Expansion of the Texas Medical Association Ambassador Program (Tabled Res 102 2020).** That (1) the Texas Medical Association House of Delegates express its gratitude for the Ambassador Program, and (2) that TMA allocate additional resources so the Ambassador Program can add at least two new CME topics each year. **Adopted.**

**Resolution 103 – A Systematic and Precise Method for AMA Public Endorsements of Proposed Legislation (Tabled Res 103 2020).** That the Texas Delegation to the American Medical Association introduce a resolution to the AMA House of Delegates that calls upon our 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 theAMA position of support or opposition; and (3) maintain an emphasis on the most problematic elements of a bill, present or omitted, that AMA finds likely to be detrimental to the quality or sustainability of our health care system and freedom of choice and practice. **Referred for action with report back.**

**Resolution 105 – Virtual Option for Delegates at Future Meetings.** That (1) the TMA House of Delegates utilize virtual during House of Delegates meetings upon approval of the Board of Trustees; and (2) the TMA evaluate the feasibility of a virtual or hybrid option during the House of Delegates session for delegates to give testimony and vote on resolutions if unable to attend the meeting in person. **Adopted as amended.**

**Resolution 106 – Creation of Ad Hoc Committee to Study and Make Recommendations Concerning Noncompete Agreements in Physician Employment Contracts.** That (1) the Texas Medical Association study noncompete agreements in physician employment contracts and evaluate the impact of noncompete agreements on physicians and patients in Texas with report made to the TMA no later than TexMed 2022; and (2) that the Texas Medical Association assess whether means other than noncompete agreements might suffice to protect physician employers’ legitimate interests with report made to the TMA no later than TexMed 2022. **Adopted as amended in lieu of Resolution 114 2021.**

**Resolution 107 – Utilization Review, Medical Necessity Determination, Prior Authorization Decisions (Tabled Res 410 2020).** That (1) 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 (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. Referred for study with report back.

**Resolution 108 – Paid Sick Leave Policies.** That (1) our Texas Medical Association promote awareness and education for physicians, legislators, and the public on the benefits and barriers of creating and expanding paid sick leave policies in Texas to improve health outcomes and the well-being of our families and workforce; and (2) our TMA support studies on the barriers to expanding paid sick leave in Texas in collaboration with, but not limited to, the Texas Department of State Health Services, Texas Health and Human Services Commission, and state higher education institutions. Referred for study with report back.

**Resolution 110 – Encouraging ADA Compliance on Virtual Platforms.** That (1) our Texas Medical Association support the compliance of telemedicine platforms with the Americans with Disability Act, and (2) TMA encourage hospitals and clinics in Texas to adhere to guidelines that maintain ADA standards within telemedicine. Adopted as amended.

**Resolution 112 – One Hundredth Anniversary of the Texas Pediatric Society.** That (1) the Texas Medical Association extends its congratulations to the Texas Pediatric Society on the occasion of its 100th anniversary; (2) TMA and its members participate in the year-long opportunity to commemorate, educate, and celebrate the accomplishments of the Texas Pediatric Society; and (3) that TMA wishes the Texas Pediatric Society continued success in prioritizing the physical, emotional, and social health of the children of the state of Texas. Adopted.

**Resolution 113 – Composition of Hospital Ethics Committees.** That (1) the Texas Medical Association study and report back to the House of Delegates regarding the current composition of hospital ethics committees around the state, and (2) TMA collaborate with the Texas Hospital Association and other relevant stakeholders to draft recommendations for the composition of hospital ethics committees. Adopted.

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

**C-HCQ Report 2 – Sunset Policy Review.** That (1) policy 30.019 Federal Care Compare Website be retained as amended, and (2) policy 105.011 Disease Management be deleted. Adopted.


**C-ME Report 1 – Sunset Policy Review.** That (1) policies 205.005 Funding Levels for Research and Medical Education and 185.015 Addressing Workforce Issues be retained; and (2) policy 290.001 Academic Libraries be retained as amended. Adopted.

**C-ME Report 2 – Referral of Resolution 202-A-18 Addressing Gender Bias in Undergraduate Medical Education and Implicit Bias Training.** That the following be adopted as new Texas Medical Association policy in lieu of Resolution 202-A-18:
Support Bias Training for All Texas Medical School Students, Resident Physicians, Staff, and Faculty of Academic Health Centers, and Promotion of Greater Diversity in Medicine.

The Texas Medical Association supports:
1. Bias training for all Texas medical school students and resident physicians, as well as staff and faculty at academic health centers.
2. 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 significant underrepresentation by gender and/or race/ethnicity within the physician workforce. Adopted in lieu of Resolution 202 2021.

C-ME Report 3 – Developing Best Practices for Educating Medical Students and Residents During a Pandemic or Other Extended Catastrophic Event. That the following be adopted as Texas Medical Association policy:

Preserving Medical Education, and Residency and Fellowship Training During a Pandemic or Other Extended Catastrophic Event

The Texas Medical Association supports a post-pandemic assessment of the policies that affect ALL involved in the teaching of medical students, residents, and fellows to evaluate policies in place for preserving education and training during a pandemic or other extended catastrophic event. The evaluation should consider what has been learned, identify best practices and needed improvements, and identify resources required for future improvements. TMA encourages the Texas Higher Education Coordinating Board to consider leading this post-pandemic assessment.

TMA encourages consideration of the following during the assessment:

Whether medical students should be treated in the same manner as visitors to teaching facilities – or treated differently, with recognition given to the role of learners in health care delivery at teaching facilities:
1. The need for a commitment to securing adequate supplies of personal protective equipment (PPE) and viral tests for all learners, within reason, recognizing frontline workers should receive the highest priority, and the need for appropriate training in the use of PPE;
2. Policies to preserve the ability of medical students to experience hands-on learning, including in-person clerkship experiences, with consideration given to alternative learning sites if needed to avoid high exposure to contagions;
3. Appropriate roles for medical students to contribute to a crisis response, with proper precautions and at a level appropriate for their education, experience, and training; and
4. More flexible policies, as needed, for unavoidable absences by students, residents, and fellows.

TMA should work with the American Medical Association to encourage federal authorities such as the U.S. Centers for Disease Control and Prevention and the U.S. Department of Homeland Security to reconsider how medical students are defined in official policies on “essential workers,” e.g., in publications such as the Cybersecurity and Infrastructure Security Agency’s Guidance on Essential Critical Infrastructure Workers.

TMA also supports an evaluation of the emergency policies enacted for residency training programs during the pandemic, including the impact on the length of training and qualifications for board certification for program completers. Adopted.
C-ME Report 5 – Opposition to Nonphysician Practitioners Serving as Attending Physicians of Residency and Fellowship Programs. That following be adopted as Texas Medical Association policy:

Opposition to Nonphysician Practitioners Serving as Attending Physicians of Residency and Fellowship Programs

The Texas Medical Association encourages graduate medical education programs in Texas to designate physicians as supervisors in the clinical training environment for residents and fellows. TMA also continues to encourage interprofessional clinical training for residents and fellows. Adopted.

C-ME Report 6 – Support for Acceptance of DACA Recipients to Texas Medical Schools. That the following be adopted as Texas Medical Association policy:

Acceptance of Applications to Texas Medical Schools From Deferred Action for Childhood Arrivals (DACA) Recipients

The Texas Medical Association recognizes admissions policies are best determined by medical school admissions committees. TMA encourages Texas medical schools to evaluate their individual policies on the acceptance of applications from Deferred Action for Childhood Arrivals (DACA) recipients and supports schools that make the decision to accept them.

DACA recipients are eligible to apply to colleges and universities for undergraduate and graduate degrees, and TMA supports the same consideration for application to medical schools. It is recognized that (1) DACA recipients are eligible for in-state tuition at higher education institutions and therefore would not be part of the state’s 10% cap on the acceptance of non-Texas residents to Texas public medical schools, and (2) DACA physicians are eligible to apply for Physician-in-Training permits, residency training, Texas medical licenses, employment in the state, and medical specialty board certification.

TMA supports communications by Texas medical schools to inform faculty, residency program directors, administrators, and other staff of the unique status of DACA recipients to promote better understanding. Adopted in lieu of Resolution 201 2021.

C-ME Report 7 – Update to TMA Policies on Advanced Practice Registered Nurses. the following as Texas Medical Association policy:

Physician-Led Patient Care Teams
TMA will continue to advocate that physicians are uniquely qualified by their extensive and broad education, training, and credentialing to lead the patient care team. TMA opposes the independent practice of advanced practice registered nurses and physician assistants and strongly supports continuation of state requirements for physician supervision and delegation of authority for these health professions.

Physician Supervision and Delegation Responsibilities
TMA supports efforts to ensure physicians are well informed of their responsibility to supervise advanced practice registered nurses and physician assistants to whom they delegate practice and prescriptive authority, including through the required content and updating of practice agreements. Both the Texas Medical Board and TMA should periodically provide reminders to physicians of these responsibilities.
Promoting Accurate Understanding of the APRN Profession, and Length and Content of APRN Training
TMA believes patients should be well informed of the distinct differences between the educational and clinical preparation of physicians and advanced practice registered nurses (APRNs). This will enable patients to make better informed decisions about their health care.

TMA determined it also critically important for state policymakers to be informed of these differences. In particular, they should be knowledgeable of the small amount of training APRNs receive in formulating a diagnosis. It should be made known that physicians are required to complete 30 times the amount of clinical training as APRNs, 15,000 hours vs. 500 hours. Further, it is critically important to understand the fundamental differences in the practice of medicine and the practice of nursing.

TMA supports clear and accurate representation of the role, education, and training of APRNs, including doctor of nursing practice (DNP) registered nurses, in the delivery of patient care, including the use of name tags and other labels. Further, APRNs have the obligation to represent themselves and their role in a clear and accurate manner in all communications with patients and other health care practitioners.

Promoting Quality Training for APRNs
TMA strongly supports assurances of high quality training for advanced practice registered nurses (APRNs). This includes consistent accreditation standards for all APRN education and training programs, and professional certification programs. TMA supports evidence-based studies of the degree of preparedness of APRNs for entry into practice. These studies should evaluate the amount of on-the-job training by physicians required to prepare APRNs to function in their role on the health care team. TMA supports clear accreditation standards that place the responsibility for securing preceptorship opportunities on the APRN training programs not the APRN student.

Physicians who elect to serve as preceptors to APRN students are strongly encouraged to see that the APRN educational programs provide the necessary guidance to enable them to serve in the role of a preceptor. Further, APRN educational programs that use physicians as preceptors for APRN clinical training should be required to adequately inform preceptors of their training role and the program’s expectations for the training experience.

TMA supports evidence-based studies of the outcomes from APRN education programs that are provided 100% online.

Different Standards for Veterans Clinics
TMA opposes a different level of care for Texans who are veterans and receive their care at U.S. Department of Veterans Affairs facilities. TMA believes veterans should be treated equitably, not differentiated through federal policies that allow independent practice for nonphysician health care practitioners despite opposing state laws. Adopted in lieu of Resolution 206 2021.

CM-PDHCA Report 1 – Requiring All Texas Licensed Physicians to Pass Texas Medical Jurisprudence Exam. That the following as Texas Medical Association policy:

Passage of Texas Medical Jurisprudence Exam by All Texas Licensed Physicians

TMA supports the requirement that all physicians licensed to practice medicine in Texas must successfully pass the Texas Medical Jurisprudence Exam in order to be aware of state laws and
administrative rules of the Texas Medical Board related to the practice of medicine, for the protection of the public and the practicing physician.

TMA reaffirms its opposition to lower licensing standards for physicians and other health care professionals practicing in physician shortage and medically underserved areas of the state. **Adopted.**

**CM-PDHCA Report 2 – Sunset Policy Review.** That (1) policy 205.004 Educational Financial Assistance be retained, and (2) policy 185.019 Rural Physician Workforce Policy be amended. **Adopted.**

**CM-PDHCA Report 3 – 2021 Texas Physician Workforce Update.** That the following be adopted as Texas Medical Association policy:

1. Recognizing that the COVID-19 pandemic resulted in unprecedented demands for physician staffing at Texas hospitals, TMA supports a post-pandemic research study by the Texas Statewide Health Coordinating Council at the Texas Department of State Health Services, in conjunction with the state’s schools of public health on the success of methods used to meet staffing needs. It is recommended that the study include identification of the most effective methods employed by individual hospital systems in the state and that the study be used to inform state emergency preparedness agencies in amending state emergency preparedness plans to better enable the state to respond to surges in hospital physician staffing needs during future extended catastrophic events.

2. TMA recommends an assessment by the Texas Medical Board of the emergency medical licensing provisions and their effectiveness in meeting the state’s emergency hospital physician staffing needs during the COVID-19 pandemic. The goal would be to determine if changes are needed in preparation for future extended catastrophic events. **Adopted.**

**CM-PDHCA Report 4 – Renewed Effort to Increase Diversity Among the Texas Physician Workforce.** That the following be adopted as Texas Medical Association policy:

Renewed Efforts to Increase Racial/Ethnic Diversity Among the Texas Physician Workforce

The Texas Medical Association recognizes the Texas physician workforce is not sufficiently diverse to reflect the racial/ethnic diversity of the Texas population.


TMA urges Texas medical schools, as well as residency and fellowship programs, to continue their efforts to increase racial and ethnic diversity among medical students, resident physicians, and fellows training in Texas. This includes continued support for pipeline programs that help foster an interest in careers in medicine among underrepresented minority students such as the high schools for the health professions that are often located in high minority areas of the state. TMA encourages support services that facilitate success for underrepresented minority students through college, medical school, and residency programs. Further, TMA recognizes the benefits of role models among academy leadership and faculty for mentorship of minority students and residents.

Health care institutions and health plans are encouraged to strive for diversity in the physician workforce.
2. Role of Physicians.
Every physician, in every type of practice or practice setting, can have a valuable role in mentoring the next generation of physicians. Students of underrepresented minorities often have a greater need for mentoring and support to counter challenges in pursuing the pathway to become a physician. TMA encourages Texas physicians to engage in their communities to guide, support, and mentor high school and undergraduate students with a calling to medicine. Students can be exposed to the physician’s practice, pursue shadowing opportunities, and progress to active roles in the office or as scribes. Each physician can make an impact in building the future workforce that is prepared to meet the needs of Texas’ diverse patient population.

TMA supports adequate funding for the state’s Joint Admission Medical Program (JAMP), which reserves medical student positions for qualified students who are economically disadvantaged, recognizing that this includes a high proportion of underrepresented minority students. TMA strongly opposes the proposed budget cut of $510,000 for the JAMP program in the proposed 2022-23 state budget and advocates for consideration of the need to increase resources to accommodate students from the new Texas medical schools. **Adopted.**

**Resolution 201 – Admission of Deferred Action for Childhood Arrivals (DACA) Students in Texas Medical Schools (Tabled Res 202 2020).** 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. **Not adopted.**

**Resolution 202 – Supporting Implicit Bias Training for Perinatal Physicians (Tabled Res 203 2020).** That TMA advocate for and support the use of implicit bias training for perinatal physicians in order to improve maternal health outcomes. **Not adopted.**

**Resolution 203 – Service Animal Assisted Therapy in Health Care (Tabled Res 205 2020).** That our TMA (1) encourage research into the use of animal-assisted therapy as a part of a therapeutic treatment plan; (2) support public education efforts on legitimately trained service animals, as defined by the Americans with Disabilities Act (ADA); (3) support a national certification program and registry for legitimately trained service animals, as defined by the ADA; and (4) encourage health care facilities to set evidence-based policy guidelines for animal visitation. **Adopted as amended.**

**Resolution 204 – Defining What Constitutes Proper Use of the Terms “Residency” and “Fellowship” When Referring to Specialty Training.** That TMA develop a position statement that highlights the historical value and current nature of the terminology “residency” and “fellowship” to describe physician postgraduate training and addresses the ramifications of nonphysician clinician groups using similar nomenclature. **Adopted.**

**Resolution 205 – Skin of Color Representation in Medical Education and Research.** That (1) the Texas Medical Association encourage dermatological conditions to be presented on varied skin tones in both preclinical curricula and clinical didactic sessions; and (2) the Texas Medical Association supports recruiting more patients with skin of color for dermatologic medical research to better represent the diversity of the patient population. **Adopted as amended.**

**Resolution 206 – Develop Guidelines for Proper Oversight of and Collaboration With Midlevel Practitioners by Physicians (Tabled Res 422 2020).** 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 AMA 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. **Not adopted.**

**Resolution 207 – Suicide Prevention Education in Medical School (Tabled Res 305 2020).** That our TMA encourages all physicians and medical students to seek out training on de-escalation of mental health crises, including acute suicidal ideation and self-harm. **Adopted as amended.**

**Resolution 208 – Facilitating Brain and Other Postmortem Tissue Donation for Research and Educational Purposes (Tabled Res 306 2020).** That (1) 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; (2) our TMA encourage the inclusion of additional information and consent options for brain tissue donation for research purposes on appropriate donor documents; (3) our TMA encourage all persons to consider consenting to brain and other tissue donation for research purposes, and that our TMA encourage efforts to develop and improve logistical frameworks for the procurement and transit of postmortem tissue for research and educational purposes. **Adopted.**

**Resolution 209 – Promoting Careers in Geriatrics Among Medical Students (Tabled Res 204 2020).** That (1) TMA recognize and support the need for more geriatricians in Texas by providing medical students with educational information and opportunities concerning geriatrics that encourage them to specialize in geriatrics, and (2) TMA support the efforts of medical schools in fostering interest in geriatrics through interest groups, shadowing opportunities, and other effective activities. **Not adopted.**

**Resolution 210 – Amending the Mental Health Question on the Physician Licensure Application to Reflect Current Impairment (Tabled Res 206 2020).** That (1) the TMA support policy as it relates to the Texas Medical Board licensure process, such that only current or active mental health conditions need be reported; and (2) that the TMA support policy and judicial decisions in line with the AMA, such that physicians are not required to disclose previous treatment for mental health conditions but are evaluated solely on performance and current impairment. **Not adopted.**

**Resolution 211 – Medical School Compliance with the Americans with Disabilities Act.** That (1) our Texas Medical Association support the activities of our medical schools in providing reasonable accommodations for students with disabilities in accordance with the Americans with Disabilities Act (ADA) and Section 504 of the Rehabilitation Act; and (2) TMA support the role of disability services providers in identifying accommodations for students at Texas medical; and (3) TMA amend policy 200.031 Medical School Admissions as follows:

Medical School Admissions: TMA reaffirms its current policy supporting medical schools’ efforts to recruit, enroll, and retain qualified underrepresented minorities and students with disabilities, and strongly supports a diverse, qualified medical student body for Texas medical schools. In addition, TMA strongly supports the State of Texas partnership with Texas medical schools in efforts to increase the representation of Hispanic and African American medical students attending Texas medical schools toward the goal of reaching their proportion in the Texas population (Council on Medical Education, p 73, I-96; reaffirmed BOT Rep. 11-I-99; reaffirmed CME Rep. 2-A-09; reaffirmed CME Rep. 1-A-19). **Adopted as amended.**

**Resolution 212 – Support Addressing, Screening, and Providing Healthy Coping Mechanisms for Burnout.** That (1) our TMA recognizes burnout be defined as emotional exhaustion, depersonalization, and reduced sense of personal accomplishment, as a pressing issue among healthcare workers and
medical students; (2) TMA supports teaching medical practitioners to recognize burnout and preventing its further development by encouraging healthy coping mechanisms and the utilization of supportive services such as physician health programs and wellness programs; and (3) TMA amend policy 215.020 Improved Funding for Mental Illness and Substance Use Disorder(s) by the addition of the following:

TMA advocates for: (1) improved prevention, identification, and treatment of mental illness, burnout, and substance use disorder(s); (2) 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) no psychiatric hospital beds to be closed based solely on budgetary concerns in Texas (Res. 402-A-10, amended C-SPH Rep. 2 2020). Referred for study.


Resolution 001 2021 – Recognizing Charles E. Cowles Jr., MD. That the Texas Medical Association House of Delegates recognize and show its sincere gratitude for the life and service of Charles E. Cowles Jr., MD, on this day, Friday, May 14, 2021. Adopted.

Reference Committee on Science and Public Health


C-SPH Report 2 – Improving Medical Clearance Policies for Traumatic Brain Injury Patients, Resolution 303-A-19 (Tabled C-SPH Report 3 2020). That (1) 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, (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. Adopted.

C-SPH Report 3 – Allow the Possession and Administration of an Epinephrine Auto-Injector in Certain Entities, Resolution 305-A-19 (Tabled C-SPH Report 5 2020). That (1) the Texas Medical Association monitor and confer with the Texas Department of State Health Services (DSHS) 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) 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. Adopted.

CM-ID Report 1 – Sunset Policy Review. That TMA amend the following policies: 135.018 Pertussis and Cocooning, 95.033 Drug Shortages and Physician Communications, 135.02 Fairness in Timely Delivery of Vaccines, and 135.019 Promotion of Antimicrobial Stewardship. **Adopted.**

CM-RWPH Report 1 – Sunset Policy Review. That TMA amend policies 140.010 Newborn Genetic Screening and 140.002 Prenatal and Perinatal Care. **Adopted.**

CM-CAH Report 1 – Sunset Policy Review. That TMA (1) retain policies 55.001 Child Safety in Pickups and 60.001 Employee Sick Leave, (2) amend policies 55.033 Children’s Mental and Behavioral Health and 260.030 Seat Belts/Motor Vehicle Restraints, and (3) delete policy 285.002 Weight Requirements. **Adopted as amended.**

CM-EMST Report 1 – Cardiac Arrest as a Reportable Condition. That the Texas Medical Association (1) support continued efforts to increase data collection on all out-of-hospital cardiac arrests in Texas in which emergency medical services personnel (EMS) attempt resuscitation, including management and evaluation by EMS personnel and outcome data from hospitals; (2) encourage management of Texas out-of-hospital cardiac arrest data by the Texas Cardiac Arrest Registry to Enhance Survival with funding from the state for the organization’s management services, data collection, and sharing; and (3) encourage the appropriate application of data protection and security laws regarding out-of-hospital cardiac arrest patient data collected by the state or a contracted entity. **Adopted as amended.**

CM-EMST Report 2 – Recommendation on Emergency Department Diversion and Saturation Policy. That (1) the Texas Medical Association support exploring the Southeast Texas Regional Advisory Council’s (RAC’s) use of emergency department saturation status in place of an emergency department diversion policy to describe when hospitals within the region are experiencing high patient volume. Each RAC should test saturation policy and gather data and feedback before TMA recommends statewide adoption. The policy should be adjusted or expanded by each RAC pending periodic reviews of data regarding policy efficacy and patient outcomes within its unique region; (2) any hospital that adopts a saturation policy in lieu of diversion must consult emergency physicians and other emergency department personnel to ensure the policy is descriptive rather than directive, and that it enables emergency medical services (EMS) medical directors and their staff to make informed decisions for the benefit of patient health and survival outcomes; and (3) TMA request that the Texas Department of State Health Services and the Governor’s EMS and Trauma Advisory Council evaluate data collected by RACs over the course of this policy change and make recommendations accordingly. **Adopted.**

Joint Report 1 – Regulatory Recommendations for Bed Bugs, Resolution 307-A-19 (Tabled Joint Report 3 2020). That TMA (1) 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) 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) encourage better public and physician education on bed bug identification, treatment, and threats to public health; (4) encourage 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) encourage municipal efforts to implement measures based on the published integrated pest management approaches and on other evidence-based examples for bed bug treatment practices. **Adopted as amended.**

Resolution 301 – Access to Direct-Acting Antiviral Therapy for Texas Medicaid Beneficiaries Infected With Hepatitis C (Tabled Res 310 2020). That the Texas Medical Association adopt the following language as policy:
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. **Adopted.**

**Resolution 302 – Advocating for the Improvement of Access to Mental Health Services Among Minority Teens (Tabled Res 311 2021).** That TMA (1) advocate for culturally informed mental health outreach and services to increase utilization by minority youth in schools, including increasing the number of minority mental health professionals; (2) advocate for school districts to incorporate best practices to reduce biases, including those against minority students facing mental health and behavioral disorders; and (3) advocate for increased data collection of mental health intervention outcomes among minority adolescents. **Referred for study.**

**Resolution 303 – Designating Texas Hospitals as Sensitive Locations (Tabled Res 315 2020).** That TMA (1) oppose U.S. Immigration and Customs Enforcement operations in hospitals, (2) advocate for state legislation designating hospitals as sensitive locations where U.S. Immigration and Customs Enforcement cannot operate, and (3) encourage hospitals to publicize their status as sensitive locations. **Referred for study.**

**Resolution 304 – Updating Texas Medical Association Teenage Sexual Health Guidelines (Tabled Res 318 2020).** That the Texas Medical Association (1) encourage its members to engage with their local communities and school boards to develop comprehensive sexual education programs for adolescents that teach more than abstinence as an effective practice to reduce the risk of unintended pregnancy or sexually transmitted infections, and (2) amend policy 55.016. **Referred for study.**

**Resolution 305 – Supporting an Opt-Out Organ, Eye, and Tissue Donation System in Texas (Tabled Res 319 2020).** That TMA (1) adopt new policy to support an opt-out organ, eye, and tissue donation system in Texas, and (2) amend policy 280.010 Physician Role in Promoting Organ and Tissue Donation and Transplantation to include this language. **Referred for study.**

**Resolution 306 – Maternal Health and Postpartum Depression Screening (Tabled Res 320 2020).** That the Texas Medical Association (1) encourage implementation of postpartum depression screenings as routine protocol for perinatal and postnatal women in health care settings, and (2) promote education about postpartum depression screenings to primary care physicians who treat perinatal and postpartum women. **Adopted.**

**Resolution 307 – Saving Energy, Reducing Costs, and Increasing Efficiency in Medical Practices (Tabled Res 321 2020).** That the Texas Medical Association recommend energy conservation guidelines for Texas medical practices and adopt AMA policy H-135.923 as follows:

TMA (1) supports initiatives to promote environmental sustainability and other efforts to halt global climate change, (2) will incorporate principles of environmental sustainability within its business operations, and (3) supports physicians in adopting programs for environmental sustainability in their practices. **Adopted as amended.**

**Resolution 308 – Mandatory Waiting Period for Firearm Purchases (Tabled Res 324 2020).** That the Texas Medical Association advocate for mandatory waiting periods following the purchase of firearms to reduce firearm-related injuries and deaths. **Amend TMA policy 260.015 Firearms in lieu of Resolution 308.**

**Resolution 309 – Promoting and Improving Health Literacy (Tabled Res 325 2020).** That TMA (1) recognize inadequate personal health literacy is a barrier to effective medical diagnosis and treatment; (2)
recommend the adoption of an organizational health literacy policy at all health care institutions that should aim to improve communication by physicians and other health care professionals, and improve educational approaches to patient visits; and (3) encourage the allocation of public and private funds for research about health literacy, as well as the development of low-cost community and health system resources focused on improving health literacy. **Adopted as amended.**

**Resolution 310 – Improving Access to Immediate Postpartum Long-Acting Reversible Contraception for Adolescents (Tabled Res 327 2020).** That TMA (1) support increased funding for postpartum long-acting reversible contraceptives and other prescriptive contraceptives for women who do not qualify for services under Healthy Texas Women and the Texas Family Planning Program and who do not have reliable access to Title X-funded clinics; (2) support and advocate for the reduction of the age in Texas at which a minor can access prescriptive contraceptives, including postpartum long-acting reversible contraceptives, without parental consent from 18 to 17 to match the Texas age of consent; and (3) advocate for the expansion of the Texas “mature minor” doctrine described in TMA policy 55.004 Adolescent Sexual Activity to include access to postpartum long-acting reversible contraceptives without parental consent. **Adopted as amended.**

**Resolution 311 – Lowering the Legal Age for Minors to Access Contraceptive Services (Tabled Res 328 2020).** That TMA (1) support lowering the legal age at which a minor can access contraceptives without a guardian or parental consent to at least age 17, and (2) continue to support initiatives, programs, and funding that eliminate barriers to adolescents accessing reproductive health care. **Adopted.**

**Resolution 312 – Advocating Against Electronic Nicotine Delivery Systems (ENDS) (Tabled Res 301 2020).** That TMA (1) educate its members on the various aspects of e-cigarette use through ongoing CME and articles in *Texas Medicine Today*; (2) advocate for legislation that bans the sale of flavored, mint, and menthol tobacco products including both e-cigarette products and combustible products; (3) advocate against social media companies using influencers to advertise electronic nicotine delivery systems; and (4) advocate against the sale of e-cigarettes and their component products and accoutrements at retail stores and pharmacies that also provide primary care and other clinical services. **Adopted as amended.**

**Resolution 313 – Elimination of Human Abuse and Persecution (Tabled Res 302 2020).** That TMA (1) urge the Texas Legislature to make laws to protect physicians from personal liability when passing confidential information regarding alleged abuse or persecution of a patient to various governmental agencies, (2) encourage physicians to make inquiry into patients’ well-being a matter of routine medical practice, and (3) urge physicians to document instances of alleged abuse or persecution in the patient’s medical records. **Referred for study.**

**Resolution 314 – Promoting Safe and Effective Disposal of Polystyrene Foam Medication Case(s) With or Without Ice Packs.** That TMA (1) encourage pharmaceutical firms to take full responsibility for the return of polystyrene foam case(s) with or without ice packs and paying for the proper and safe disposal or reuse of these materials. **Adopted as amended.**

**Resolution 315 – Possible Upcoming Shortage of Fentanyl and Other Opioid Injections.** That TMA (1) work with stakeholders and policymakers to ensure that the legitimate availability and affordability of fentanyl and other injectable opioids do not fall below the current and future medical need for procedures performed in Texas as well as for disaster preparedness; and (2) advocate physicians using the minimum amount of opioids needed for procedures to make patients comfortable. **Adopted as amended.**

**Resolution 316 – Use of Human Tissue for Beneficial Applications (Tabled Res 303 2020).** That the Texas Medical Association study and make active recommendations for a safe harbor in Texas allowing certified entities that have non fetal tissue and non-whole-organ human tissue waste from a consenting adult patient to use the tissue strictly for research purposes and clinical diagnostics. **Adopted.**
Resolution 317 – Decommissioning Existing and Not Constructing New Wastewater Treatment Plants in or Near Flood Plains and Waterways (Tabled Res 307 2020). That the Texas Medical Association support the need for local, county, and state governmental entities for environmental safety in existing wastewater treatment plants in or near flood plains and waterways. Adopted as amended.

Resolution 318 – Recurrent Flooding in Texas Must Be Resolved (Tabled Res 308 2020). That the Texas Medical Association support the need for local, county, and state governmental entities to commit to and be responsible for the necessary resources to effectively minimize and mitigate recurrent flooding in highly populated areas of Texas. Adopted as amended.

Resolution 319 – Support for the Texas-CARES Program (Tabled Res 312 2020). That TMA (1) investigate options, identify strategies, and support ongoing efforts to sustain the Texas Cardiac Arrest Registry to Enhance Survival (Texas-CARES) Program to collect data on out-of-hospital cardiac arrest (OHCA) incidence, 9-1-1 response, emergency medical services (EMS) treatment, and patient outcomes; (2) 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 to maximize survival after OHCA; (3) work to ensure the state of Texas shall own the data collected by the Texas-CARES registry; and (4) that the Texas Delegation to the American Medical Association carry a similar resolution to the AMA House of Delegates for consideration. Adopted as amended.

Resolution 320 – Impact of Social Networking Services on the Health of Adolescents. (1) That the Texas Medical Association affirm that use of social networking services has the potential to negatively impact the physical and mental health of individuals, especially adolescents and those with preexisting psychosocial conditions, and therefore these services should have established, evidence-based, reliable safeguards to protect vulnerable populations from harm, and (2) That the Texas Delegation to the American Medical Association introduce a resolution to the AMA House of Delegates to advocate for the study of the biological, psychological, and social effects of social networking services use, and to advocate for legislative or regulatory action, including the expansion of Children’s Online Privacy Protection Act of 1998 protections, to mitigate the potential harm from the use of social networking services to adolescents and other vulnerable populations. Adopted.

Resolution 321 – Restore and Add Funding to Public Health. That the Texas Medical Association, which represents more than 55,000 Texas physicians and medical students, work with academic centers, medical schools, and schools of public health to encourage the Texas Legislature to restore and add funding to public health to assist with the current pandemic crisis and prepare for the next. Adopted as amended.

Resolution 322 – Improving Physician Access to Immigrant Detention Facilities (Tabled Res 304 2020). That TMA (1) 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) advocate for the right of community physicians to contact physicians and 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. Referred for study.

Resolution 323 – Education and Action to Arrest the Effects of Climate Change on Health (Tabled Res 309 2020). That TMA (1) 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) 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) that the substance of the education and advocacy be managed through the established mechanisms of the TMA Council on Science and Public Health and the Council on Legislation. **Adopted.**

**Resolution 324 – Required Platelet Products at a Facility in Maternal Levels of Care Designation (Tabled Res 314 2020).** 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. **Adopted as amended.**

**Resolution 325 – Employee Rights to Lactation Accommodation (Tabled Res 317 2020).** 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. **Adopted as amended.**

**Resolution 326 – Pediatric Iron Deficiency Anemia Treatment and Diagnosis Guidelines (Tabled Res 326 2020).** 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.

**Resolution 327 – Expanding Access to Regularly-Scheduled Dialysis for All Individuals With ESRD (Tabled Res 330 2020).** That TMA (1) recognize the need for 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 which dialysis is appropriately indicated; and (2) collaborate with relevant stakeholders in identifying and implementing potential solutions to achieving regularly scheduled dialysis as a standard of care for all individuals with ESRD in Texas. **Adopted as amended.**

**Resolution 328 – Outreach and Education in Mixed-Status and Undocumented Communities Regarding Information Gathering and COVID-19 Vaccine Distribution.** That our Texas Medical Association (1) amend policy 260.080 Vaccine Delivery; (2) continue to create and implement accessible outreach and education programs pertaining to the COVID-19 vaccine that can be distributed via community-based, faith-based, and grassroots organizations in mixed-status and undocumented communities; and (3) TMA encourage collaboration with community-based, faith-based, and grassroots organizations to create outreach and education programs for undocumented and mixed-status immigrant communities. **Adopted as amended.**

**Resolution 329 – In Support of Comprehensive Sexuality Education Reform.** That TMA amend Policy 55.016 Sexuality Education. **Referred for study.**

**Resolution 330 – In Support of Reevaluating the Use of Race in Estimated Glomerular Filtration Rate.** That our Texas Medical Association (1) recognize that race is an incorrect metric to use in estimating glomerular filtration rate (GFR); and (2) support and encourage efforts to study and redefine the currently used race correction factor, so that GFR can be estimated with factors other than self-identified race. **Adopted as amended.**
Resolution 331 — Support for Increasing Digital Access. That TMA (1) advocate for increased availability of, access to, and affordability of high-speed home broadband internet, in order to improve telehealth access and reduce health care disparities, particularly among the elderly and in underprivileged communities; and (2) advocate to improve digital literacy in order to improve telehealth access and reduce health care disparities, particularly among the elderly and in underprivileged communities. **Adopted as amended.**

Resolution 332 — Opposition to Criminalization of Gender-Affirming Care for Transgender Youth. That TMA (1) opposes efforts to criminalize evidence-based, gender-affirming care for transgender youth; and (2) rename Policy 55.058 as Sexual Orientation Change Efforts and Gender-Affirmation Therapies for Minors and amend it. **Adopted as amended.**

Reservation 333 — Opposition to Sobriety Requirement for Hepatitis C Treatment. That TMA (1) oppose the Texas Medicaid 90-day sobriety requirement for hepatitis C virus (HCV) treatment, (2) support efforts to remove the sobriety requirement as a barrier to HCV treatment, and (3) encourage the awareness and avoidance of barriers relating to access to HCV treatment. **Adopted.**

Reservation 334 — Racism as a Public Health Issue. That TMA (1) acknowledge that systemic and structural racism within the health care system has caused and continues to cause health inequity that harms marginalized communities; (2) recognize racism, in its systemic, cultural, interpersonal, and other forms, poses a threat to public health, the advancement of health equity, and the delivery of appropriate medical care; and (3) support resource development for health care institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, physicians, providers, and populations. **Referred for study.**

Reservation 335 — Public Health and Health Care Protections While Incarcerated. That our Texas Medical Association recognize incarcerated health is public health by protecting the health and safety of incarcerated and detained individuals through the following actions including, but not limited to:

1. Advocating for equivalence of care for those incarcerated and detained;
2. During infectious disease outbreaks, (a) advocating for the urgent provisioning of personal protective equipment and needed hygiene supplies, and (b) encouraging the adoption of safety measures such as social distancing, reduced crowding, and decarceration to mitigate disease spread in facilities;
3. Promoting access to nonemergency health services during disease outbreaks;
4. Opposing using incarcerated people to respond to public health emergencies;
5. Recognizing incarcerated and detained individuals as a high-risk group for prioritization of vaccine access;
6. Encouraging the enactment of safeguards that protect the ability of incarcerated people to access care without fear of retaliation;
7. Supporting strengthening the Eighth Amendment rights of incarcerated people to access adequate medical care;
8. Supporting legislation requiring U.S. Occupational Safety and Health Administration protections in incarcerated workplaces;
9. Encouraging the Texas state Medicaid agency to accept and process Medicaid applications from eligible juveniles and adults who are incarcerated to improve access to care, particularly during a pandemic;
10. Advocate for adequate payment to physicians and health care providers, including primary care, mental health, and addiction treatment professionals, to encourage improved access to comprehensive physical and behavioral health care services to juveniles and adults throughout the incarceration process from intake to reentry into the community;
11. Supporting partnerships and information-sharing among correctional systems, community health systems, and state insurance programs to provide access to a continuum of health care services for juveniles and adults in the correctional system; and

12. Supporting (a) linkage of those incarcerated to community clinics upon release to accelerate access to comprehensive health care, including mental health and substance abuse disorder services, and improve health outcomes among this vulnerable patient population, as well as adequate funding; and (b) the collaboration of correctional health workers and community physicians and health care providers for those transitioning from a correctional institution to the community. Referred for study.

Resolution 336 – Results and Regulation of Freestanding Birthing Centers and at Home Birthing Services (Tabled Res 426 2020). That TMA (1) work with state agencies to study the results, regulation, and quality review mechanisms of freestanding birthing centers and at-home birthing services, and (2) determine if additional regulations and public education are needed. Adopted.

Resolution 337 – Advocating for Evidence-Based Care for Incarcerated Pregnant Women in Texas Correctional Facilities. That TMA (1) recognize the lack of uniform prenatal care provided to incarcerated pregnant women in Texas correctional facilities, (2) encourage the Texas Commission on Jail Standards and Texas Department of Criminal Justice to comply with evidence-based guidelines from national physician organizations regarding the care and management of incarcerated pregnant women in Texas correctional facilities, and (3) encourage the Texas Commission on Jail Standards and Texas Department of Criminal Justice to report all pregnant inmates’ pregnancies and outcomes. Adopted.

Resolution 338 – Support for Immunization Information System Interjurisdictional Data Exchange. That our Texas Medical Association support sharing Texas immunization registry (ImmTrac2) data interjurisdictionally with other state and regional immunization information systems to help ensure accurate and complete patient immunization records while maintaining patient privacy. Adopted.

Resolution 339 – Support for Texas Department of State Health Services Efforts to Address Racial and Ethnic Disparities in Health. That TMA (1) support the Texas Department of State Health Services prioritizing continued efforts to address racial and ethnic disparities in health; and (2) advocate to reinstate a statewide office to reduce racial and ethnic health disparities within the Texas Health and Human Services Commission with appropriate levels of funding. Adopted as amended.

Resolution 340 – Supporting the Health of Undocumented Immigrants During the COVID-19 Pandemic and Future Pandemics. That TMA (1) advocate for reducing communication barriers regarding COVID-19 and any future pandemic-associated information such as testing, treatment, and vaccination availability, particularly with limited-English-proficient individuals; (2) support physician participation in pandemic-related government assistance programs such as the Health Resources and Services Administration (HRSA) COVID-19 Uninsured Program; and (3) support the distribution of life-saving vaccinations to all individuals in the community, including undocumented immigrants, during a pandemic in order to swiftly achieve herd immunity. Adopted as amended.


Resolution 343 – Study to Improve Healthcare Access and Care for Persons with Disabilities. (1) That our Texas Medical Association study and recommend actions to address the following issues related
to patients with disabilities: (a) identification of problems that lead to poor health outcomes in people with disabilities; (b) how to improve health outcomes for patients with disabilities; (c) ways to increase health care screenings among patients with disabilities; (d) how to improve training in medical schools and residency programs related to caring for patients with disabilities; and (e) how TMA can best educate its members about caring for patients with disabilities, including reviewing laws, regulations, and activities that impact the disability community; and (2) that the results of this study be reported back to the TMA House of Delegates at TexMed 2022. **Not adopted.**

**Resolution 344 – Supporting Mature Minors Ability to Receive Vaccinations Without Parental Consent.** That TMA (1) support a physician’s right, if deemed appropriate by the state, to provide vaccinations to mature minors who provide consent; (2) will encourage physicians to have age-appropriate materials for vaccine information and documentation methods for minors considering obtaining a vaccination; and (3) encourage our legislature to support model legislation expanding access to vaccines by broadening the rights of mature minors who comprehend the need for, nature of, and any risks inherent to a vaccination to be able to give informed consent to receive a vaccination recommended by the U.S. Advisory Committee on Immunization Practices. **Not adopted.**

**Resolution 345 – TMA Statement on the Health Impact of Racism.** (1) That the Texas Medical Association develop an Official Statement on Racism; (2) that comprehensive policy be developed to support the statement and ensure that anti-racism and health equity strategies are prioritized for inclusion in organizational, educational, and advocacy activities; and (3) that TMA support identifying racism as a public health emergency. **Referred for study.**

**Resolution 346 – Educating Physicians on the Rights of Immigrant Patients (Tabled Res 107 2020).** That our Texas Medical Association advocate for policies that protect the rights of immigrants when seeking medical care and oppose policies that would deter or restrict access to health care for immigrants and or their dependents such as the collection of patient immigration status information. **Adopted as amended.**

**Resolution 347 – Increasing Education Regarding the Effects of Bias and Discrimination on Patients Experiencing Homelessness.** That TMA (1) recognize individuals facing homelessness suffer significant barriers in accessing health care that result in health care disparities; (2) encourage the use of multicomponent stigma-reduction interventions, including but not limited to increased education and advocacy to reduce the harmful effects of discrimination and promote health equity for patients experiencing homelessness; (3) support the use of social determinants of health screenings to address the issue of housing status such that patients experiencing homelessness can receive care tailored to their specific situations; and (4) encourage further research on how barriers to care negatively impact outcomes of patients experiencing homelessness. **Adopted as amended.**

**Resolution 348 – School Physicals Should Be Conducted by Physicians or Their Supervised Designee (Tabled Res 409 2020).** 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.

**Resolution 349 – Reducing Intimate Partner Homicide.** That TMA (1) support Texas law being consistent with federal law in declaring possession of a firearm unlawful for an individual convicted of intimate partner violence; (2) support efforts to establish guidelines for removal of firearms from those at high risk for committing intimate partner violence, such as people with domestic violence misdemeanors and those convicted of stalking; and (3) advocate for data collection on gun violence including the greater likelihood of lethality when guns are involved. **Adopted as amended.**
**Resolution 350 – Restricting School Immunization Exemptions to Exemptions for Medical Reasons.** That our Texas Medical Association advocate for the removal through legislation of nonmedical exemptions from vaccinations approved and recommended by the Advisory Committee on Immunization Practices (ACIP). **Adopted as amended.**

**Resolution 351 – Support of a Statewide Contact Tracing App.** That TMA (1) support the development of a statewide contact tracing app made by the Texas Department of State Health Service (DSHS) in accordance with Centers for Disease Control and Prevention preliminary criteria for digital contact tracing in addition to conventional tracing methods; (2) support efforts to promote and make widely known the use of contact tracing app made by DSHS; and (3) support the efforts to educate the general public that a contact tracing app made by DSHS ensures patient safety and privacy to encourage public buy-in. **Referred for study.**

**Resolution 352 – Mental Health Education in Schools.** That the Texas Medical Association urge state legislators to make mental health education and awareness part of school curriculum in Texas from elementary through high school. **Adopted as amended.**

**Resolution 353 – Recognizing the Effect of Climate Change on Public Health (Tabled Res 323 2020).** That the Texas Medical Association concur with the scientific consensus that Earth is undergoing adverse global climate change and acknowledge that climate change will increasingly affect public health, with disproportionate impacts on vulnerable populations such as children, the elderly, and people of low socioeconomic status. **Adopted as amended.**

**Resolution 354 – Addressing Race in Medicine.** That TMA (1) support the development of curriculum in Texas medical schools that addresses the history of race in medicine and its present-day effects for minority groups including but not limited to Black, Latinx, Indigenous (American Indians and Alaska Natives, native Hawaiians/Pacific Islanders), and Asian populations; (2) encourage all members to participate in a continuing medical education program that addresses the history of race in medicine and its present-day effects for minority groups including but not limited to Black, Latinx, Indigenous (American Indians and Alaska Natives, native Hawaiians/Pacific Islanders), and Asian populations; and (3) create a Committee for Minority Health and Issues to address health disparities among minorities in Texas. **Referred for study.**

**Resolution 355 – Support of Medical Student Health and Wellness.**

**A:** That TMA (1) encourage the development of evidence-based methods to detect, treat, and prevent mental health issues in medical students, (2) promote awareness of the prevalence of mental illness among medical students and therapeutic resources available to treat these illnesses. **Adopted.**

**B:** That TMA (3) encourage Texas medical schools to recognize common barriers that deter medical students from seeking counseling services, and (4) encourage the development of peer support group sessions within medical schools to promote open discussion of mental health and build support among students. **Referred for study.**

**Resolution 356 – Support Statewide Planning and Communication for a Vaccine Plan During a Pandemic.** That TMA (1) support modifying the state’s current emergency vaccination plan to better meet Texas’s population needs, with specific attention given to Texas’s large population, Texas’s elderly population, minority population, and rural populations, and allow for improved communication to citizens in the event of an emergency vaccination rollout; (2) study ways to improve and simplify vaccine rollout in the future to combat vaccine hesitancy; and (3) support the use of user-friendly, easily accessible
resources for information about new vaccines and vaccine roll-out plans in the state of Texas, to decrease vaccine hesitancy and aid in distribution. **Adopted.**

**Reference Committee on Socioeconomics**

**C-SE Report 2 – Sunset Policy Review.** That TMA (1) retain policies: 30.001 CRNA Direct Reimbursement, 115.014 Out-of-Network Referral Requirements, 115.016 “A Modest Proposal” to Save our Health Care System, 130.001 Hospital Contracts, 145.015 Mandatory Referral and Precertification of Chronic Renal Failure Treatment, 190.002 Medicaid Medications, 190.003 Medicaid Payments to Increase Participation, 195.009 Medicare Hospital Incentive Payments, 230.006 Physician Charge Transparency, 235.033 Coordination of Benefits, and 240.001 Geographic Practice Cost Indices (GPCIs); (2) amend policies: 100.003 Patient Transfers, 115.001 Indigent Care, 115.015 Accountable Care Organizations, 180.002 Managed Care Incentive Withholds, 190.020 Sterilization Services, 190.030 Physician Enrollment in Medicaid HMOs, 195.002 Medicare HMO Disclosure of Limitations on Choice of Physicians, 195.004 Disproportionate Share Fund, 195.006 Medicare Program Cutbacks, 235.001 Fee for Service, 235.002 Individual Responsibility for Health Care and Funding, 235.003 Reimbursement Based on Years in Practice, 235.004 Third-Party Payer Physician Payment Reductions, 235.006 Bundled Payment Proposals, 235.008 Surgical Assistants, 235.023 Reimbursement for Uncompensated Services to the Uninsured or Underinsured, 240.004 Medicare Reimbursement for Emergencies, and 280.002 Insurance Coverage for New Medical Procedures; and (3) delete policies: 95.036 Tax-Deferred Health Benefits Mandate on Over-the-Counter Medication, 190.004 Medicaid Allowance for Preterm Labor, 235.007 Reimbursement of Preventive Health Care, and 95.001 Prescription Triplicate Forms. **Adopted as amended.**

**C-SE Report 3 – Opposition to New Federal Public Charge Definition.** That TMA (1) adopt new policy opposing revisions to the federal definition of public charge that penalize legal immigrants or their children for using local, state, or national health, nutrition, and housing services, including Medicaid and the Children’s Health Insurance Program; (2) continue to advocate that the new federal rules be rescinded to protect the health of all Texans; and (3) develop resources to help physicians accurately and concisely convey to their patients what federal rules relating to public charge do and do not say. **Adopted.**

**PPAC Report 3 – Legislative Changes Regarding Vacating Orders.** 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, the 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 the 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, all parties shall be notified that the temporary restriction or suspension is void, unless and until the TMB appeals the case to district court and that court reverses the administrative law judge’s findings of facts and conclusion of law. **Adopted as amended.**

**BOT Report 18 – Compensation to Physicians for Activities Other Than Direct Patient Care (Tabled BOT Report 13 2020).** 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.**

**CM-MHPC Report 1 – Sunset Policy Review.** That policy 260.005 Community and Migrant Health Centers be retained. **Adopted.**
CM-RH Report 1 – Sunset Policy Review. TMA retain policy 55.003 School Career Programs in Rural Areas. **Adopted.**

**Resolution 401 – Caps on Insulin Copayments with Insurance (Tabled Res 413 2020).** (1) That TMA support a limit on the patient cost sharing amount patients pay per month for prescribed insulin, and (2) that the TMA Delegation to the AMA take a similar resolution to the AMA House of Delegates. **Adopted as amended.**

**Resolution 402 – Postpartum Maternal Healthcare Coverage Under Children’s Insurance (Tabled Res 414 2020).** (1) That the Texas Medical Association 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; and (2) That the TMA Delegation to the AMA take a similar resolution to the AMA House of Delegates. **Adopted as amended.**

**Resolution 403 – Insurance Promotion of Preventive Care Services via Incentive-Based Program (Tabled Res 417 2020).** (1) That the Texas Medical Association advocate for health insurance companies to adopt cash-based incentive programs similar to the Medicare Incentives for Prevention of Chronic Disease program to promote usage of preventive care services and that TMA support further research on health care initiatives that increase usage of preventive care services, and (2) That the TMA Delegation to the AMA take a similar resolution to the AMA House of Delegates. **Adopted as amended.**

**Resolution 404 – Training Requirements Imposed by Insurance Companies Preventing Patients’ Access to Quality Medical Care (Tabled Res 420 2020).** That TMA (1) 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) urge the Texas Medical Board to condemn such practice by insurance companies as beyond the companies’ purview of physician training responsibilities; (3) 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) 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. **Adopted.**

**Resolution 405 – Ensuring Medical Practice Viability Through Reallocation of Insurance Savings During the COVID-19 Pandemic.** (1) That the Texas Medical Association advocate for full transparency regarding Medicaid expenditures relative to allocated funds, as well as expenditures relative to gross income for all commercial payers during the pandemic; (2) that TMA urge adoption of legislation that would mandate a review of the difference between the current physician financial deficit created by the COVID-19 pandemic and subsequent profits the insurance companies have reaped due to the government shutdowns and mandates; (3) that a fair and equitable formula be implemented to divide and allocate the savings directly resulting from decreased patient encounters among patients/employers who paid their premiums, physicians who have been impacted directly by government mandates and shutdowns, and the insurance companies; and (4) that the Texas Delegation to the American Medical Association take a similar resolution to the AMA House of Delegates for consideration. **Referred for study.**

**Resolution 406 – Medicaid-Medicare Parity Needed for Patient Access Exacerbated by COVID-19.** That the Texas Medical Association advocate to increase Texas Medicaid reimbursement rates to physicians at least equal to Medicare rates, as the COVID-19 pandemic has made operating a physician practice financially impossible for many practices with a large Medicaid population. **Adopted.**
Resolution 407 – Ensuring That Telehealth Coverage Does Not Discourage Use of Local Physicians. (1) That the Texas Medical Association recognize that a benefit of having local physicians and their team of local health care providers provide telemedicine services is that they have the ability to ask the patient to switch to an in-person visit if circumstances warrant this approach, (2) that TMA advocate for legislation that requires insurance carriers not to establish cost-sharing policies that encourage patients to use nonlocal physicians and providers instead of local physicians, and (3) That the Texas Delegation to the American Medical Association take a similar resolution to the AMA House of Delegates for consideration. Referred for study.

Resolution 408 – Need for and Funding of Level I and Level II Trauma Centers (Tabled Res 402 2020). That the Texas Medical Association work with state officials to determine the number of Level I and Level II trauma centers needed to support communities throughout Texas and to provide funding to make Level I and Level II trauma centers viable for all other service lines. Adopted.

Resolution 409 – Taxes on Medical Billing Services (Tabled Res 403 2020). 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 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. Adopted.

Resolution 410 – Individual Physicians Be Paid While Awaiting Credentialing Approval (Tabled Res 404 2021). 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 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. Adopted.

Resolution 411 – Physicians to Retain Payment During Credentialing (Tabled Res 405 2020). 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 That TMA advocate to amend, by changing “may cover” 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 “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.” Adopted.

Resolution 412 – Maintaining the Integrity of Physicians Orders in an Electronic Environment. That the Texas Medical Association support legislation stating that altering physician orders in the inpatient setting, without the approval of the order’s original author or the covering physician is practicing medicine and is prohibited except in an emergency (i.e., a patient safety situation). Orders and order sets approved by the medical executive committee and/or the medical staff should be exempt, with those altered orders permitted. Adopted as amended.

Resolution 413 – Compensation to Physicians for Activities Other Than Direct Patient Care (Tabled Res 407 2020). That TMA adopt a Funding for Physician Noncare Services policy as follows:

The Texas Medical Association advocates for payers – insurance companies and managed care companies, including companies managing governmental insurance plans – to 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 as gathering, compiling, and submitting medical records and data.

TMA also recommends such compensation be promptly paid in full by payers to physicians at a level commensurate with their education, training, and expertise, and at a rate comparable to that of the most highly trained professionals.

Physicians shall bill the payers for time spent by them and their staff to perform noncare services including, but 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, payers shall pay the physician promptly, with significant interest penalties assessed for payment delays. Because noncare services benefit payers, compensation to physicians for these services should not be billable to patients. **Adopted.**

**Resolution 414 – Contracted Health Plans Must Apply the Same Level of Benefits Concerning Patient Responsibility (Tabled Res 408 2020).** (1) That the Texas Medical Association adopt as 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, (2) that TMA take this issue to the state legislature for potential statutory action, and (3) 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. **Adopted.**

**Resolution 415 – Paper Medical Record Chart Preparedness for Electronic Health Record Interruptions.** (1) That the Texas Medical Association encourage all users of electronic health records (EHRs) in all health care environments to have an easily accessible training manual instructing clinical staff on how to maintain medical records during planned and unplanned EHR downtimes and interruptions; and (2) That the Texas Delegation to the American Medical Association take a similar resolution to the AMA House of Delegates for consideration. **Adopted as amended.**

**Resolution 416 – Physician Societies to Create a Self-Funded, Balanced, and Nonpartisan Center for the Study of Health Care Reform (Tabled Res 421 2020).** 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; and that this entity maintain and promote an online platform to provide for balanced critique about general and specific policy proposals, health care reports, and national health care systems for the benefit of the general public and 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. **Referred for action.**

**Resolution 417 – Verbal Physicians Orders.** That the Texas Medical Association encourages facilities to allow for physician orders to be given in the most efficient manner to accommodate patient care safely and in a timely manner. **Adopted as amended.**

**Resolution 418 – Electronic Prescribing of Controlled Substances (EPCS) Unfunded Mandate and Pharma Financial Settlements.** (1) That the Texas Medical Association work with the American Medical Association to initiate a request to the federal government to use the dollars from the Purdue
Pharma settlement, and other such settlements, to help pay for the electronic prescribing of controlled substances financial unfunded mandate; (2) That the Texas Delegation to the American Medical Association take a resolution to the AMA House of Delegates to lobby the federal government to require certified electronic health record companies to provide electronic prescribing of controlled substances as standard basic service, and (3) that TMA review the electronic prescribing of controlled substances laws in other states to inquire on their implementation of this law to see if their law(s) have implicated dollars to cover this cost and better waiver language. **Adopted as amended.**

**Resolution 419 – Advocating for Increased Capacity of Local State Mental Health Facilities and Coordination of Behavioral Health Services (Tabled Res 313 2020).** (1) That the Texas Medical Association advocate for increased funding and capacity for inpatient psychiatric beds throughout Texas with a priority emphasis in areas that lack local access to mental health facilities, and (2) that TMA policy 215.019 Public Mental Health Care Funding be amended. **Adopted.**

**Resolution 420 – Step-Edit Therapy Contributes to Denial of Care and Has Not Demonstrated Improved Patient Outcomes or Overall Cost Savings (Tabled Res 412 2020).** 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 that TMA ask the American Medical Association to review the ethical implication of step-edit therapy and make further recommendations on its use. **Adopted.**

**Resolution 421 – Augmented Intelligence (AI) in Health Care (Tabled Res 201 2020).** That the Texas Medical Association Council on Socioeconomics, TMA Committee on Health Information Technology, and TMA Council on Medical Education collaboratively develop augmented intelligence (AI) policy. **Adopted as amended.**

**Resolution 422 – Adjustments to Hospice Dementia Enrollment Criteria (Tabled Res 427 2020).** 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 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. **Adopted.**

**Resolution 423 – Insurance Coverage for Fertility Preservation Procedures for Cancer Patients Undergoing Gonadotoxic Therapy.** That the Texas Medical Association advocate for payment of fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician. **Adopted.**

**Resolution 424 – Encourage the Establishment of an Express Lane Eligibility (ELE) Program in Texas.** That our Texas Medical Association encourage the establishment of an express lane eligibility (ELE) program in Texas that permits the use of income, household size, or other eligibility information previously collected from an Express Lane Agency (ELA), as described by the Centers for Medicare & Medicaid Services, to facilitate enrollment in Medicaid and the Children’s Health Insurance Program (CHIP). **Adopted.**

**Resolution 425 – Making COVID-19 Emergency Telehealth Policies Permanent.** That the Texas Medical Association support policy for payment parity, as initiated by the COVID-19 PHE declaration and 28 TAC §35.1 enacted by Governor Abbott, for the same covered service provided to an enrolled
patient by a contracted physician via telemedicine and That TMA support research on the use of telemedicine services in rural settings in response to 28 TAC §35.1 to determine its effect on increasing access to health care services across the state. Not adopted.

Resolution 426 – Support for Rural Labor and Delivery Departments. That TMA (1) support legislation and advocate for increased funding for rural labor and delivery departments under financial strain to allow for improved access to intrapartum care; (2) promote awareness to the general public, policy-makers, and physicians about the challenges rural women face when seeking obstetric care that result from decreased access to local labor and delivery departments; and (3) explore incentivizing physicians to practice obstetrics in rural settings in addition to Texas’ existing rural primary care recruitment programs. Adopted as amended.

Resolution 427 – Limiting Out-of-Network Ground Ambulance Costs. (1) That the Texas Medical Association support increased data collection and price transparency of ground ambulance providers and services, (2) that TMA support policies and initiatives to reduce surprise, out-of-network billing related to ground ambulance services, and (3) That the TMA Delegation to the AMA take this resolution to the AMA House of Delegates. Adopted as amended.

Resolution 428 – Insurance Coverage Transparency (Tabled Resolution 401 2020). (1) That the Texas Medical Association advocate for legislation that requires 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 and CPT codes via phone or the internet; (2) that TMA advocate for legislation that requires commercial insurance carriers, during insurance eligibility verification, to provide information regarding factors that may result in denial of the claim, e.g., the insurance carrier is waiting for the primary policyholder to verify whether he or she has other health insurance coverage; (3) that TMA advocate for legislation that requires commercial insurance carriers to respond to telephone inquiries about the patient’s cost-sharing liability by providing accurate information verbally and via fax confirmation; (4) that TMA advocate for legislation that penalizes commercial insurance carriers, via fines and the publication of each carrier’s number of noncompliance complaints, when the above information is inaccurate or not provided in a timely manner; and (5) that the Texas Delegation to the American Medical Association carry a similar resolution to the AMA House of Delegates. Adopted.

Resolution 429 – Adoption of Principles of Physician Value-Based Decisionmaking in Medical Practice and Professionalism. That TMA (1) adopt the American Medical Association policy Value-Based Decision-Making in the Health Care System H-450.938; and (2) adopt policy encouraging physicians to practice value-based decisionmaking, to the best of their ability, as a core tenet of physician professionalism. Referred for study.

Resolution 430 – Paid Parental Leave (Tabled Res 418 2020). That TMA (1) 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) 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) support policies that provide at least 12 weeks of paid parental leave following the birth or adoption of a child; (4) support that paid parental leave policies incorporate funding mechanisms that do not put an undue burden on solo or small business owners; and (5) evaluate how internal policies for employees should be updated to provide paid parental leave following the birth or adoption of a child. Referred for study.
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NOTE: Some navigation links inside this book do not work on mobile devices. It is recommended you view the *Handbook* on a desktop or laptop computer.
Keeping the Business Meetings Efficient

Your speakers wish to keep the business sessions of the TMA House of Delegates effective, efficient, and enjoyable. They strongly encourage members to submit any testimony on business items (including requests to amend or refer items) prior to the virtual reference committee hearings on May 8 and use the hearings to wordsmith the final document prior to the May 14-15 house meetings.

Submit Testimony Online
Please make every effort to provide formal and substantive comments online prior to the live reference committee hearings. This will help streamline the hearings. The written testimony website will be available until April 22. You may upload up to three documents per business item and provide testimony in the comment box of up to 2,000 characters. Everything submitted will be reviewed by TMA reference committees and visible to all members through the testimony website.

Testify at the Live Reference Committee Hearings
Reference committees will review online testimony and publish their initial recommendations to the house by May 3. Members are encouraged to testify on these recommendations at the live reference committee hearings May 8.

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<tr>
<th>Virtual Reference Committee Hearings</th>
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<td>Reference Committee on Financial and Organizational Affairs</td>
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WHAT TO DO WHEN

THURSDAY, March 25
Handbook for Delegates Posted Online
View the handbook at texmed.org/HOD.

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

Candidate Materials Posted for Delegate Review
Review candidate profiles and videos before elections at texmed.org/Elections.

TUESDAY, March 30
Due Date for Items for Supplement to the Handbook for Delegates

THURSDAY, April 8
Supplement to the Handbook for Delegates Posted Online
View the handbook at texmed.org/HOD.

THURSDAY, April 22
Online Testimony Closes
Submit your testimony before end of day, April 22. Your reference committees will meet in executive session to review testimony and write interim reports between April 23-30.

FRIDAY, April 23
Deadline for Reporting Delegates
County medical societies and sections, please submit your delegate roster to TMA by April 23.

THURSDAY, April 29
TMA House of Delegates Opening Session
Delegates and alternates, check your email for a link to view a prerecorded opening session.

Voting on Elected Offices, House Standing Rules, House Standing Rules Special Circumstances, and Elections Policy Amendments Opens (midnight)
Delegates will be emailed a link.

MONDAY, May 3
Interim Reference Committee Reports Posted
A link to the interim reference committee reports will be emailed to house members and posted online. View the reports at texmed.org/HOD.

Voting Closes (11:59 pm)

THURSDAY, May 6
Runoff Election Voting Opens (If Necessary)

SATURDAY, May 8
Live Virtual Reference Committee Hearings
Links and instructions to join Zoom meetings will be emailed to members and posted at texmed.org/HOD.

8 am: Financial and Organizational Affairs
8 am: Medical Education and Health Care Quality
-Break-
Noon: Science and Public Health
Noon: Socioeconomics

SUNDAY, May 9
Runoff Election Voting Closes (If Necessary)

MONDAY, May 10
Final Reference Committee Reports Posted
A link to the final reference committee reports will be emailed to house members and posted online. View the report at texmed.org/HOD.

FRIDAY, May 14
Live TMA House of Delegates First Business Session
9 am
Check your email for a link to join as either delegate, alternate, or guest.

SATURDAY, May 15
Live TMA House of Delegates Second Business Session
9 am
Check your email for a link to join as either delegate, alternate, or guest.

NOTES

• Availability of Reference Committee Reports: We will post the interim and final reports 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 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.

House Meeting Dates and Times
The speakers will announce the dates and times of the annual session of the House of Delegates, and any special meeting of the house, well in advance in the Speakers’ Letter. The letter will specify the dates and times of deadlines to include delegation reporting of delegates and alternates, deadlines for candidate nominations, and deadlines for submission of business items.

Credentialing Delegates
Delegations, including county medical societies and other recognized delegations, must submit the names of TMA members who will serve as delegates and alternates by the published dates in the Speakers’ Letter preceding any formal meeting of the House of Delegates.

Substitution of Alternates for Delegates: If at any time after formal submission of the delegation an alternate wishes to serve as a delegate for all or part of the meeting, the delegation chair shall notify the chair of the Tellers and Credentials Committee of the name(s) of alternate(s) replacing delegates and if for the entire meeting or any specific part of the meeting. Once a formal request is received and the alternate designation and availability are verified, the chair of the Tellers and Credentials Committee (or the designee) may authorize the alternate to serve as a delegate.

Substitution of Members on Delegation: In the event of a delegation needing to add a TMA member as a voting delegate, or alternate, who was not initially submitted as a delegate or alternate, formal written notice must be submitted to the chair of the Tellers and Credentials Committee. After confirmation of the individual’s membership, presence, and intention to participate, and review by TMA staff and the chair of the Tellers and Credentials Committee, the individual member may be added as a delegate or alternate for all or part of the meeting.

Alternate Delegates Addressing the House of Delegates
During in-person meetings, 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.

House Steering Caucus
For purposes of discussing these standing rules and to help facilitate house function, the speaker may call a meeting composed of caucus chairs and representatives. The speakers, in collaboration with this House Steering Caucus, will develop appropriate guidelines for this function. This role is advisory, and any formal policy decision will be made only by a convened House of Delegates.
**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.

**Rules Governing Time Limits During House Sessions**
Delegates, once recognized by the speaker, shall be given two minutes to speak. A member of the house may not be recognized more than twice on any given motion. The speaker retains the right to grant a point of personal privilege to those who wish to address the house for longer than two minutes, such as special guests and invited dignitaries.

For a meeting of the house using virtual technology, debate on resolutions considered by the full house shall be limited to 15 collective minutes of testimony per resolution. When the time expires, the speaker may allow a motion to extend this period; otherwise the speaker will enact the motion to close debate and vote on all pending motions.

**Reference Committee Referrals**
Each year, the speaker shall appoint and convene reference committees, and appoint a chair for each committee. Prior to any resolution being considered by the full house, the resolutions will be assigned a reference committee hearing by the speakers, who charge each reference committee to hold hearings on their designated resolutions and report back their recommendations to the House of Delegates.

**Written Testimony**
The acceptance of written testimony for reference committees will close before the start of each house meeting at a time announced in the Speakers’ Letter or *Handbook for Delegates*.

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

Staff Review: Once written testimony is received, TMA staff will review each submission for potential malware. Submissions will then be reviewed 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 online testimony portal for all TMA members to access.

Testimony submitted after the deadline 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.

**Live Reference Committee Hearings**
During in-person meetings of the house, times and rules for live reference committee hearings will be announced in the Handbook for Delegates. For house meetings using virtual technology, the times of the hearings will be announced in advance in the Handbook with instructions on how to participate. Rules will be provided in the Handbook, and additional limits may be announced by chairs of the committees, including limits on the duration of each individual’s testimony and the duration of consideration for each item. Any TMA member may speak to issues in the reference committee meetings but should identify his or her role as an alternate or nondelegate member.

**Referral for Study or Action/Decision**

Items brought for consideration to the House of Delegates may be referred to either the Board of Trustees or the Board of Councilors for action/decision. The motion to “refer for action/decision” shall be a higher-order motion than “refer for study,” and the two types of referrals shall be considered separate, nonduplicative motions. Items may be “referred for study” to any TMA body. All referred items will include a report back at the next annual meeting of the house. Once a motion to refer is adopted, the original item shall be considered disposed of by the house and becomes the business of the body to which it is assigned.

**House Standing Rules**

The speakers shall annually propose House Standing Rules, and rules shall be adopted by a majority vote and become effective immediately. Once adopted, these rules shall remain in effect until the house is called to order the following year.

**House Standing Rules – Special Circumstances**

In the event of unusual or special circumstances requiring use of virtual technology or other circumstances where the house is not able to meet in a routine manner or in a common session with all delegates present, the speakers may propose additional rules, termed “House of Delegates Standing Rules – Special Circumstances,” to allow clear guidelines for the conduct of business in these circumstances. These rules will apply only for the year proposed and will require adoption by the house by vote. These House Standing Rules – Special Circumstances will be communicated to the house in a routine manner and in the Speakers’ Letter or Handbook for Delegate.

**Elections and Voting**

The speakers may establish a process for voting and election using electronic technology that is consistent with the TMA Bylaws and the TMA Election Process. This process will be communicated in the Speakers’ Letter and/or Handbook for Delegates.
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 business due to the unusual circumstances requiring a virtual meeting for the 2021 session, which opens April 29 and concludes May 15, 2021. The TMA House of Delegates will adopt these standing rules by majority vote once the house opens. 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 Elections
1. Nominations for 2021 TMA House of Delegates elections will close Feb. 26 as announced in the January Speakers’ Letter.
2. Candidates for elections must submit their candidate materials, including a two-minute campaign video to be posted on the TMA website, by March 19. This material will be made available to delegates and TMA members on March 25. No other candidate videos will be posted or allowed to be forwarded.
3. Candidates are limited to two mass communications (an impersonal, one-way email or mail communication, sponsored by or on behalf of a candidate) to all or part of the house membership.
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 April 23 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 starting Thursday morning, April 29, at 12 am. A “Voting for Candidates Is Now Open“ email will be sent the morning of April 29 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 Monday, May 3, at 11:59 pm. Voting may allow adoption of items of business before the house, such as House Standing Rules, in addition to election of candidates.
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 open Thursday, May 6, at 12 am, and close Sunday, May 9, 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 and canvass election results. The final confirmed election results will be presented during the final house session on Saturday, May 15.
10. Due to logistical issues using electronic technology, the speaker will call the house to order using a virtual session prior the formal meeting of the house May 14 and 15. This will place the house in session, allow for formal voting on the conduct of the meeting and for elections, and be considered as part of the layover for TMA Bylaws amendments.
Special Circumstances Rules for TMA House of Delegates Business

1. Due to logistical issues with a virtual meeting, 2021 house business should focus on essential business. Every effort should be made both to provide testimony and to finalize business during the two-phase reference committee process to attempt to find consensus prior to the formal house meeting.

2. All 2021 business items will be referred by the speakers to the appropriate TMA reference committee (Financial and Organizational Affairs, Medical Education and Health Care Quality, Science and Public Health, or Socioeconomics) and posted online for written testimony. After reference committee consideration of this testimony, interim reference committee reports will be published on the TMA website.

3. Virtual reference committee hearings will take place May 8. Following these hearings, the reference committee members will meet in executive session to create final reference committee reports. These reports will be the order of business for the house meeting.

4. Final Session Consideration of Business: After review by the speakers of the final special session reference committee reports, the reports will be posted as the order of business, as consent items. 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 2022 TMA House of Delegates) any final business considered on the house floor that becomes too confusing, complex, or intricate or that creates a prolonged or confusing deliberation during the final session. This decision by the speakers may be overruled but a two-thirds affirmative vote of the house.

5. Extraction of Consent Items from the Reference Committee Report: Extractions of consent items from the final reference committee report order of business will allow parliamentary consideration and changes for adoption by the house. However, every effort should be made to submit substantive changes or information during the initial call for written testimony in preparation for the interim reference committee report. Every effort should be made for consideration of final wording changes during the virtual May 8 reference committee hearings prior to the preparation of the final reference committee report. For changes during the full house meeting, the speakers strongly encourage that motions be limited to either a motion to table the item to the 2022 House of Delegates or a motion to refer to the board (for consideration or action) with report back at the 2022 annual session.

Caucus Representation at the TMA House of Delegates Broadcasting Headquarters, May 14-15

To facilitate communication among members during the business meetings, one to two delegates from each of the six geographical TMA caucuses (Bexar, Dallas, Harris, Lone Star, Tarrant, Travis) as well as one to two delegates each from the Medical Student Section, Resident and Fellow Section, and Young Physician Section will be permitted to attend the May 14 and 15 meeting broadcasting headquarters at the JW Marriott. These members shall be selected through their caucus or section. Delegates who attend in person must still use the virtual platform to queue up to testify during the meeting.
REFERENCE COMMITTEES
May 2021

TELLER AND CREDENTIALS COMMITTEE
Vani S. Vallabhaneni, MD, chair and chief teller, Travis County Medical Society
Timothy Rae Chappell, MD, Collin-Fannin County Medical Society
Leah Hanselka Jacobson, MD, Bexar County Medical Society

FINANCIAL AND ORGANIZATIONAL AFFAIRS
Lisa Jennifer Go, MD, chair, Bell County Medical Society
Audrey E. Ahuero, MD, Harris County Medical Society
Zahra Ali, MD (Resident), Ector County Medical Society
David J. Donahue, MD, Tarrant County Medical Society
Samuel E. Mathis, MD, Galveston County Medical Society
Kanchan A. Phalak, MD, Harris County Medical Society
Lisa Louise Swanson, MD, Dallas County Medical Society

MEDICAL EDUCATION AND HEALTH CARE QUALITY
Linda M. Siy, MD, chair, Tarrant County Medical Society
Apeksha Nitendra Agarwal, MD (Resident), Bexar County Medical Society
Stephanie Copeland, MD, Dallas County Medical Society
Robert K. Cowan, MD, Travis County Medical Society
Alison J. Haddock, MD, Harris County Medical Society
Alejandro Joglar (Student), Galveston County Medical Society
Holli T. Sadler, MD, Travis County Medical Society

SCIENCE AND PUBLIC HEALTH
Emily D. Briggs, MD, chair, Comal County Medical Society
Tilden L. Childs, III, MD, Tarrant County Medical Society
Anh Q. Dang, MD, Harris County Medical Society
Li-Yu H. Mitchell, MD, Smith County Medical Society
Maria Claire Monge, MD, Travis County Medical Society
Jennifer R. Rushton, MD, Bexar County Medical Society
Mammen A. Sam, MD, Brazoria County Medical Society
Joshua Baker (Student), Tarrant County Medical Society

SOCIOECONOMICS
John Joseph Nava, MD, chair, Bexar County Medical Society
Roel E. Cantu, MD, Hidalgo-Starr County Medical Society
Chad P. Dieterichs, MD, Travis County Medical Society
Kireet Koganti (Student), Dallas County Medical Society
Arathi A. Shah, MD, Travis County Medical Society
Ezequiel Silva III, MD, Bexar County Medical Society
Michael J. Snyder, MD, Harris County Medical Society
Speakers refer implementation to TMA components; Audit trail action may be forwarded to AMA

House of Delegates Takes Action on Reference Committee Reports

Reference Committees Final Report to House of Delegates

Reference Committee Executive Sessions

Reference Committee Hearings

Reference Committees Interim Report to House of Delegates

Reference Committees Review Online Testimony

Reference Committee on Socioeconomics
Reference Committee on Financial & Organizational Affairs
Reference Committee on Medical Education and Health Care Quality
Reference Committee on Science and Public Health

Speaker of House of Delegates

Resolution or Action Report
FLOW CHART FOR BUSINESS ITEMS

1. Did a member of the house request the item be extracted from the consent calendar? **NO**

   YES:
   The reference committee recommendation is enacted when consent calendar is adopted.

   NO:
   The original item of business is before the house, and the reference committee suggests a “yes” vote.

2. Did the reference committee suggest “adopt”? **YES**

   NO:
   The original item of business is before the house, and the reference committee suggests a “no” vote.

3. Did the reference committee recommend “do not adopt”? **YES**

   NO:
   Original item is before the house as the Main Motion, with the subsidiary motion “refer” as the immediately pending motion; discussion is on the “refer.” The reference committee suggests a “yes” vote on referral.

4. Did the reference committee recommend a “refer”? **YES**

   NO:
   Original item is disposed of and will be considered by the body to which it is referred.

5. Did the reference committee recommend “amend” or “adopt the following in lieu of the original”? **YES**

   NO:
   Original item is before the house as the Main Motion, with subsidiary motion “amend” or “in lieu of” as the immediately pending motion; discussion is on “amend” or “in lieu of.”

   YES:
   Did the house adopt the proposed amendment?

   NO:
   Did the house adopt the “in lieu of”?

   YES:
   The “in lieu of” is enacted.

   NO:
   Original item is before the house as the Main Motion; discussion is on the original item.

6. The speaker will explain the situation.
## Basic Rules Governing Motions

<table>
<thead>
<tr>
<th>PRIVILEGED MOTIONS</th>
<th>In order of precedence</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Adjourn</td>
<td>No Yes Yes² Yes² Majority None Amend, close debate, limit debate Yes</td>
</tr>
<tr>
<td>2. Recess</td>
<td>No Yes Yes² Yes² Majority None Amend, close debate, limit debate Yes²</td>
</tr>
<tr>
<td>3. Question of privilege</td>
<td>Yes No No No None None None Yes</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SUBSIDIARY MOTIONS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>4. Table</td>
<td>No Yes No No 2/3 Main motion None No</td>
</tr>
<tr>
<td>5. Close debate</td>
<td>No Yes No No 2/3 Debatable motions None Yes</td>
</tr>
<tr>
<td>6. Limit or extend debate</td>
<td>No Yes Yes² Yes² 2/3 Debatable motions Amend, close debate Yes²</td>
</tr>
<tr>
<td>7. Postpone to a certain time</td>
<td>No Yes Yes² Yes² Majority Main motion Amend, close debate, limit debate Yes²</td>
</tr>
<tr>
<td>8. Refer to committee</td>
<td>No Yes Yes² Yes² Majority Main motion Amend, close debate, limit debate Yes²</td>
</tr>
<tr>
<td>9. Amend</td>
<td>No Yes Yes³ Yes Majority Rewordable motions Amend, close debate, limit debate No²</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>MAIN MOTIONS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>10. a. The main motion</td>
<td>No Yes Yes Yes Majority None Subsidiary No</td>
</tr>
<tr>
<td>b. Specific main motions</td>
<td></td>
</tr>
<tr>
<td>Adopt in-lieu-of</td>
<td>No Yes Yes Yes Majority None Subsidiary No</td>
</tr>
<tr>
<td>Amend a previous action</td>
<td>No Yes Yes Yes Same Vote Adopted main motion Subsidiary No</td>
</tr>
<tr>
<td>Ratify</td>
<td>No Yes Yes Yes Same Vote Adopted main motion Subsidiary No</td>
</tr>
<tr>
<td>Recall from committee</td>
<td>No Yes Yes² No Majority Referred main motion Close debate, limit debate No</td>
</tr>
<tr>
<td>Reconsider</td>
<td>Yes⁴ Yes Yes² No Majority Vote on main motion Close debate, limit debate No</td>
</tr>
<tr>
<td>Rescind</td>
<td>No Yes Yes No Same Vote Adopted main motion Subsidiary, except amend No</td>
</tr>
</tbody>
</table>

## Incidental Motions

<table>
<thead>
<tr>
<th>MOTIONS</th>
<th>No order of precedence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Appeal</td>
<td>Yes Yes Yes No Majority⁷ Ruling of chair Close debate, limit debate No</td>
</tr>
<tr>
<td>Suspend the rules</td>
<td>No Yes No No 2/3 Procedural rules None Yes</td>
</tr>
<tr>
<td>Consider informally</td>
<td>No Yes No No Majority Main motion or subject None Yes</td>
</tr>
</tbody>
</table>

## REQUESTS

<table>
<thead>
<tr>
<th>REQUESTS</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Point of order</td>
<td>Yes No No No None Procedural error None No</td>
</tr>
<tr>
<td>Inquiries</td>
<td>Yes No No No None All motions None No</td>
</tr>
<tr>
<td>Withdraw a motion</td>
<td>Yes No No No None⁴ All motions None No</td>
</tr>
<tr>
<td>Division of question</td>
<td>No No No No None⁴ Main motion None No</td>
</tr>
<tr>
<td>Division of assembly</td>
<td>Yes No No No None⁴ Indecisive vote None No</td>
</tr>
</tbody>
</table>
## The Chief Purposes of Motions *

<table>
<thead>
<tr>
<th>Purpose</th>
<th>Motion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Present an idea for consideration and action</td>
<td>Main motion&lt;br&gt;Resolution&lt;br&gt;Consider informally</td>
</tr>
<tr>
<td>Improve a pending motion</td>
<td>Amend&lt;br&gt;Division of question</td>
</tr>
<tr>
<td>Regulate or cut off debate</td>
<td>Limit or extend debate&lt;br&gt;Close debate</td>
</tr>
<tr>
<td>Delay a decision</td>
<td>Refer to committee&lt;br&gt;Postpone to a certain time&lt;br&gt;Postpone temporarily&lt;br&gt;Recess&lt;br&gt;Adjourn</td>
</tr>
<tr>
<td>Suppress a proposal</td>
<td>Table&lt;br&gt;Withdraw a motion</td>
</tr>
<tr>
<td>Meet an emergency</td>
<td>Question of privilege&lt;br&gt;Suspend rules</td>
</tr>
<tr>
<td>Gain information on a pending motion</td>
<td>Parliamentary inquiry&lt;br&gt;Request for information&lt;br&gt;Request to ask member a question&lt;br&gt;Question of privilege</td>
</tr>
<tr>
<td>Question the decision of the presiding officer</td>
<td>Point of order&lt;br&gt;Appeal from decision of chair</td>
</tr>
<tr>
<td>Enforce rights and privileges</td>
<td>Division of assembly&lt;br&gt;Division of question&lt;br&gt;Parliamentary inquiry&lt;br&gt;Point of order&lt;br&gt;Appeal from decision of chair</td>
</tr>
<tr>
<td>Consider a question again</td>
<td>Resume consideration&lt;br&gt;Reconsider&lt;br&gt;Rescind&lt;br&gt;Renew a motion&lt;br&gt;Amend a previous action&lt;br&gt;Ratify</td>
</tr>
<tr>
<td>Change an action already taken</td>
<td>Reconsider&lt;br&gt;Rescind&lt;br&gt;Amend a previous action</td>
</tr>
<tr>
<td>Terminate a meeting</td>
<td>Adjourn&lt;br&gt;Recess</td>
</tr>
</tbody>
</table>

*TMA follows the American Institute of Parliamentarians Standard Code of Parliamentary Procedure*
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.
### 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
- Michelle A. Berger, MD, Secretary
- Gary W. Floyd, MD, Chair
- Richard Wesley Snyder, II, MD, Vice Chair
- Sue S. Bornstein, MD
- Keith A. Bourgeois, MD
- Gerald R. Callas, MD
- Gary W. Floyd, MD
- Cynthia Ann Jumper, MD, MPH
- Kimberly E. Monday, MD
- Jayesh B. Shah, MD
- Richard Wesley Snyder, II, MD
- Joseph S. Valenti, MD
- M. Brett Cooper, MD, YPS Trustee
- Kayla A. Riggs, MD, RFS Trustee
- Vamsi K. Potluri, MSS Trustee

### TMA Board of Councilors
- Gilberto A. Handal, MD, Dist. 1
- Vivek U. Rao, MD, Dist. 2, Secretary
- Harry Eugene Hall, MD, Dist. 3
- Stuart L. Abramson, MD, Dist. 4
- Donald Joseph Gordon, MD, PhD, Dist. 5
- Mario Rudy Anzaldua, MD, Dist. 6
- James R. Eskew, MD, Dist. 7
- David Christian Nickeson, MD, Dist. 8
- Steven M. Petak, MD, Dist. 9, Chair
- Kyle Gregory Krohn, MD, Dist. 10
- Brenda Marie Vozza, MD, Dist. 11
- Roland Adolph Goertz, MD, MBA, Dist. 12
- Jeediah James Grisel, MD, Dist. 13
- Edward Wilmar Tuthill, MD, Dist. 14
- Louis John Kirk, III, MD, Dist. 15

### TMA Board of Councilors (continued)
- Angel Manuel Rios, MD, Dist. 1
- James William Huston, MD, Dist. 2
- Jack E. DuBose, MD, Dist. 3
- Kaparaboyina Ashok Kumar, MD, Dist. 5
- Sandra Esquivel, MD, Dist. 6
- Jeffrey M. Apple, MD, Dist. 7
- Ana L. Leech, MD, Dist. 9
- David D. Vineyard, MD, Dist. 10
- Alisa M. Berger, MD, Dist. 12, Vice Chair
- Chad White, MD, Dist. 13
- Steven Ray Hays, MD, Dist. 14
- Cindy Renea Porter, MD, Dist. 15
- Akshat Kumar, MSS Rep.

### Texas Delegation to AMA
- David Norman Henkes, MD, Chair
- Michelle A. Berger, MD, Vice Chair
- Gary W. Floyd, MD, Vice Chair
- Michelle A. Berger, MD
- Gerald R. Callas, MD
- Diana L. Fite, MD
- William H. Fleming, III, MD
- John Gerard Flores, MD
- Gary W. Floyd, MD
- Gregory M. Fuller, MD
- John T. Gill, MD
- Robert Tau Gunby, Jr., MD
- David Norman Henkes, MD
- Cynthia Ann Jumper, MD, MPH
- Asa C. Lockhart, MD, MBA
- Kenneth L. Mattox, MD
- Kevin Hood McKinney, MD
- Leslie Harold Secrest, MD
- Jayesh B. Shah, MD
- Lyle Sheldon Thorstenson, MD
- Roxanne Marie Tyroch, MD
- E. Linda Villarreal, MD
- Arlo F. Weltge, MD, MPH
Texas Delegation to AMA (continued)

Alternate Delegates
John T. Carlo, MD
Shanna Marie Combs, MD
Robert Harold Emmick, Jr., MD
John Gerard Flores, MD
Steven Ray Hays, MD
Bryan G. Johnson, MD
Eddie L. Patton, Jr., MD
Jennifer R. Rushton, MD
Ezequiel Silva, III, MD
Elizabeth Torres, MD
Sherif Z. Zaafran, MD
Yasser Fahmy Zeid, MD
Matthew McGlennon, DO, RFS Alt. Rep
Delegate Emeritus
Susan Rudd Bailey, MD

Council on Health Care Quality (continued)

Vani Venkatachalam, MD
Eyuel Solomon Terefe, MD, RFS Rep.
Maliha A. Khan, MSS Rep.
Consultant
George H. Perkins, MD

Council on Health Promotion

Eman N. Attaya, MD, Chair
Louise H. Bethea, MD
Brandon Robert Cantazaro, MD
Neha V. Dhudhia, MD
Angela Donahue
Alison J. Haddock, MD
Raymond Moss Hampton, MD
Azalia Veronica Martinez, MD
Li-Yu H. Mitchell, MD
Eddie L. Patton, Jr., MD
Janice Ann Stachowiak, MD
Charlotte M. Stelly-Seitz, MD
Patricia Trifilo
Caroline Leilani Valdes, MD
Blessy Varughese, MD, RFS Rep.
Beatrice K. Huang, MSS Rep.
Debbie Massigil, Alliance Rep.
Chris McGilvery, Alliance Rep.
Julie Cowan, Alliance Rep.
Consultant
Susan M. Pike, MD

Council on Constitution and Bylaws

William S. Gilmer, MD, Chair
Nefertiti C. Dupont, MD
Samuel E. Mathis, MD
Kiran Kumar Panuganti, MD
Jeffery Matthew Pinnow, MD
Dexter G. Turnquest, MD
Roxanne Marie Tyr Roch, MD
Rejesh Vijaya Vasudev, MD
Patrick D. Crowley, DO, RFS Rep.
Nichele Christiane Henkes, MSS Alt. Rep

Council on Health Care Quality

Chelsea I. Clinton, MD, Chair
Lindsay K. Botsford, MD, MBA
David P. Brigati, MD
Lee Budin, MD
Kenneth Mckay Davis, MD
Olga Ovdyeenkov Dowell, MD
Jorge A. Duchicela, MD
Keith Ryan Eppich, MD
Oscar Garza, MD
Marina C. George, MD
Ajay K. Gupta, MD
Ann C. Hughes Bass, MD
Nishant B. Jalandhara, MD
January Y. Tsai, MD

Council on Health Service Organizations

Mark A. Casanova, MD, Chair
LeeChuan Andy Chen, MD
Raymond L. Fowler, MD
Robert A. Friedman, MD
Douglas Arthur Fullington, MD
Aakash H. Gajjar, MD
Nelly Ivonne Garcia-Blow, DO
Faraz A. Khan, MD
Evan C. Meyer, MD
Kalarickal J. Oommen, MD
Archana Rao, MD
Holli T. Sadler, MD
Mina K. Sinacori, MD
TMA Officers, Board, Council Committee Members and Section Officers
May 2021
Page 3

Council on Health Service Organizations (continued)

Diogenes Ivan Valderrama Torres, MD
Vani S. Vallabhaneni, MD
Eyuel Solomon Terefe, MD, RFS Rep.
Sneha Chebrolu, MSS Rep.

Consultants
Robert Lee Fine, MD
James S. Guo, MD
Stuart C. Pickell, MD

Council on Legislation

Debra A. Patt, MD, Chair
Michael A. Battista, MD
Celeste X. Caballero, MD
John T. Carlo, MD
Tilden L. Childs, III, MD
Robert K. Cowan, MD
Troy T. Fiesinger, MD
Victor Hugo Gonzalez, MD
Robert E. Jackson, MD, MACP
Yvonne Kew, MD, PhD
Thomas J. Kim, MD, MPH
John David Myers, MD
J. Timothy Parker, MD
Victor A. Simms, MD
Linda M. Siy, MD
Michelle Babb Tarbox, MD
Gerad A. Troutman, MD
Yasser Fahmy Zeid, MD
Bradford S. Patt, MD, TEXPAC Liaison
Hussain Saleem Lalani, MD, RFS Rep.
Sara E. Buckley, MSS Rep.
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Committee on Reproductive, Women’s, and Perinatal Health (continued)

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May 2021

County society delegates ........................................................................................................369

Ex officio-voting positions......................................................................................................167
  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 .........................................................................................31
  Members of the Council on Legislation .........................................................................18
  Chairs of all other councils ............................................................................................8
  International Medical Graduate Section delegate .......................................................1
  Young Physician Section delegates ..............................................................................8
  Resident and Fellow Section delegates ..........................................................................9
  Medical Student Section delegates .............................................................................15
  Specialty society delegates ............................................................................................23
  Past Presidents ..................................................................................................................21

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

Total voting membership....................................................................................................478
  Delegates ..........................................................................................................................369
  Voting Ex officio ...............................................................................................................149
  Less those holding multiple voting positions ............................................................40

*Past presidents who are active or emeritus members have a vote, but are not included in the Total voting membership to determine a quorum.
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May 2021

KEY
D Delegate
A Alternate Delegate
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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

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<td>CIM</td>
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<td>3rd</td>
</tr>
</tbody>
</table>
# Delegates and Alternates by County Medical Society

## As Of 3/30/2021

<table>
<thead>
<tr>
<th>County CMS</th>
<th>Delegate</th>
<th>Alternate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anderson-Leon CMS</td>
<td>Edward Wallace Johnson, III, MD</td>
<td>Leah Hanselka Jacobson, MD</td>
</tr>
<tr>
<td>Andrews CMS</td>
<td>Bonnie Muncy, MD</td>
<td>Wendy Bay Kang, MD, JD</td>
</tr>
<tr>
<td>Angelina CMS</td>
<td>Richard Earl Roby, MD</td>
<td>Margaret Ann Kelley, MD</td>
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<tr>
<td>At-Large No CMS</td>
<td>William Dean Strinden, MD</td>
<td>Alexander B. Kenton, MD</td>
</tr>
<tr>
<td>Bell CMS</td>
<td>Oscar Garza, MD</td>
<td>Kaparaboyna Ashok Kumar, MD</td>
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<tr>
<td>Bexar CMS</td>
<td>Hongjing Cao, MD</td>
<td>David Trueson Lam, MD</td>
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<td></td>
<td>Patrick D. Crowley, DO</td>
<td>William Cannon Lewis, MD</td>
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<td></td>
<td>Christa C. DeFries, MD</td>
<td>Juan Diego Martinez, MD</td>
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<td></td>
<td>Robert Daniel Greenberg, MD</td>
<td>John A. Menchaca, MD</td>
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<td></td>
<td>James Andrew Hall, DO</td>
<td>Darlene Metter, MD, FACP</td>
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<td></td>
<td>Belur Janakray Patel, MD</td>
<td>Rodolfo Molina, MD</td>
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<td></td>
<td>Abirami Subramanian, MD</td>
<td>Jesse Moss, Jr., MD</td>
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<tr>
<td></td>
<td>John R. Asbury, MD</td>
<td>Erika Maria Sehne Munch, MD</td>
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<td></td>
<td>A Keith Cryar, MD</td>
<td>Lubna Naeem, MD</td>
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<td>Lisa Jennifer Go, MD, MPH</td>
<td>John Joseph Nava, MD</td>
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<td>Duren Michael Ready, MD</td>
<td>Gerardo Ortega, MD</td>
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<td>Sandra S. Vexler, MD</td>
<td>Adam V. Ratner, MD</td>
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<td>Jennifer R. Rushton, MD</td>
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<td>Jayesh B. Shah, MD</td>
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<td>Umang Hasmukhlal Shah, MD</td>
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<td>John Milton Shepherd, MD</td>
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<td>Ezequiel Silva, III, MD</td>
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<td>J. Marvin Smith, III, MD</td>
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<td>Rajeev Suri, MD</td>
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<td>Marc T. Taylor, MD</td>
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<td></td>
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<td>Alexis A. Wiesenthal, MD</td>
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<td></td>
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<td>Roya Clements, MD</td>
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<td></td>
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<td>Ramon Colen, MD</td>
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<td>Francisco Javier Garcia, MD</td>
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<td>Prabhdeep Kaur Grewal, MD</td>
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<td>John W. Hinchey, MD</td>
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<td>David Pyor Jones, DO</td>
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<td></td>
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<td>Tzy-Shiuan B. Kuo, MD</td>
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<td></td>
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<td>Sekinat Kassim McCormick, MD</td>
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<td>Maulik P. Purohit, MD</td>
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<td>Brent W. Sanderlin, DO</td>
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<tr>
<td></td>
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<td>Nora Linda Vasquez, MD</td>
</tr>
</tbody>
</table>
Alternate: Veronica Marie Vasquez, MD
Alternate: Aruna Venkatesh, MD

Big Country CMS
Delegate: Charlotte M. Akor, MD
Delegate: Indira C. Maharaj-Mikiel, MD
Delegate: Daniel James Vaughan, MD
Alternate: Ashley Goodnight Hall, MD
Alternate: Ralph F. Heaven, Jr., MD
Alternate: H. Miller Richert, MD

Brazoria CMS
Delegate: Mitesh M. Patel, DO
Delegate: Mammen A. Sam, MD

Brazos-Robertson CMS
Delegate: Mark J. Florian, MD
Delegate: Malcolm J. Rude, MD

Burnet-Lampasas CMS
Delegate: Heather M. Chambers, MD
Alternate: Brian L. Ransdell, MD

Calhoun CMS
Delegate: John B. Wright, MD
Alternate: Leigh A. Falcon, MD

Collin-Fannin CMS
Delegate: Timothy Rae Chappell, MD
Delegate: Carrie E. De Moor, MD
Delegate: Neha V. Dhudhia, MD
Delegate: Marlene Diaz, MD
Delegate: Aimee C. Garza, MD
Delegate: Mei Melvin Hu, MD
Delegate: Bryan G. Johnson, MD
Delegate: Paul Daniel Kivela, MD
Delegate: Sejal S. Mehta, MD
Delegate: Sherine E Boyd Reno, MD
Alternate: Keith Ryan Eppich, MD
Alternate: Douglas Arthur Fullington, MD
Alternate: Radha Gopal Iyengar, MD
Alternate: Alan David Koenigsberg, MD
Alternate: Darren Eric Meyer, MD
Alternate: Brent A. Spencer, MD
Alternate: Daniel Joseph Verret, MD

Concho Valley CMS
Delegate: Bradly Bundrant, MD, MPH

Dallas CMS
Delegate: Akinwande A. Akinfolarin, MD
Delegate: Drew Wilson Alexander, MD
Delegate: Leyka M. Barbosa, MD
Delegate: Christine Ann Becker, MD
Delegate: Justine M. Bishop, MD
Delegate: Adam C. Carter, MD
Delegate: William Hampton Caudill, MD
Delegate: Samuel J. Chantilis, MD
Delegate: Christopher R. Cook, MD
Delegate: Stephanie M. Copeland, MD
Delegate: Cindy Lou Corpier, MD
Delegate: Rohit R. Das, MD
Delegate: Jennifer Ann Denning, MD
Delegate: Shashi K. Dharma, MD
Delegate: Emma L. Dishner, MD
Delegate: Shaina Marie Drummond, MD
Delegate: John Stockton Early, MD
Delegate: Walter Francis Evans, II, MD
Delegate: Robert Lee Fine, MD, FACP, FAAHPM
Delegate: Victor Gonzalez, MD
Delegate: Robert D. Gross, MD
Delegate: Robert Ware Haley, MD
Delegate: Madeline Weinstein Harford, MD
Delegate: Joseph Maxwell Hendrix, MD
Delegate: Eugene Pitts Hunt, III, MD
Delegate: Zachary S. Jones, MD
Delegate: Seth David Kaplan, MD
Delegate: R. Elizabeth Kassanoff-Piper, MD
Delegate: Rainer Anil Khetan, MD
Delegate: Roger Sunil Khetan, MD
Delegate: Yolanda R. Lawson, MD
Delegate: Benjamin C. Lee, MD
Delegate: C. Turner Lewis, III, MD
Delegate: Aekta Malhotra, MD
Delegate: Dan Ken McCoy, MD
Delegate: David Scott Miller, MD
Delegate: Marcial Andres Oquendo Rincon, MD
Delegate: Harveer Singh Parmar, MD
Delegate: Nishi Hamantkumar Patel, MD
Delegate: Lee Ann Pearse, MD
Delegate: Daniel B. Pearson, III, MD
Delegate: Shawnta R. Pittman-Hobbs, MD
Delegate: James E. Race, MD
Delegate: Noah Munn Rosenberg, MD
Delegate: Assad Joe Saad, MD
Delegate: Karen B. Saland, MD
Delegate: Aurelia M. Schmalstieg, MD
Delegate: F. David Schneider, MD, MSPH
Delegate: John Stuart Scott, DO, MHA, FASA
Delegate: Elizabeth Ruth Seymour, MD
Delegate: Austin D. Street, MD
Delegate: Baran Devrim Sumer, MD
Delegate: Robert Eduard Suter, DO
Delegate: Laurie Jayne Sutor, MD
Delegate: Lisa Louise Swanson, MD
Delegate: Bharath Thankavel, MD
Delegate: Anil Kumar Tibrewal, MD
Delegate: John Morrow Truelson, MD
Delegate: Michael Ian Vengrow, MD
Delegate: Joe B. Ventimiglia, MD
Delegate: Jim Walton, DO, MBA
Delegate: Gabriela M. Zandomeni, MD
Alternate: Jerry Alvin Allison, MD
Alternate: Matthew G. Brooker, DO
Alternate: Hina Dave, MD
Alternate: Jeremy Epstein, MD
Alternate: Lauren Kylie Lazar, MD
Alternate: Warren E. Lichliter, MD
Alternate: Nathan P. Long, MD
Alternate: Preei Malladi, MD
Alternate: Rory R. Mayer, MD
Alternate: Jack M. McDaniel
Alternate: David Wayne Mercier, MD
Alternate: Benjamin R. Morrissey, MD
Alternate: Dawood Nasir, MD
Alternate: Wendy Carmen Parnell, MD
Alternate: Adnan Rafique, MD
Alternate: Roy Lynn Rea, MD
Alternate: Grant P. Redrow, MD
Alternate: Tami R. Redrow, MD
Alternate: Anjali N. Shah, MD
Alternate: Lisa Carole Taylor-Kennedy, MD

Denton CMS
Delegate: Shikha Kaushik Mane, MD
Alternate: Folahan Kolawole Ayoola, MD
Alternate: Hannah G. Moussa, MD

Ector CMS
Delegate: Olga Ovdyeyenko Dowell, MD
Delegate: Ikemefuna C. Okwuwa, MD
Delegate: Jeffery Matthew Pinnow, MD
Alternate: Nimat Alam, MD
Alternate: Sara Suzanne Dyrstad, MD
Alternate: Michael L. Galloway, DO
Alternate: Victor H. Gil, MD
Alternate: Vivek U. Rao, MD
Alternate: Ritchie Rosso, Jr., MD

El Paso CMS
Delegate: James Byron Boone, III, MD
Delegate: Alison L. Days, MD, MPH
Delegate: Jose Manuel De La Rosa, MD

Ellis CMS
Delegate: Basem M. Jassin, MD

Ft. Somervell-Comanche CMS
Delegate: Matthew C. Maruska, DO
Alternate: Kelly Smith Doggett, MD

Fort Bend CMS
Delegate: Cedela Abdulla, MD
Delegate: Jontel Dansby Pierce, MD
Delegate: Sapna Singh, MD

Galveston CMS
Delegate: Ludwik Branski, MD
Delegate: Lena R. Bruce, MD
Delegate: Aakash H. Gajjar, MD
Delegate: John George Knecht, III, MD
Delegate: Samuel E. Mathis, MD
Delegate: Brian John Mckinnon, MD
Delegate: Bethany E. Powell, MD
Delegate: Christine Li Shokrzadeh, MD
Delegate: Helen Colleen Silva, MD
Delegate: Beth M. Teegarden, MD
Delegate: Steven E. Wolf, MD
Alternate: Abbey Belina Berenson, MD
Alternate: Carolyn Eaton, MD
Alternate: Quratulanne Haroon Jan, MD
Alternate: Jeffrey S. Richards, MD
Alternate: Wasy1 Szeremeta, MD

Grayson CMS
Delegate: Sanober Kable, MD

Harris CMS
Delegate: Na Aakash, MD
Delegate: Audrey E. Ahuero, MD
Delegate: Raymond T. Alexander, MD
Delegate: Paul M. Allison, MD
Delegate: Janette K. Bateman, MD
Delegate: Lindsay K. Botsford, MD, MBA
Delegate: Richard N. Bradley, MD
Delegate: Brian M. Bruel, MD
Delegate: Lucy A. Buencamino, MD
Delegate: Leanne Burnett, MD
Delegate: Sudipta K. Chaudhuri, DO
Delegate: Steven M. Croft, MD
Delegate: Anh Q. Dang, MD
Delegate: Kyle F. Dickson, MD, MBA
Delegate: Rakhi C. Dimino, MD
Delegate: Swapan Dubey, MD
Delegate: Lisa L. Ehrlich, MD
Delegate: David P. Ellent, MD
Delegate: Angelina Farella, MD
Delegate: Silvana D. Faria, MD
Delegate: Lewis E. Foxhall, MD
Delegate: Clare N. Gentry, MD
Delegate: Marina C. George, MD
Delegate: Bernard M. Gerber, MD
Delegate: Noel M. Giesecke, MD
Delegate: Alan P. Glombicki, MD
Delegate: Angela M. Guerra, MD
Delegate: James S. Guo, MD
Delegate: Shiva Gupta, MD
Delegate: Leslie M. Haber, MD
Delegate: Steven E. Haber, MD
Delegate: Alison J. Haddock, MD
Delegate: Ori Z. Hampel, MD
Delegate: Shannon B. Hancher-Hodges, MD
Delegate: Lindsey D. Harris, MD
Delegate: Hattie E. Henderson, MD, CMD
Delegate: Stephen A. Herrmann, MD
Delegate: Susanna C. Spence, MD
Delegate: Charlotte M. Stelly-Seitz, MD
Delegate: Richard Strax, MD
Delegate: Angela K. Sturm, MD
Delegate: Spencer H. Su, MD
Delegate: Irvin Sulapas, MD
Delegate: Arthur L. Taitel, MD
Delegate: Rosa A. Tang, MD, MPH, MBA
Delegate: Theresa Q. Tran, MD
Delegate: January Y. Tsai, MD
Delegate: Dexter G. Turnquest, MD
Delegate: Mohammad A. Ursani, MD
Delegate: John R. Vanderzyl, MD
Delegate: Robert C. Vanzant, MD
Delegate: Carlos J. Vital, MD
Delegate: Ronald S. Walters, MD
Delegate: Stephen E. Whitney, MD
Delegate: Thomas C. Wiener, MD
Delegate: George W. Williams, II, MD
Delegate: Wendell H. Williams, III, MD
Delegate: Barbara J. Wilson, MD
Delegate: Kevin Scott Winfield, MD, MBA
Delegate: Alisha Y. Young, MD
Delegate: Acsa M. Zavala, MD
Alternate: Sairah Ahmed, MD
Alternate: Jessica A. Alexander, MD
Alternate: Jaya S. Amaram-Davila, MD
Alternate: Amelia Averty, MD
Alternate: Nabil K. Bissada, MD
Alternate: Dwane G. Broussard, MD
Alternate: Victoria C. Chang, MD
Alternate: Avais M. Chatha, MD
Alternate: Daniel H. Darmadi, MD
Alternate: Lillete E. Daumas-Britsch, MD
Alternate: Randi E. Durden, MD
Alternate: John D. Edwards, MD
Alternate: Hilary E. Fairbrother, MD
Alternate: Renee J. Flores, MD
Alternate: Semhar J. Ghebremichael, MD
Alternate: R. Andrew Harper, III, MD
Alternate: Janice E. Hobbs, MD
Alternate: Daniel L. Howell, Jr., MD
Alternate: Nesreen S. Ibrahim, MD
Alternate: Techechia T. Idowu, MD
Alternate: Valarie Lee Allman, MD
Alternate: William Alex Elfarr, MD
Alternate: Roel E. Cantu, MD
Alternate: Lenore C. DePagter, DO, MBA
Delegate: Sandra Esquivel, MD
Delegate: Alexander John Feigl, MD
Delegate: Audrey Lee Jones, DO
Delegate: Rogelio Sergio Ramirez, Jr., MD
Delegate: Leticia Marie Volpe, MD

Hill Country CMS
Delegate: Matthew Emanuel Stotz, MD

Jasper-Newton CMS
Delegate: Ronnie A. McMurry, MD

Jefferson CMS
Delegate: Benjamin Wallace Beckert, MD
Delegate: Robert Barry Berndt, MD
Delegate: LeeChuan Andy Chen, MD
Delegate: Amy Michelle Townsend, MD
Alternate: John Kerry Badlissi, MD
Alternate: Ramzi S. Dakour, MD
Alternate: Nicole Ashley Hancock, MD
Alternate: Jurswin Coffy Pieternelle, MD

Kaufman CMS
Delegate: Benjamin R. Brashear, MD

Kerr-Bandera CMS
Delegate: Phillip Eugene Balfanz, MD
Delegate: Kathleen Rose Wilson, MD
Alternate: William E. Morris, Jr., MD, FACP

Liberty-Chambers CMS
Alternate: Joseph Ebitenbo Goin, MD

Lubbock CMS
Delegate: Kalarickal J. Oommen, MD
Delegate: Melinda Garcia Schalow, MD
Delegate: Ashley Lillian Sturgeon, MD
Delegate: Shiraz A. Yazdani, MD
Alternate: Eman N. Attaya, MD
Alternate: Naidu K. Chekuru, MD
Alternate: Ronald Lynn Cook, DO
Alternate: Joehassin Cordero, MD
Alternate: Angela Gremillion Ferguson, DO
Alternate: Joshua G. Hill, MD
Alternate: Cynthia Ann Jumper, MD, MPH
Alternate: Patti Nelson May, MD
Alternate: Mario Pena, Jr., MD
Alternate: Janice Ann Stachowiak, MD
Alternate: Joel Dow Starnes, III, MD
Alternate: Michelle Babb Tarbox, MD
Alternate: Gerard A. Troutman, MD

McLennan CMS
Delegate: Scott E. Blattman, MD
Delegate: Bradford W. Holland, MD
Delegate: William T. McCunniff, MD
Delegate: Clint W. McHenry, DO
Delegate: Robert E. Wolf, MD
Alternate: Randy J. Hartman, MD
Alternate: Jeffrey T. Manning, MD
Alternate: Young T. McMahan, MD
Alternate: David M. Pinkstaff, MD
Alternate: Russell Scott Warren, MD

Montgomery CMS
Delegate: Nefertiti C. Dupont, MD

Nueces CMS
Delegate: Jack Locardi Cortese, MD
Delegate: George H. Fisher, Jr., MD
Delegate: Albert Lee Gest, DO
Delegate: Justin Paul Hensley, MD
Delegate: Jerry Dean Hunsaker, MD
Delegate: Michael D. McCutchon, MD
Delegate: Jacob J. Moore, MD
Delegate: Mary Dahlen Peterson, MD
Alternate: Rafael Francisco Coutin, MD
Alternate: John T. Dugan, II, MD
Alternate: Mohammad A. Emran, MD
Alternate: Shaheen Karim, MD
Alternate: Suresh Kulkarni, MD
Alternate: Rajeev Narang, MD
Alternate: Karl Leon Serrao, MD
Alternate: Adam L. Spengler, MD

Potter-Randall CMS
Delegate: Neil Roger Veggeberg, MD

Rusk CMS
Delegate: Gerald Joseph Akpassa, MD
Alternate: Charles M. Perricone, MD

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

Shelby-Sabine CMS
Delegate: Keith Edward Miller, MD

Smith CMS
Delegate: Gina Mapes Jetter, MD
Delegate: Joseph T. Martins, MD
Delegate: William M. McCrady, MD
Delegate: James P. Michaels, MD
Delegate: Evans S. Smith, MD
Delegate: David L. Young, MD

Tarrant CMS
Delegate: Susan K. Blue, MD
Delegate: Jeffrey Chase, MD
Delegate: C. Mark Chassay, MD
Delegate: Theresa V. Crouch, MD
Delegate: David J. Donahue, MD
Delegate: Michael G. Enger, MD
Delegate: Triwanna L. Fisher-Wikoff, MD
Delegate: Stevan A. Gonzalez, MD
Delegate: Ken C. Hopper, MD
Delegate: Cheryl Lynn Hurd, MD
Delegate: Nishant B. Jalandhara, MD
Delegate: R. Larry Marshall, MD
Delegate: George Sealy Massingill, MD
Delegate: Gregory J. Phillips, MD
Delegate: Stuart C. Pickell, MD, FACP, FAAP
Delegate: Ann E. Ranelle, DO
Delegate: Larry E. Reaves, MD
Delegate: Rebecca J. Rogers, MD
Delegate: Robert J. Rogers, MD
Delegate: Angela D. Self, MD
Delegate: Omar F. Selod, DO
Delegate: Mark M. Shelton, MD
Delegate: Jason V. Terk, MD
Delegate: Melanie M. Vettimattam, MD
Delegate: Veer D. Vithalani, MD
Delegate: Johnathan D. Warinski, MD
Delegate: Michael E. Wimmer, MD
Alternate: David P. Brigati, MD
Alternate: Jeffrey M. Bullard, MD
Alternate: Brett L. Cochrum, MD
Alternate: Miguel De Valdenebro, MD
Alternate: Rajesh Ramesh Gandhi, MD, PhD
Alternate: Catherine E. Harrell, MD
Alternate: Matthew M. Murray, MD
Alternate: Lisa R. Nash, DO
Alternate: John A. Queralt, MD
Alternate: Morvarid Rezaie, DO, FACOI
Alternate: Hujefa Y. Vora, MD
Alternate: Austen M. Watkins, DO

Travis CMS
Delegate: Tony R. Aventa, MD
Delegate: Kimberly C. Avila Edwards, MD
Delegate: Ira Bell, III, MD
Delegate: Michelle A. Berger, 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: Robert Harold Emmick, Jr., MD
Delegate: James R. Eskew, MD
Delegate: Colby C. Evans, MD
Delegate: Nancy Thorne Foster, MD
Delegate: Vimal T. George, MD
Delegate: Albert T. Gros, MD
Delegate: Katharina Hathaway, MD
Delegate: Felix Hull, MD
Delegate: Anand Joshi, MD
Delegate: Jeffrey B. Kahn, MD
Delegate: Thomas J. Kim, MD, MPH
Delegate: Craig Allen Kuhns, MD
Delegate: Pradeep Kumar, MD
Delegate: Daniel J. Leeman, MD
Delegate: Jonathan E. MacClements, MD
Delegate: Hillary Miller, MD
Delegate: Celia B. Neavel, MD
Delegate: Dennis Samuel Pacl, MD
Delegate: Jack W. Pierce, MD
Delegate: Harris S. Rose, MD
Delegate: Dora L. Salazar, MD
Delegate: Sarah I. Smiley, DO
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: Stanley S. Wang, MD, JD, MPH
Delegate: Belda Zamora, MD
Delegate: Guadalupe Zamora, MD
Alternate: Alexander J. Alvarez, MD
Alternate: Maneesh R. Amancharla, MD
Alternate: Anna Buteau, MD
Alternate: Kimberly Carter, MD
Alternate: Vineet Choudhry, MD
Alternate: Goddy T. Corpuz, MD
Alternate: Robert K. Cowan, MD
Alternate: J. Lauren Crawford, MD
Alternate: Chad P. Dieterichs, MD
Alternate: Grace L. Honles, MD, MBA
Alternate: Sunil C. Kolli, MD
Alternate: Megan K. Kressin, MD
Alternate: Paraag Kumar, MD
Alternate: Carlos-Nicholas L. Lee, MD
Alternate: Hector A. Miranda-Grajales, MD
Alternate: Maria Claire Monge, MD
Alternate: Michelle C.M. Owens, DO
Alternate: Tina J. Philip, DO
Alternate: A. Melinda Rainey, MD
Alternate: Fara Ranjbaran, MD
Alternate: Roxana A. Rhodes, MD
Alternate: Holli T. Sadler, MD
Alternate: Arathi A. Shah, MD
Alternate: Koonj A. Shah, MD
Alternate: Shaina M. Sheppard, MD
Alternate: Ricardo L. Solis, MD
Alternate: F. Douglas Srygley, IV, MD
Alternate: Lynn N. Stewart, MD
Alternate: Brian W. Temple, MD
Alternate: Elizabeth Truong, MD
Alternate: Deepti V. Varshney, MD
Alternate: Sara A. Westgate, MD, PhD
Alternate: J. Stuart Wolf, Jr., MD
Alternate: Jeffrey S. Zapalac, MD
Alternate: Jay R. Zdunek, DO, MBA

**Williamson CMS**

Delegate: Maryann Miyun Choi, MD
Delegate: Susan M. Pike, MD
Delegate: Ami Amar Shah Vira, MD
Alternate: Valerie M. Chavez, MD
Alternate: Ronak D. Ghiya, MD
Alternate: Grace Patricia Tamesis, MD

**Tri-County CMS**

Delegate: John J. Fraser, Jr., MD
Delegate: Mark B. Randolph, MD
Alternate: Alberto Santos, DO

**Walker-Madison-Trinity CMS**

Delegate: Lane Joseph Aiena, 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
Voting Ex-Officio Members of the House of Delegates  
As of March 17, 2021 (multiple voting positions are listed but member only has ONE vote)

<table>
<thead>
<tr>
<th>Name</th>
<th>CMS</th>
<th>Committee</th>
<th>Position</th>
</tr>
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<tbody>
<tr>
<td>Stuart L. Abramson, MD</td>
<td>Concho Valley</td>
<td>TMA Board of Councilors</td>
<td>Councilor</td>
</tr>
<tr>
<td>Apeksha Nitendra Agarwal, MD</td>
<td>Bexar</td>
<td>Resident and Fellow Section</td>
<td>Delegate</td>
</tr>
<tr>
<td>Zahra Ali, MD</td>
<td>Ector</td>
<td>Resident and Fellow Section</td>
<td>Delegate</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>Mario Rudy Anzaldua, MD</td>
<td>Hidalgo-Starr</td>
<td>TMA Board of Councilors</td>
<td>Councilor</td>
</tr>
<tr>
<td>Ramsey R. Ashour, MD</td>
<td>Travis</td>
<td>Texas' Inter-Specialty Society</td>
<td>Delegate</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>Charles W. Bailey, Jr., MD</td>
<td>Travis</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>Joshua Baker</td>
<td>Tarrant</td>
<td>Medical Student Section</td>
<td>Delegate</td>
</tr>
<tr>
<td>Vin Shen Ban, MD</td>
<td>Dallas</td>
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<td>Nikki Verma</td>
<td>Bexar</td>
<td>Medical Student Section</td>
<td>Delegate</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>Brenda Marie Vozza, MD</td>
<td>Rusk</td>
<td>TMA Board of Councilors</td>
<td>Councilor</td>
</tr>
<tr>
<td>Sonia Wadekar</td>
<td>Hidalgo-Starr</td>
<td>Medical Student Section</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>Name</td>
<td>CMS</td>
<td>Committee</td>
<td>Position</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>---------------</td>
<td>------------------------------------------------</td>
<td>------------------------------</td>
</tr>
<tr>
<td>Arlo F. Weltge, MD, MPH</td>
<td>Harris</td>
<td>Texas Delegation to AMA</td>
<td>Texas Delegate</td>
</tr>
<tr>
<td>Arlo F. Weltge, MD, MPH</td>
<td>Harris</td>
<td>TMA Officers</td>
<td>Speaker</td>
</tr>
<tr>
<td>Josie R. Williams, MD, MMM</td>
<td>Lamar-Delta</td>
<td>Texas Medical Association Past Presidents</td>
<td>Member</td>
</tr>
<tr>
<td>Kristin A. Wong, MD</td>
<td>Travis</td>
<td>Texas' Inter-Specialty Society</td>
<td>Delegate</td>
</tr>
<tr>
<td>Rodney B. Young, MD</td>
<td>Potter-Randall</td>
<td>Council on Socioeconomics</td>
<td>Chair</td>
</tr>
<tr>
<td>Sherif Z. Zaafran, MD</td>
<td>Harris</td>
<td>Texas Delegation to AMA</td>
<td>Texas Alternate Delegate</td>
</tr>
<tr>
<td>Yasser Fahmy Zeid, MD</td>
<td>Smith</td>
<td>Council on Legislation</td>
<td>Member</td>
</tr>
<tr>
<td>Yasser Fahmy Zeid, MD</td>
<td>Smith</td>
<td>Texas Delegation to AMA</td>
<td>Texas Alternate Delegate</td>
</tr>
<tr>
<td>Tina Zhu</td>
<td>Lubbock</td>
<td>Medical Student Section</td>
<td>Delegate</td>
</tr>
<tr>
<td>Stuart L. Abramson, MD</td>
<td>Concho Valley</td>
<td>TMA Board of Councilors</td>
<td>Councilor</td>
</tr>
<tr>
<td>Apeksha Nitendra Agarwal, MD</td>
<td>Bexar</td>
<td>Resident and Fellow Section</td>
<td>Delegate</td>
</tr>
<tr>
<td>Zahra Ali, MD</td>
<td>Ector</td>
<td>Resident and Fellow Section</td>
<td>Delegate</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>Mario Rudy Anzaldua, MD</td>
<td>Hidalgo-Starr</td>
<td>TMA Board of Councilors</td>
<td>Councilor</td>
</tr>
<tr>
<td>Ramsey R. Ashour, MD</td>
<td>Travis</td>
<td>Texas' Inter-Specialty Society</td>
<td>Delegate</td>
</tr>
</tbody>
</table>
Elections
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 2021 TMA House of Delegates races.
ELECTIONS
May 2021

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 Jan. 21</th>
</tr>
</thead>
<tbody>
<tr>
<td>President-Elect</td>
<td>E. Linda Villarreal</td>
<td>No</td>
<td>2021-22</td>
<td>Gary W. Floyd Tarrant</td>
</tr>
<tr>
<td>Speaker, House of Delegates</td>
<td>Arlo F. Weltge</td>
<td>Yes</td>
<td>2021-22</td>
<td>Bradford W. Holland McLennan</td>
</tr>
<tr>
<td>Vice Speaker, House of Delegates</td>
<td>Bradford W. Holland</td>
<td>Yes</td>
<td>2021-22</td>
<td>John G. Flores Denton</td>
</tr>
</tbody>
</table>
| Four Trustees*          | Keith A. Bourgeois
                          Jayesh B. Shah
                          Richard W. Snyder II
                          Joseph S. Valenti | Yes Yes Yes Yes      | 2021-24          | Keith A. Bourgeois
                          Lisa L. Ehrlich
                          Harris
                          Jayesh B. Shah
                          Bexar
                          Richard W. Snyder II
                          Dallas
                          Joseph S. Valenti
                          Denton |

General officers listed serve one-year terms except trustee which is a three-year term.

House policy also provides that the names of candidates seeking election or reelection be distributed in advance.

*Trustee positions are “at large,” not slotted. TMA Bylaws provide that all nominees for trustee will be listed on a single ballot. To view candidate videos, visit the TMA Elections webpage. If Dr. Floyd is elected president-elect there will be a vacancy for an at-large trustee.
## COUNCILOR AND VICE COUNCILOR ELECTIONS
### May 2021

### COUNCILORS

<table>
<thead>
<tr>
<th>Office</th>
<th>Incumbent</th>
<th>Eligible for Election</th>
<th>Term of Position</th>
<th>Candidates Announced as of Jan. 21</th>
</tr>
</thead>
<tbody>
<tr>
<td>District 1</td>
<td>Gilbert A. Handal</td>
<td>Yes</td>
<td>2021-24</td>
<td>Gilbert A. Handal</td>
</tr>
<tr>
<td>District 2</td>
<td>Vivek U. Rao</td>
<td>Yes</td>
<td>2021-24</td>
<td>Vivek U. Rao</td>
</tr>
<tr>
<td>District 4</td>
<td>Stuart L. Abramson</td>
<td>Yes</td>
<td>2021-24</td>
<td>Stuart L. Abramson</td>
</tr>
<tr>
<td>District 11</td>
<td>Sheldon Y. Freeberg</td>
<td>Yes</td>
<td>2021-24</td>
<td>Brenda M. Vozza</td>
</tr>
<tr>
<td>District 14</td>
<td>Edward W. Tuthill</td>
<td>Yes</td>
<td>2021-24</td>
<td>Edward W. Tuthill</td>
</tr>
</tbody>
</table>

### VICE COUNCILORS*

<table>
<thead>
<tr>
<th>Office</th>
<th>Incumbent</th>
<th>Eligible for Election</th>
<th>Term of Position</th>
<th>Candidates Announced as of Jan. 21</th>
</tr>
</thead>
<tbody>
<tr>
<td>District 1</td>
<td>Angel M. Rios</td>
<td>Yes</td>
<td>2021-24</td>
<td>Angel M. Rios</td>
</tr>
<tr>
<td>District 2</td>
<td>James W. Huston</td>
<td>Yes</td>
<td>2021-24</td>
<td>James W. Huston</td>
</tr>
<tr>
<td>District 4</td>
<td>Vacant</td>
<td>Yes</td>
<td>2021-24</td>
<td></td>
</tr>
<tr>
<td>District 11</td>
<td>Brenda M. Vozza</td>
<td>Yes</td>
<td>2021-24</td>
<td>Gina Mapes Jetter</td>
</tr>
<tr>
<td>District 14</td>
<td>Steven R. Hays</td>
<td>Yes</td>
<td>2021-24</td>
<td>Steven R. Hays</td>
</tr>
<tr>
<td>District 8</td>
<td>Vacant</td>
<td>Yes</td>
<td>2021-23</td>
<td>Steven E. Wolf</td>
</tr>
</tbody>
</table>

District elections are held for vice councilors and names are forwarded to the House of Delegates for confirmation. Terms are three years, unless filling an unexpired term. See map in this section for councilor districts.

*As provided in TMA Bylaws, nominations for vice councilor positions are determined by district elections and confirmed by the House of Delegates.
Table of Contents
### AMA DELEGATION ELECTIONS
May 2021

#### DELEGATES

<table>
<thead>
<tr>
<th>Office</th>
<th>Incumbent</th>
<th>Eligible for Election</th>
<th>Term of Position</th>
<th>Candidates Announced as of Jan. 21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Delegate</td>
<td>Brad. G. Butler</td>
<td>No</td>
<td>2022-23</td>
<td>Roxanne M. Tyroch</td>
</tr>
<tr>
<td>Delegate</td>
<td>Diana L. Fite</td>
<td>Yes</td>
<td>2022-23</td>
<td>Diana L. Fite</td>
</tr>
<tr>
<td>Delegate</td>
<td>Gary W. Floyd</td>
<td>Yes</td>
<td>2022-23</td>
<td>Gary W. Floyd</td>
</tr>
<tr>
<td>Delegate</td>
<td>John T. Gill</td>
<td>Yes</td>
<td>2022-23</td>
<td>John T. Gill</td>
</tr>
<tr>
<td>Delegate</td>
<td>Robert T. Gunby Jr.</td>
<td>No</td>
<td>2022-23</td>
<td>John T. Carlo</td>
</tr>
<tr>
<td>Delegate</td>
<td>David N. Henkes</td>
<td>Yes</td>
<td>2022-23</td>
<td>David N. Henkes</td>
</tr>
<tr>
<td>Delegate</td>
<td>Jayesh Shah</td>
<td>Yes</td>
<td>2022-23</td>
<td>Jayesh Shah</td>
</tr>
<tr>
<td>Delegate</td>
<td>Lyle S. Thorstenson</td>
<td>No</td>
<td>2022-23</td>
<td>Elizabeth Torres</td>
</tr>
</tbody>
</table>

#### ALTERNATE DELEGATES

<table>
<thead>
<tr>
<th>Office</th>
<th>Incumbent</th>
<th>Eligible for Election</th>
<th>Term of Position</th>
<th>Candidates Announced as of Jan. 21</th>
</tr>
</thead>
<tbody>
<tr>
<td>Alternate Delegate</td>
<td>Steven R. Hays</td>
<td>Yes</td>
<td>2022-23</td>
<td>Steven R. Hays</td>
</tr>
<tr>
<td>Alternate Delegate</td>
<td>Jennifer R. Rushton</td>
<td>Yes</td>
<td>2022-23</td>
<td>Jennifer R. Rushton</td>
</tr>
<tr>
<td>Alternate Delegate</td>
<td>Sherif Z. Zaafran</td>
<td>Yes</td>
<td>2022-23</td>
<td>Sherif Z. Zaafran</td>
</tr>
<tr>
<td>Alternate Delegate</td>
<td>Zeke Silva III</td>
<td>Yes</td>
<td>2022-23</td>
<td>Zeke Silva III</td>
</tr>
<tr>
<td>Alternate Delegate</td>
<td>Bryan G. Johnson</td>
<td>Yes</td>
<td>2022-23</td>
<td>Bryan G. Johnson</td>
</tr>
<tr>
<td>Alternate Delegate</td>
<td>Three Vacancies</td>
<td>—</td>
<td>2022-23</td>
<td>Kimberly Avila Edwards</td>
</tr>
<tr>
<td>Alternate Delegate</td>
<td>Three Vacancies</td>
<td>—</td>
<td>2022-23</td>
<td>Mark A. Casanova</td>
</tr>
<tr>
<td>Alternate Delegate</td>
<td>Three Vacancies</td>
<td>—</td>
<td>2022-23</td>
<td>Angela Self</td>
</tr>
<tr>
<td>Alternate Delegate</td>
<td>Matthew McGlennon*</td>
<td>—</td>
<td>2021-22</td>
<td>Matthew McGlennon*</td>
</tr>
<tr>
<td>Alternate Delegate</td>
<td>Patrick Bettiol*</td>
<td>—</td>
<td>2021-22</td>
<td>Alwyn Mathew*</td>
</tr>
</tbody>
</table>

Delegates and alternate delegates serve two-year terms, Jan. 1 2021-Dec. 31, 2022; except that the terms for the resident and medical student alternate delegates are May 16, 2021-May 1, 2022.

*Nominations are made by the Resident and Fellow Section and Medical Student Section.*
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 comply 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

ATTACHMENT A

Two 501c3 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
  - Patricia Lee Palmer, MD, Memorial Resident Loan Fund
  - directed public health and educational program funds
  - History of Medicine fund
  - Texas Medical Association Alliance Student Loan Fund

Four 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.

- **PSO SERVICES, LLC**
  Formed 2016
  Members (3): CMA Holdings, LLC, FMA Holdings LLC, and TMA Practice Management Holdings, LLC
  Managers (6): CEO of the California Medical Association (CMA) or individual designated to serve in his or her place, licensed physician serving as an officer of the board of trustees of the CMA, CEO of the Florida Medical Association (FMA) or individual designated to serve in his or her place, licensed physician serving as an officer of the board of directors of the FMA, CEO of the Texas Medical Association (TMA) or individual designated to serve in his or her place, licensed physician serving as an officer of the board of directors of the TMA.
One unincorporated nonprofit association for which the TMA Board of Trustees is denominated as the **Board of Trustees**.

- **THE PHYSICIANS BENEVOLENT FUND**

One 501c4 corporation for which the members of the TMA Board of Trustees serve as **Trustees**.

- **IMPROVING THE HEALTH OF ALL TEXANS**
  The Board of Trustees consists of the current Chair, Vice Chair, President, Immediate Past President, President-Elect, Chief Executive Officer, Chief Operating Officer and General Counsel of the Texas Medical Association.

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**
President-Elect
(vote for one)

Gary W. Floyd, MD

The members of the Tarrant County Medical Society are proud to nominate one of their proven leaders, Gary W. Floyd, MD, for the position of president-elect of the Texas Medical Association (TMA).

Dr. Floyd received his medical degree from The University of Texas Medical Branch School of Medicine in Galveston and completed his pediatric residency at Children’s Hospital of Oklahoma. 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 a chief medical officer. He is board certified by the American Board of Pediatrics and is a fellow of the American Academy of Pediatrics (AAP).

Dr. Floyd is a recognized leader at the local, state, and national levels:

- Local: Past president of Tarrant County Medical Society; Chair of the Metropolitan Area EMS Authority’s Emergency Physicians’ Advisory Board.
- State: Chair of TMA Board of Trustees; past chair of TMA Council on Legislation; past president of Texas Pediatric Society and the Texas Chapter of the AAP; TEXPAC Patron Club member; a strong voice for TMA policies before state and national legislators for many years including testifying before Texas House and Senate committees on health care issues dealing with safe management and treatment of patients, access to medical care, scope of practice issues, viability of medical practice, reduction of regulatory burdens, and protection of physicians’ clinical autonomy and independent medical judgment.
- National: AAP District VII (AR, LA, MS, OK, TX) Chair and member of AAP Board of Directors; vice chair and delegate for our Texas Delegation to the American Medical Association; Executive Committee of AMA Council on Legislation; AMPAC Capitol Club member.

Experienced leaders will be critical in guiding TMA through the transitions and challenges facing our organization; we must ensure that we continue to provide a unified voice for the practice of medicine. Dr. Floyd’s career is a legacy of service – he will continue to relentlessly advocate for patients, support physicians, and protect our profession.
Personal Statement: “Good physicians take care of their patients; great physicians take care of their patients and their profession. These are challenging times, with many wanting to do what we do without doing what we have done, and the government trying to insert itself between us and our patients. I understand the issues, I am willing to prioritize the time, and I will never give up in my efforts to serve patients, physicians, and our profession.”

PROFILE
Specialty: Pediatrics
Medical School: The University of Texas Medical Branch School of Medicine, Galveston, 1972-76
Residency: Pediatrics at Children’s Hospital of Oklahoma, University of Oklahoma Health Sciences Center, 1976-79
Board Certification(s): American Board of Pediatrics - Lifetime Certificate - 1983
Primary Residence: Keller, Texas
Practice Type/Employment Status: Self-employed consultant in government affairs & select pediatric primary and urgent care locum coverage
Employer/Employment Location: Self-employed/Keller, Texas
Do you expect to maintain your current employment status and location through your term of office? Yes
Does your current employment situation require you to work outside of Texas? No
Including the past 5 years, list all other organizations from which you have received payment, reimbursement, or financial consideration for consulting, advisory, or leadership responsibilities exceeding $1,000/year in excess of actual expenses:
  - American Academy of Pediatrics, District VII chair and member of AAP Board of Directors, 2020-present
  - TMA PracticeEdge Board of Trustees, 2016-present
  - Texas Medical Foundation Health Quality Institute Board of Trustees, 2015-present; chair, 2019-20
Have you been convicted of a felony or is your medical license restricted? No
What TMA positions have you held?
  - TMA Board of Trustees: 2014-present; chair, 2020-21; vice chair, 2019-20; chair, Investments Committee, 2016-20; Executive Committee, 2016-present
  - Tarrant County Medical Society Delegation to TMA: alternate, 1996-97; delegate 1998-present
  - TMA Council on Constitution and Bylaws, 2002-06
  - TMA Council on Legislation: chair, 2011-12; member, 2006-12; consultant, 2012-16
  - TMA Ad Hoc Committee on Retail Health Clinics: chair, 2008-09
  - TMA Select Committee on Medicaid, CHIP, and the Uninsured, 2007-14
  - TMA PracticeEdge Board of Trustees, 2016-present
  - TEXPAC: District 9 chair, 2006-14; vice chair, 2005-06
  - TMA Delegation to the AMA: vice chair, 2016-present; delegate, 2016-present; alternate, 2006-16
  - AMA Reference Committee B (Legislation), 2011, 2014
  - AMA Reference Committee F, 2015-17
  - AMA Council on Legislation, 2017-present

DISCLOSURE OF AFFILIATIONS
American Academy of Pediatrics
Texas Medical Association PracticeEdge Board of Trustees
Texas Medical Foundation (TMF) Health Quality Institute Board of Trustees
American Medical Association Council on Legislation
The Lone Star Caucus and McLennan County Medical Society (MCMS) are proud to endorse Waco otolaryngologist Bradford W. Holland, MD, for election as speaker of the Texas Medical Association’s (TMA’s) House of Delegates.

Dr. Holland’s first TMA meeting was 28 years ago, and ever since he has been a leader among leaders. In his two years as vice speaker, he has shown he can be transformative in modernizing the house. He has been active in formulating House Standing Rules and adjusting to making the House of Delegates a “virtual organization” for the time-being.

Dr. Holland is an inaugural-year graduate of TMA’s Leadership College and has held multiple positions within TMA and MCMS, including past president of MCMS and six years of service on TMA’s Committee on Professional Liability. Dr. Holland served as chair of the Membership Committee, Candidate Evaluation Committee, the Executive Committee of TEXPAC, and ultimately as TEXPAC chair. He served on the Council on Legislation and in 2014 helped form the Lone Star Caucus, serving as its founding co-chair.

Outside TMA, Dr. Holland is a member of the American Institute of Parliamentarians and is active in his specialty society, having served in many roles, including president of the Texas Association of Otolaryngology. He is a graduate of Leadership Waco, past member of the Board of Directors of the Central Texas American Cancer Society and the Greater Waco Chamber of Commerce, and past president of the Waco Symphony Association. Dr. Holland is an adjunct faculty member in Baylor University’s Department of Communication Sciences and Disorders. His wife, Amanda, is director of Baylor University’s Department of Advising for the Robbins College, and they have four children.

**Personal Statement:** “Who could’ve foreseen the tremendous changes COVID-19 has wrought in the way TMA conducts the House of Delegates? Creating online platforms, online voting, virtual candidate forums, and a virtual house meeting were all challenges the speakers faced in 2020. I believe we rose to those challenges and made it through this trying year.

“But 2021 will be much better! Now that we’ve had sufficient time to prepare and have some experience with virtual TMA meetings, I am proud to say that the TexMed 2021 meeting will be as much like a traditional meeting as one can imagine. We know we need to make a secure, representative, interactive, and understandable mechanism for house business at all levels to be completed. I am excited that we have made amazing progress, and I believe every delegate to the TMA house will be pleased with the TexMed 2021 experience.”
“In my time as vice speaker, I have taken an active role to ensure that the myriad problems facing physicians are being addressed in the business of the house. TMA and the speakers need to do everything we can to procure relevant policy changes such that the reforms we need to protect our profession and our patients are being debated in the House of Delegates. I ask for your vote as speaker to continue to make the TMA house the flagship policymaking body of state medical societies in our country.”

PROFILE
Name: Bradford W. Holland, MD
Specialty: Otolaryngology – Head and Neck Surgery
Medical School (with year graduated): UT Southwestern Medical School, 1997
Residency Program: Bowman Gray School of Medicine, general surgery internship
Wake Forest University School of Medicine/North Carolina Baptist Hospitals, otolaryngology residency
Board Certifications(s): American Board of Otolaryngology
Primary Residence: Waco
Practice Type/Employment Status: Direct Patient Care: solo, small group, or shared overhead, 100%
Primary Practice/Employment Location: Waco Ear, Nose, and Throat, Waco
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:
- Waco Real Estate Holdings
- Fishpond Surgery Center General Partnership
- Extraco Banks Community Board Member
- Baylor University Adjunct Faculty, Department of Communication Sciences and Disorders

Have you been convicted of a felony or is your medical license restricted? Please explain. No
What TMA positions have you held?
Current
- Vice Speaker, TMA House of Delegates
- Member, TMA Board of Trustees
- Vice Chair, Speaker’s Advisory Council

Past
- Chair, TEXPAC
- Founder and chair, Lone Star Caucus
- Chair, Small Districts Caucus
- Member, Council on Legislation
- Chair, Candidate Evaluation Committee
- Chair, TEXPAC Membership Committee
- Chair, TEXPAC Executive Committee
- Member, Committee on Professional Liability
- Member, Reference Committee on Science and Public Health
- TMA Leadership College Inaugural Graduate
- President, UT-Southwestern TMA-MSS Chapter
- TMA-MSS Delegation to AMA Leader

DISCLOSURE OF AFFILIATIONS
- Waco Ear, Nose, and Throat
- Physicians Hearing Center
- Fishpond Surgery Center
- Extraco Banks, Board of Directors
- Baylor University Adjunct Faculty, Department of Communication Sciences and Disorders
The Denton County Medical Society and the Lone Star Caucus are proud to present Little Elm internist John G. Flores, MD, for the position of vice speaker of the Texas Medical Association. Dr. Flores was born in Dallas and grew up on the southern border of Dallas County in the city of Duncanville. He graduated 15th in his class of more than 800 students. He was a drum major, president of the Spanish club, newspaper writer and photo editor, and graduated with honors in government. He attended The University of Texas at Austin and graduated with Plan 1 honors. He graduated in 1993 from the UT Southwestern Medical School, where he was editor of the student newspaper, The Murmur, and also served as president of the Texas Association of Mexican-American Medical Students. After graduation from the Methodist Central Hospital Internal Medicine program in 1997, he opened a private internal medicine clinic in Little Elm, where his wife Jill, also an internist, joined him in 2003.

Dr. Flores has been actively involved in organized medicine since early in his career. He chaired the TMA Council on Socioeconomics and the Council on Health Service Organizations. He is currently serving as a TMA alternate delegate to the American Medical Association (AMA) and he cochairs the Lone Star Caucus. At the AMA, he has served on the AMA Organized Medical Staff Section’s Governing Council since 2017 and was elected as its secretary in 2020. He previously served as the legislative chair and president of the Denton County Medical Society. Dr. Flores has been with his wife, Jill, for 26 years and has four boys. He has enjoyed watching them grow and participating as their Boy Scout cub master and associate scoutmaster. He enjoys reading thick books, graphic novels, and golfing.

**Personal Statement:** “The COVID-19 pandemic has demonstrated how far our state has come to improve the health care of Texans and yet how far it still has to go. The health of our brothers and sisters in the Valley and rural and urban areas is especially at risk. We must continue efforts at all levels to erase the smoldering social iniquities that these populations suffer from. By improving the broadband infrastructure and with our quick and timely adoption of telemedicine, we have made inroads in this process. Our pandemic-induced wins with the insurance industry on this front must be secured with the appropriate legislation. In addition, the pandemic has also altered the way we interact with each other. The TMA has made great strides in how its House of Delegates conducts business using virtual technology; this is a paradigm shift which has increased participation throughout the state and with our younger physicians who lacked the time needed to participate in our initiatives because they were building their practices or raising a family. My involvement in TMA leadership has always been centered around creating and cementing relevancy for its members and improving the health of Texans in the process.”
PROFILE
Specialty: Internal Medicine
Medical School (with year graduated): UT Southwestern Medical School 1993
Residency Program: University of Tennessee Chattanooga General Surgery Internship 1993-94
   Methodist Central Hospital Dallas Internal Medicine Residency 1994-97
Board Certification(s): American Board of Internal Medicine 1997-2027
Primary Residence (City, State): Carrollton
Practice Type/Employment Status: Direct Patient Care: solo, small group, or shared overhead, 100%
Primary Practice/Employment Location (City, State): Little Elm Medical Clinic, Little Elm, Texas. Full-
time outpatient primary care.
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:
   • Novo Nordisk: Speaker for GLP-1 diabetic medicine
   • Blue Cross Blue Shield: member of Physician Advisory Board
   • Southwestern Health Resources: regional medical director for community physicians
   • Concord hospice: medical director
   • ARC Home Health Care: medical director, delegating physician for two nurse practitioners.
Have you been convicted of a felony or is your medical license restricted? Please explain. No
What TMA positions have you held?
Current
   • Alternate Delegate, Texas Delegation to the AMA
Past
   • Chair, Council on Socioeconomics
   • Chair, Council on Health Service Organizations

DISCLOSURE OF AFFILIATIONS
Little Elm Medical Clinic, PA, private practice, 50% owner
Texas American College of Physicians Services, President 2020-21
Southwestern Health Resources (Integrated Accountable Care Organization)
AMA Organized Medical Staff Section 2019-present
AMA Governing Council Secretary 2020-22
The Harris County Medical Society is honored to endorse the candidacy of Keith A. Bourgeois, MD, for reelection to the Texas Medical Association (TMA) Board of Trustees.

Dr. Bourgeois is completing his second term of office on the board, and while he has contributed much to the work of the board, there is much more he would like to accomplish.

In his first year on the board, Dr. Bourgeois chaired the Balance Billing Task Force. In this role, he was instrumental in helping TMA develop policy positions that convinced the legislature to allow physicians to retain their right to balance bill, while at the same time improving the system to make it better for patients.

A past president of the Texas Ophthalmological Association and of the Harris County Medical Society, Dr. Bourgeois has been in private practice since 1988. His main office in downtown Houston is a two-person ophthalmology practice specializing in diseases and surgery of the retina and vitreous. To address the physician shortage before tort reform, he and his partner treated patients in the Rio Grande Valley, as well as in the Beaumont and Conroe areas, from 1992 to 2001. Following on that tradition of addressing the need for a retina specialist in a rural community, he also has been treating patients at a satellite office in Columbus for the past 27 years.

From personal experience, Dr. Bourgeois understands the problems of both urban and rural physicians and patients. Every day he deals with the burdens placed upon physicians by the bureaucrats in Austin and Washington, D.C. He also is intimately familiar with the difficult relationships physicians have with hospitals and health plans. Before serving on the Board of Trustees, his six years each on the TMA Council on Socioeconomics and the Council on Legislation trained him how to develop effective policy that can pass the legislature.

In short, Dr. Bourgeois’ vast experience in medical issues that affect all physicians across the state makes him a valuable member of the TMA Board of Trustees. His ability to evaluate issue positions and understand their impact on both urban and rural as well as on small-practice or hospital-based physicians will be a critical asset to the board’s decisionmaking in the years to come.
**Personal Statement:** “I am proud of the ongoing efforts of the TMA and local medical societies in enhancing practice viability and fully support continuing these efforts to ensure our practices can thrive as we care for our patients.”

**PROFILE**
Specialty: Ophthalmology-Retina and Vitreous
Medical School and Post Graduate Education (with years): Louisiana State University, New Orleans, 1979-83
Residency Program:
- Internship, Louisiana State University, Lafayette, Louisiana, 1983-84
- Residency, The University of Texas Health Science Center at Houston (UTHSC), 1984-87
- Fellowship in retina, UTHSC-Houston, 1987-88
Board Certification(s): American Board of Ophthalmology, 1988
Primary Residence (City, State): Houston, Texas
What is your current practice status? Check all that apply and provide percentages:
Direct Patient Care: solo, small group, or shared overhead, 100%
Primary Employer and Employment Location (city, state): Keith A. Bourgeois, MD, PA, 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.
- St. Joseph Medical Center, Houston, Texas
- Texas Medical Liability Trust
- Occasional review of medical records for various law firms
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
- Ex Officio Member, TMA House of Delegates
Past
- District Chair, TEXPAC Board of Directors
- District Vice Chair, TEXPAC Board of Directors
- Member, Council on Legislation
- Chair, Council on Socioeconomics
- Member, Council on Socioeconomics
- Program Chair, TexMed CME Program

**DISCLOSURE OF AFFILIATIONS**
Keith A. Bourgeois, MD, PA – DBA Downtown Eye Associates
St. Joseph Medical Center, Houston, Texas
Texas Medical Liability Trust
Board of Trustees
(vote for four)

Lisa L. Ehrlich, MD

It has been said that these are “unprecedented times.” Since such times require exceptional leadership, the Harris County Medical Society (HCMS) is proud to nominate Lisa L. Ehrlich, MD, for a position on the Texas Medical Association Board of Trustees as an at-large member in 2021.

Dr. Ehrlich has significant experience leading in organized medicine. You will find those positions listed in her profile below. Dr. Ehrlich can run a board meeting efficiently while engaging her board members, and as a meeting participant, she is a rare combination of disruptor and consensus builder. If you know her, you know she likes to get things done through democracy and participation, playing on the strengths and differences of stakeholders. Importantly, Dr. Ehrlich has the breadth of passion and depth of experience to be an asset to the board in these unprecedented times.

Lisa is a mother, wife, business owner, and loyal friend. She loves dinner conversation, listening to live music, reading, and snow skiing. She brings her experiences to the care of her patients as well as to leadership. But it is her love for the profession of medicine and her deep care for her patients that drives her strong passion for leadership in medicine. She recognizes that, while she has striven to deliver excellent care as an accomplished private internal medicine physician, over those decades the system has become ever more averse to physicians as well as their patients. Dr. Ehrlich has identified this as a crisis for which she has dedicated her time in organized medicine to address.

Dr. Ehrlich is no stranger to crisis. After nine years in leadership positions serving her county medical society, she was proud to lead 12,000 Harris County physicians as president during the aftermath of Hurricane Harvey in 2017. At the request of Harris County Judge Ed Emmett, she drew on her experience as a business owner, physician, collaborator, and leader to organize multiple stakeholders to run the medical operations at the NRG shelter, where an average of 4,000 displaced residents per day were housed. Not only did she help organize the day-to-day medical care for the residents (essentially in-house urgent care and emergency center), but she was able to coordinate Baker-Ripley, Harris Health, HCMS, federal support troops (Army Reserves and DMAT), Harris County Public Health, pharmacies, and volunteer health care personnel to provide immediate care and community follow-up. Besides emergency and chronic care, Dr. Ehrlich helped to organize 24-hour mental health identification and support, public health, pharmacy, dentistry, eye care, and even AA meetings.

With the ongoing pandemic, 2021 calls for experienced, proven, and dedicated leaders. Dr. Lisa Ehrlich is ready to go.
**Personal Statement:** “Put simply, 2021 needs leadership by physicians who have immersive experience with patient care and organized medicine, an understanding of the problems facing health care derived from years of everyday experience, and a logical approach to the issues based on what improves patient care. Therefore, I respectfully request your support for my election to the TMA Board of Trustees.”

**PROFILE**

Specialty: Internal Medicine  
Medical School and Post Graduate Education: The University of Texas Medical Branch, 1989-93  
Residency Program: University of Michigan Medical Center, 1993-96  
Board Certification(s): American Board of Internal Medicine, 1996-2026  
Primary Residence (City, State): Houston, Texas  
What is your current practice status? Direct Patient Care: solo, small group, or shared overhead, 100%  
Primary Employer and Employment Location (city, state):  
L. Ehrlich and Associates Medical Clinic, PLLC, 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.  
TMF Health Quality Institute  
Have you been convicted of a felony or is your medical license restricted? Please explain. No  
What TMA positions have you held?  
Board member, TMF Health Quality Institute, 2019-present  
TMA Council on Socioeconomics, 2018-present  
TEXPAC Board of Directors, 2004-present  
AMA Delegate for TMA Young Physicians section, 2003-06

**DISCLOSURE OF AFFILIATIONS**

L. Ehrlich and Associates Medical Clinic, PLLC, managing partner  
Texas Immunization Partnership, advocacy
The Bexar County Medical Society (BCMS) is proud to nominate one of its outstanding leaders, Jayesh (Jay) Shah, MD, for reelection to the Texas Medical Association (TMA) Board of Trustees.

With the unprecedented challenges affecting medicine, TMA needs a strong leader like Dr. Shah. Dr. Shah is a collaborative and innovation-driven physician-executive leader who has led physicians in hospitals, group practice, and in nonprofit physician organizations both locally and nationally.

Dr. Shah was the president of the American Association of Physicians of Indian Origin, a national organization representing 100,000 physicians. He is the immediate past president of the American College of Hyperbaric Medicine and past chair of the American College of Clinical Wound Specialists. He is past president of the BCMS and the Texas Indo-American Physician Society.

Dr. Shah received his bachelor of medicine-bachelor of surgery from Medical College Baroda in India. He served his internal medicine residency at St. Luke’s Roosevelt Hospital at Columbia University in New York and took part in the Master of Health Care Administration program at Trinity University in San Antonio. He is board certified in internal medicine as well as undersea and hyperbaric medicine.

Dr. Shah has been a TMA member since 2000. He is currently serving on the Board of Trustees and is a TMA Delegate to the American Medical Association (AMA). Dr. Shah has served three years as a member of the TMA Council on Health Services; the Select Committee on Medicaid, CHIP, and the Uninsured; and the Council on Health Promotion. Dr. Shah also has served for six years on the Committee on Membership. Likewise, he has served as vice chair for TEXPAC District 21; co-chair of 2018 TMA Foundation Gala; and as chair of the International Medical Graduates Section for both TMA and AMA. He is a long-standing delegate of BCMS to TMA and is current co-chair of the BCMS Delegation to TMA.

Dr. Shah is a thought leader and educator in wound care and hyperbaric medicine, having published three books, 50 peer-reviewed papers, and has given more than 200 invited lectures. He is a member of the adjunct faculty at UT Health San Antonio and the University of the Incarnate Word School of Osteopathic Medicine in San Antonio. He has received numerous awards not only for his academic achievements but also for his community service and leadership.
Dr. Shah is an actively practicing physician with sound business knowledge who understands the issues and can provide novel solutions. He also advocates on behalf of Texas physicians to keep the private practice of medicine alive. He is the right prescription for the TMA Board of Trustees.

**Personal Statement:** “I have a passion to serve Texas patients and physicians. It is a great honor to be your Board of Trustees member during these unprecedented times. I advocated on behalf of Texas physicians during the unprecedented COVID-19 pandemic so that private practices can survive, can receive PPE, loans, vaccinations, and all the necessary support they need. I have testified and advocated against prior authorization red tape and scope issues. I have used my health care administration skills to steer TMA’s finances in the right direction. My unparalleled experience in organized medicine, 25 years of private practice, business, and academia will be the right prescription for TMA.”

**PROFILE**

Specialty: Internal medicine, undersea and hyperbaric medicine, wound care  
Medical School (with year graduated): Medical College Baroda, Maharaja Sayajirao University, Baroda, India, 1986-92  
Residency Program: Columbia University’s St. Luke’s Roosevelt Hospital, New York, 1993-96  
Board Certification(s): American Board of Internal Medicine, American Board of Preventive Medicine (Undersea and Hyperbaric Medicine)  
Primary Residence (City, State): San Antonio, Texas  
Practice Type/Employment Status:  
- Direct Patient Care: solo, small group, or shared overhead, 80%  
- Direct Patient Care: nonprofit corporation (formerly 5.01(A) corporation), 5%  
- Academic, 10%  
- Administrative: government, health plan, or health-related, but no direct patient care, 5%  
Primary Practice/Employment Location (City, State): Self-employed at South Texas Wound Associates, PA, San Antonio, 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:  
Tenet Healthcare Corp.; International ATMO, Inc.; Acelity  
Have you been convicted of a felony or is your medical license restricted? Please explain. No  
TMA positions held:  
Member, Board of Trustees, 2018-21  
Co-Chair, TMA Foundation Gala, 2018  
Vice Chair, TEXPAC District 21  
Member, Council on Health Promotion (three years)  
Member, AMA Delegation (10 years)  
Member, Select Committee on Medicaid, CHIP, and the Uninsured (three years)  
Member, Committee on Membership (three years)  
Member, Council on Health Service Organizations (three years)  
Chair, International Medical Graduate Section, 2004-05  
Member, Governing Council of the International Medical Graduate Section, 2000-06

**DISCLOSURES**

South Texas Wound Associates, PA  
TIMEO2 Healing Concepts, LLC  
Wound Care Centers at Northeast Baptist Hospital and Mission Trail Baptist Hospital  
Wound Care Alliance  
American College of Hyperbaric Medicine
The Dallas County Medical Society (DCMS) is pleased to nominate a leader in organized medicine, Rick Snyder, MD, for reelection to the Texas Medical Association Board of Trustees.

After graduating with honors from the University of Notre Dame and the L’Universite Catholique de L’Ouest in France, Dr. Snyder earned his medical degree from the UT Southwestern Medical School, where he also completed his residency in internal medicine and fellowship in cardiology. He is board certified in cardiovascular disease, interventional cardiology, advanced heart failure, and transplant cardiology.

Dr. Snyder has since 1996 practiced at Medical City Dallas Hospital, where he previously served as department of medicine chair and medical staff president. He also served on the board of trustees. In addition to his full-time clinical practice, Dr. Snyder serves as president of HeartPlace, a 62-physician cardiology practice with more than 25 offices in Dallas-Fort Worth, as well as vice chair of Cardiovascular Provider Resources, Inc., and as a board member for Specialty Physician Assurance Company, Ltd. Dr. Snyder also represents HeartPlace as chair of the board of ASPEN Physician Network, PLLC, a clinically integrated network of independent specialty groups.

Dr. Snyder is a passionate advocate of protecting the physician-patient relationship. He believes physicians must be the voice for their patients, and he demonstrates that by participating in state legislative and federal congressional advocacy activities. He and his wife, Shelley Hall, MD, host numerous fundraisers in their home on behalf of TEXPAC.

Dr. Snyder was president (2012) and chair of the board (2013) of DCMS. While president he led the physician response to the West Nile virus epidemic. Dr. Snyder’s leadership resulted in his appointment to the Dallas County Health and Human Services Public Health Advisory Committee by County Judge Clay Jenkins. Dr. Snyder previously served DCMS as secretary/treasurer and as chair of the Legislative Affairs Committee. He continues his volunteerism as a member of the DCMS Community Emergency Response Committee and the North Texas Mass Critical Care Task Force.

As an American College of Cardiology representative, he was a member of the board of governors and the ACC Political Action Committee board in Washington, D.C., and has served as president of the Texas chapter. Dr. Snyder additionally was vice chair of the National Physicians’ Council for Health Care Policy.
A member of the TMA Board of Trustees since 2015, Dr. Snyder formally served as secretary/treasurer and is currently vice chair. He has held leadership positions as a member of the TMA House of Delegates, TEXPAC Board of Directors, Committee on Physician and Hospital Issues, Committee on Insurance and Managed Care, Council on Legislation, and the TMA Specialty Services, LLC Board.

**Personal Statement:** “We need to make the capitol buildings in Austin and D.C. as familiar as our own hospitals. As physicians, we can have as much impact, if not more, on patient care through our work in legislative chambers and regulators’ offices, as exam rooms and operating rooms. As clinicians we treat one patient at a time, but as physician advocates we can treat everyone all at once.”

**PROFILE**
Specialty: Cardiology
Medical School and Post Graduate Education (with years): UT Southwestern Medical School, 1983-87
Residency and Fellowship Programs: UT Southwestern Medical Center, 1987-1993
Board Certification(s): Internal Medicine, Interventional Cardiology, Cardiovascular Disease, Advanced Heart Failure and Transplant Cardiology
Primary Residence (City, State): Dallas
Practice Type/Employment Status: Direct Patient Care – Large Group Practice (over 20 members), 100%
Primary Practice/Employment Location (City, State): HeartPlace, Dallas
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
All other organizations from which payment, reimbursement, or financial consideration for consulting, advisory, or leadership responsibilities exceeding $1,000 per year in excess of actual expenses has been received including the past 5 years:
- HeartPlace, president and legislative director
- Cardiovascular Provider Resources, Inc., vice chair
Have you been convicted of a felony or is your medical license restricted? No
TMA positions held:
  - Vice Chair, Board of Trustees, 2020-present
  - At-Large Member, Board of Trustees, 2015-present
  - Secretary/Treasurer, Board of Trustees, 2015, 2019
  - Member, House of Delegates, 2005-present
  - Secretary/Treasurer, Board of Directors, TMA Specialty Services, LLC, 2017-present
  - Member, Council on Legislation 2013-15
  - Member, Council on Legislation Ad Hoc Committee on Transparency, 2015
  - Member, Council on Socioeconomics Ad Hoc Committee on ACOs, 2008
  - Member, Committee on Insurance and Managed Care, 2008
  - Member, Inter-Specialty Society Committee, 2007-10
  - Member, Board of Directors, TEXPAC, 2006-15
  - Member, Committee on Physician and Hospital Issues, 2006

**DISCLOSURES**
**Self:** HeartPlace, PA, president; Cardiovascular Provider Resources, Inc., board vice chair; Specialty Physician Assurance Company, Ltd., board of directors; Blue Cross and Blue Shield of Texas, Texas Physicians Advisory Council; ASPEN Specialty Physicians Network, board chair; Novitas Solutions, Inc., Medicare administrative contractor JH, Contractor Advisory Committee; Dallas County Health and Human Services Public Health Advisory Committee; American College of Cardiology Political Action Committee; Medfinity Health Plano.

**Spouse Shelly Hall, MD:** Texas Chapter of American College of Cardiology, president-elect; American Society of Transplantation Thoracic and Critical Care Council, chair; United Network for Organ Sharing Heart Committee, chair; Cardiovascular Provider Resources, Inc., board of directors; Baylor Scott & White Heart and Vascular Hospital board of directors; Health Texas Provider Network, Baylor University Medical Center; consultant for Abbott, Abiomed, Medtronic, SynCardia Systems, Everheart, CareDx, Natera; speaker for CareDx.
Board of Trustees
(vote for four)

Joseph S. Valenti, MD

The Lone Star Caucus is very pleased to nominate Joseph S. Valenti, MD, for reelection to the position of at-large member of the Texas Medical Association (TMA) Board of Trustees.

A gynecologist in private practice in Denton for the past 22 years, Dr. Valenti is a fellow of the American College of Obstetricians and Gynecologists. He graduated with honors from the State University of New York at Buffalo School of Medicine and completed residency at Women & Children’s Hospital of Buffalo.

Dr. Valenti has the experience necessary to serve on the TMA Board of Trustees. He has chaired three TMA councils and committees: the Council on Socioeconomics, Council on Constitution and Bylaws, and Committee on Maternal and Perinatal Health. He currently serves the physicians of Texas as a member of The Physicians Foundation Board of Directors. He previously served as president of the Denton County Medical Society and chief of staff of North Texas Hospital, a physician-owned facility.

Dr. Valenti is actively involved in advocating for awareness of the social determinants of health care outcomes and costs while promoting the primacy of physicians and patients in Texas and the U.S. He has participated in organized medicine since 1991, beginning with his first year of medical school. Throughout his service to the Texas and New York state medical organizations, he has chaired and served as a delegate of the medical student, resident and fellow, and young physician sections. During his residency, he held the at-large position on the Resident and Fellow Section Governing Council of the American Medical Association. He is a member of the Texas Medical Liability Trust Business Development Committee.

Dr. Valenti has extensive organizational and leadership experience, serving his peers at almost every level of the Texas Medical Association. Both at the state and national levels, he has been a consistent stalwart for physician-owned, physician-driven, physician-led health care.
**Personal Statement:** “The history of the Texas Medical Association from 1853 to today is one replete with a common thread: Physicians joining together to accomplish a vision, “To Improve the Health of All Texans.” TMA’s 2025 strategic plan outlines the path forward, and certainly our original 35 founders could hardly have imagined how complex this task would become: tort reform, balance billing, political action, value-based care, and evidence-based regulation, to name a few of the factors. Nonetheless, we are faced with a future that we must walk together with our patients. We are their stewards, and they are our partners, and we can succeed only if we are kept always vigilant of that fact. Required of us is leadership, dedication, honesty, a working understanding of the determinants of health care costs, and an unwavering belief that we can never give up the ability to do what is in the aligned physician and patient best interest. We must be the leaders of the health care team, and we must defend that only those who have gone to medical school can practice medicine. I humbly ask for your support so that I may continue to carry the fight forward on behalf of our TMA, our patients, and all Texans.”

**PROFILE**
Name: Joseph S. Valenti, MD  
Specialty: Gynecology  
Medical School (with year graduated): Roswell Park, 1986-89 Immunology Masters; SUNY Buffalo School of Medicine, 1989-94  
Residency Program: Children’s Hospital of Buffalo, OB-Gyn Residency, 1994-68  
Board Certification(s): American Board of Obstetrics and Gynecology Fellow, 2001-present  
Primary Residence (City, State): Dallas, Texas  
Practice Type/Employment Status: Direct patient care: solo, small group, or shared overhead, 100%  
Primary Practice/Employment Location (City, State): Caring for Women, PA, Denton, Texas. Founder and co-owner.
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:
  - Physicians Foundation
Have you ever been convicted of a felony or is your medical license restricted? Please explain. No  
TMA positions held:  
**Current**  
TMA Board of Trustees, 2018-present  
Delegate to TMA, Denton County Medical Society, 2003-present  
**Past**  
Chair, Denton County Medical Society  
Chair and member, TMA Council on Socioeconomics, 2011-16  
Chair and member, TMA Council on Constitution and Bylaws, 2009-11  
Chair and member, TMA Committee on Maternal and Perinatal Health, 2002-03  
Chair, TMA Young Physician Section, 2000-01  
Delegate, TMA Young Physician Section House of Delegates, 1999-2003  

**DISCLOSURE OF AFFILIATIONS**
Caring for Women, PA  
Physicians Foundation  
Blue Cross and Blue Shield of Texas, Texas Physicians Advisory Council
The Dallas County Medical Society (DCMS) is pleased to nominate a dedicated leader, Mark A. Casanova, MD, for election as Alternate Delegate to the American Medical Association (AMA).

Dr. Casanova has a long history as a palliative care physician, ethics consultant, and patient care advocate. He serves as chair of the Supportive and Palliative Care and the Institutional Ethics Committee at Baylor University Medical Center in Dallas. He also maintains a component of his general clinical internal medicine practice.

Dr. Casanova received his medical degree from The University of Texas Medical Branch at Galveston and a residency in internal medicine at Baylor University Medical Center in Dallas. He received his bachelor’s degree in biology from Texas A&M University. He holds a clinical associate faculty position with the Texas A&M Health Science Center College of Medicine, and leads the Baylor University Medical Center HEAL III curriculum (Humanities, Ethics, Altruism and Leadership). He founded and chairs the Supportive and Palliative Care Service team at Baylor University, for which the American Hospital Association recognized Dr. Casanova and his team with a Circle of Life Citation of Honor in 2007.

Dr. Casanova was president (2020) and chair of the Board (2021) of DCMS. Throughout the COVID-19 pandemic, Dr. Casanova has served on the Dallas County COVID-19 Public Health Subcommittee and the TMA COVID-19 Taskforce. Additionally, his leadership contributed to the formation of the North Texas County Medical Society Coalition, an organization that provides public-facing COVID-19 information and expertise to the residents of North Texas. Dr. Casanova’s involvement in DCMS includes co-chairing the DCMS Delegation to TMA, serving on the Community Emergency Response Committee, the North Texas Alliance for Clinician Resilience, and co-chair of the North Texas Mass Critical Care Task Force. As an active member of TMA, Dr. Casanova serves on the TMA Council on Health Service Organizations and previously chaired the TMA Council on Constitutional Bylaws.

Beyond educating medical students, he is also intimately involved in the education of both residents and fellows in areas of palliative medicine and clinical ethics. Dr. Casanova’s greatest joy, beyond his devotion to medicine, is being a husband and father to two of the most remarkable ladies in the world.
Personal Statement: “I seek to serve as an AMA Alternate Delegate in order to protect and advance the sanctity of the patient-physician relationship. I have dedicated myself the past several years to expanding my health policy influence in North Texas and across the entire state, and believe I am ready to represent Texas at the level of the AMA. In upholding the principles of medical and clinical ethics as unwavering guideposts, I would like to share my devotion for living well while struggling with illness, ensuring a sustainable profession for the future, and the importance of educating our next generation of physicians. These attributes, along with my knowledge base and skill set surrounding professional society constitution and bylaws, provides a well-balanced asset for the Texas AMA delegation.”

PROFILE
Specialty: Palliative Medicine
Medical School and Post Graduate Education (with years):
   - The University of Texas Medical Branch at Galveston, Doctor of Medicine, 1996-2000
   - Baylor University Medical Center, Internship in internal medicine, 2000-01
Residency Program: Baylor University Medical Center, Residency in Internal Medicine, 2001-03
Board Certification(s):
   - American Board of Internal Medicine
   - American Board of Hospice and Palliative Medicine
Primary Residence (City, State): Dallas, Texas
Practice Type/Employment Status: Direct Patient Care: large group practice (over 20 members), 80%; Academic, 15%; Public Health, 5%
Primary Employer and Employment Location (city, state): Baylor University 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 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. None
Have you been convicted of a felony or is your medical license restricted? No
TMA Positions Held:
   - Council on Health Service Organizations, Member
   - Council on Health Service Organizations, Chair
   - Council on Constitutional Bylaws, Member
   - Council on Constitutional Bylaws, Chair
AMA Alternate Delegate
(vote for three)

Kimberly Avila Edwards, MD

Kimberly Avila Edwards, MD, has been a member of the Texas Medical Association (TMA) and the Travis County Medical Society (TCMS) since beginning her career as a general pediatrician in Austin in 2002. At the local level, Dr. Avila Edwards has served as a member of the Board of Ethics and as a member of the Executive Board for TCMS. At the state level, she has been actively engaged in TMA as well as the Texas Pediatric Society (TPS), the state chapter of the American Academy of Pediatrics (AAP). She is honored to have been part of the TMA Leadership College Class of 2012. In 2012, Dr. Avila Edwards served as the youngest and first Hispanic president of the Texas Pediatric Society. Since then, she has served in national roles in the AAP as the Texas Alternate chapter chair, the chapter chair for Texas, and as of March 2019 as the AAP District VII Chapter Forum Management Committee member, a role she holds to date. Dr. Avila Edwards understands amplifying the voice of Texas physicians and their patients within our professional national organizations.

Dr. Avila Edwards brings her considerable state and national leadership experience to the potential role of American Medical Association Alternate Delegate. Dr. Avila Edwards has served on the TMA Council on Science and Public Health and currently serves as Chair of the TMA Committee on Child and Adolescent Health. She has led efforts at both TMA and TPS around childhood obesity and, currently, around health equity. She has actively participated in multiple Texas legislative sessions, sharing her content expertise and testifying before various state legislative committees on behalf of TMA, TPS, and the Texas Academy of Family Physicians on various obesity and other child health-related bills.

Dr. Avila Edwards currently serves as director of Advocacy and External Affairs at Dell Children’s Medical Center in Austin. Since August 2020, Dr. Avila Edwards has had the honor of serving as the associate chair for Advocacy for the Department of Pediatrics at Dell Medical School. Dr. Avila Edwards practices primary general pediatrics onboard the Dell Children’s Medical Center mobile clinic, a clinic that serves as the primary medical home for uninsured children. She understands firsthand the disparities faced by underinsured and uninsured children in our community. Dr. Avila Edwards has volunteered at El
Buen Samaritano as well as the Volunteer Healthcare Clinic in Austin. She also has served as a camp physician for Laity Lodge and as the medical director for El Ranchito.

Dr. Avila Edwards has been recognized for her work by four Special Achievement Awards from the American Academy of Pediatrics, the TPS Executive Board Award, and in 2020, the Sidney R. Kaliski, MD, Award of Merit by TPS.

**Personal statement:** “As the largest and only national association that convenes almost 200 state and specialty medical societies and other critical stakeholders, the responsibility to serve the American Medical Association as part of the Texas Delegation is great. It is a tremendous honor to be considered and if elected, I will work hard to be the voice for all Texas physicians and their patients, including children.”

**PROFILE**

Specialty: Pediatrics  
Medical School (with year graduated): Harvard Medical School, 1999  
Residency Program:  
- Pediatric Internship: Texas Children’s/Baylor College of Medicine: 2000  
- Pediatric Residency: Texas Children’s/Baylor College of Medicine: 2002  
- Chief Resident, Neonatal Chief, 2002  
Board Certification(s): Pediatrics, 2002, Recertification 2012  
Primary Residence (City, State): Austin, Texas  
Practice Type/Employment Status:  
- Direct Patient Care: nonprofit corporation (formerly 5.01(A) corporation), 10%  
- Academic: Associate Chair for Advocacy, Department of Pediatrics, Dell Medical School, 30%  
- Administrative: government, health plan, or health-related, but not direct patient care. Director of Advocacy and External Affairs at Dell Children’s Medical Center, 60%

Primary Practice/Employment Location (City, State): Dell Children’s Medical Center/Ascension Texas, Austin, 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:  
- Department of State Health Services: Texas Health and Human Services Texas Health Steps  
- Texas Pediatric Society, state chapter of the American Academy of Pediatrics  
Have you ever been convicted of a felony or is your medical license restricted? Please explain. No  
TMA positions held:
- TMA Committee on Child and Adolescent Health, chair, 2020-present  
- Council on Science and Public Health, 2009-15  
- Alternate Delegate to the TMA Interspecialty Society, Texas Pediatric Society, 2008-09  
- TMA Leadership College Class of 2012  
- TMA Member, 2002-present  
- Member, Executive Board, Travis County Medical Society, 2014-16  
- Member, Board of Ethics, Travis County Medical Society, 2013-16
AMA Alternate Delegate
(vote for three)

Angela Self, MD

The members of the Tarrant County Medical Society (TCMS) are proud to nominate their president, Angela Self, MD, for the position of alternate delegate to the Texas Medical Association’s (TMA’s) delegation to the American Medical Association (AMA).

Dr. Self received her medical degree from St. George’s University School of Medicine and completed her internal medicine residency at Saint Paul University Hospital in Dallas, Texas. She has practiced internal medicine for almost 20 years in various capacities including in a private general internal medicine practice with a focus on geriatrics, and as a hospice physician, skilled nursing physician, hospitalist, and managed care executive administrator. Dr. Self is board certified by the American Board of Internal Medicine and a certified physician executive. She is currently serving as a senior director at Southwestern Health Resources.

Organized medicine has always been a priority for Dr. Self. When in medical school, she co-founded St. George’s Emergency Medicine Club. This dedication carried over to her career: Dr. Self has been a longtime member of the AMA, TMA, TCMS, and the American Association for Physician Leadership.

Dr. Self is an active member of TCMS. Before beginning her current term as president, she served as secretary-treasurer, vice president, and president-elect. Dr. Self was a member of the Public Grievance Committee from 2004-07, has been a member of the Board of Advisors since 2014, and has served on the Women in Medicine Committee since its inception in 2016.

Dr. Self also served as a leader in other medical organizations. She was on the Baylor Regional Medical Center Bylaws Committee from 2003-05, and served on the Ethicus Hospital Pharmacy and Therapeutics Committee from 2012-14 and has been a member of the Emergency Physician Advisory Board since 2017.

We need passionate leaders who are dedicated to patient and physician advocacy in TMA’s delegation to the AMA. Dr. Self has both the background and the determination to be an asset in this role.

Personal Statement: “I am an advocate for a high standard of medical care, which is synonymous with
patient advocacy. Through education, collaboration, and tight association (organized medicine), I believe we can raise the standard of care. My vision is to increase access to care for the most vulnerable in our society and ensure they are able to exercise their patient rights. I am willing to commit my time and effort to the initiatives that are ongoing at the American Medical Association and stand with my fellow physicians to make a better, more affordable, and more equitable health care system for our patients and our families.”

PROFILE
Specialty: Internal Medicine
Medical School: St. George’s University School of Medicine, 1994-98
Internship: Medical College of Virginia, 1998-99
Residency: Saint Paul University Medical Center, Dallas, Texas, 2000-02
Board Certification(s): American Board of Internal Medicine
Primary Residence (City, State): Grapevine, Texas

What is your current practice status: Physician Volunteer at Cornerstone Assistance Network, Fort Worth
  • Administrative: government, health plan, or health-related, but no direct patient care, 95%
  • Direct Patient Care: non-profit corporation [formerly 5.01(A) corporation], 5%

Employer/Employment Location: Southwestern Health Resources, Dallas, Texas

Do you expect to maintain your current employment status and location through your term of office? Yes

Does your current employment situation require you to work outside of Texas? No

Including the past 5 years, list all other organizations from which you have received payment, reimbursement, or financial consideration for consulting, advisory, or leadership responsibilities exceeding $1,000/year in excess of actual expenses: None

Have you been convicted of a felony or is your medical license restricted? No

What TMA positions have you held?

Current
Delegate, Tarrant County Medical Society Delegation to TMA
Member, Patient-Physician Advocacy Committee

Past
Alternate Delegate, Tarrant County Medical Society Delegation to TMA
2020 Audit Trail
Awards/nominations, amendments to the Constitution and Bylaws, and policy review recommendations are not included.

FROM REFERENCE COMMITTEE ON FINANCIAL AND ORGANIZATIONAL AFFAIRS:

BOT Report 9 2020 – Online Communications Policy for TMA Physician Leaders. That TMA adopt the
Online Communications Policy for Texas Medical Association Physician Leaders. Adopted as amended.

REFERRED TO: Add to policy compendium.
STATUS: 295.017 Online Communications Policy for TMA Physician Leaders added to TMA Policy Compendium.

WIM Report 1 2020 – Women in Medicine Operating Procedures Changes. 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.

REFERRED TO: (1) Office of the EVP and (2) Council on Constitution and Bylaws
STATUS: (1) Women Physicians Section Operating Procedures have been filed with
the Office of the EVP; and (2) The TMA Bylaws have been amended to
reflect the section’s name change from “Women in Medicine Section” to
“Women Physicians Section.”

C-SPH Report 1 2020 – Recommendation for the Laurance N. Nickey, MD Award. 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.

REFERRED TO: Council on Science and Public Health
STATUS: (1) The Council on Science and Public Health created the Laurance N.
Nickey, MD, Lifetime Achievement Award; and (2) The Council on
Science and Public Health plans on calling for nominations, sorting through
applications, and selecting the next Laurance N. Nickey, MD, Lifetime
Achievement Award recipient in three to five years since the last award in
2020, which will be in 2023-2025.

Legislation to Allow Physicians to Dispense Pharmaceuticals, be reaffirmed in lieu of Resolution 107-A-19.
Adopted.

REFERRED TO: Add to policy compendium.
<table>
<thead>
<tr>
<th>Status</th>
<th>Title</th>
<th>Description</th>
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<tbody>
<tr>
<td>Status</td>
<td>95.034 Legislation to Allow Physicians to Dispense Pharmaceuticals</td>
<td>reaffirmed in Policy Compendium.</td>
</tr>
<tr>
<td>Status</td>
<td>BOT Report 10 2020 – Establish a Coalition of Medical Societies to Protect Competition and sustainability in the Health Insurance Marketplace, Resolution 106-A-19</td>
<td>That TMA not adopt Resolution 106-A-19, Establish a Coalition of Medical Societies to Protect Competition and Sustainability in the Health Insurance Marketplace. <strong>Tabbed to 2021.</strong></td>
</tr>
<tr>
<td>Status</td>
<td>BOT Report 12 2020 – Physicians in Employed Settings</td>
<td>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. <strong>Tabbed to 2021.</strong></td>
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<tr>
<td>Status</td>
<td>CM-M Report 2 2020 – New Telemedicine TMA Dues Category</td>
<td>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. <strong>Tabbed to 2021.</strong></td>
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<td>Status</td>
<td>Resolution 101 2020 – The Creation of an Independent Physician Section</td>
<td>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. <strong>Tabbed to 2021.</strong></td>
</tr>
<tr>
<td>Status</td>
<td>Resolution 102 2020 – Expansion of TMA Ambassador Program</td>
<td>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. <strong>Tabbed to 2021.</strong></td>
</tr>
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<td>Status</td>
<td>Resolution 103 2020 – A Systematic and Precise Method for AMA Public Endorsements of Proposed Legislation</td>
<td>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. <strong>Tabbed to 2021.</strong></td>
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</tbody>
</table>
Resolution 104 2020 – The Term Physician Should Be Used Rather Than Provider. 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 for action with report back.

REferred to: TMA Board of Trustees

STATUS: In lieu of adopting resolution 104, the board reaffirmed existing TMA policy 245.002. Policy 245.002 reaffirmed in Policy Compendium.


Resolution 105 2020 – Supporting Proportionate Representation of Special Interest Groups. 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.

STATUS: Tabled to 2021. Withdrawn by authors.

Resolution 106 2020 – Physician and Medical Student Promotion in Exchange for Gifts on Social Media. 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.

STATUS: Tabled to 2021. Withdrawn by authors.

Resolution 107 2020 – Educating Physicians on the Rights of Immigrant Patients. 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 – 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. 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.

FROM REFERENCE COMMITTEE ON MEDICAL EDUCATION AND HEALTH CARE QUALITY:

C-ME Report 1 2020 – Amendment to Policy 185.023 Support of Rural. 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.

REFERRED TO: Add to policy compendium and Council on Legislation.

STATUS: 185.023 Support of Rural Residency Training and State Grant Program for Promoting Rural Training Tracks amended in Policy Compendium. TMA is communicating these new policies to state legislators through letters and one-pagers during the 2021 Texas Legislative Session.

C-ME Report 3 2020 – Opposition to Diversion of Medicare Funding for Graduate Medical Education From Physicians to Training Programs for Midlevel Practitioners. 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.

REFERRED TO: (1) Add to policy compendium; and (2) Texas Delegation to the AMA

STATUS: (1) 205.039 Opposition to Diversion of Medicare Funding for GME to Training Programs for Midlevel Practitioners added to Policy Compendium; and (2) TMA’s Council on Medical Education communicated this policy to the AMA House of Delegates at the Special November Meeting 2020 through online testimony.


REFERRED TO: Add to policy compendium.

STATUS: 205.040 Support for Interest-Free Deferment of Education Loans for Residents in Training added to Policy Compendium.


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


REferred to: Add to policy compendium and Council on Legislation.

Status: 200.047 Clinical Training Resources for Texas Medical Students amended in Policy Compendium. TMA is communicating these new policies to state legislators through letters and one-pagers during the 2021 Texas Legislative Session.

C-ME Report 5 2020 – Amendment of Policy 320.007 Town Gown Medical School Funding. That policy 320.007, Town Gown Medical School Funding, be amended. Adopted.

Referred to: Add to policy compendium.

Status: 320.007 Town Gown Medical School Funding amended in Policy Compendium.


Referred to: Add to policy compendium and Council on Medical Education.

Status: 265.031 Promoting Education of Sexual Orientation and Gender Identity Health Issues in Academic Health Centers added to Policy Compendium. TMA sent a letter to Texas medical school deans to inform them of this new TMA policy.


Resolution 201 2020 – Augmented Intelligence (AI) in Health Care. 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 – Admission of Deferred Action for Childhood Arrivals (DACA) Students in Texas Medical Schools. 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 – Supporting Implicit Bias Training for Perinatal Physicians. 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 – Promoting Careers in Geriatrics Among Medical Students. 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.**

**STATUS:** **TABLED TO 2021.** See Resolution 209 2021 in Handbook.

Resolution 205 2020 – Service Animal Assisted Therapy in Healthcare. 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.**

**STATUS:** **TABLED TO 2021.** See Resolution 203 2021 in Handbook.

Resolution 206 2020 – Amending the Mental Health Question on Physician Licensure Application to Reflect Current Impairment. 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.**

**STATUS:** **TABLED TO 2021.** See Resolution 210 2021 in Handbook.

FROM REFERENCE COMMITTEE ON SCIENCE AND PUBLIC HEALTH:

C-SPH Report 4 2020 – Requirement for Food Allergy Posters and Employee Training in Food Establishments, Resolution 304-A-19. 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.**

**REFERRED TO:** Add to TMA policy compendium.

**STATUS:** 260.115 Requirement for Food Allergy Posters and Employee Training in Food Establishments added to Policy Compendium.

CM-C Report 1 2020 – Addressing Cancer Health Disparities. 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.**

**REFERRED TO:** (1) Add to policy compendium; and (2) Committee on Cancer

**STATUS:** (1) 50.012 Addressing Cancer Health Disparities added to Policy Compendium; and (2) TMA will hold an initial meeting of workgroup
representatives from interested councils and committees in Summer 2021 to complete the research required to develop comprehensive policy on disparities in health care.

Joint Report 2 2020 – Regulation of Electric Scooters, Resolution 308-A-19. 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.

REFERRED TO:  Council on Science and Public Health

STATUS: The Council on Science and Public Health is currently developing a policy for electronic scooters, to potentially include electronic bikes and other electronic modes of transportation, for submission at TexMed 2022.

C-SPH Report 3 2020 – Improving Medical Clearance Policies for Traumatic Brain Injury Patients, Resolution 303-A-19. 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 – Allow the Possession and Administration of an Epinephrine Auto-Injector in Certain Entities, Resolution 305-A-19. 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 – Regulatory Recommendations for Bed Bugs, Resolution 307-A-19. 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.**

**STATUS:** Tabled to 2021. See Joint Report 1 2021 in Handbook.

**Resolution 301 2020 – Advocating Against Electronic Nicotine Delivery Systems (ENDS).** 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.**

**STATUS:** Tabled to 2021. See Resolution 312 2021 in Handbook.

**Resolution 302 2020 – Elimination of Human Abuse and Persecution.** 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.**

**STATUS:** Tabled to 2021. See Resolution 313 2021 in Handbook.

**Resolution 303 2020 – Use of Human Tissue for Beneficial Applications.** 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.**

**STATUS:** Tabled to 2021. See Resolution 316 2021 in Handbook.

**Resolution 304 2020 – Improving Physician Access to Immigrant Detention Facilities.** 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.**

**STATUS:** Tabled to 2021. See Resolution 322 2021 in Handbook.

**Resolution 305 2020 – Suicide Prevention Education in Medical School.** 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 – Facilitating Brain and other Postmortem Tissue Donation for Research and Educational Purposes. 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 – Decommissioning Existing and Not Constructing New Wastewater Treatment Plants in or Near Flood Plains and Waterways. 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 – Recurrent Flooding in Texas Must Be Resolved. 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 – Education and Action to Arrest the Effects of Climate Change on Health. 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 – Access to Direct-acting Antiviral Therapy for Texas Medicaid Beneficiaries Infected with Hepatitis C. 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 – Advocating for the Improvement of Access to Mental Health Services Among Minority Teens. 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.**

**STATUS:** **TABLED TO 2021.** See Resolution 302 2021 in Handbook.

**Resolution 312 2020 – Support for the Texas-CARES Program.** 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.**

**STATUS:** **TABLED TO 2021.** See Resolution 319 2021 in Handbook.

**Resolution 313 2020 – Advocating for Increased Capacity of Local State Mental Health Facilities and
Coordination of Behavioral Health Services.** 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.**

**STATUS:** **TABLED TO 2021.** See Resolution 419 2021 in Handbook.

**Resolution 314 2020 – Required Platelet Products at a Facility in Maternal Levels of Care Designation.**
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.**

**STATUS:** **TABLED TO 2021.** See Resolution 324 2021 in Handbook.

**Resolution 315 2020 – Designating Texas Hospitals as Sensitive Locations.** 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.**

**STATUS:** **TABLED TO 2021.** See Resolution 303 2021 in Handbook.

**Resolution 316 2020 – Concurrent Prescribing of Opioid Antagonists with Opioid Prescriptions.** 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.**

**STATUS:** **TABLED TO 2021**
Resolution 317 2020 – Employee Rights to Lactation Accommodation. 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.**

**STATUS:**
 **TABLED TO 2021.** See Resolution 325 2021 in Handbook.

Resolution 318 2020 – Updating Texas Medical Association Teenage Sexual Health Guidelines. 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.**

**STATUS:**
 **TABLED TO 2021.** See Resolution 304 2021 in Handbook.

Resolution 319 2020 – Supporting an Opt-Out Organ, Eye, and Tissue Donation System in Texas. 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.**

**STATUS:**
 **TABLED TO 2021.** See Resolution 305 2021 in Handbook.

Resolution 320 2020 – Maternal Health and Postpartum Depression Screening. 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.**

**STATUS:**
 **TABLED TO 2021.** See Resolution 306 2021 in Handbook.

Resolution 321 2020 – Saving Energy, Reducing Costs and Increasing Efficiency in Medical Practices. 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.**

**STATUS:**
 **TABLED TO 2021.** See Resolution 307 2021 in Handbook.

Resolution 322 2020 – Recommendation for the Use of Low Titer Group O Whole Blood for Hemorrhagic. 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.**

**STATUS:**
 **TABLED TO 2021.** Withdrawn by authors.

Resolution 323 2020 – Recognizing the Effect of Climate Change on Public Health. 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.**

**STATUS:** **TABLED TO 2021.** See Resolution 353 2021 in Handbook.

**Resolution 324 2020 – Mandatory Waiting Period for Firearm Purchases.** That TMA advocate for mandatory waiting periods following the purchase of firearms to reduce firearm-related injuries and deaths. **Tabled to 2021.**

**STATUS:** **TABLED TO 2021.** See Resolution 308 2021 in Handbook.

**Resolution 325 2020 – Promoting and Improving Health Literacy.** 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.**

**STATUS:** **TABLED TO 2021.** See Resolution 309 2021 in Handbook.

**Resolution 326 2020 – Pediatric Iron Deficiency Anemia Treatment and Diagnosis Guidelines.** 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.**

**STATUS:** **TABLED TO 2021.** See Resolution 326 2021 in Handbook.

**Resolution 327 2020 – Improving Access to Immediate Postpartum Long-Acting Reversible Contraception for Adolescents.** 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.**

**STATUS:** **TABLED TO 2021.** See Resolution 310 2021 in Handbook.

**Resolution 328 2020 – Lowering the Legal Age for Minors to Access Contraceptive Services.** 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.**

**STATUS:** **TABLED TO 2021.** See Resolution 311 2021 in Handbook.

**Resolution 329 2020 – Flu Vaccinations in Immigrant Holding Facilities at the Border.** 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.**

**REFERRED TO:** TMA Board of Trustees.

**STATUS:** After recommendations from the Council on Science and Public Health, in lieu of adopting Resolution 329 in its entirety, the board approved adopting the second resolve of Resolution 329, “That our TMA acknowledge the importance of vaccinations for the health immigrants in holding facilities on the border, which can also directly affect the health of Texas citizens.”

The board approved also that the TMA delegation to the AMA support AMA’s efforts calling for better federal oversight to provide appropriate infectious disease prevention and control, including vaccinations for immigrants in holding facilities.

135.027 Vaccinations in Immigrant Holding Facilities at the Border added to TMA Policy Compendium.


**Resolution 330 2020 – Expanding Access to Regularly-Scheduled Dialysis for All Individuals with ESRD.** 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;
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.**

**STATUS:** **TABLED TO 2021.** See Resolution 327 2021 in Handbook.

**Resolution 331 2020 – Incorporating Helmet Safety Education to Texas Elementary Schools.** 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.**

**REFERRED TO:** TMA Board of Trustees

**STATUS:** The board referred Resolution 331 to the Council on Science and Public Health. The council recommended, and the board adopted, amending TMA Policy 55.021 Bicycle Helmets to the following language:

**TMA Policy 55.021 Bicycle Helmets:** The Texas Medical Association supports the use of bicycle helmets certified by the U.S. Consumer Products Safety Commission, by Texans of all ages and passage of a law mandating approved helmet use for all cyclists. TMA encourages physicians to be informed about the benefits of helmet use, particularly for elementary school-age cyclists, and to promote evidence-based, best practices regarding helmet safety education to school and community safety advisory committees.
FROM REFERENCE COMMITTEE ON SOCIOECONOMICS:

BOT Report 11 2020 – Principles for Community-Based Accountable Care Organization. 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.

REFERRED TO: (1) Add to TMA policy compendium (2) Workgroup on Value-Based Initiatives and Select Committee on Medicaid, CHIP, and the Uninsured

STATUS: (1) 115.021 Principles for Community-Based Accountable Care Organizations added to Policy Compendium; and (2) The Workgroup on Value-Based Initiatives and Select Committee on Medicaid, CHIP, and the Uninsured have presented the principles to the Texas Health and Human Services Commission, state lawmakers, and external stakeholders with an interest in the model. TMA will continue to advocate for inclusion of the model as part of its efforts to ensure low-wage Texans and their families have access to meaningful, comprehensive health care coverage.

CM-RH Report 1 2020 – Studying Financial Barriers of Rural Hospitals, Resolution 414-A-19. 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.

REFERRED TO: (1) Add to TMA policy compendium; and (2)-(8) Council on Legislation and Council on Socioeconomics and Committee on Rural Health

STATUS: (1) 190.032 Medicaid Coverage and Reform reaffirmed in Policy Compendium; and (2)-(8) Since adoption of Report CM-RH 1 at TexMed 2020, TMA collaborated with rural health stakeholders, including the Texas Academy of Family Physicians and Texas Organization of Rural and Community Hospitals, to advocate for implementation of the report’s recommendations to address the high risk of rural hospital closures in Texas and improve physician practice viability. During the 2021 legislative session, TMA will advocate for legislation to advance the association’s rural health policy, including reducing Texas’ uninsured rate, maintaining and expanding telehealth and telemedicine flexibilities, enhancing broadband access, funding physician loan repayment and educational grant programs, and improving rural hospital and physician payments.
CM-HIT Report 1 2020 – Data Migration Responsibilities of Electronic Health Records Vendors in Client Contract Termination, Resolution 411-A-19. 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.

REFERRED TO: Texas Delegation to the AMA

STATUS:

BOT Report 13 2020 – Compensation to Physicians for Activities Other Than Direct Patient Care. 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 – Opposition to New Federal Public Charge Definition. 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 – Legislative Changes Regarding Vacating Orders. 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 – Insurance Coverage Transparency. 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.**

**STATUS:** **TABLED TO 2021.** See Resolution 428 in Handbook.

**Resolution 402 2020 – Need for and Funding of Level I and II Trauma Centers.** 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.**

**STATUS:** **TABLED TO 2021.** See Resolution 402 2021 in Handbook.

**Resolution 403 2020 – Taxes on Medical Billing Services.** 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.**

**STATUS:** **TABLED TO 2021.** See Resolution 409 2021 in Handbook.

**Resolution 404 2020 – Individual Physicians Be Paid While Awaiting Credentialing Approval.** 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.**

**STATUS:** **TABLED TO 2021.** See Resolution 410 2021 in Handbook.

**Resolution 405 2020 – Physicians to Retain Payment During Credentialing.** 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.**

**STATUS:** **TABLED TO 2021.** See Resolution 411 2021 in Handbook.

**Resolution 406 2020 – Physicians’ Salary Survey.** 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.**

**STATUS:** **TABLED TO 2021.** See Resolution 109 2021 in Handbook.

**Resolution 407 2020 – Compensation to Physicians for Activities Other Than Direct Patient Care.** 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 – Contracted Health Plans Must Apply the Same Level of Benefits Concerning Patient Responsibility. 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 – School Physicals Should Be Conducted by Physicians or Their Supervised Designee. 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 – Utilization Review, Medical Necessity Determination, Prior Authorization Decisions. 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 – Prior Authorizations. 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.

REFERRED TO: TMA Board of Trustees

STATUS: The board referred this resolution to the Task Force on Prior Authorization. The task force met twice in 2020 to discuss the need for a wide variety of prior authorization reforms. The task force’s legislative recommendations
have been incorporated into TMA’s legislative agenda for the 87th Session of the Texas Legislature. While the task force has not pursued directly the resolution in Resolution 411, it has taken a multi-pronged approach directed at reducing the number and burden of prior authorizations in Texas. The board approved that in lieu of Resolution 411, TMA continue to pursue these ongoing legislative reforms formulated by the Taskforce on Prior Authorization to decrease the burden and negative impact of prior authorization related to state-regulated health plans.


Resolution 412 2020 – Step-Edit Therapy Contributes to Denial of Care and Has Not Demonstrated Improved Patient Outcomes or Overall Cost Savings. 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 – Caps on Insulin Copayments with Insurance. That TMA support limiting the copayments insured patients pay 38 per month for prescribed insulin. Tabled to 2021.


Resolution 414 2020 – Postpartum Maternal Healthcare Coverage Under Children’s Insurance. 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 – Promotion of LGBTQ+ friendly and Gender-Neutral Options on Medical Documentation and Intake Forms. 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.

STATUS: TABLED TO 2021

Resolution 416 2020 – Interstate Medical Malpractice Tort Protection for Physicians Treating Patients in Neighboring States. 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. **Referred for action with report back.**

**REFERRED TO:** TMA Board of Trustees

**STATUS:** The board referred Resolution 416 to the Council on Socioeconomics. The council discussed how this resolution applies nationally and recommended rewording the language in the second resolve to call on the AMA to take action and create a model bill for other states to consider. The council also recommended rewording the language in the first resolve for readability:

RESOLVED, The Texas Medical Association recognize that the appropriate legal forum for medical professional liability claims is in the state where the patient received the medical care rendered; and be it further 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 create model legislation and support corrective legislation to assure that the appropriate legal forum for medical liability claims is in the state where the patient received the medical care rendered. 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.

Acting upon the recommendation of the council, the board approved adopting the resolution language as amended.

170.014 Interstate Medical Malpractice Tort Protection for Physicians Treating Patients in Neighboring States added to Policy Compendium.


**Resolution 417 2020 – Insurance Promotion of Preventive Care Services via Incentive-Based Programs.** 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.**

**STATUS:** **TABLED TO 2021.** See Resolution 403 2021 in Handbook.

**Resolution 418 2020 – Paid Parental Leave.** 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 – Placing Medicaid Expansion on a Statewide Voting Ballot. 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. Referenced for action with report back.

REFERRED TO: TMA Board of Trustees

STATUS: Regarding placing Medicaid expansion on a statewide voting ballot: Texas law does not allow voters to bring ballot initiatives forward for consideration. Instead, the Texas Legislature must pass a constitutional amendment for voters to have the opportunity to consider the question. The board approved that TMA continue its advocacy efforts on Medicaid expansion, and that Resolution 419 not be adopted. See BOT Report 13 2021 in Handbook.

Resolution 420 2020 – Training Requirements Imposed by Insurance Companies Preventing Patients’ Access to Quality Medical Care. 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 – Physician Societies to Create a Self-Funded, Balanced and Nonpartisan Center for the Study of Healthcare Reform. 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 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 – Develop Guidelines for Proper Oversight and Collaboration of Mid-Level Providers by Physicians. 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 – A Push for Mobile-First Design Principles within Medical IOT (Internet of Things) Interfaces. 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.

STATUS: TABLED TO 2021

Resolution 424 2020 – Adoption of Principles of Physician Value-Based Decision-Making in Medical Practice and Professionalism. 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 – Plastic Surgery Board-Certification. 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.

STATUS: TABLED TO 2021. Withdrawn by authors.

Resolution 426 2020 – Results and Regulation of Freestanding Birthing Centers and at Home Birthing Services. 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 – Adjustments to Hospice Dementia Enrollment Criteria. 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.

Agendas
TEXAS MEDICAL ASSOCIATION
2021 HOUSE OF DELEGATES ANNUAL SESSION

OPENING SESSION
Thursday, April 29, 2021
(Prerecorded)

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

2. National Anthem and Pledge of Allegiance

3. Invocation
   TBA

4. Board of Trustees Annual Association Finances Report
   Gary W. Floyd, MD, chair, BOT

5. Council on Legislation Update
   Debra A. Patt, Chair

6. Distinguished Service Award
   William H. Fleming III, MD

7. Address of Texas Medical Association Alliance Presidents
   Martha Vijjeswarapu, Outgoing TMAA President
   Jennifer Hailey Lewis, Incoming TMAA President

8. Address of Texas Medical Association President
   Diana L. Fite, MD, TMA President

9. Recognition of MSS, RFS, IMG, and YPS Award Recipients
   Bradford Holland, MD, Vice Speaker

10. Presentation of TMA-Established Organizations (video-taped)
    Texas Medical Liability Trust
        Robert D. Donohoe, President and CEO
    TEXPAC
        Bradford Patt, MD, Chair, Board of Directors
    Texas Medical Association Foundation
        Susan M. Pike, MD, President
    Texas Medical Association Insurance Trust Board of Trustees

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

2. Technology Orientation  
   Arlo F. Weltge, MD, Speaker

3. Introductions  
   Arlo F. Weltge, MD, Speaker

4. Report of Teller and Credentials Committee  
   Vani S. Vallabhaneni, MD, Chief Teller

5. Announcements and Voting Test  
   Arlo F. Weltge, MD, Speaker

6. Approval of September 12, 2020 Minutes  
   Michelle A. Berger, MD, Secretary/Treasurer

7. Election of Incoming President’s Council Nominations (by consent)  
   Arlo F. Weltge, MD, Speaker

8. Initial Call for Extractions  
   Arlo F. Weltge, MD, Speaker

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

10. TMA President Address  
    Diana L. Fite, MD, TMA President

11. Moment of Silence  
    Arlo F. Weltge, MD, Speaker

12. Projection of What Has Been Extracted

13. Reference Committee Reports  
    Arlo F. Weltge, MD, Speaker  
    Bradford Holland, MD, Vice Speaker

14. Distinguished Service Award (11 am)  
    William H. Fleming III, MD, TMA Past President  
    Introduction by Gary Sheppard, MD

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

2. Report of Teller and Credentials Committee
   Vani S. Vallabhaneni, MD, Chief Teller

3. Projection of What Has Been Extracted

4. Reference Committee Reports, Continued
   Arlo F. Weltge, MD, Speaker
   Bradford Holland, MD, Vice Speaker

5. Election Results
   Arlo F. Weltge, MD, Speaker

6. Installation of TMA
   E. Linda Villarreal, MD, TMA President

7. Adjourn
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES
ORDER OF BUSINESS
2021 TexMed
May 14-15, 2021

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

REPORTS:
1. Reports of Speakers
   1. Amending Policy 295.013 Election Process
   2. Amending TMA Constitution Article V House of Delegates
      and TMA Bylaws Chapter 3 House of Delegates

2. Reports of Board of Trustees
   1. 2020-21 Board Officers and Committees
   2. Disclosure of Affiliations
   3. TMA Insurance Trust, TMF Health Quality Institute, and
      Texas Medical Liability Trust
   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
   8. Audit of 2019 Financial Statements and 2020-21 Operating Budgets
   9. Investments
   10. Sunset Review of TMA Standing Committees
   11. The Term Physician Should Be Used Rather Than Provider, Resolution 104 2020
   12. Flu Vaccinations in Immigrant Holding Facilities at the Border, Resolution 329 2020
   13. Placing Medicaid Expansion on a Statewide Voting Ballot, Resolution 419 2020
   14. Prior Authorizations, Resolution 411 2020
   15. Interstate Medical Liability Tort Protection for Physicians Treating Patients in
      Neighboring States, Resolution 416 2020
   16. Establish a Coalition of Medical Societies to Protect Competition and Sustainability
   17. Physicians in Employed Settings (Tabled BOT Report 12 2020)
   18. Compensation to Physicians for Activities Other Than Direct
      Patient Care (Tabled BOT Report 13 2020)
   19. Incorporating Helmet Safety Education Into Texas Elementary Schools, Resolution 331 2020
   20. Nominations for Board of Governors, Texas Medical Liability Trust
   21. TMA Social Media Conduct Policy

3. Report of Committee on Membership

4. Reports of Board of Councilors
   1. Emeritus Nominations
   2. Honorary Nominations
      (Tabled BOC Report 4 2020)
5. Reports of Committee on Physician Health and Wellness
   1. Educational Activities

6. Reports of Texas Delegation to the AMA
   1. AMA House of Delegates Meetings in 2020
   2. AMA Membership, Representation, and Delegation Leadership

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

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

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

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

11. Report of Women Physicians Section
    1. Women Physicians Section Update

12. Reports of Council on Constitution and Bylaws
    1. Amendment to Bylaws to Remove “Spring” Requirement for the Annual Session
    2. Amendments to Bylaws to Establish an Application and Appeal Process for At-Large Members, and to Clarify the Disciplinary Process for Small County Medical Societies
    3. Amendments to Bylaws to Allow Two-Year Terms for County Medical Society Officers
    4. Amendment to Bylaws to Tie Council Meeting Requirements to the TMA Session Year
    5. Amendments to Bylaws to Allow Sections to Determine Members’ Right to Vote and Hold Office
    6. Amendments to Bylaws to Update and Clarify Existing Language
    7. Amendments to Bylaws to Allow Use of Virtual Platforms, In-Person Voting
    8. Amendments to Article V of the TMA Constitution

13. Reports of Council on Health Care Quality
    1. Council on Health Care Quality Update
    2. Sunset Policy Review

14. Reports of Council on Medical Education
    1. Sunset Policy Review
    2. Referral of Resolution 202-A-18 Addressing Gender Bias in Undergraduate
    3. Developing Best Practices for Educating Medical Students and Residents during a Pandemic or Other Extended Catastrophic Event Medical Education and Implicit Bias Training
    4. Status of Graduate Medical Education Capacity in Texas
    5. Opposition to Nonphysician Practitioners Serving as Attending Physicians of Residency and Fellowship Programs
    6. Support for Acceptance of DACA Recipients to Texas Medical Schools
    7. Update to TMA Policies on Advanced Practice Registered Nurses
    8. Recognizing Charles E. Cowles, Jr., MD

15. Report of Committee on Continuing Education
1. Texas Medical Association Continuing Medical Education Program Update  
2. Requiring All Texas Licensed Physicians to Pass Texas Medical Jurisprudence Exam  
3. 2021 Texas Physician Workforce Update  
4. Renewed Effort to Increase Diversity Among the Texas Physician Workforce

1. Sunset Policy Review

18. Reports of Council on Science and Public Health
1. Sunset Policy Review

19. Report of Committee on Cancer
1. Sunset Policy Review

20. Report of Committee on Child and Adolescent Health
1. Sunset Policy Review

21. Reports of Committee on Emergency Medical Services and Trauma
1. Cardiac Arrest as a Reportable Condition
2. Recommendation on Emergency Department Diversion and Saturation Policy

22. Report of Committee on Infectious Diseases
1. Sunset Policy Review

23. Report of Committee on Reproductive, Women’s, and Perinatal Health
1. Sunset Policy Review

24. Reports of Council on Socioeconomics
1. Activities of the Council on Socioeconomic
2. Sunset Policy Review
3. Opposition to New Federal Public Charge Definition

25. Reports of Committee on Medical Home and Primary Care
1. Sunset Policy Review
2. Medical Home and Primary Care Activities Update

26. Reports of Patient-Physician Advocacy Committee
1. Patient-Physician Advocacy Update
2. Sunset Policy Review
3. Legislative Changes Regarding Vacating Orders

27. Reports of Committee on Rural Health
1. Sunset Policy Review
2. Rural Health Activities Update
28. Report of TEXPAC
   1. Texpac Updates

29. Report of Texas Medical Association Foundation
   1. 2020 Texas Medical Association Foundation Annual Report

30. Report of TMF Health Quality Institute
   1. TMF Health Quality Institute Annual Report

31. Report of Texas Medical Association Alliance
   1. Texas Medical Association Alliance Activities and Accomplishments

32. Joint Report of Committee on Infectious Diseases and Council on Science and Public Health
      (Tabled Joint Report 3 2020) SPH

33. Report of LGBTQ Health Section
   1. LGBTQ Health Section Update

RESOLUTIONS:

101. The Creation of an Independent Physician Section (Tabled Res 101 2020) FOA
102. Expansion of the Texas Medical Association Ambassador Program (Tabled Res 102 2020) FOA
103. A Systematic and Precise Method for AMA Public Endorsements of Proposed Legislation
      (Tabled Res103 2020) FOA
104. 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 (Tabled Res 108 2020) FOA
105. Virtual Option for Delegates at Future Meetings FOA
106. Creation of Ad Hoc Committee to Study and Make Recommendations Concerning
      Non-Compete Agreements in Physician Employment Contracts FOA
      (Tabled Res 410 2020) FOA
108. Paid Sick Leave Policies FOA
110. Encouraging ADA Compliance on Virtual Platforms FOA
111. RESOLUTION 111 DELETED BECAUSE IT WAS A DUPLICATE FOR RESOLUTION 106.
      WE APOLOGIZE FOR THE ERROR. FOA
112. One Hundredth Anniversary of the Texas Pediatric Society FOA
113. Composition of Hospital Ethics Committees FOA
114. Noncompete Clauses Within Physician Contracts FOA
201. Admission of Deferred Action for Childhood Arrivals (DACA) Students in Texas Medical Schools
      (Tabled Res 202 2020) MEHCQ
202. Supporting Implicit Bias Training for Perinatal Physicians (Tabled Res 203 2020) MEHCQ
203. Service Animal Assisted Therapy in Health Care (Tabled Res 205 2020) MEHCQ
204. Defining What Constitutes Proper Use of the Terms “Residency” and “Fellowship” When
      Referring to Specialty Training MEHCQ
205. Skin of Color Representation in Medical Education and Research MEHCQ
206. Develop Guidelines for Proper Oversight of and Collaboration With Midlevel Practitioners
      by Physicians (Tabled Res 422 2020) MEHCQ
207. Suicide Prevention Education in Medical School (Tabled Res 305 2020) MEHCQ
208. Facilitating Brain and Other Postmortem Tissue Donation for Research and Educational Purposes (Tabled Res 306 2020) MEHCQ
209. Promoting Careers in Geriatrics Among Medical Students (Tabled Res 204 2020) MEHCQ
210. Amending the Mental Health Question on the Physician Licensure Application to Reflect Current Impairment (Tabled Res 206 2020) MEHCQ
211. Medical School Compliance with the Americans With Disabilities Act MEHCQ
212. Support Addressing, Screening, and Providing Healthy Coping Mechanisms for Burnout MEHCQ
213. Access to Direct-acting Antiviral Therapy for Texas Medicaid Beneficiaries Infected With Hepatitis C (Tabled Res 310 2020) SPH
214. Advocating for the Improvement of Access to Mental Health Services Among Minority Teens (Tabled Res 311 2021) SPH
215. Designating Texas Hospitals as Sensitive Locations (Tabled Res 315 2020) SPH
216. Updating Texas Medical Association Teenage Sexual Health Guidelines (Tabled Res 318 2020) SPH
218. Maternal Health and Postpartum Depression Screening (Tabled Res 320 2020) SPH
220. Mandatory Waiting Period for Firearm Purchases (Tabled Res 324 2020) SPH
221. Promoting and Improving Health Literacy (Tabled Res 325 2020) SPH
222. Improving Access to Immediate Postpartum Long-Acting Reversible Contraception for Adolescents (Tabled Res 327 2020) SPH
223. Lowering the Legal Age for Minors to Access Contraceptive Services (Tabled Res 328 2020) SPH
224. Advocating Against Electronic Nicotine Delivery Systems (ENDS) (Tabled Res 301 2020) SPH
225. Elimination of Human Abuse and Persecution (Tabled Res 302 2020) SPH
226. Promoting Safe and Effective Disposal of Polystyrene Foam Medication Case(s) With or Without Ice Packs SPH
227. Possible Upcoming Shortage of Fentanyl and Other Opioid Injections SPH
228. Use of Human Tissue for Beneficial Applications (Tabled Res 303 2020) SPH
229. Decommissioning Existing and Not Constructing New Wastewater Treatment Plants in or Near Flood Plains and Waterways (Tabled Res 307 2020) SPH
230. Recurrent Flooding in Texas Must Be Resolved (Tabled Res 308 2020) SPH
231. Support for the Texas-CARES Program (Tabled Res 312 2020) SPH
232. Impact of Social Networking Services on the Health of Adolescents SPH
233. Restore and Add Funding to Public Health SPH
234. Improving Physician Access to Immigrant Detention Facilities (Tabled Res 304 2020) SPH
235. Education and Action to Arrest the Effects of Climate Change on Health (Tabled Res 309 2020) SPH
236. Required Platelet Products at a Facility in Maternal Levels of Care Designation (Tabled Res 314 2020) SPH
237. Employee Rights to Lactation Accommodation (Tabled Res 317 2020) SPH
238. Pediatric Iron Deficiency Anemia Treatment and Diagnosis Guidelines (Tabled Res 326 2020) SPH
239. Expanding Access to Regularly-Scheduled Dialysis for All Individuals with ESRD (Tabled Res 330 2020) SPH
240. Outreach and Education in Mixed-Status and Undocumented Communities Regarding Information Gathering and COVID-19 Vaccine Distribution SPH
241. In Support of Comprehensive Sexuality Education Reform SPH
242. In Support of Reevaluating the Use of Race in Estimated Glomerular Filtration Rate SPH
243. Support for Increasing Digital Access SPH
244. Opposition to Criminalization of Gender-Affirming Care for Transgender Youth SPH
245. Opposition to Sobriety Requirement for Hepatitis C Treatment SPH
246. Racism as a Public Health Issue SPH
247. Public Health and Health Care Protections While Incarcerated SPH
248. Results and Regulation of Freestanding Birthing Centers and at Home Birthing Services (Tabled Res 426 2020) SPH
337. Advocating for Evidence-Based Care for Incarcerated Pregnant Women in Texas Correctional Facilities

338. Support for Immunization Information System Interjurisdictional Data Exchange

339. Support for Texas Department of State Health Services Efforts to Address Racial and Ethnic Disparities in Health

340. Supporting the Health of Undocumented Immigrants During the COVID-19 Pandemic and Future Pandemics

341. Acknowledging Abortion is a Time-Sensitive Medical Procedure

342. Advocating for Increased Transparency at “Crisis Pregnancy Centers”

343. Study to Improve Healthcare Access and Care for Persons with Disabilities

344. Supporting Mature Minors Ability to Receive Vaccinations Without Parental Consent

345. TMA Statement on the Health Impact of Racism


347. Increasing Education Regarding the Effects of Bias and Discrimination on Patients Experiencing Homelessness

348. School Physicals Should Be Conducted by Physicians or Their Supervised Designee (Tabled Res 409 2020)

349. Reducing Intimate Partner Homicide

350. Restricting School Immunization Exemptions to Exemptions for Medical Reasons

351. Support of a Statewide Contact Tracing App

352. Mental Health Education in Schools

353. Recognizing the Effect of Climate Change on Public Health (Tabled Res 323 2020)

354. Addressing Race in Medicine

355. Support of Medical Student Health and Wellness

356. Support Statewide Planning and Communication for a Vaccine Plan During a Pandemic

401. Caps on Insulin Copayments with Insurance (Tabled Res 413 2020)


403. Insurance Promotion of Preventive Care Services via Incentive-Based Program (Tabled Res 417 2020)

404. Training Requirements Imposed by Insurance Companies Preventing Patients’ Access to Quality Medical Care (Tabled Res 420 2020)

405. Ensuring Medical Practice Viability Through Reallocation of Insurance Savings During the COVID-19 Pandemic


407. Ensuring That Telehealth Coverage Does Not Discourage Use of Local Physicians

408. Need for and Funding of Level I and Level II Trauma Centers (Tabled Res 402 2020)

409. Taxes on Medical Billing Services (Tabled Res 403 2020)

410. Individual Physicians Be Paid While Awaiting Credentialing Approval (Tabled Res 404 2021)

411. Physicians to Retain Payment During Credentialing (Tabled Res 405 2020)

412. Maintaining the Integrity of Physicians Orders in an Electronic Environment

413. Compensation to Physicians for Activities Other Than Direct Patient Care (Tabled Res 407 2020)

414. Contracted Health Plans Must Apply the Same Level of Benefits Concerning Patient Responsibility (Tabled Res 408 2020)

415. Paper Medical Record Chart Preparedness for Electronic Health Record Interruptions

416. Physician Societies to Create a Self-Funded, Balanced, and Nonpartisan Center for the Study of Health Care Reform (Tabled Res 421 2020)

417. Verbal Physicians Orders

418. Electronic Prescribing of Controlled Substances (EPCS) Unfunded Mandate and Pharma Financial Settlements

419. Advocating for Increased Capacity of Local State Mental Health Facilities and Coordination of Behavioral Health Services (Tabled Res 313 2020)
420. Step-Edit Therapy Contributes to Denial of Care and Has Not Demonstrated Improved Patient Outcomes or Overall Cost Savings (Tabled Res 412 2020)

421. Augmented Intelligence (AI) in Health Care (Tabled Res 201 2020)

422. Adjustments to Hospice Dementia Enrollment Criteria (Tabled Res 427 2020)

423. Insurance Coverage for Fertility Preservation Procedures for Cancer Patients Undergoing Gonadotoxic Therapy

424. Encourage the Establishment of an Express Lane Eligibility (ELE) Program in Texas


426. Support for Rural Labor and Delivery Departments

427. Limiting Out-of-Network Ground Ambulance Costs

428. Insurance Coverage Transparency (Tabled Resolution 401 2020)

429. Adoption of Principles of Physician Value-Based Decisionmaking in Medical Practice and Professionalism (Tabled Resolution 424 2020)

430. Paid Parental Leave (Tabled Resolution 418 2020)
Informational Reports
Report of Committee on Physician Health and Wellness
1. Educational Activities

Reports of Texas Delegation to the AMA
1. AMA House of Delegates Meetings in 2020
2. AMA Membership, Representation, and Delegation Leadership

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

Report of Medical Student Section
1. Medical Student Section Update

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

Report of Young Physician Section
1. Young Physician Section Update

Report of Women Physicians Section
1. Women Physicians Section Update

Report of Council on Health Care Quality
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Report of Committee on Continuing Education
1. Texas Medical Association Continuing Medical Education Program Update

Reports of Council on Socioeconomics
1. Activities of the Council on Socioeconomics

Reports of Patient-Physician Advocacy Committee
1. Patient-Physician Advocacy Update

Report of TEXPAC
1. TEXPAC Update

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1. 2020 Texas Medical Association Foundation Annual Report

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1. TMF Health Quality Institute Annual Report

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7. Pending Lawsuits Involving Texas Medical Association and Audit Trail
8. Audit of 2019 Financial Statements and 2020-21 Operating Budgets
9. Investments
11. The Term Physician Should Be Used Rather Than Provider, Resolution 104 2020
12. Flu Vaccinations in Immigrant Holding Facilities at the Border, Resolution 329 2020
13. Placing Medicaid Expansion on a Statewide Voting Ballot, Resolution 419 2020
14. Prior Authorizations, Resolution 411 2020
15. Interstate Medical Liability Tort Protection for Physicians Treating Patients in Neighboring States, Resolution 416 2020
19. Incorporating Helmet Safety Education Into Texas Elementary Schools, Resolution 331-2020
21. TMA Social Media Conduct Policy

Report of Committee on Medical Home and Primary Care
  2. Medical Home and Primary Care Activities Update

Report of Committee on Rural Health
  2. Rural Health Activities Update
REPORT OF COMMITTEE ON PHYSICIAN HEALTH AND WELLNESS

CM-PHW 1
2021

Subject: Educational Activities

Presented by: Sejal S. Mehta, MD, MBA, Chair

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**Background**

In 1976, the TMA House of Delegates established the Impaired Physicians Committee and charged it with studying the problem of impairment 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, with advanced understanding of physician health and wellness, the committee’s name was changed to the Committee on Physician Health and Wellness (PHW).

After an extensive evaluation of the program, the program’s charge was revised in 2019 and the committee’s function was outlined as such: 1) to promote healthy lifestyles in Texas to medical students, residents, and physicians, 2) to provide advocacy and support for education on physicians’ wellness, and 3) to promote prevention of potentially impairing conditions.

**Live Virtual Presentations and Online CME Courses**

PHW activities encourage medical students, resident physicians, and physicians to promote and nurture personal health and wellness, fostering healthy lifestyles in patients. Currently, 26 CME courses are available as live, virtual presentations and online courses. In 2020, 3,469 physicians participated in online education, and 853 physicians watched 16 live and virtual presentations.

In 2018, the PHW committee added free health and wellness presentations for medical students and residents. Since then, 13 presentations have been given, up from one in 2017.

In 2020, the education team reviewed and developed 11 courses, adding COVID-19 related information. In 2021-22, the committee’s education team will review and develop these 12 courses:

- Spirituality, Leadership and Values in The World of Medicine (formerly Spirituality and Medicine)
- Power Reimagined: The Positive Role Women Contribute to Medicine (formerly The Professional Landscape of Medicine)
- Aging and Retirement: Optimizing the Physician Workforce (formerly Aging and Retirement: Practice Dilemmas)
- Building Better Boundaries (formerly Challenges: Professional Boundaries and Patient Encounters)
- Navigating a Healthy Relationship with Anger (new)
- Role of Cultural Competence and Cultural Humility in Achieving Health Equity
- Get Moving! Improve Your Work-Life Balance (formerly Balance for Life)
- Beyond Substance Abuse: Exploring the Other Addictions (formerly Addictive Behavioral Disorders)
- Breathe, Relax, Heal (new)
- Enhancing Communication to Improve Patient Safety and Professional Satisfaction (formerly Effective Communication With Patients)
- Manifest Happiness (formerly Hardwiring Happiness)
• Optimal Cultures for Promoting Resilience and Well-Being (formerly Promoting Resilience and Well-Being in Our Work and Learning Environments)

Annual PHW Exchange
The inaugural Physician Health and Wellness Exchange occurred in 2019 at Baylor College of Medicine. Seven medical schools participated in the conference: Baylor, McGovern Medical School, Texas A&M College of Medicine, University of the Incarnate Word School of Osteopathic Medicine, The University of Texas Medical Branch School of Medicine, UT Health San Antonio Long School of Medicine, and UT Southwestern Medical School. Rice University also participated. Educational activities included a Think Tank discussion, CME programming, and a poster session. The 2020 PHW Exchange was canceled because of the pandemic. The next exchange will focus on overcoming obstacles to individual and organizational well-being.

Recent and Upcoming PHW Projects
An “In Memory” resolution was submitted to the Texas Legislature to honor the physicians and other members of the medical community who lost their lives to COVID-19 for reading on National Doctor’s Day, March 30. TMA sought co-sponsorship by the House and Senate physician members and Chairs of House Public Health and Senate Health and Human Services.

PHW will provide a comprehensive professional development CME program for physicians who have received disciplinary orders from the Texas Medical Board (TMB). The committee’s charge includes “prevention of potentially impairing conditions.” Physicians who receive a disciplinary order from the TMB are assessed and evaluated by a qualified team within a physician assessment program. Those who are assessed are not always diagnosed with an impairing condition and/or not always ordered to have an evaluation/assessment; however, the majority are ordered to obtain CME. The committee’s education team will equip physicians with tools and strategies to prevent potentially impairing conditions through small group and individual education sessions.

PHW also will provide cost-effective online therapy services, tailored for physicians, who require a sustainable method of service. The pandemic has intensified the need for mental health care services, and has magnified the disparities and impact on solo and small group practice physicians. They often do not have access to employee assistance programs (EAPs) through their workplace. And if access is provided, the associated cost is included in the overall small practice health care budget. Additionally, EAP fees often are based on the number of employees and/or require a minimum number of participants. Support and implementation of a pay-as-you-go billing method is required to sustain these services; and should be modeled to fit solo physician and small group practice contexts. EAP services often include online therapy by licensed professional psychologists and referrals to medical doctors, but have not progressed to include additional services such as extending counseling/therapy services for family members, providing an alternative to therapy such as individual coaching, and offering more financial health resources.
REPORT OF TEXAS DELEGATION TO THE AMA

TEXDEL Report 1 2021

Subject: AMA House of Delegates Meetings in 2020

Presented by: David N. Henkes, MD, Chair

2020 AMA Special Meeting, June
On Friday April 3, 2020, your American Medical Association Board of Trustees made the very difficult decision to suspend the 2020 Annual Meeting of the House of Delegates.

Pursuant to AMA by-laws §2.12.2 and the action of the Board of Trustees on April 3, a virtual special meeting was held on June 7, 2020, at 2 pm (CT) for the purposes of inauguration, elections, and “essential business” only. By the end of the meeting, the house had installed Fort Worth allergist and TMA past president Susan R. Bailey, MD, as AMA president and Russell W.H. Kridel, MD, a facial plastic surgeon from Houston, as chair of the AMA Board of Trustees.

Elections and Appointments
Larry E. Reaves, MD, of Fort Worth, was appointed to the Council on Ethical and Judicial Affairs. Cynthia Jumper, MD, of Lubbock, was reelected to the Council on Medical Education.

Business of the House
Business of the house was severely limited to essential business only. This business was approved by the Board of Trustees and included sunset review of polices for the councils on Ethical and Judicial Affairs, Medical Education, Medical Service, Legislation, and Science and Public Health; the annual report; new specialty societies; and AMA dues.

2020 AMA Special Meeting, November
Nearly 700 physicians, residents, and medical students gathered virtually Nov. 13-17 to consider proposals addressing a wide range of clinical practice, payment, medical education, and public health topics.

AMA Adopts Standards for “Public Option”
Addressing what is expected to be a top agenda item for incoming President Joe Biden and his administration, delegates passed policy allowing AMA to advocate that any “public option” proposal to expand health insurance coverage to the nation’s uninsured and underinsured must adhere to a set of standards that include protections for patients and physicians.

But the final decision did not come easily. And for physicians who participated in the fiery Affordable Care Act (ACA) debates on the floor of the AMA House of Delegates meeting a decade ago, the 2020 interim meeting may have felt like déjà vu.

Testimony reflected strong feelings from many delegates, including the Texas Delegation to the AMA, that the complicated issue required more deliberation than a virtual meeting could provide and should have been referred for more study until the AMA’s next annual meeting in June 2021. Seeing that the house had no plans to postpone the vote, Texas physicians got to work and were instrumental in securing at least some, if not all, the changes they asked for to ensure comprehensive guardrails.
TMA policy supports the expansion of affordable health insurance coverage for those with little to no access, and the Texas delegation expressed its support for establishing standards for future health insurance reform discussions.

However, in anticipation of what is expected once again to be a flashpoint in the debate – and to give states like Texas more flexibility in such negotiations – Texas delegates, in collaboration with other state delegations, argued against use of the term “public option.”

Austin ophthalmologist Michelle Berger, MD, proffered an amendment favoring instead use of more general terminology that would allow for various “expanded” health insurance options.

“We in Texas want every American patient and physician to have minimal worries about coverage of their health care,” she testified before the house. But “good sound policy,” she said, should incorporate “expanded and broadened terminology to include any changes in coverage and different points of view so we do not have to keep returning to the House amending our policy for the politically popular program-du-jour.”

Delegates in the end voted to retain the term “public option” by a vote of 308 to 134.

The AMA policy “has some very good guidelines, and we’re not opposed to using those standards,” San Antonio pathologist David Henkes, MD, chair of the Texas Delegation to the AMA, told Texas Medicine.

But the policy still leaves Texas physicians with some concerns, he said. “We felt ‘public option’ was too politically charged to use and best removed,” Dr. Henkes said. “And it’s a term without a definition. It’s a non-specific entity that could be anything from ‘Medicare-for-all’ to all different types of subsidized health care plans.”

However, after five days of meetings that involved hours of passionate debate, deliberation, politicking, and fine-tuning, supporters of the public option concept won their bid for AMA to take a more definitive stand on the issue sooner rather than later.

In addition to political momentum for the concept, delegates expressed concerns that the COVID-19 pandemic continues to expose the shortcomings of the private health insurance market, pointing to the spread of high-deductible plans providing limited coverage, and losses in employer-sponsored coverage.

“The AMA believes that now is the time to build upon the ACA to cover more of the uninsured,” AMA President Bailey said in a statement. “We look forward to being at the table to represent physicians and our patients to ensure that our patients are able to secure affordable and meaningful coverage and access the care that they need. A public option should not be seen as a panacea to cover the uninsured. It should not be used to replace private insurance; rather it can be used to maximize competition. With appropriate guardrails, the AMA will examine proposals that would provide additional coverage options to our patients.”

The new AMA policy states, “The primary goals of establishing a public option are to maximize patient choice of health plan and maximize health plan marketplace competition.” Among the other standards the policy says a public option must follow:

- Eligibility for financial assistance is restricted to “individuals without access to affordable employer-sponsored coverage that meets standards for minimum value of benefits.”
- Physician payments are established “through meaningful negotiations and contracts” and “must be higher than prevailing Medicare rates and at rates sufficient to sustain the costs of medical practice.”
• Physicians can choose whether to participate in the public option, and their participation should not be tied to Medicare or Medicaid participation.
• The public option should be “financially self-sustaining” and “not receive advantageous government subsidies” compared with other health plans.
• In states that don’t expand Medicaid, the public option must be available to uninsured individuals who fall into the “coverage gap,” meaning those individuals who earn too much money to qualify for Medicaid but not enough to qualify for subsidies in the ACA exchanges.

The AMA policy also lays out standards for auto-enrolling uninsured individuals who have other coverage options available to them – such as Medicaid or the ACA exchanges – but do not take advantage of them. Those standards include allowing patients to opt out; not penalizing them for auto-enrollment in plans they are not eligible for; notifying patients of any cost-sharing; and incentivizing health plans to offer predeductible coverage, including for physician services.

Despite efforts to the contrary, supporters of the public option concept also won their bid to keep the option open to people who already have access to employer-sponsored insurance but find it unaffordable, rather than restricting the public option to those without access to any kind of health coverage.

As in past reform debates, testimony was split over whether a public option that was too broad would crowd out employer-sponsored insurance alternatives from the private market. There was significant concern from the Texas delegation and others that the move could discourage employer coverage altogether and, in turn, reduce physician payments because employer plans tend to pay higher rates.

The House did, however, ultimately incorporate changes that Dr. Henkes said will “give AMA flexibility and discretion [in negotiations] if elements other than standards listed turn out to be not so good for patients and doctors.”

Delegates also approved the stronger language that Texas physicians helped craft to ensure adequate physician payments.

When all was said and done, AMA Speaker of the House Bruce Scott, MD, recognized the “strong emotions on both sides” of the public option issue but praised the house for “the collegial nature of that debate.”

**Medicine Opposes Racism, Recognizes It As a Public Health Threat**

The nation’s physicians confronted racism by adopting several policies that recognize it as a public health threat; commit AMA to dismantling racist policies and practices throughout health care; and recognize race as a social construct, not an inherent biological trait.

“Racism is detrimental in all its forms. This has been extensively researched,” said Luis Seija, MD, an internal medicine and pediatrics resident in New York who studied at the Texas A&M College of Medicine. “It’s time for our AMA to recognize that Black lives matter.”

Specifically, a policy approved calls on all physicians, residents, and medical students nationwide to oppose racism in all forms, and for AMA to take steps to combat racism.

Delegates also voted to recognize police brutality as a manifestation of structural racism that disproportionately affects minorities. They directed AMA to work with state and local medical groups, like the Texas Medical Association and county medical societies, to support eliminating excessive use of force by law enforcement.
Debate was at times intense, particularly over a section of a resolution that would have urged an end to the use of ketamine and similar medicines by first responders for nonmedically indicated law enforcement purposes. That part of the resolution was ultimately referred to the AMA Board of Trustees for future action.

**COVID-19 Vaccine Skepticism, Future Pandemics**

The COVID-19 pandemic permeated activities at the AMA meeting, culminating in passage of two public health measures designed to help contain the disease.

With the support of the Texas delegation, the house voted to create a program that educates both physicians and the public about COVID-19 vaccines.

At this writing, two vaccines – one produced by Pfizer and one by Moderna – were reportedly at least 90% effective in preventing COVID-19. However, public opinion polls showed widespread public skepticism about the vaccines.

The new policy calls on AMA to form a coalition of medical and public health organizations – including groups representing physicians, nurses, hospitals, and public health – to develop and implement an education program promoting facts about the COVID-19 vaccines.

The measure also calls on AMA to continue monitoring the COVID-19 vaccines to ensure evidence supports their ongoing use.

Delegates, including the Texas delegation, also directed AMA to champion improved public health programs to prepare for pandemics and find solutions to ongoing health inequities. The measure, which mirrors TMA’s priorities for the 2021 session of the Texas Legislature, also called on AMA to study and recommend the best ways to improve public health nationwide.

Yet another policy the house adopted calls on AMA to advocate for policies that prevent evictions and the shutoff of utilities during public health emergencies.

Anmol Gupta, a student at Baylor College of Medicine in Houston, argued in favor of the resolution, pointing out some of the difficulties Houstonians faced in September from flooding caused by Tropical Storm Beta.

“While some of us were cleaning up debris, restocking essentials, or managing a day or two without power, 600 Houstonians in that week alone were on the court docket to be evicted,” he testified during a reference committee meeting. “Thousands more were at risk of getting their utilities shut off for good once the state’s moratorium on utilities [expired] on Oct. 1.”

**Expanding Telemedicine, Financial Relief Programs**

As telemedicine expands because of the COVID-19 pandemic, delegates approved a measure that called for telemedicine’s use to continue beyond the national public health emergency.

At the urging of the Texas delegation, the measure includes language that supports increased funding and planning for infrastructure, such as broadband internet, to ensure more patients can receive health care via telemedicine.

“We feel every American deserves access to physicians, and the only way to achieve that is through broadband access,” Beaumont anesthesiologist Ray Callas, MD, testified.
The measure also calls for uniform state and federal laws, policies, and regulations and policies regarding telemedicine, including ensuring that devices contain “appropriate privacy and security protections.”

“Telemedicine is the practice of medicine … so we’re trying to make telemedicine another tool in a physician’s toolbox,” Dr. Callas said during his testimony. “Telemedicine should be the choice of patient and physician.”

TMA had pushed for an amendment that would call for all insurers to pay the contracted rate for a covered service provided to an enrolled patient. However, that amendment was referred to the AMA board for its decision at a later date.

24/7 Prior Authorization Processing

The AMA house once again tackled onerous, care-impeding prior authorization requirements. This time, delegates discussed and passed policy that advocates for insurers and benefit managers who require prior authorization to have staff available to process those approvals 24 hours a day, year-round, “including holidays and weekends.”

One proposed amendment, ultimately rejected, would have curbed the policy to targeting only “urgent/emergent clinical/administrative” prior authorizations. San Antonio internist Jayesh Shah, MD, was one of several house members to speak against that amendment.

“We have the statistics that prior authorization delays proper care, causes harm, and my patients suffer every day because of inadequate work by these insurance companies,” Dr. Shah testified. “Insurance companies make enough money, and they can provide this 24/7 service. It should not be just limited to urgent and emergent. It should be for every prior authorization. They should provide 24/7 care, period.”

End National Clinical Skills Exams for U.S. Medical Students

In discussions on medical education, delegates called on AMA to urge the speedy end to the clinical skills part of the United States Medical Licensing Examination (USMLE) Step 2 and Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2 for U.S. medical students.

The exams have been suspended during the pandemic and are not scheduled to restart before June 2021.

The clinical skills exams have been unpopular with medical students and faculty since their inception because of the financial and time pressures placed on students. Opponents also pointed to exceptionally high passage rates of 97% to 98% and questioned the need for the exams.

During debate, supporters of the exams argued they are an independent assessment of clinical skills using a national standard. But Galveston endocrinologist Kevin McKinney, MD, speaking on behalf of the Texas delegation, argued that medical schools are capable of teaching and evaluating students’ clinical skills. He is a professor at The University of Texas Medical Branch School of Medicine.

Medical students “tell us when they go take the exam that our [school’s] exam is just as hard if not harder than the one they’re taking [for the USMLE Step 2],” Dr. McKinney testified.

The directive also urged AMA to work with the Educational Commission for Foreign Medical Graduates to advocate for an equivalent, equitable, and timely pathway for international medical graduates to demonstrate clinical skills competency.
In a related move, delegates also called on AMA to advocate for all U.S. medical students or residents who took and failed any part of the USMLE or the COMLEX between March 1, 2020, and May 31, 2021, to be reexamined at no charge to the student or resident.

Cannabis Still a “Serious Public Health Concern”

As more states relax marijuana use and possession laws, delegates voted to clarify AMA policy to say that the association “believes that cannabis is a dangerous drug and as such is a serious public health concern.”

The policy also was amended to clarify that sale of cannabis should not be legalized; that physicians should discourage its use, particularly among youth and pregnant and breast-feeding women; and that “states that have already legalized cannabis (for medical or adult use or both) should be required to take steps to regulate the product effectively in order to protect public health and safety.”

Other policy amendments include requiring “meaningful and easily understood units of consumption” on packaging, and requiring “that for commercially available edibles, packaging must be child resistant and come with messaging about the hazards about unintentional ingestion in children and youth.”

Delegates also recommended “AMA study the expungement, destruction, and sealing of criminal records for legal offenses related to cannabis use or possession.”

In other debates, the house endorsed the use of home injections and/or infusions of certain drugs approved by the Food and Drug Administration – such as antibiotic therapy – only if recommended and supervised by a physician. The measure also calls for the Centers for Medicare & Medicaid Services and private payers to provide adequate physician payment for such treatments.

Other Business of the House

- Establish a Private Practice Physicians Section.
- Continue to advocate for payment to physicians for extra expenses incurred during the COVID-19 public emergency.
- Work on alternative methods to reimburse physicians and hospitals for the cost of Medicare Part B drugs, including vaccines.
- Support increases in states’ federal medical assistance percentages or other funding during significant economic downturns to allow state Medicaid programs to continue serving Medicaid patients and cover rising enrollment.
- Acknowledge that racism and unconscious bias in medical research and health care harm marginalized communities.
- Support developing policy to combat racism and its effects.
- Identify current best practices among health care facilities, practices, and academic medical centers that recognize, address, and mitigate the effects of racism.
- Prevent and combat racism and bias in innovative health technologies.
- Address physician wellness, burnout, and suicide by advocating that “physicians, medical students and all members of the health care team maintain self-care, and are supported by their institutions in their self-care efforts.” That support should include “access to affordable health care, including mental and physical health care,” as well as access to out-of-network care “in person and/or via telemedicine.”
- Help develop workplace policies designed to prevent and address bullying in medicine.
- Support policies that facilitate compassionate release for incarcerated patients on the basis of serious medical conditions and advanced age.
- Work toward reducing physical threats and violence directed at health care professionals and to educate the public about the prevalence of this problem.
• Work toward prioritizing vaccinations for people who are incarcerated – and the workers who oversee them – while also improving their access to personal protective equipment (PPE) and quarantines.
• Initiate several steps designed to improve physician access to PPE.
• Encourage the Centers for Disease Control and Prevention to study and issue guidance on the most effective strategies to reduce the spread of influenza in hospitals.
• Support restarting the suspended Medicare advance payment program.
• Support expanding eligibility for the federal Provider Relief Fund.
• Work to reform the Paycheck Protection Program to ensure greater flexibility in how the funds are spent and lengthening the repayment period.
• Pursue loan forgiveness for medical school debt.
• Actively oppose policies limiting physician access to hospital services based on quantity and type of referrals, number of procedures performed, their use of hospital services, or employment affiliation.
• Recognize that credentialing, physician onboarding, and peer review should “not be tied in a discriminatory manner to hospital employment status.”
• Oppose the diversion of any funding away from graduate medical education (GME) funding programs.
• Monitor progress on concerns about continuing board certification programs.
• Examine the role of corporate entities in GME.
• Outline ways to protect residents and GME positions in the event of a sudden hospital or training program closure.

Delegates also approved new policies aimed at mitigating the negative effects of high-deductible health plans. Those measures call on AMA to encourage “ongoing research and advocacy to develop and promote innovative health plan designs”; push employers to give patients “robust education” to help them make good use of their plan benefits; and encourage state and national medical associations and specialty societies “to actively collaborate with payers” in innovative plan designs.

Elections and Appointments
Several Texas residents and students nabbed AMA leadership positions. For the AMA Resident and Fellow Section: Theresa Phan, MD, of Austin, was reelected as the section’s speaker; Jerome Jeevarajan, MD, of Houston, was elected as the section’s delegate in the AMA House of Delegates; and Michael Metzner, MD, of San Antonio, was elected as alternate delegate.

For Region 3 of the AMA Medical Student Section, which represents Texas, Oklahoma, Kansas, Arkansas, Louisiana, and Mississippi: Chris Wong, a third-year student at Baylor College of Medicine; Swetha Maddipudi, a third-year student at UT Health San Antonio Long School of Medicine; Abhaishhek Dharian, a third-year student at Texas Tech University Health Sciences Center Paul L. Foster School of Medicine; and Whitney Stuard, who is in the medical scientist training program at UT Southwestern Medical School.

Elected as regional alternate delegates: Brittany Ikwuagwu, a third-year student at McGovern Medical School at UTHealth; and Alyssa Greenwood Francis, a second-year student at the Foster School of Medicine.

Members Leaving the Delegation
Brad Butler, MD, submitted his letter of resignation due to his military service obligations. Arlo Weltge, MD, and David Fleeger, MD, finished their last term as delegates and were recognized for their years of service and commitment to the Texas delegation.
REPORT OF TEXAS DELEGATION TO THE AMA

TEXDEL Report 2 2021

Subject: AMA Membership, Representation, and Delegation Leadership

Presented by: David N. Henkes, MD, Chair

As of Jan. 24, American Medical Association membership in Texas totaled 19,900 compared with 19,081 at year-end 2019, an increase of 819 members.

**Representation in AMA**

Twenty physician delegates represent Texas in the AMA House of Delegates. Numerous Texas physicians and medical students hold positions of leadership within the AMA organizational structure:

Susan R. Bailey, MD, was installed as president; Russell W.H. Kridel, MD, was installed as chair of the Board of Trustees; and Larry Reaves, MD, was appointed to the Council of Ethical and Judicial Affairs.

Lyle Thorstenson, MD, completed eight years on the Board of Directors for AMPAC, serving from 2018-2020 as chair. 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:

- Michelle Berger, MD, member, Council on Long Range Planning and Development
- John T. Carlo, MD, member, Council on Science and Public Health
- Jose M. de la Rosa, MD, immediate past chair, Academic Physician Section
- Hilary Fairbrother, MD, immediate past chair, Young Physicians Section
- Diana Fite, MD, member, House of Delegates Compensation Committee
- John G. Flores, MD, member-at-large, Organized Medical Staff Section Governing Council
- Gary Floyd, MD, member, Council on Legislation
- Greg Fuller, MD, member-at-large, Integrated Physician Practice Section
- Cynthia A Jumper, MD, member, Council on Medical Education
- Ken Mattox, MD, member, Senior Physicians Group Governing Council
- Monique A. Spillman, MD, PhD, Council on Ethical and Judicial Affairs

Several Texas residents and students secured AMA leadership positions. For the AMA Resident and Fellow Section: Theresa Phan, MD, of Austin, was re-elected as the section’s speaker; Jerome Jeevarajan, MD, of Houston, was elected as the section’s delegate in the AMA House of Delegates; and Michael Metzner, MD, of San Antonio, was elected as alternate delegate.

Four Texans were elected as delegates for Region 3 of the AMA Medical Student Section, which represents Texas, Oklahoma, Kansas, Arkansas, Louisiana, and Mississippi:

- Chris Wong, a third-year student at Baylor College of Medicine;
- Swetha Maddipudi, a third-year student at UT Health San Antonio Long School of Medicine;
- AbhaiaShek Dharan, a third-year student at Texas Tech University Health Sciences Center Paul L. Foster School of Medicine; and
- Whitney Stuard, a student in the medical scientist training program at UT Southwestern Medical School.
Elected as regional alternate delegates were:

- Brittany Ikwuagwu, a third-year student at McGovern Medical School at UTHealth; and
- Alyssa Greenwood Francis, a second-year student at Foster School of Medicine.

In addition to the delegates and alternate delegates representing the Texas Medical Association in the AMA House of Delegates in 2020, many other Texas physicians serve in the AMA house as specialty society delegates and alternate delegates:

- C. Bob Basu, MD, alternate delegate, American Society of Plastic Surgeons
- Donna Bloodworth, MD, alternate delegate, American Academy of Pain Medicine
- Emily Briggs, MD, alternate delegate, American Academy of Family Physicians
- Ankita Brahmaroutu, MD, alternate delegate, American Academy of Neurology
- Sue Bornstein, MD, delegate, American College of Physicians
- Sarah G Candler, delegate, American College of Physicians
- Tilden L. Childs III, MD, delegate, American College of Radiology
- Ronald J. Crossno, MD, delegate, American Academy of Hospice and Palliative Medicine
- Gary Dennis, MD, alternate 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, delegate, American Academy of Pediatrics
- Osvaldo Steven Gigliotti, MD, alternate delegate, Society of Cardiovascular Angiography and Interventions
- Robert C. Kramer, MD, alternate delegate, American Society for Surgery of the Hand
- Rashmi Kudesia, MD, 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
- Samer Mattar, alternate delegate, American Society for Metabolic and Bariatric Surgery
- Hernando J. Ortega Jr., MD, MPH, delegate, Aerospace Medical Association
- Ray D. Page, DO, delegate, American Society of Clinical Oncology
- Harry Papaconstantinou, delegate, American Society of Colon and Rectal Surgeons
- Mary Dale Peterson, MD, alternate delegate, American Society of Anesthesiologists
- Carlos J. Puig, DO, delegate, International Society of Hair Restoration
- Craig Rubin, delegate, American Geriatrics Society
- Divya Srivastava, MD, alternate delegate, American College of Mohs Surgery
- Susan M. Strate, MD, alternate delegate, College of American Pathologists
- David Teuscher, alternate delegate, American Academy of Orthopaedic Surgeons
- Crystal C. Wright, MD, alternate delegate, American Society of Anesthesiologists

2021 Officers

At the Texas Delegation’s Jan. 29 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 2021

Subject: International Medical Graduate Section Update
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 exchange 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 TMA Winter Conference and TexMed. Additionally, the section hosts a mixer at Winter Conference the evening prior to its business meeting.

The section has taken a keen interest in increasing international medical graduate membership and member involvement within the section. During the meeting at Winter Conference, section members discussed recruitment, retention, and involvement activities.

One of the projects the section initiated to help with recruitment was to meet with other international physician organization across Texas. The purpose of these meetings is to build connections with these organizations and encourage participation within the TMA-IMG section. So far, the section has met with physician leaders from the Association of Physicians of Pakistani Descent of North America, and the Female Doctors of Austin of Indian Origin. Additional meetings have been put on hold due to demands on physician time due to COVID-19. However, section leadership plan to resume these meetings in late 2021.

Prior to Winter Conference, the section held a joint section educational program along with the Medical Student Section, Resident and Fellow Section, and Young Physician Section. The program, “Advocacy 101: The Relationship,” was provided to help section members understand the importance of legislative relationships. Section members learned how to craft effective messaging, identify their personal stories, conduct legislative visits, and build long-lasting relationships. Participating physicians were offered the opportunity to obtain 1 AMA PRA Category 1 Credit™ with Ethics.

The section hosted a very successful Winter Conference business meeting. During this meeting, section members heard from TMA Vice President of Advocacy, Dan Finch. Mr. Finch outlined medicine’s legislative priorities and how to get involved in the 2021 Texas legislative session on behalf of medicine.

During Winter Conference, the section also hosted American Medical Association-IMG Section chair, Deepak Kumar, MD, and AMA-IMG Section staff, Carolyn Carter-Ellis, who joined the meeting to discuss the AMA’s current activities supporting IMG physicians, and how to get involved on the national level. Dr. Kumar encouraged participants to join the AMA, if they are not already members, explaining the more IMG physicians the AMA represents, the more power IMG physicians will have to influence federal legislation.
Looking Ahead

The section will continue to focus on increasing IMG membership, engagement, and meeting participation. The section also plans to provide educational programming relevant to its members. The section will elect new governing council members during their business meeting at TexMed 2021.
Subject: Medical Student Section Update

Presented by: Sarah Miller, 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. Their purpose is to foster dialogue between individuals and organizations within medicine, promote and aid in programs which 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 membership has reached an all-time high. As of Dec. 31, 2020, student membership in TMA was 7,660 – an increase of 515 students or 7.2% from 2019. These numbers include 13 of the 15 medical school chapters who joined TMA at 100% membership. TMA is anticipating medical school growth within Texas to reach 16 schools by 2021.

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 2020, this was evident when more than 80 students applied for approximately 60 TMA Board, Council, and Committee positions.

Due to COVID-19, the section business meeting for 2020, which was to be held in conjunction with TexMed, was cancelled. The section was able to reschedule these elections during a virtual meeting in July. The following students were elected for a term of one year:

- Chair: Sarah Miller, MS4, The University of Texas Rio Grande Valley School of Medicine;
- Vice Chair: Swetha Maddipudi, MS3, UT Health San Antonio Long School of Medicine;
- Reporter: Ryan Wealther, MS3, UT Health San Antonio Long School of Medicine;
- TMA Delegate Co-Chairs: Alyssa Greenwood Francis, MS2, Texas Tech University Health Sciences Center Paul L. Foster School of Medicine, and Aman Narayan, MS3, UT Southwestern Medical School; and
- AMA Delegate Co-Chairs: Amier Haidar, MS3, McGovern Medical School at UTHealth, and Kate Holder, MS2, Texas Tech University Health Sciences Center School of Medicine Lubbock.

During their Executive Council meeting at TMA’s 2021 Winter Conference, members appointed the following two executive council positions for a one-year term which begins after the conclusion of TexMed:

- Alternate Delegate, Texas Delegation to the AMA: Alwyn Mathew, MS1, San Houston State University; and
- Board of Trustees Student Representative: Swetha Maddipudi, MS3, UT Health San Antonio Long School of Medicine.
At the AMA November 2020 meeting several Texas students were elected to serve at the national level, including:

- Region 3 Chair-Elect: Natasha Topolski, McGovern Medical School;
- Region 3 Delegates: Abhishek Dharan, Texas Tech University Health Sciences Center Paul L. Foster School of Medicine, Chris Wong, Baylor College of Medicine, Swetha Maddipudi (UTHSA), and Whitney Stuard, UT Southwestern;
- Region 3 Alternate Delegates: Alyssa Greenwood Francis, Texas Tech University Health Sciences Center Paul L. Foster School of Medicine, and Brittany Ikwuagwu, McGovern Medical School.

Along with positions listed above, several students from Texas were also appointed or elected to leadership positions in various AMA-MSS Standing Committees, as well as other state and national specialty societies.

During the virtual meeting in July 2020, the section recognized 14 members as part of the Leadership Honor Society, which recognizes fourth-year medical students that have actively participated in Texas organized medicine.

Advocacy
MSS Delegates from across the state collaborated on 45 resolutions submitted to the House of Delegates at TexMed 2020. These were tabled when TexMed 2020 was postponed. However, four were referred for action during TMA Fall Conference 2020. Twenty-eight of the tabled resolutions from TexMed 2020 were resubmitted for consideration at TexMed 2021, alongside several new resolutions. Resolution topics include: caps on insulin copayments, support for postpartum depression services, social media ethical guidelines, support for increased digital access, telemedicine payment parity, skin of color representation in medical education, addressing burnout, and several others.

Section Mentors
To continue improving the guidelines for student authorship of resolutions, physician delegate mentors connected with student resolution authors to offer suggestions and guide the sections’ resolution work. Furthermore, section leaders have introduced an urgency filter to streamline and improve resolutions submitted for consideration by the HOD. Leaders also hosted a section-wide call during which authors sought feedback from the section at-large. These improvements are the first of many designed to further strengthen MSS-authored resolutions. Section leadership anticipates these changes will increase the success of MSS resolutions submitted.

Region 3, which includes Texas, had the highest number of resolutions that were authored and sent to the MSS Assembly and/or the AMA HOD at the AMA November 2020 Meeting. Region 3 has been known to be one of the most active regions within the MSS and the strong Texas presence plays a role in that.

Awards
The MSS Executive Council recognized several award winners including: Texas Tech University Health Sciences Center School of Medicine Lubbock as the 2021 Chapter of the Year; Whitney Stuard, UT Southwestern, as Student of the Year; and Ashley Sturgeon, MD, Lubbock as the recipient of the 2021 C. Frank Webber, MD, Award for providing outstanding service to the TMA-MSS. These awards will be officially presented during TexMed 2021.

Chapter Service
Multiple chapters coordinated community outreach programs during the year, many of which were focused on ways medical students could provide local services during the pandemic, including PPE
collection and distribution. Other chapters have established a telemedicine program to provide free care to clinic patients, conducted vaccine drives, and created programs to deliver letters and cards to lift the spirits of nursing home residents who have been isolated during the pandemic. Chapters have also hosted virtual educational and networking events to keep members engaged.

Multiple grants were awarded by the TMA Foundation to chapters for the work they have implemented within their community, including:

- Patient Navigator Program for Individuals Experiencing Homelessness (UT Southwestern);
- STEM Education and Empowerment Course (UT Southwestern);
- Take Control: Home Blood Pressure Monitoring in Virtual Care (Baylor);
- Fifth Annual HOPE Health Fair (The University of Texas Medical Branch School of Medicine);
- Alliance Refugee Health Fair (Baylor); and
- Reducing Healthcare Disparities in Underserved Populations: Breast Cancer Screening in Colonias (Texas Tech University Health Sciences Center Paul L. Foster School of Medicine).

The Foundation also awarded UT Southwestern the 2021 John P. McGovern Champion of Health Award for their work on the Patient Navigator Program for Individuals Experiencing Homelessness.
The Resident and Fellow Section (RFS) was established by the House of Delegates to encourage participation in shaping the future of medicine in Texas through involvement in county medical societies, the Texas Medical Association, and the American Medical Association. This participation fosters dialogue between individuals and organizations within medicine; promotes and supports programs that may unify and direct health-related activities at all levels of education; and provides a useful service to residents and fellows in Texas.

Membership

Resident membership in the Texas Medical Association has reached an all-time high. As of Dec. 31, 2020, resident membership was 7,858 physicians, an increase of 1,383, or 21%, over 2019. The increase can be attributed to the number of residency programs now participating at 100% membership, which provide rosters and contact information to TMA.

Section Activities

The RFS typically meets three times annually in conjunction with TMA meetings. Because of the COVID-19 pandemic, the regular 2020 RFS business meeting did not take place, as it was to occur in conjunction with TexMed, which was cancelled. The section rescheduled elections during a virtual meeting in July 2020. The following residents were elected for a one-year term:

- Chair-Elect: Patrick Crowley, DO
- Secretary: Amir Ahmadian, DO
- TMA Delegates: Mai-Anh Dam, MD; Zahra Ali, MD; Pruthali Kulkarni, DO; Matthew McGlenon, DO; Ahmed Mohsen, MD; and Vin Shen Ban, MD

In the months since the virtual meeting, the following residents expressed interest in and filled the remaining TMA delegate positions: Apeksha Agarwal, MD, and Phuong Trinh, MD.

During its Winter Conference meeting, the RFS discussed supporting a non-compete clause resolution introduced by TMA members Craig King, MD, and Glenn A. McDonald, MD. The section also hosted TMA Director of Legislative Affairs, Michelle Romero, to discuss TMA’s agenda during the 2021 Texas Legislature. Finally, the section held elections for two executive council positions: Abdul Abid, MD, as Board of Trustees resident representative, and Matthew McGleenon, DO, as resident AMA Alternate Delegate position on the TMA delegation. The one-year term for these positions will begin after the conclusion of TexMed 2021.

The section also hosted multiple educational programs. TMA Practice Consultant, Yvonne Mounkhoune, spoke to resident members about the business of medicine including practice start-up costs, compensation, vendor contracts, and more. The RFS also hosted a joint section educational program, Advocacy 101: The Relationship, with the Medical Student Section and Young Physician Section to explore the importance of legislative relationships. Section members learned how to craft effective messaging, identify their personal stories, conduct legislative visits, and build long-lasting relationships.
Three TMA RFS section members secured positions in the AMA RFS during the AMA’s 2020 Special Meeting of the HOD. Myphuong “Theresa” Phan, MD, MPH, was re-elected as section speaker; Jerome Jeevarajan, MD, was elected as a section delegate, and Michael John Metzner, MD, was elected to as a section alternate delegate.

**Planned activities**

TMA provides free early career education for residents to help navigate contracts, develop negotiation skills, and more. TMA also is in the process of turning these into online modules.

The section plans to continue its business meetings in conjunction with regularly scheduled TMA meetings, offer virtual educational speakers throughout the year, and work to increase attendance and engagement.
REPORT OF YOUNG PHYSICIAN SECTION

YPS Report 1 2021

Subject: Young Physician Section Update

Presented by: Samuel Mathis, MD, Chair

The Texas Medical Association Young Physician Section (TMA-YPS) met virtually twice in 2020-2021. The first meeting was held in September 2020 to hold elections, and the second was in conjunction with TMA Winter Conference. Engagement in virtual meetings has been high, with lively discussion and member participation. The fall meeting began with the opening of virtual elections on Sept. 15, 2020 and concluded with the final election results on Sept. 21, 2020. The Winter Conference meeting featured a legislative update from TMA advocacy staff and new AMA-YPS delegates were elected to one-year terms.

The section also hosted a joint section educational program along with the Medical Student, Resident and Fellow, and International Medical Graduate Sections. The program, “Advocacy 101: The Relationship,” was offered to help section members understand the importance of legislative relationships and provide tools to establish and build upon this foundation. Section members learned how to craft effective messaging, identify their personal stories, conduct legislative visits, and build long-lasting relationships.

The members of the Executive Council are listed below along with applicable terms:

Officers (one-year terms):

Chair: Samuel Mathis, MD
Chair-Elect: Justin Bishop, MD
Immediate Past Chair: Gates Colbert, MD

TMA Delegates (two-year staggered terms):

Eman Attaya, MD (2019-2021)
Gates Colbert, MD (2019-2021)
Stephen Herrmann, MD (2020-2022)
Angelica Knickerbocker, MD (2020-2022)
Jason McKnight, MD (2019-2021)
Aliza Norwood, MD (2020-2022)
Jacob Stetler, DO (2019-2021)
Colleen Yard, MD (2020-2022)

TMA Alternate Delegates (two-year staggered terms):

Ashley Bailey-Classen, DO (2020-2022)
Justin Bishop, MD (2020-2022)
Ann Hughes Bass, MD (2019-2021)
Samuel Mathis, MD (2020-2022)
Kanchan Phalak, MD (2019-2021)
Joshua Reed, DO (2019-2021)
Elizabeth Seymour, MD (2020-2022)
AMA-YPS Delegates (one-year terms):
Gates Colbert, MD
M. Brett Cooper, MD
Marcial Oquendo, MD
Elizabeth Seymour, MD

AMA-YPS Alternate Delegates (one-year terms):
Ashley Bailey-Classen, DO
Angelica Knickerbocker, MD
Samuel Mathis, MD
Evan Perez, MD

TMA Board of Trustees YPS Representative:
M. Brett Cooper, MD

TMA Foundation Board of Trustees YPS Representative:
Gates Colbert, MD

In 2021-22, the YPS will continue partnering with the other sections for educational offerings and utilizing virtual platforms like Zoom to increase attendance at meetings and provide opportunities for networking and socialization between formal meetings.
REPORT OF WOMEN PHYSICIANS SECTION

WPS Report 1 2021

Subject: Women Physicians Section Update

Presented by: Elizabeth Rebello, MD, Chair

The Texas Medical Association Women Physicians Section (WPS) was established by the TMA House of Delegates to strengthen engagement and representation of female physicians in organized medicine through the development of relevant policies, programming, and services. The WPS provides female physician members an effective means to participate in TMA activities and influence association policy through access to and representation in the TMA House of Delegates.

Though originally organized as the Women in Medicine Section, the House of Delegates approved the section’s operating procedures and name change to Women Physicians Section during its virtual session on Sept. 12, 2020.

Elections

The WPS conducted elections virtually and announced results during its Sept. 12, 2020, meeting. The following executive council was elected to terms that will conclude at TexMed:

- Chair: Elizabeth Rebello, MD
- Chair-Elect: Tina Philip, DO
- Secretary: Vani Vallabhaneni, MD
- TMA Delegate: Deborah Fuller, MD
- TMA Alternate Delegate: Ruhi Singh Soni, MD
- AMA-WPS Associate: Sejal Mehta, MD
- AMA-WPS Alternate Associate: Anastasia Ruiz, MD

Priorities

During the executive council’s first meeting on Sept. 28, 2020, members affirmed the top three priorities and corresponding strategies for their term of office.

1. Empower women physicians to take an active role in organized medicine
   - TMA board, council, and committee leadership training
   - Advocacy training
   - Providing support for physician involvement in the American Medical Association Women Physicians Section

2. Create diverse paths to leadership for women physicians
   - Mentoring and sponsorship training
   - Negotiation skills
   - Career path planning

3. Encourage systemic culture change throughout medical and professional settings related to gender equity
   - Gender pay parity
   - Implicit (unconscious) bias in the workplace
   - Parental leave policies
Workgroup
The chair appointed a workgroup to explore potential resolutions on behalf of the section. The workgroup drafted a resolution supporting paid parental leave (Resolution 418) which was tabled for consideration by the House of Delegates until TexMed 2021.

Engagement
Engagement for women physicians has steadily increased during the past two years. The number of women physician members who regularly participate in TMA activities has grown from 55% in 2018 to nearly 59% at the end of 2020. Among women physicians in employed settings, the increase was more pronounced, up to more than 52% participating in 2020 from slightly more than 44% in 2018.

Section Activities
A series of virtual events, hosted by the section, are helping keep members engaged and connected throughout the ongoing COVID-19 pandemic:

1. The Equity Equation, Sept. 12, 2020 (now a webinar in the TMA Education Center)
2. Strengthening Medicine Through Advocacy, Nov. 9, 2020
3. Making Your Mark in Medicine, Jan. 30 (now a webinar in the TMA Education Center)
4. Maternal Health Equity in Texas: How Can We Get There? March 9

Implicit Bias Training
The WPS selected Unconscious Bias in Medicine, an enduring CME program offered by Stanford University School of Medicine, as a training program to address gender disparity in the physician workforce and promote greater diversity in medicine. The program is open to all TMA members and can be accessed at www.texmed.org/wps.

Next Steps
The section is committed to providing opportunities for women physicians to engage and grow professionally. Virtual programs will be scheduled throughout the remainder of 2021, and the section will elect new governing council officers to be announced at TexMed 2021. Virtual networking opportunities and section awards are being investigated.
REPORT OF COUNCIL ON HEALTH CARE QUALITY

C-HCQ 1 2021

Subject: Council on Health Care Quality

Presented by: Chelsea I. Clinton, MD, Chair

The Council on Health Care Quality oversees and supports the direction for the Texas Medical Association’s policy and advocacy on quality improvement, patient safety, performance measurement, and clinical effectiveness. The council has been active in several strategic activities summarized below.

Centers for Medicare & Medicaid Services’ (CMS’) Quality Payment Program (QPP)

In response to CMS’ proposed rules for the 2021 QPP performance year, and as part of TMA’s ongoing advocacy and policy analysis, staff from the TMA Medicare Access and CHIP Reauthorization Act (MACRA) Task Force, with input from the councils on Health Care Quality and Socioeconomics and the Committee on Health Information Technology, composed a 25-page TMA comment letter to recommend improvements to QPP governing policies. It is important to note TMA supports voluntary participation in the Merit-Based Incentive Payment System (MIPS) and advanced payment models (APMs), and advocates for fair and ethical program policies and appropriate 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, and adopted resolutions by the House of Delegates, such as Resolution 316-A-19 Determinants of Health. TMA also includes its physician survey data as part of the narrative in comment letters to support advocacy positions.

QPP Education and Resources

Due to the complexity of the QPP along with annual federal updates to the program, developing physician education and resources to help physicians learn about and stay abreast of program requirements remains an ongoing priority of the council. All information is located on the TMA MACRA Resource Center. This website provides the following for physicians:

- Free CME,
- Access to customized on-site assistance by TMA Practice Consulting,
- Free access to a separate MACRA QPP Resource Center,
- Access to 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 services for physician-led accountable care organizations/APMs.

TMF Health Quality Institute

In 2019, CMS awarded the TMF Health Quality Institute a new five-year contract to serve as the state’s Quality Innovation Network-Quality Improvement Organization. Under this contract, the following TMF networks provide Texas physicians no-cost technical assistance and education on quality improvement.
and patient safety topics: 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.

TMA Resolutions Referred to the Council


Resolution 108-A-19, Initial Assessment and Treatment Recommendation by Specialists, resolved that TMA recognize that the best practice of patient care dictates the physician is responsible for developing the diagnosis and treatment in a patient’s initial evaluation, while acknowledging that under limited circumstances a nurse practitioner or physician assistant may conduct an initial evaluation. The resolution was referred for study and report back. The council along with the Interspecialty Society Committee discussed the resolution at fall and winter meetings, and the resolution was referred for further study to the council and Interspecialty Society Committee with a report back at TexMed 2021. After thorough review and discussion, the council voted to recommend not adopting Resolution 108-A-19 due to a lack of consensus and legal concerns. For details, see the report in Handbook for Delegates.

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/provider control. Following discussion, the council recommended advocacy letters. TMA sent formal letters to the following advocating for standard methodologies and improvements to value-based care quality measures for medication adherence: U.S. Department of Health and Human Services, Centers for Medicare & Medicaid Services, Center for Medicare and Medicaid Innovation, National Committee on Quality Assurance, Blue Cross and Blue Shield of Texas, UnitedHealthcare, 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 (SDOH) to help them better understand SDOH impact on patient health outcomes and well-being; (2) educate state and federal policymakers, business leaders, and governmental and commercial payers about the influence of SDOH on overall health care quality and health care costs; (3) collaborate with innovative public and private partnerships on policies to address SDOH and advocate for their adoption by state policymakers; and (4) advocate that governmental and commercial payers modify existing performance and quality programs to reflect the higher expected health care utilization and costs in populations at greater risk of exposure to SDOH, and appropriately risk adjust physician compensation to reflect these higher costs.

The council and TMA have undertaken numerous initiatives related to social determinants of health, including (1) developed a TMA resource webpage; (2) partnered with The Physicians Foundation and The Health Initiatives to conduct a study on SDOH; (3) advocated that CMS adopt policies to implement risk adjustment methodologies related to SDOH and account for social risk factors in QPP and Medicare payment; and (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. TMA plans to testify where needed 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, SDOH advocacy and education will remain a high priority.

Subcommittee on Quality Programs and Clinical Measures
At TMA Winter Conference 2019, the council formed the Subcommittee on Quality Programs and Clinical Measures. The subcommittee’s vision is to establish TMA as a meaningful and influential player in 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 assess health care 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.

Following up on the employer panel meetings conducted in 2019, a survey was created in collaboration with the Texas Business Group on Health and sent to employers. The survey goal was to obtain employer insights on value-based purchasing, gain a deeper understanding of employers’ 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. The was deployed survey in February 2020 but had a low response rate. Due to the urgent needs of the COVID-19 pandemic and the changes in strategic direction, further action on this activity was terminated.

After exploring approaches to standardizing measures, the subcommittee evaluated the Core Quality Measures Collaborative (CQMC) and met with a representative from America’s Health Insurance Plans (AHIP) about the collaborative. The council believed TMA’s presence in the collaborative would give the association a crucial seat at the table to select quality measures, align quality measures across payers, and reduce physician burden. Upon approval of the TMA Board of Trustees, TMA became a member of CQMC with nonvoting status, making TMA the first state medical association to join the collaborative.

Core Quality Measures Collaborative
TMA began participation in CQMC after Winter Conference 2020. CQMC is a broad-based coalition of health care organizations convened by AHIP; membership includes CMS, National Quality Forum, health insurance providers, national medical associations (e.g., the American Medical Association, American Academy of Family Physicians, American College of Physicians), consumer groups, purchasers and employer group representatives, and other quality collaboratives to recommend core sets of measures by clinical area to assess American health care quality. CQMC aims are to (1) identify high-value, high-impact, evidence-based measures that promote better patient outcomes and provide useful information for improvement, decisionmaking, 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.

Due to the COVID-19 pandemic, meetings for the CQMC workgroup were postponed until midsummer. Upon the resumption of activities, CQMC’s representative and executive director for clinical performance and transformation for AHIP has met with the council to provide updates and information on participating in existing and new workgroups. The council has invited all TMA members to partake in this activity.
Telemedicine and Telemedicine Quality Outcomes

The COVID-19 pandemic has created an opportunity to expand telemedicine, due to the need for social distancing to reduce the spread of the virus and manage vital resources like personal protective equipment. Physicians have turned to telemedicine as an alternative to seeing patients in person so they can reduce exposure to the virus and increase access to care. The council met during the COVID-19 pandemic with TMA lead staff for the Health Information Technology Committee to receive telemedicine updates. The council reviewed literature published in 2020 on quality in telehealth implementation during the COVID-19 pandemic. Based on this limited literature review, it was determined further research is needed to assess the patient health outcomes and physician experiences with telehealth. In addition, data specifically on Texas physicians’ experience and quality outcomes with telemedicine during the pandemic are limited but will likely grow in the future. Furthermore, payment parity, regulatory reform, physician guidelines for the use of telemedicine, and ongoing research on health outcomes are needed. The council next plans to survey large group practices in Texas to understand what data they are collecting on telemedicine quality outcomes that can support advocacy of payment parity for telemedicine services.

CMS Qualified Entity – The Health of Texas

In 2017, CMS approved The University of Texas School of Public Health (UTSPH) in Houston to establish a qualified entity (QE) to research claims data from Medicare and other payers to evaluate physician performance and regional variations in Texas. Council member Marina C. George, MD, served 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. Cecilia Ganduglia-Cazaban, MD, DrPH, co-director of the UTSPH Center for Health Care Research Data, and her staff routinely present at council meetings on the QE’s research progress and to gather feedback. UTSPH is 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. The council will continue to support this activity.

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 council meetings. During 2020-21, 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. A Texas Medicine article specific to health care quality was “A Social Shift: COVID-19 Disparities Prompt Emphasis on Value-Based Care.”

TexMed 2021 Quality Track

The council plans to host quality activities at TexMed 2021. Due to the COVID-19 pandemic, the quality track will take place on a virtual platform and will consist only of a one-hour keynote speaker presentation that will provide 1 hour of CME credit at no cost to attendees. Dr. Clinton will chair the quality track. Some potential topics are 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 practice strategies for successful participation in innovative health care delivery models.

Review and Resolution Services Quality Outcomes

The council is interested in understanding quality issues as they relate to TMA’s Reimbursement Review and Resolution Services (formerly the TMA Hassle Factor Log). The council is to meet with TMA staff overseeing these activities to understand the current issues and determine the best course of action.
Update on CME Providers in TMA’s Intrastate Accreditation Program
In 2020, 13 organizations received accreditation decisions. Twelve providers were granted full accreditation for four years; and one received accreditation with commendation for six years. The organization receiving accreditation with commendation was the Texas Department of State Health Services. 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.

Medical Center Hospital, Odessa, voluntarily dropped CME accreditation from TMA. The organization stated in their letter of withdrawal “there have been too many critical circumstances within our institution that have prevented us moving forward.”

TMA’s current roster of CME-accredited organizations includes 51 organizations. The breakdown for type of organization is as follows: 38 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.

Standards for Integrity and Independence in Accredited Continuing Education Released in December 2020
The Standards for Integrity and Independence in Accredited Continuing Education were released in December 2020, replacing the Standards for Commercial Support: Standards to Ensure Independence in CME Activities℠, which were first adopted in 1992 and updated in 2004. The new standards have been adopted by accrediting bodies representing multiple health professions – Accreditation Council for Continuing Medical Education; Accreditation Council for Pharmacy Education; American Academy of Family Practice; American Nurses Credentialing Center; Association of Regulatory Boards of Optometry’s Council on Optometric Practitioner Education; and Joint Accreditation for Interprofessional Education. All providers in the Accreditation Council for Continuing Medical Education (ACCME) System (ACCME-accredited, state-accredited, or jointly-accredited) are expected to comply with the new standards by Jan. 1, 2022.

New Standards at a Glance:

Structure

- New name to reflect the scope and intent of the standards.
- Preamble to explain the principles and purpose of the standards and the role of accredited continuing education providers in ensuring that accredited education serves the needs of patients.
- Eligibility Section includes updated definitions and lists of organizations that are eligible and ineligible for accreditation, and clarification about how corporate structure (parent and subsidiary companies) affects eligibility.
- New structure beginning with standards applicable to all accredited continuing education, followed by the standards applicable to education that is commercially supported and education that includes ancillary activities.
Policies have been integrated into the standards to provide all relevant requirements in one document.

Definitions have been simplified and integrated into the standards.

Brief introductions to each standard describe its overall purpose and when it is applicable.

New Terms

- Eligible organizations: Organizations that are eligible to be accredited in the ACCME System.
- Ineligible companies: Organizations that are not eligible for accreditation. These organizations were referred to as commercial interests in the Standards for Commercial Support. The new term is intended to clarify that eligibility for accreditation is not based on whether an organization is for-profit or nonprofit but is based on its primary mission and function. Please note the definition as well as the term for ineligible companies has been updated from the Standards for Commercial Support.
- Mitigate: The term mitigate replaces resolve, in guidance related to relevant financial relationships, to clarify that accredited providers are expected to mitigate the potential effect of these relationships on accredited continuing education. The expectation hasn’t changed, only the term used to describe it.
- Accredited continuing education: The term accredited continuing education replaces continuing medical education to be inclusive of all health professions.

ACCME Data Report Shows Steady Growth in Accredited Continuing Medical Education – 2019

In July 2020, the ACCME released their annual ACCME Data Report. The annual report includes data from a community of 1,720 accredited (ACCME-accredited, state-accredited, and jointly accredited) organizations that offer physicians, other health care professionals, and health care teams an array of continuing education resources to promote high-quality, safe, and effective care for patients. Here are ACCME’s five key takeaways from the report:

- More than 1,700 accredited continuing medical education (CME) providers offered nearly 190,000 educational activities in 2019.
- The number of activities, hours of instruction, and interactions with learners have increased, despite some consolidation among CME providers, continuing a 10-year trajectory of growth.
- This education comprised approximately 1.3 million hours of instruction and approximately 37 million interactions with health care professionals.
- Since 2018, the number of educational events has increased 5%, hours of instruction have increased 6%, and the number of learner interactions increased 2%.
- This is the second year that other learner interactions have surpassed physician interactions. (Other learners are nonphysician health care professionals such as nurses and pharmacists).

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. Due to the coronavirus pandemic, the 2020 Texas CME Professional Development Conference scheduled for June 17-19 at the Embassy Suites San Antonio Landmark has been postponed until June 2021. In place of the conference, TMA provided a three-part virtual meeting series addressing accredited providers’ most burning questions related to virtual meetings. Sessions included best practices for moving live CME online, virtual meetings and exhibits – a how-to guide, and lessons learned going virtual.

TMA will survey TMA-accredited providers and ACCME-accredited providers in Texas to gather information to help determine plans for the 2021 conference.
REPORT OF COUNCIL ON SOCIOECONOMIC

CSE Report 1
2021

Subject: Activities of the Council on Socioeconomics

Presented by: Rodney B. Young, MD, FAAFP, Chair

At 2020 Winter Conference, TMA staff gave updates on resolutions before the council. The council discussed items to present at TexMed 2021 including a resolution to study banning restrictive covenants and to educate residents on starting a private practice. Staff provided a update on TMA’s work done in the last legislative session. The council learned that TMA had established a task force on prior authorization and that the February TMA survey would cover this topic. Council members were urged to provide input on preauthorization issues. The council heard a report on opposition to a federal public charge definition, about which the Select Committee on Medicaid, CHIP, and the Uninsured submitted comments. The council also heard a report from the Committee on EMS and Trauma.

During an August 2020 meeting, the council heard another presentation on prior authorization as well as a presentation on the upcoming 87th legislative session. Highlights reported from TMA’s prior authorization survey were:

- 87% of Texas physicians reported that prior authorization-associated burden has increased over the past five years. This result nearly mirrors that of a 2018 American Medical Association survey (88%).
- Texas physicians reported an increase over the past five years in the number of prior authorizations required for prescription medications (85%) and medical services (80%).
- 48% of practices in Texas have staff working exclusively on prior authorizations, while the AMA national survey reported 36%.

The council also heard an overview of state Senate Bill 1264 (2019), the Texas surprise billing/arbitration bill, and related issues that need further evaluation. The council then heard a presentation on the Texas Department of Insurance’s (TDI’s) biennial report and recommendations to the legislature.

During a September 2020 meeting, the council heard a presentation on the proposed 2021 Medicare Physician Fee Schedule, notably with a discussion about the 2021 conversion factor and evaluation and management coding changes. Staff promoted a related TMA webinar on the fee schedule. The council discussed whether the proposed telehealth code additions are appropriate.

During the October 2020 call, staff discussed the value-based workgroup and its efforts to bring together perspectives of different TMA committees and councils. A presentation was given on price transparency and data collection in Texas. The council also discussed the all-payer claim database and TDI’s surprise billing arbitration process, and reviewed sunset policies.

During the December 2020 call, the council heard a legislative update, particularly the federal surprise billing efforts. Staff discussed letters to Texas Sens. Ted Cruz and John Cornyn and upcoming meetings in the U.S. House of Representatives. The council also discussed UnitedHealthcare’s (UHC’s) credentialing and recredentialing policy changes. In a response to TMA, UHC said it would postpone the policy until further notice.

The council also heard a presentation by Harris County Medical Society on its efforts with Blue Cross/Sanitas Medical Group, Humana, Humana/Iora Health, and Aetna and UnitedHealth Group and their subsidiaries UnitedHealthcare and Optum Care. The council then discussed an AMA resolution.
regarding Healthcare Effectiveness Data and Information Set scores. Staff presented on a memo to private
payers urging they extend 2020 annual patient deductible renewals that would occur at the first of the
year, where legally permissible and not disadvantageous to the beneficiary.

The council discussed a letter about Ambetter (the Superior Exchange Plan), which was denying payment
for all well visits, claiming “overuse of modifier 25.” In addition, the council discussed UHC copay
accumulators, and efforts to ban copay accumulators. Finally, the council again discussed sunset review
policies assigned it.

During the January 2021 call, the council completed its review of sunset recommendations regarding
committees and policies. Staff gave presentations on telehealth and TMA’s role in launching the
Telehealth Initiative to help physicians start telehealth care, and on Medicaid telemedicine issues and
TMA’s efforts to retain favorable policy changes made during the public health emergency. The council
heard an update on the audit trail report for the Committee on Rural Health as it pertains to looking at
alternatives to areas unable to sustain rural hospitals. The council also heard highlights of the projected
Medicaid budget and discussed the Texas Medicaid 1115 Transformation Waiver. The council identified
hospital transparency as a possible area to explore in 2021.

During the February 2021 call, the council discussed a tort-reform-related resolution and voted
unanimously to adopt it as amended. Staff then gave a detailed presentation comparing the state and
federal surprise billing laws. The council was reminded to enter HIPAA-compliant prior authorization
nightmares into a TMA portal designed for this purpose. A brief discussion occurred regarding UHC’s
policy change to discontinue the ability for nonphysician practitioners to bill incident to a physician’s
service.
The Patient-Physician Advocacy Committee presents the following informational report regarding the committee’s recent activities.

Texas Medical Board

In furtherance of its role as the association’s liaison with the Texas Medical Board (TMB), the Patient-Physician Advocacy Committee (PPAC) met with TMB representatives at each of the committee’s regular meetings in 2020 and at the 2021 Texas Medical Association Winter Conference. During these meetings, PPAC had an engaging dialogue with TMB representatives concerning a wide variety of TMB regulatory efforts and updates. Among the topics discussed were: (1) the TMB’s response to the pandemic; (2) recent TMB rule adoptions (e.g., opioid-related rules and CME); (3) complaints filed with the TMB related to SB 1264 (Texas’ surprise billing law); (4) continuing physician concerns, brought to TMA’s attention over the last few months, about pharmacies filling pain prescriptions for fewer days than the number prescribed by the physician; and (5) the new e-prescribing mandate for controlled substances.

Amicus Curiae “Friend of the Court” Brief Vetting

The committee reviewed and provided input on various 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 alleged defamation issues to licensure revocation issues and the alleged retroactive application of TMB rules. 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.

More specifically, in 2020, PPAC reviewed the case of a physician requesting that TMA submit an amicus curiae “friend of the court” brief in support of his position that the district court should overturn the TMB’s decision to revoke his license. PPAC voted to recommend that the chair of the TMA Board of Trustees support TMA filing an amicus brief in his case on the issue of the TMB’s alleged retroactive application of a TMB rule. TMA submitted its amicus curiae brief in June of 2020. TMA’s amicus brief argued that the TMB’s decision: (1) has serious implications for Texas physicians; and (2) was arbitrary and capricious, unconstitutional, and incorrect in that it applied a rule to a physician’s conduct that occurred before the rule was adopted. On October 6, 2020, the trial court ruled in favor of the TMB. The plaintiff physician has appealed.

In 2020, PPAC also continued to monitor and support TMA amicus curiae involvement in a case originally brought to PPAC in 2014 and 2015 involving a physician who was in litigation against a former employer involving allegations that the facility defamed the physician (along with claims of business disparagement, tortious interference, and restraint of trade claims). The physician sought key documents, but the facility alleged that the documents were protected under a peer review privilege. TMA previously filed an amicus brief (after receiving a supportive recommendation from the committee and approval by the TMA Board of Trustee’s chair) arguing that the privilege did not apply because the case was anticompetitive in nature. That issue came before the Texas Supreme Court and was decided in agreement with TMA’s position. The physician eventually won a significant judgment on the issue. The case was appealed by the hospital to the court of appeals and TMA filed another amicus brief. That appeal was not
successful, so the hospital appealed to the Texas Supreme Court. TMA filed an amicus curiae brief, once again, in support of the physician, in early March 2021.

Input into Association Policy and Legislative Efforts

The committee also recently: (1) reviewed six TMA sunset policy review items to make recommendations to the House of Delegates; (2) had a legislative preview discussion with TMA’s Vice President of Advocacy; and (3) continued to recommend that the House of Delegates adopt new policy (tabled in 2020) that PPAC developed related to overturning and vacating certain temporary suspensions or restrictions of an individual’s medical license by the TMB.
The worldwide COVID-19 pandemic has changed almost every aspect of our daily lives, and our Texas Medical Association physicians have become local heroes to all. Thousands of businesses, associations, and PACs have seen a dramatic decline in sales, membership renewals, and contributions. Thankfully, through TMA’s extensive personal protective equipment distribution and other COVID-19 resources, TMA and TEXPAC have managed to continue in a positive direction. TEXPAC is beyond grateful to all the TMA members who have continued to contribute to the PAC during this trying time.

Many aspects of campaigning have changed during the pandemic including TEXPAC’s involvement in key races. During any other election year, TEXPAC staff will travel 2,500-5,000 miles across the state to help secure victories for the TEXPAC-endorsed candidates. This election cycle, TEXPAC was not able to travel safely nor were in-person events allowed. TEXPAC adapted, using the digital market. Over the 2020 election season, TEXPAC contributed $1.2 million, an all-time high, to TEXPAC-endorsed candidates. These contributions included monetary, advertising, and campaign mailer contributions. Some of the key races and endorsed candidates TEXPAC focused on for this election were:

- House District (HD) 54 – Rep. Brad Buckley (R-Salado);
- HD 64 – Rep. Lynn Stucky (R-Sanger);
- Open seat, HD 96 – David Cook (R-Mansfield);
- HD 108 – Rep. Morgan Meyer (R-Highland Park);
- HD 113 – Rep. Rhetta Bowers (D-Mesquite);
- HD 114 – Rep. John Turner (D-Dallas);
- HD 121 – Rep. Steve Allison (R-Alamo Heights);
- HD 130 – Rep. Tom Oliverson, MD (R-Cypress); and

TEXPAC was successful in 97% of the races in which it endorsed a candidate. The biggest loss for TEXPAC was Rep. Sarah Davis, who unfortunately was defeated by her Democratic challenger, now-Rep. Ann Johnson. TEXPAC was fortunate to have Representative Davis as medicine’s advocate, and now we are confident we can find a friend in Representative Johnson. TEXPAC did prevail in hindering some candidates deemed not friendly to medicine from claiming victory.

TEXPAC ended the 2020 dues cycle having raised nearly $800,000 – the highest amount raised in the past decade. TEXPAC also surpassed past-year membership counts with more than 5,000 members by the end of the dues year, thanks to group practices, returning members, and new members joining the PAC. The goals for the 2021 dues year, as set by the PAC board, are to reach 5,500 members and raise $850,000. The TEXPAC board has tasked each board member with recruiting at least five new members to contribute to the PAC as well as seek other group practices to contribute on their staff’s behalf. TEXPAC’s current number of members is more than half our 2021 goal, and TEXPAC will continue to work on this challenge.
In addition to the November general elections, a few special elections were called for newly vacated legislative seats. In Senate District 30, Sen. Pat Fallon (R-Frisco) decided to run for an open seat in Congress, District 4, in East Texas. Among those who filed to run for his vacated state Senate seat were Rep. Drew Springer (R-Muenster) and Shelley Luther (R-Pilot Point). Ms. Luther gained notoriety in April 2020 when she publicly violated the governor’s lockdown orders by opening her hair salon. Ultimately, five candidates filed for the open seat, with Representative Springer and Ms. Luther pushed into a runoff. The special election runoff was held Dec. 19; Representative Springer claimed victory and was sworn into the Senate in January. His victory led to another special election to fill his House seat in District 68. Five candidates filed for the race, with the initial election on Jan. 23. The top two candidates, David Spiller (R-Jacksboro) and Craig Carter (R-Nocona), faced each other in a runoff election held Feb. 23, with Mr. Spiller claiming victory (62%-38%). TEXPAC endorsed Mr. Spiller in this runoff election as he has an extensive background in medicine in his role as attorney for county hospitals. Gov. Greg Abbott ordered a May 1 special election to succeed the late U.S. Rep. Ron Wright (R-Arlington). Candidates must file with the secretary of state by March 3. At least 17 candidates have taken formal action towards running, and four have officially filed to run.

After a year of COVID-19 restrictions and lockdowns, TEXPAC has continued to hold its head high. Medicine is the No. 1 issue in the eyes of Texans, and TEXPAC is ready to respond. The Texas legislative chambers can be successful only if TEXPAC is successful in electing candidates who will support physicians and medicine’s legislative agenda. Despite the challenges before us, TEXPAC will continue to grow in members and contributions and be a top player in Texas state and congressional campaigns.
Grants Support 2020 Programs

The generosity of donors, plus investment earnings from endowments, enabled the Texas Medical Association Foundation to support the following 46 programs carried out in 2020 for a total of $789,724 in grant support. The supported programs reflect the TMA population health, science, medical education, and quality-of care-priorities. TMA’s vision, to improve the health of all Texans, is realized through the trusted leadership of TMA physicians who join with TMA Alliance members and others who guide and carry out these programs to improve the health of people in their community. Attachment A lists these programs by grant category.

Grants awarded to TMA’s 2020 programs totaled $514,629. This means for every $1 TMA provides in support of TMAF, the foundation and donors provide TMA more than a five-fold benefit in community health improvement and positive physician image.

New in 2020 was TMAF’s creation of an opportunity for TMA county medical societies to apply for a grant of up to $12,000 for their physician health and wellness activities, which are described in Attachment A.

TMA Programs
- Ernest and Sarah Butler Awards for Excellent in Science Teaching
- Hard Hats for Little Heads
- Minority Scholarship Program
- Walk With a Doc Texas
- History of Medicine “Courage and Determination” traveling exhibit
- History of Medicine “Art of Observation” traveling exhibit
- Texas Two Step CPR
- Be Wise – ImmunizeSM
- Health Alliance for Austin Musicians for “Stay Home” public service announcement

Caring for Physician Healers: Mental Health and Wellness Resources During COVID-19 Grants
- Bell County Medical Society: Women in Medicine Physician Health and Wellness
- Dallas County Medical Society: Emotional PPE Project
- Ector County Medical Society: Yoga – Building Self-Regulation and Higher Consciousness
- Lubbock County Medical Society: Physicians Connecting and Contributing
- McLennan County Medical Society: LifeBridge
- Smith County Medical Society: Physician Wellness Program
- Travis County Medical Society: Physician Wellness Program

County Medical Society/Alliance/Medical Student Grants
- Anderson-Leon County Medical Society: Grapeland Immunization Project
- Bexar County Medical Society Alliance: Campaign to Reduce Bullying and Build Self-Esteem
• Lamar Delta County Medical Society: Drive Thru, Prevent Flu
• Lubbock County Medical Society Alliance: Pneumonia Vaccine for the South Plains Food Bank
• Nueces County Medical Society Alliance: Battling Opioid Misuse in Nueces County
• Smith County Medical Society: Northeast Texas Public Health District Health on Wheels
• Tarrant County Medical Society: Project Access Tarrant County
• Tarrant County Medical Society Alliance Foundation: Immunization Collaboration of Tarrant County
• Baylor College of Medicine/Medical Student Chapter: Alliance Refugee Wellness Fair
• Baylor College of Medicine/Medical Student Chapter: Healthy Minds, Healthy Bodies
• Baylor College of Medicine/Medical Student Chapter: Refugee Resettlement Needs Assessment
• Dell Medical School/Medical Student Chapter: Flu Crew
• Texas A&M Health Science Center College of Medicine/Medical Student Chapter: Feed My Sheep Mobile Pediatric Clinic
• Texas A&M Health Science Center College of Medicine/Medical Student Chapter: Community Week
• Texas Tech University Health Sciences Center El Paso: Breast Cancer Screening in Underserved Populations
• Texas Tech University Health Sciences Center Lubbock/Medical Student Chapter: Smoking Cessation Program at The Free Clinic
• The University of Texas Health Science Center at Houston McGovern Medical School/Medical Student Chapter: UTHealth Cares Third Annual Health Fair
• The University of Texas Health Science Center at Houston McGovern Medical School/Medical Student Chapter: Frontera de Salud
• The University of Texas Medical Branch/Medical Student Chapter: HOPE Health Fair
• UT Southwestern/Medical Student Chapter: Implementing a Smoking Cessation Program in a Dallas Homeless Population
• The University of Texas Rio Grande Valley School of Medicine/Medical Student Chapter: COVID-19’s Impact on Medical Students’ Well-Being and Residency Choices

TMAF 2020 John P. McGovern Champion of Health Award
• Health for All by the Health for All Clinic, Bryan
• Cornerstone Assistance Network’s Cataract Procedure Center, Fort Worth

TMAF Family of Funds Grants
• The TMAF Hispanic Nursing Scholarship Trust Fund of Dr. Roberto J. and Agniela (Annie) M. Bayardo supported two grants for seven scholarships awarded by the Harris County Medical Society Alliance and the Travis County Medical Society Alliance.
• The TMAF Medical Student Scholarship and Grant Trust Fund by Dr. Roberto J. and Agniela (Annie) Bayardo supported the Lubbock, Midland, and Travis county medical societies with two scholarships each matching those awarded by their own scholarship programs.
• The TMAF Hispanic Medical Student Scholarship Fund of Dr. Roberto J. and Agniela (Annie) Bayardo supported the Midland and Travis county medical societies with two scholarships each matching those awarded by their own programs.

Funds Raised
The TMA Foundation raised $946,257 in 2020, exceeding its fundraising goal for 2020 by $15,257 or 1.64%. This achievement is thanks to generous gala donors who allowed TMAF to retain their purchases despite gala cancellation, in addition to more than 1,200 other donors who supported programs and the mission of TMAF.
Included in this total raised is the grant from The Pfizer Foundation to address the health and wellness needs of physicians during the COVID-19 pandemic.

**Additional Achievements**

- In 2020, TMAF had the greatest number of individuals donating (1,434) and greatest number of new donors (506) in the past six years, as well as the greatest number of institutions donating (74) since 2017.
- TMA’s 2021 programs supported by TMAF are in Attachment B. New for this year is Vaccines Defends What Matters, which replaces Be Wise – Immunize.
- Members of the board who joined in 2020 are Abdul Abid, MD, Resident and Fellow Section representative; Gates B. Colbert, MD, FASN, Young Physician Section representative; and Helen Schafer, Medical Student Section representative.
- Sixteen individuals became new or upgraded Major Donors and were recognized at TMA Winter Conference. They join 249 other Major Donors on the digital display in the TMA building and on the TMAF website. Attachment C lists all 259 TMAF Major Donors who individually or as a couple have donated $10,000 and more cumulatively to TMAF.

**First TMAF Virtual Gala – Superheroes: Meeting the Challenge**

TMAF’S 28th annual gala will honor medicine’s trusted leadership and other healthcare team superheroes on May 14 as part of TMA’s TexMed annual meeting. Co-chairs are David Fleeger, MD, and his wife, Jamie, and Belda Zamora, MD, and her husband, F. Javier Otero, MD, all of Austin. Susan Rudd Bailey, MD, Fort Worth, president of the American Medical Association, is honorary chair.

The lead sponsor for the event is H-E-B. Confirmed sponsors from the $30,000 level to the $3,500 level as of Feb. 10, 2021, are H-E-B; St. David’s HealthCare and St. David’s Foundation; Texas Medical Liability Trust; Baylor Scott & White Health; TMA Insurance Trust; Prudential; Texas Health Resources; Travis County Medical Society; Austin Ear, Nose & Throat Clinic; Catalyst Health Network; Dallas Nephrology Associates; Harris County Medical Society/Houston Academy of Medicine; Luther King Capital Management; Carla F. Ortique, MD, and Morris Overstreet; The Quantitative Group at Graystone Consulting; Rudd and Wisdom, Inc; TMF Health Quality Institute; Texas Scottish Rite Hospital for Children; TTUHSC SOM, Dean’s Office; Texas Oncology; University of the Incarnate Word School of Osteopathic Medicine; UTMB Health; UT Southwestern Medical Center; and Vaughan Nelson Investment Management, LP.

Livestreaming from the TMA building, the event begins at 6:30 pm with a preshow. The main event runs from 7 to 8:15 pm and includes an online silent auction, prerecorded messages from special guests, and Austin musicians providing entertainment.

The event is the single largest fundraising effort of TMAF and makes TMA health improvement, science, and quality-of-care programs possible.

Regular individual tickets are $275 each, and special VIP tickets are $375. Tickets may be purchased through midnight May 12. Individuals may sponsor a table of eight for $2,500. For more information and to purchase tickets, contact TMA Foundation at (800) 880-1300, extension 1466 or (512) 370-1466.
**TMA GRANTS – In support of TMA’s population health and science priorities**

**TMA’s Be Wise – Immunize**: This public health initiative increases immunization rates by providing educational materials, grants, and infrastructure to physicians, TMA Alliance members, and medical student members (Family of Medicine) so that they can (1) counter vaccine hesitancy, (2) provide needed immunizations, (3) carry out vaccination education events in collaboration with others, and (4) support the Texas Department of State Health Services in physician outreach related to the Texas Vaccines for Children and Adult Safety Net programs. Since its beginning in 2004, Be Wise – Immunize has provided nearly 360,000 vaccinations to Texas children, adolescents, and adults.

**TMA’s Hard Hats for Little Heads** encourages safe exercise and prevention of life-altering or fatal brain injuries in Texas children engaged in wheeled sports. Since its inception in 1994, more than 350,000 free helmets have been given to youths aged 14 and younger at community events such as bicycle safety rodeos and health fairs. TMA and TMA Alliance members and community collaborators educate parents and children about the importance of wearing a properly fitted helmet when bicycling, inline skating, skateboarding, or riding a scooter.

**TMA’s Ernest and Sarah Butler Awards for Excellence in Science Teaching**: TMA is committed to elevating the importance and credibility of science in our modern society by recognizing and rewarding outstanding science teachers in elementary and junior and senior high schools. Since 1990, TMA has helped increase science literacy by providing cash awards to winning teachers and their schools to enhance their science curriculum.

**TMA’s Minority Scholarship Program**: Established in 1998, this program was designed as a unique means to fill a gap brought about by the Hopwood ruling barring public medical schools from offering minority-specific scholarships. In Texas, minority groups underrepresented with regard to population-to-physician ratios are Hispanic, Black, and Native American. Annually, a qualified student entering each of Texas’ medical schools is selected to receive a $10,000 scholarship.

**Walk With a Doc Texas** engages physicians, their patients and the community in healthy physical activity to reverse the consequences of a sedentary lifestyle, especially obesity. TMA members lead virtual walks that engage patients in walking with them at least once a month for 12 months. When live walks resume, participants enjoy a healthy snack and a brief health-related presentation before each 45-90-minute walk.

**History of Medicine Banner Program/Two Exhibits**: This program enables TMA’s History of Medicine Committee to offer seven banner exhibit sets to schools, libraries, and other venues to educate the public on a range of health and medical subjects, enhance the image of physicians, and encourage the pursuit of research and science education. The banner exhibits promote TMA’s patient health advocacy goals through education and historical content. With TMAF support, recent museum exhibits “Art of Medicine” and “Courage and Determination: Pioneering African American Physicians in Texas” have been added to the catalog of available banner exhibits.

**Texas Two Step CPR**: Texas Two Step provides skills training to Texans in how to act quickly in the event of cardiac emergencies following two easy steps: (1) call 911 and (2) initiate hands-only CPR. The project has trained more than 27,800 individuals on how to save lives with hands-only CPR. It was
established by Texas medical students, the Texas College of Emergency Physicians, and HealthCorps and in 2018 expanded from Texas-only to a national scale.

MENTAL HEALTH AND WELLNESS RESOURCES DURING COVID-19

Spurred by the demands and circumstances of delivering care during the COVID-19 pandemic, TMA established its Caring for Physician Healers: Mental Health and Wellness Resources During COVID-19 Fund with support from The Pfizer Foundation.

Women in Medicine Physician Health and Wellness/Bell County Medical Society: This program provides leader training in the Finding Meaning in Medicine program and facilitates virtual meetings throughout Bell County. Driven by the Bell County Medical Society Women in Medicine Physician Health and Wellness Task Force, the program will use gender-specific group interaction to reduce burnout and improved retention and engagement for female physicians.

Emotional PPE Project/Dallas County Medical Society: This program is a collaboration between Dallas County Medical Society and the national Emotional PPE Project. The Emotional PPE Project is a robust, nationally built-out program that addresses the mental health crisis among health care workers that has been exacerbated due to COVID-19. The project has volunteer mental health counselors mobilized nationwide with capacity to serve any health care worker, free of charge, anywhere in the country. As of Sept 1, health care workers in 21 states have accessed the service and received counseling.

Yoga – Building Self-Regulation and Higher Consciousness/Ector County Medical Society: This 90-minute, biweekly yoga session with experienced instructors is offered to address physicians’ well-being and reduce stress during the pandemic. Classes will be conducted via Zoom to teach various stress management techniques, breathing exercises, and balance poses.

Physicians Connecting and Contributing/Lubbock County Medical Society: This program consists of weekly meetings of four physicians each. A certified life coach will cover a different topic at each session including finances, relationships (family and colleagues as well as staff and workplace), compulsions, self-care, mentoring/leadership, and compassion.

LifeBridge/McLennan County Medical Society: This program provides a resource for handling stress and anxiety in a safe and positive environment. The LifeBridge Program offers an outlet for physicians experiencing burnout, chronic stress, depression, addiction, distress by making available up to four counseling or coaching sessions with a licensed therapist per year at no cost to the physician.

Physician Wellness Program/Smith County Medical Society: This program will cast a broad safety net over physician members by helping with awareness and improvement of their mental health and well-being. The program will (1) introduce health and wellness topics via an annual video conference, and provide monthly instruction on meditation, exercise, and yoga practices; (2) provide online educational resources; and (3) provide a confidential counseling and coaching program to member physicians.

Physician Wellness Program/Travis County Medical Society: The Physician Wellness Program is designed to be a safe harbor for physicians to address normal life difficulties in a confidential and professional environment by providing a confidential counseling/intervention service to physicians in need and opportunities for physicians to share experiences in small groups and participate in educational events including the nationally recognized Finding Meaning in Medicine monthly video conference.
COUNTY MEDICAL SOCIETIES AND ALLIANCE CHAPTERS – Medical Community Grants

Grapeland Immunization Project/Anderson-Leon County Medical Society: This project provides flu vaccinations to Grapeland (in Houston County) school students during flu season. Volunteers will give flu shots to students who lack local access to health care so they stay healthy and avoid missing school.

Campaign to Reduce Bullying and Build Self-Esteem/Bexar County Medical Society Alliance: This campaign aims to reduce bullying and build self-esteem among children with craniofacial deformities and birth defects of the face or head such as a cleft palate. The program educates children and their families when they undergo treatment for this medical condition. Outreach to the patients’ peers addresses teasing and social exclusion, which can lead to depression and low self-esteem.

Drive Thru, Prevent Flu/Lamar Delta County Medical Society: The Paris-Lamar County Health District partnered with the Lamar-Delta County Medical Society and other community groups to provide an efficient method for 400 citizens, aged 18 or older, to receive the influenza vaccine. The “drive-thru” shot clinic is an easy-access option for both the elderly and a vast majority of the rural community who find it difficult to visit a regular, walk-in clinic.

Pneumonia Vaccine for the South Plains Food Bank/Lubbock County Medical Society Alliance: The South Plains Immunization Network in partnership with the Lubbock County Medical Society Alliance decreased the incidence of pneumonia in this underinsured population. Prevnar 13 was offered to clients of the South Plains Food Bank who qualify for the vaccine during the annual flu vaccine clinic at the food bank.

Battling Opioid Misuse in Nueces County/Nueces County Medical Society Alliance: Opioid misuse has become a public health crisis, and the Nueces Alliance raised awareness through a series of public service announcements and a symposium. Messaging stressed that opioids can be addictive and dangerous, how to prevent the start of opioid misuse, and how to support those already struggling.

Northeast Texas Public Health District Health on Wheels/Smith County Medical Society: The Northeast Texas Public Health District will bolster existing community health programs and services to residents of 21 East Texas counties with a donated Mobile Coach from Carter BloodCare. Among the outreach efforts will be the provision of mobile immunization services for children and adults in Wood County and rural Smith County.

Project Access Tarrant County (PATC)/Tarrant County Medical Society: Project Access Tarrant County is a community collaboration that provides compassionate specialty care for Tarrant County’s uninsured. A network of volunteer TMA member physicians collaborates with hospitals (by donating ancillary services), charitable community clinics, and providers to serve the target population, the uninsured working poor. To date, PATC has enrolled more than 1,300 patients and has provided more than $11.5 million in donated care this population otherwise would have been unable to obtain.

Immunization Collaboration of Tarrant County (ICTC)/Tarrant County Medical Society Alliance Foundation (TCMSAF): With a membership of more than 35 organizations including TCMSAF, this program provides (1) low-cost vaccine events that provide more than 7,000 eligible children and adults annually with required vaccines for kindergarten, seventh grade, and college school registrations; (2) vaccine education for parents, the community, health care workers, and providers through a website and social media channels so ICTC becomes a go-to source for information about the importance and safety of immunizations; and (3) vaccine advocacy collaboration with TMA and The Immunization Partnership leading to science-based vaccine policies.
Funding for these grants is made possible by the TMAF Medical Student Scholarship and Grant Trust Fund of Dr. Roberto J. and Agniela (Annie) M. Bayardo.

Alliance Refugee Wellness Fair/Baylor College of Medicine: This annual event provides direct medical and preventive health services, education about health and well-being, and access to medical care resources to the underserved refugee population that has resettled in Harris County. In partnership with several area not-for-profit refugee resettlement agencies, the fair provides refugees with culturally competent resources to navigate the Harris Health System.

Healthy Minds, Healthy Bodies/Baylor College of Medicine: This after-school education program for elementary students at an underserved school in Houston covers physical health and mental health. Students educate a primarily underserved community about holistic well-being and healthy habits, while simultaneously inspiring and encouraging interest in STEM fields and higher education.

Refugee Resettlement Needs Assessment/Baylor College of Medicine: This project is a collaboration among Baylor College of Medicine faculty and medical students and refugee communities in Houston to identify unmet needs of recently resettled refugees and explore social determinants of health. The results are used to strategically organize future initiatives and address specific community needs.

Flu Crew/Dell Medical School: The Dell Medical Students Flu Crew provides free vaccinations and vaccine education at community events to help keep Travis County residents healthy. The program also provides interprofessional, community-based learning opportunities for medical students.

Feed My Sheep Mobile Pediatric Clinic/Texas A&M Health Science Center College of Medicine: Feed My Sheep is a volunteer-based mobile clinic that provides health care to medically underserved children in Central Texas, with a primary focus on the uninsured. Students take a care van to low-income areas of the community to serve children with limited transportation and financial resources.

Community Week/Texas A&M Health Science Center College of Medicine: Community Week is a six-day event in collaboration with the colleges of Nursing and Pharmacy, the School of Public Health, and others to provide information, care, and services to the uninsured of Brazos County. The final day features an all-day health fair where community members learn about health and medicine and connect with people and local resources.

Breast Cancer Screening in Underserved Populations/Texas Tech University Health Sciences Center (TTUHSC) El Paso: The Medical Student Run Clinic of the Paul L. Foster School of Medicine currently serves the Sparks Colonia in rural El Paso County, providing free care including regular clinic visits, sports physicals, and breast cancer screening services. This program will expand to offer breast health education and mammography services to the Agua Dulce Colonia in El Paso County. TTUHSC El Paso medical students and physicians volunteer their time for this effort.

Smoking Cessation Program at the Free Clinic/ Texas Tech University Health Science Center Lubbock: This four-week class helps patients relearn the meaning of addiction, habit, and support. The program motivates patients to reflect on their personal reasons for quitting, become more aware of their smoking triggers, and understand how to separate their triggers from smoking, and it equips them with the tools and resources they need to quit.
UTHealthCares Third Annual Health Fair/The University of Texas Health Science Center at Houston – McGovern Medical School: This student-led interprofessional organization at McGovern Medical School serves the members of the Eastex-Jensen community of Houston. The primary service, an annual community health fair, is supplemented by monthly events. Attendees leave the health fairs with educational information and tools to create impactful changes to their health.

Frontera de Salud/The University of Texas Health Science Center at Houston – McGovern Medical School: This student-run community health project addresses health disparities in the Rio Grande Valley by providing medical students the opportunity to practice exam and communication skills through free health screenings and education for people in medically underserved communities. Collaborating with the Cameron County Health Department, the students screen 200-400 residents yearly and connect uninsured and high-risk attendees with local low-cost clinics and health services.

HOPE Health Fair/The University of Texas Medical Branch: This collaborative event provides vaccines, health screenings, and a meal to homeless and uninsured individuals in Galveston. The UTMB Family Medicine Interest Group and Gold Humanism Honor Society work with St. Vincent’s Student-Run Clinic to host the second annual HOPE (Helping Others Through Partnered Empowerment) Health Fair. In 2018, more than 200 vaccines were provided to this community, and in 2019, HOPE expects to serve at least 250 individuals.

Implementing a Smoking Cessation Program in a Dallas Homeless Population/UT Southwestern: UT Southwestern medical students address tobacco use by homeless people at a local shelter, Union Gospel Mission, through support groups, pharmacotherapy, and health education. This immersive educational opportunity for medical students in preventive and community medicine teaches building a future commitment to these communities by interacting with vulnerable populations and gaining knowledge about health disparities and cultural competency.

FAMILY OF FUNDS

The Family of Funds is the umbrella for TMAF funds and endowments that support the charitable health improvement and education goals of TMA and TMA Alliance members and the related efforts of TMA county medical societies and TMA Alliance and medical student chapters.

TMAF Hispanic Nursing Scholarship Trust Fund of Dr. Roberto J. and Agniela (Annie) M. Bayardo: This trust provides eight $10,000 scholarships annually for nursing students in Harris and Travis counties and is administered by the Harris County Medical Society Alliance Philanthropic Fund and the Travis County Medical Society Alliance Foundation.

TMAF Medical Student Scholarship and Grant Trust Fund of Dr. Roberto J. and Agniela (Annie) M. Bayardo: TMA county medical societies and alliance chapters that have a medical student scholarship program may apply for one scholarship grant up to $5,000 that matches the amount of the county medical society or alliance scholarship. In 2020, Lubbock, Midland, and Travis county medical societies each were granted two $5,000 scholarships to award through their programs. This fund also supports TMAF community health grants to TMA medical student chapters.

TMAF Hispanic Medical Student Scholarship Fund of Dr. Roberto J. and Agniela (Annie) M. Bayardo: This fund provides scholarships to Hispanic individuals accepted to or attending a Texas medical school. Grants are based on TMAF board-approved funding requests from TMA county medical societies or alliance chapters that have a medical student scholarship program and meet the fund
requirements. In 2020, Midland and Travis County Medical Societies each were granted two $5,000 scholarships to award through their programs.

Be Wise – Immunize is a service mark of the Texas Medical Association
Attachment B

TMA GRANTS - In support of TMA’s public health and science priorities

Vaccines Defend What Matters (VDWM) is TMA’s integrated, multimedia education and advocacy effort to overcome vaccine hesitancy and increase vaccination rates in Texas. This message is especially critical now that there are approved COVID-19 vaccines. While people are hearing mixed messages about the safety of vaccines, VDWM sends a strong message from today’s medical heroes that choosing to be immunized against COVID-19 and other infectious disease safeguards good health, jobs, schools, and the Texas economy.

VDWM replaces TMA’s Be Wise – Immunize℠ community education and outreach program after a 16-year run. VDWM will educate leaders and policymakers about the importance of vaccines, physicians on how to counter vaccine hesitancy in their patients, and the public on the impact immunization can have on their lives. VDWM will support individual county medical societies and TMA Alliance and medical student chapters that want to bring the campaign’s message into their communities through outreach that can be supported with a grant, including sharing the information with their members and the public via social media.

TMA’s Hard Hats for Little Heads encourages safe exercise and prevention of life-altering or fatal brain injuries in Texas children engaged in wheeled sports. Since inception in 1994, more than 350,000 free helmets have been given to youths aged 14 and younger at community events such as bicycle safety rodeos and health fairs. TMA and TMA Alliance members and community collaborators educate parents and children about the importance of wearing a properly fitted helmet when bicycling, inline skating, skateboarding, or riding a scooter.

TMA’s Ernest and Sarah Butler Awards for Excellence in Science Teaching: TMA is committed to elevating the importance of science in our modern society by recognizing and rewarding outstanding science teachers in elementary and junior and senior high schools. Since 1990, TMA has helped increase science literacy by providing cash awards to winning teachers and their schools to enhance their science curriculum.

TMA’s Minority Scholarship Program: Established in 1998, the program was designed as a unique means to fill a gap brought about by the Hopwood ruling barring public medical schools from offering minority-specific scholarships. In Texas, minority groups underrepresented regarding population-to-physician ratios are Hispanic, Black, and Native American. Annually, a qualified student entering each of Texas’ medical schools is selected to receive a $10,000 scholarship and named a “Bayardo Scholar” after Dr. and Mrs. Roberto Bayardo, who established an endowment that provides major support for this program.

Walk With a Doc Texas engages physicians, their patients, and the community in healthy physical activity to reverse the consequences of a sedentary lifestyle, especially obesity. During the pandemic, the program has shifted primarily to virtual “walks.”

TMA Alliance Texas BookShare: The BookShare program promotes healthy habits in children of all ages by supplying them with books on topics like the importance of physical activity, growing fruits and vegetables, and maintaining a healthy diet. County chapters partner with local pediatricians and family doctors to distribute the books to young patients, and each book includes a personal message from an alliance member written inside.
History of Medicine Banner Program: This program enables TMA’s History of Medicine Committee to offer the seven banner exhibit sets to schools, libraries, and other venues to educate the public on a range of health and medical subjects, enhance the image of physicians, and encourage the pursuit of research and science education. The banner exhibits promote TMA’s patient health advocacy goals through education and historical content.

Be Wise – Immunize is a service mark of the Texas Medical Association
Attachment C

TMA FOUNDATION MAJOR DONORS

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TMF Health Quality Institute has worked with Texas physicians for 50 years to help improve the health of Texans and health care in our communities.

TMF is recognized for our expertise and successes in delivering measurable improvements in the quality and delivery of health care, which derives from the strength of our relationship with Texas physicians.

As the Centers for Medicare & Medicaid Services (CMS) Quality Innovation Network-Quality Improvement Organization (QIN-QIO) for Texas, Arkansas, Mississippi, Nebraska, Puerto Rico, and the U.S. Virgin Islands, TMF conducts various health care initiatives. These initiatives include assisting the health care community with increasing screening for behavioral health issues; increasing the number of practitioners effectively implementing and providing chronic care management services to patients; helping communities improve coordination of health care for patients to reduce unnecessary hospital readmissions and adverse drug events; and reducing infections and injuries in addition to improving antibiotic stewardship programs in nursing homes.

Our QIN-QIO contract also provides new guidance on patient and family engagement in the patient’s health care. Through classes and various other outreach efforts, TMF is empowering patients and their family caregivers to be more confident participants in their health care. They are encouraged to be more open, informative, and helpful to their physicians to get the best care, and to be more inquisitive about the self-management of their health.

In our ongoing efforts to engage patients, caregivers, physicians, health care providers, advocates, and other stakeholders in a collaborative community, TMF continues to enhance our online Learning and Action Networks, which include thousands of U.S. and international users. These networks provide a forum for positive interaction, learning, and sharing of resources and best practices.

TMF is helping to improve health care in our communities through a variety of other state and federal contracts. We are increasing vaccination rates for children across Texas, training community health workers on chronic disease, and providing various health care facilities with data to help them self-audit to stay in compliance with Medicare regulations. Since TMF began working to promote childhood immunizations more than 15 years ago, we have successfully managed and completed more than 38,500 provider site reviews in multiple states.

Through the CMS Civil Money Penalty (CMP) Reinvestment Program, TMF was awarded CMP contracts to support the continued improvement of dementia care in Texas nursing homes, provide resident-focused assessment training in Texas nursing homes, and improve oral hygiene for nursing home residents in Louisiana and Mississippi.

TMF also is providing support for small medical practices in the CMS Quality Payment Program. Through this program, TMF provides Texas practices with technical assistance and services. This technical assistance brings direct support to thousands of MIPS-eligible clinicians in small practices with 15 or fewer clinicians, including small practices in rural locations, Health Professional Shortage Areas and Medically Underserved Areas. The direct technical assistance is free to all Merit-Based Incentive
Payment System (MIPS) eligible clinicians and delivers support for up to a five-year period. TMF is also supporting physicians who are part of this program in Arkansas, Colorado, Kansas, Louisiana, Mississippi, Missouri, Oklahoma, and Puerto Rico. This program concludes Feb. 15, 2022.

We are honored to partner with the Texas Medical Association (TMA) and the Texas Osteopathic Medical Association (TOMA) in offering the Texas Physician Practice Quality Improvement Award Program. Due to the public health crises of COVID-19, the awards program is on hold. Once the program resumes, TMF will update the award program website, https://award.tmf.org/, and distribute more information to practices that may qualify to participate.

We are grateful to TMA and TOMA for their foresight in setting up TMF Health Quality Institute. Together, we are in the best position to help Texas physicians and their patients realize outstanding health care in an ever-changing health care environment.
REPORT OF TEXAS MEDICAL ASSOCIATION ALLIANCE

TMAA Report 1 2021

Subject: Texas Medical Association Alliance Activities and Accomplishments

Presented by: Martha Vijjeswarapu, TMAA president

TMAA’s Successful Virtual Year

The Texas Medical Association Alliance started 2020 with visits to West Texas county alliances and county medical societies to learn more about their challenges and how TMAA could help bolster their membership. Additional trips planned around the state were put on hold in March because of the pandemic.

TMAA quickly pivoted its efforts to a virtual format (Zoom), which already was used regularly with the TMAA Board of Directors.

The alliance had its annual business meeting and president’s installation virtually in May 2020 to great success, garnering greater participation across the state. Since then, all business meetings have occurred virtually, with better response than TMAA in-person meetings because of the convenience.

The alliance also built bridges between its county chapters and TMAA leadership through free virtual programming including: (1) monthly county leadership listening sessions; (2) a Monthly Enrichment Series featuring speakers on such topics as dealing with uncertainty during the pandemic, managing conflict, financial planning, and building resiliency, as well as learning about the challenges and successes TMA President Diana Fite, MD, encountered as a mom, spouse, and physician; and (3) an online fitness challenge to encourage members’ improved physical and mental health.

The alliance also started two initiatives aimed at resident and early-career spouses: Allies in Medicine (AIM), and a Resident Emergency Fund. The AIM program links seasoned alliance members with young resident or early-career spouses to welcome them to organized medicine and provide support. The Resident Emergency Fund provides up to $1,000 for resident families who are in crisis.

Legislation/Political Action

In August 2019, the Alliance, in conjunction with TMA’s advocacy division, launched its newest grassroots advocacy program – First Tuesdays at the Capitol. The program encourages physicians, alliance members, and medical students to schedule short, informal visits with local legislators and their staff to build or maintain meaningful relationships.

Bell, Bexar, Big Country, Dallas, Harris, Hidalgo-Starr, Lubbock, Jefferson, Nueces, Tarrant, and Travis county medical societies and alliance chapters embraced the program and customized it to fit their advocacy needs.

In March 2020, the program changed from in-person to Zoom visits with even greater success. Because of the ease of coordinating and hosting virtual meetings with elected officials and the Family of Medicine, more than 120 meetings occurred in 2020. Two or three meetings were held each week during the fall involving physicians, alliance members, and medical students. The meetings provided a relaxed, informal atmosphere to discuss TMA’s legislative agenda, share physicians’ stories, and strengthen relationships.
TMA Foundation

TMAA applied for and received a grant of $12,000 to expand the Texas BookShare to five new county chapters and to sustain the program in four chapters. Texas BookShare promotes early literacy and health during wellness visits for children who live in underserved communities. Alliance chapters provide books to local physicians, who then prescribe the books to promote language development, healthy habits, and that help every child in Texas read.

Additionally, three local chapters applied for and were awarded TMAF grants: $7,500 to Tarrant CMS/Tarrant CMS Alliance to fund the Immunization Collaboration of Tarrant County; $2,500 to Bexar CMS Alliance for a campaign to reduce bullying and build self-esteem; and $5,000 to Nueces CMS Alliance for a project promoting literacy and healthy habits in a Title I school. Despite the COVID-19 pandemic, several alliance chapters participated in TMA’s Hard Hats for Little Heads, Walk With a Doc Texas, and Be Wise – ImmunizeSM programs, all funded by TMAF with cumulative grants of $234,334.

For the fourth year, two alliance chapters (Travis and Harris) received grants to provide Hispanic nursing scholarships, thanks to a fund established by Roberto Bayardo, MD, and his late wife, Agniela. Scholarships are $10,000 each.

The TMAA Holiday Sharing Card was repeated in 2020, raising $3,190. Currently, Angela Donahue, Sunshine Moore, and Debbie Pitts represent TMAA on the TMA Foundation Board of Trustees. Hundreds of TMA Alliance members and their spouses are TMAF donors, helping make programs such as Hard Hats for Little Heads, Vaccines Defend What Matters, and Walk With a Doc Texas possible.
Six new medical schools have opened in Texas in the past five years, increasing the state total to 15. The new matriculants (first-year enrollments) combined with enrollment expansions at existing schools resulted in an increase of 449 (24.8%) in the state’s composite class size, raising the total to 2,262 for the 2020-21 academic year. When the Paul L. Foster School of Medicine opened at Texas Tech University Health Sciences Center in El Paso in 2009, it was the first new medical school in Texas since 1971. During that same 38-year span – 1971-2009 – Texas grew by 13.4 million residents or 116%. The next new medical school didn’t open until 2016. The recent opening of six medical schools is a delayed response to the robust population growth experienced in the state in recent decades. Without enrollment growth, Texans would have less opportunity to go to medical school in their home state, and Texas would have fewer homegrown physicians.

TMA has policy (185.018) in support of expanded medical school enrollments and aligning graduate medical education (GME) capacity with these expansions to help retain graduates who want to train in the state and to prepare physicians in the specialties most needed for Texas.

Texas, California in second place
With 15 medical schools, Texas now ties with California for second place in number of medical schools. California and Texas are ranked first and second in population, while New York, ranked fourth in population, leads the country in the number of medical schools with 17.

TMA supports study for projected need of more medical schools
Another medical school is coming. The University of Texas System recently announced the development of a school in Tyler, for a planned opening in 2023 with an initial 30 to 35 students. TMA adopted policy in 2019 that supports a study of the projected need for more medical schools in the state, as follows:

200.058 Projected Need for More Medical Schools in Texas: 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 the Texas Higher Education Coordinating Board to commission a comprehensive study to be done on the projected need for additional medical schools. TMA supports the board’s use of the study in evaluating future proposals for the establishment of new medical schools in the state. (CME Rep. 4-A-19) (Emphasis added.)

To demonstrate the pace of growth at medical schools in Texas, Figure 1 shows the historical trend for matriculants. Starting with the oldest data available, 1990, and projecting to 2023, matriculants are projected to double from 1,220 to 2,471. To obtain matriculant projections, TMA surveyed Texas medical school deans in December 2020.
In 2002, the Association of American Medical Colleges encouraged U.S. allopathic medical schools to increase enrollments by 30% by 2015 to boost the national physician workforce. The Texas response was enthusiastic, and the number of matriculants exceeded the 2015 goal, growing by 35%. In a year-by-year comparison, the council learned the highest level of growth occurred more recently.

The biggest single-year increase in medical school matriculants occurred in 2020, with a jump of 187, as shown in Figure 2. For the 22-year period of 2002 to 2023, Texas had an average annual growth of 53 matriculants (including projections). That means the jump in 2020 was 3.5 times the annual average for this period.

Despite the high rate of growth, Texas ranks 37th in the number of medical students per capita in national state rankings (third quartile), with 28.3 medical students per 100,000 population. In comparison, the U.S. per-capita number is 36.8.
The jump in number of matriculants in 2020 resulted from the opening of two medical schools and growth at several others, including an increase of 54 at Texas A&M University, as shown in Table 1.

### Table 1

**Changes in Medical School Matriculants in Texas, By Medical School, 2020**  
(Excluding Schools with Changes <5 Matriculants)

<table>
<thead>
<tr>
<th>Medical School</th>
<th>Matriculants 2019</th>
<th>Matriculants 2020</th>
<th>Net Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sam Houston State Univ. Osteopathic Medical School, Conroe <em>(Opened in 2020)</em></td>
<td>0</td>
<td>75</td>
<td>75</td>
</tr>
<tr>
<td>Texas A&amp;M Univ.</td>
<td>123</td>
<td>177</td>
<td>54</td>
</tr>
<tr>
<td>Texas Tech Univ. Health Sciences Center El Paso</td>
<td>104</td>
<td>110</td>
<td>6</td>
</tr>
<tr>
<td>Univ. of Houston <em>(Opened in 2020)</em></td>
<td>0</td>
<td>30</td>
<td>30</td>
</tr>
<tr>
<td>Univ. of North Texas Health Science Center</td>
<td>230</td>
<td>247</td>
<td>17</td>
</tr>
<tr>
<td>Univ. of Texas Health Science Center at San Antonio</td>
<td>211</td>
<td>219</td>
<td>8</td>
</tr>
</tbody>
</table>

Recent enrollment increases have created a greater demand for clinical training sites. At the same time, Texas medical schools are competing with several out-of-state medical schools that are sending students to Texas for clinical rotations. Competition for clinical sites is further exaggerated by training needs for many other health professionals such as nurses, advanced practice registered nurses, physician assistants, physical therapists, and podiatrists. Concerns about out-of-state medical schools seeking clerkship sites in
Texas motivated the Texas Higher Education Coordinating Board to form a workgroup in February 2021 composed of Texas academic health center representatives. The workgroup is evaluating the coordinating board’s current process for approving out-of-state medical school students for clinical training in Texas.

To ensure Texas medical students have access to clinical training in Texas, the following TMA policy was amended in 2020 to include medical schools in other states. The policy was initially focused only on medical schools in the Caribbean and Mexico.

200.047 Clinical Training Resources for Texas Medical Students: TMA adopted the following principles as policy regarding clinical training resources for Texas Medical Students: …

3. TMA opposes extraordinary payments by any medical school for access to clinical rotations.

4. 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, amended C-ME Rep 4 2020).

GME positions growing, need funding

Like medical school enrollments, the number of residents physicians in the state is also at historic levels, with 7,953 residents at 648 residency programs (American Medical Association, 2019). Texas GME programs had higher growth rates than U.S. totals over the past decade, with an increase of 23% in the number of residents and 29% more residency programs. In a 2019 national ranking of states by the ratio of residents per capita, Texas ranked 25th (second quartile) with a ratio of 29.9 residents per 100,000 population, well below the U.S. total of 41. Texas had a better state ranking for residents per capita (25th) than for medical students per capita (37th).

Recent additions to medical school enrollments will put greater demands on the state’s GME capacity, and TMA has placed a high priority on getting this message out. TMA created a legislative one-pager to inform lawmakers during the 2021 state legislative session of the need to protect GME programs from potential cuts in the 2022-23 state biennial budget. Cuts of about 5% are proposed to the state’s GME funding programs.

Similar to the single-year jump in medical school matriculants in 2020, Texas also saw a historic jump in first-year GME positions in the past year, as shown in Figure 3. GME positions rose by 161 (8.1%) from 2019 to 2020, twice the annual average change for the past decade.
Figure 3
Net Annual Change in Texas First-Year GME Positions
Offered in Annual Match(s), 2011-20

Note: Data are not available for offered first-year residency positions in Texas for 2017 American Osteopathic Association Match; this year was omitted from the graph. Source: Results and Data 2020 Main Residency Match® National Resident Matching Program, Washington, DC; American Osteopathic Association Match. Prepared by TMA.

Will Texas maintain the 1.1 to 1 target ratio in the near future?
A target ratio of 1.1 to 1 first-year residency positions per Texas medical school graduate is defined in state policies, and TMA has policy in support of this target (185.024). An additional 10% first-year GME capacity is planned beyond the number of graduates to allow for graduates of medical schools in other states and other countries to train in the state, and physician retraining.

The council monitors how the state is doing in meeting this target ratio and recognized that the ratio was met for the first time in 2018 and maintained in 2019 and 2020, as seen in Figure 4. To assist TMA in advocacy, the council ran projections for this ratio through 2027. Ratios of the number of first-year GME positions per Texas medical graduate are shown in Figure 4 for 2016 to 2027. Actual ratios are shown for 2016 to 2020 and projected for 2021 to 2027.

Projected ratios for 2021 through 2027 are intended to demonstrate what COULD happen if there is no change in the number of first-year GME positions after 2020. The ratio is projected to drop below 1.1 to 1 beginning in 2024 and continue declining through 2027, even to below a ratio of 1 to 1.
Figure 4
Ratio of First-Year GME Positions per Texas Medical School Graduate 2016-27

Numbers for 2021-27 are projections.

Note: Data are not available on offered positions in Texas for the 2017 American Osteopathic Association Match; 2017 was omitted. Sources: Texas Higher Education Coordinating Board and TMA survey of Texas medical school deans; Results and Data 2020 Main Residency Match® National Resident Matching Program, Washington, DC; and American Osteopathic Association Match. Prepared by: TMA.

Expanding GME growth to meet medical school enrollment presents a challenge

The council calculated the number of additional first-year GME positions needed to maintain the ratio of 1.1 to 1 in the near future. As shown in Table 2, Texas needs to create 250 first-year GME positions between 2020 and 2024, an additional 300 by 2025, 400 more by 2026, and 475 more by 2027. These projections reflect the expected increase in medical school graduates. The three medical schools that opened since 2019 will each graduate their first class by 2024.

Table 2: Projected Deficit in First-Year GME Capacity for Projected Texas Medical School Graduates if No Change in GME Capacity from 2020 (Projected to 2027)

<table>
<thead>
<tr>
<th>Academic Year</th>
<th>Projected # Texas Graduates</th>
<th>First-Year GME Capacity in 2020</th>
<th>Projected Deficit in First-Year GME Capacity IF NO CHANGE FROM 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td>2024</td>
<td>2,402</td>
<td>2,148</td>
<td>-254</td>
</tr>
<tr>
<td>2025</td>
<td>2,457</td>
<td>2,148</td>
<td>-309</td>
</tr>
<tr>
<td>2026</td>
<td>2,542</td>
<td>2,148</td>
<td>-394</td>
</tr>
<tr>
<td>2027</td>
<td>2,624</td>
<td>2,148</td>
<td>-476</td>
</tr>
</tbody>
</table>

Sources: Texas Higher Education Coordinating Board and TMA survey of Texas medical school deans; and Results and Data 2020 Main Residency Match® National Resident Matching Program, Washington, D.C. Prepared by: TMA.
A 2017 state law requires new medical schools to formulate a plan to meet the GME needs of their future graduates. The two public medical schools that opened in 2020, University of Houston and Sam Houston State University, will be the first schools affected by this law, and the council will monitor the law’s impact. These schools will graduate their first students in 2024. TMA policy supports this requirement for public medical schools and voluntary participation by private schools:

200.052 Aligning Future Graduate Medical Education Capacity With Target Enrollments of New Texas Medical Schools: … TMA believes it is in the best interest of the state that any medical school operating in the state, public or private, should plan for the GME needs of its graduates and that its plans should focus on the GME capacity needed for the school’s target class size, with an emphasis on expanding care for patients by creating new GME positions rather than displacing GME programs already in existence. (CME Rep. 3-A-18)

Family medicine leads in new GME programs offered in 2020

As part of the monitoring of the state’s GME capacity, the council wanted to gain a better understanding of the kinds of residency programs opened in 2020. A total of 37 new residency programs in 19 medical specialties participated in the Texas National Resident Matching Program (NRMP) for the first time in 2020, with a total of 161 new positions, as shown in Table 3. The council learned that the largest number of new residency programs were in family medicine, with a gain of 43 first-year residency positions at seven new residency programs. The second largest was transitional with 39 new positions across three programs, and the third largest was internal medicine with 20 positions at one new residency program. Two out of three new positions were filled on Match Day in 2020 (65%), and 13 of the 19 specialties filled 100% of offered positions. Most specialties with new programs (11 of 19) offered fewer than five positions.
Table 3: New Residency Programs in 2020 Texas National Resident Matching Program (NRMP) by Type of Specialty

<table>
<thead>
<tr>
<th>Specialty</th>
<th># New Residency Programs</th>
<th># Filled</th>
<th>% Filled</th>
</tr>
</thead>
<tbody>
<tr>
<td>Anesthesiology</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>Dermatology</td>
<td>3</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>1</td>
<td>8</td>
<td>100%</td>
</tr>
<tr>
<td>Family Medicine</td>
<td>7</td>
<td>43</td>
<td>37.2%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>2</td>
<td>10</td>
<td>80%</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>1</td>
<td>20</td>
<td>100%</td>
</tr>
<tr>
<td>Medicine/Research</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>Medicine-Preliminary/Ophthalmology</td>
<td>3</td>
<td>12</td>
<td>100%</td>
</tr>
<tr>
<td>Medicine-Preliminary/Aerospace Medicine</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>Neurology</td>
<td>2</td>
<td>2</td>
<td>50%</td>
</tr>
<tr>
<td>Neurology, Child/Neuroscience</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>Obstetrics/Gynecology</td>
<td>2</td>
<td>6</td>
<td>100%</td>
</tr>
<tr>
<td>Pathology/Research</td>
<td>1</td>
<td>2</td>
<td>0%</td>
</tr>
<tr>
<td>Pediatrics-Preliminary/Neurodevelopmental</td>
<td>1</td>
<td>1</td>
<td>0%</td>
</tr>
<tr>
<td>Diseases</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Medicine &amp; Rehab</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>Radiology-Diagnostic</td>
<td>2</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>Surgery-Preliminary</td>
<td>3</td>
<td>6</td>
<td>100%</td>
</tr>
<tr>
<td>Transitional</td>
<td>3</td>
<td>39</td>
<td>38%</td>
</tr>
<tr>
<td>Vascular Surgery</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
</tbody>
</table>

TOTAL NEW PROGRAMS (19 specialties) 37 161 104 64.6%

Total Entry-Level Positions 28 151 95 62.9%

Total Advanced Level First-Year Residency Positions (Reserved for Physicians) 9 10 9 90%

Please Note: Statistics on fill rates reflect Match Day only; most programs will fill all positions by the end of Match Week or post-Match.
ADDITIONAL MATCHES: Please note, this report includes statistics only for the NRMP Match, excluding statistics for other match programs such as American Urological Association Match for urology training programs and San Francisco Matching Program for ophthalmology and most plastic surgery programs.
Source: Results and Data 2020 Main Residency Match® National Resident Matching Program, Washington, DC.
Prepared by: TMG.

Table 4 shows that Houston and Tyler had the largest number of positions among the new residency programs, with 45 and 23, respectively. Cities that did not gain new residency programs were Amarillo in the Panhandle, Wichita Falls in far north Texas, and Corpus Christi and Laredo in the south central regions of the state. Fort Worth was the only metro area with population over 1 million that did not have new programs.

HCA Gulf Coast Education Consortium in Houston had the largest number of new residency positions (41). For accuracy in reporting, Texoma Medical Center’s family medicine residency program
participated in the NRMP for the first time in 2020 but was not a new program. This program participated in the American Osteopathic Association’s Osteopathic Match in previous years. Accreditation of osteopathic residency programs transitioned to the Accreditation Council for Graduate Medical Education in 2020, and there is now a single national residency program accreditation system and a single annual residency match.

<table>
<thead>
<tr>
<th>Table 4: New Residency Programs in 2020 Texas NRMP by City and Sponsoring Institution</th>
<th># Pos. Offered</th>
<th># Pos. Filled</th>
<th>% Filled</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>ARLINGTON</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medical City Arlington</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Medicine</td>
<td>18</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>General Surgery</td>
<td>7</td>
<td>5</td>
<td>71%</td>
</tr>
<tr>
<td><strong>Total (2)</strong></td>
<td>25</td>
<td>5</td>
<td>20%</td>
</tr>
<tr>
<td><strong>AUSTIN</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UT Austin Dell Medical School</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dermatology</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td><strong>DALLAS</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UT Southwestern Medical Center</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurology, Child/Neuroscience</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>Pathology/Research</td>
<td>2</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Pediatrics-Preliminary/Neurodevelopmental Diseases</td>
<td>1</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Vascular Surgery</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Total (4)</strong></td>
<td>5</td>
<td>2</td>
<td>40%</td>
</tr>
<tr>
<td><strong>DENISON</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Texoma Medical Center</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Medicine</td>
<td>8</td>
<td>8</td>
<td>100%</td>
</tr>
<tr>
<td><em>(Note: participated in osteopathic Match in previous year)</em></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>EDINBURG</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UT Rio Grande Valley Med School/Doctor’s Hospital Renaissance</td>
<td>4</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td><strong>EL PASO</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Las Palmas Del Sol Healthcare</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Transitional</td>
<td>13</td>
<td>9</td>
<td>69%</td>
</tr>
<tr>
<td><strong>GALVESTON</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UT Medical Branch</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dermatology</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>Medicine-Preliminary/Ophthalmology</td>
<td>4</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Medicine-Preventive Medicine/Aerospace Medicine</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>Radiology-Diagnostic</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>Surgery-Preliminary</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Total (5)</strong></td>
<td>8</td>
<td>8</td>
<td>100%</td>
</tr>
<tr>
<td>City and Sponsoring Institution</td>
<td># Pos. Offered</td>
<td># Pos. Filled</td>
<td>% Filled</td>
</tr>
<tr>
<td>-------------------------------</td>
<td>---------------</td>
<td>--------------</td>
<td>----------</td>
</tr>
<tr>
<td>HARLINGEN</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UT Rio Grande Valley Medical School</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>Obstetrics/Gynecology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HOUSTON</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Baylor College of Medicine</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>Medicine/Research</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Physical Medicine &amp; Rehab</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>Total (2)</td>
<td>2</td>
<td>2</td>
<td>100%</td>
</tr>
<tr>
<td>HCA Gulf Coast Education Consortium</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Medicine</td>
<td>10</td>
<td>3</td>
<td>30%</td>
</tr>
<tr>
<td>Obstetrics/Gynecology</td>
<td>5</td>
<td>5</td>
<td>100%</td>
</tr>
<tr>
<td>Transitional (2 programs with 13 positions at each)</td>
<td>26</td>
<td>6</td>
<td>23%</td>
</tr>
<tr>
<td>Total (4)</td>
<td>41</td>
<td>14</td>
<td>34%</td>
</tr>
<tr>
<td>Methodist Hospital</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Neurology</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>UT Health Science Center at Houston</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>Dermatology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery-Preliminary</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>Total (2)</td>
<td>2</td>
<td>2</td>
<td>100%</td>
</tr>
<tr>
<td>HOUSTON Total (9)</td>
<td>46</td>
<td>19</td>
<td>41%</td>
</tr>
<tr>
<td>LUBBOCK</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Texas Tech Univ Health Sciences Center</td>
<td>8</td>
<td>8</td>
<td>100%</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicine-Preliminary/Ophthalmology</td>
<td>4</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Total (2)</td>
<td>12</td>
<td>12</td>
<td>100%</td>
</tr>
<tr>
<td>MIDLAND</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Texas Tech Univ Health Sciences Center</td>
<td>4</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Family Medicine</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>ODESSA</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Medicine/Rural (2 programs with 1 position at each)</td>
<td>2</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Note: The two rural training tracks in Odessa are part of a regional consortium. They will start in Texas in the first year and transfer to New Mexico for second and third years.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>PECOS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Family Medicine/Rural</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>SAN ANTONIO</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>UT Health Science Center at San Antonio</td>
<td>1</td>
<td>1</td>
<td>100%</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Medicine-Preliminary/Ophthalmology</td>
<td>4</td>
<td>4</td>
<td>100%</td>
</tr>
<tr>
<td>Radiology-Diagnostic</td>
<td>2</td>
<td>2</td>
<td>100%</td>
</tr>
<tr>
<td>Total (3)</td>
<td>7</td>
<td>7</td>
<td>100%</td>
</tr>
</tbody>
</table>
New Texas Residency Programs in 2020 NRMP Match by City and Sponsoring Institution

<table>
<thead>
<tr>
<th>City and Sponsoring Institution</th>
<th># Pos. Offered</th>
<th># Pos. Filled</th>
<th>% Filled</th>
</tr>
</thead>
<tbody>
<tr>
<td>TEMPLE</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Texas A&amp;M College of Medicine, Scott &amp; White Hosp.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Neurology</td>
<td>1</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>TYLER</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UT Health Science Center at Tyler</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>General Surgery</td>
<td>3</td>
<td>3</td>
<td>100%</td>
</tr>
<tr>
<td>Internal Medicine</td>
<td>20</td>
<td>20</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Total (2)</strong></td>
<td><strong>23</strong></td>
<td><strong>23</strong></td>
<td><strong>100%</strong></td>
</tr>
<tr>
<td><strong>State Totals (37)</strong></td>
<td><strong>161</strong></td>
<td><strong>104</strong></td>
<td><strong>64.6%</strong></td>
</tr>
</tbody>
</table>

Source: Results and Data 2020 Main Residency Match® National Resident Matching Program, Washington, DC.
Prepared by: TMA

TMA supports rural training track funding

Table 4 lists three rural training track programs in the West Texas cities of Midland, Odessa, and Pecos, developed by Texas Tech University Health Sciences Center-Permian Basin. TMA has policy that recognizes the important role of rural training tracks in preparing physicians for rural practice, including the following:

185.023 Support of Rural Residency Training and State Grant Program for Promoting Rural Training Tracks: … 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. 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. …(CME Rep. 4-A-17, amended C-ME Rep 1 2020).

To facilitate the creation of more rural training tracks in the state, TMA initiated House Bill 1065 (Trent Ashby, R-Lufkin) in 2019 that created a state grant program for rural training tracks. This bill was passed by the Texas Legislature but lacks funding, and TMA is advocating for $1 million in the state’s 2022-23 biennial budget to kick-start the state grant program.

Specialty match results: 2020 Match Day

For residency programs that offered at least 10 first-year positions in the 2020 match, only medicine-pediatrics filled 100% of the positions on Match Day with U.S. medical school seniors. In addition to medicine-pediatrics, the following specialties filled more than 90% of offered positions with U.S. seniors (in order by fill rate): dermatology, orthopedic surgery, anesthesiology, obstetrics-gynecology, emergency medicine, neurological surgery, and plastic surgery.

The 2020 match had new programs for four of the eight specialties in high demand by U.S. graduates, as shown in Table 3: dermatology (3 new programs), obstetrics-gynecology (two), anesthesiology (one), and emergency medicine (one). Medicine-pediatrics, orthopedic surgery, neurological surgery, and plastic surgery had no new programs.

Pathology filled the lowest percentage of offered positions on Match Day, at 42%. When match rates for seniors are separated for allopathic and osteopathic schools, pathology had the lowest fill rate of allopathic students (31.1%), followed by family medicine (39%). Family medicine has had a similar fill
rate for allopathic seniors for some time. The percentage of first-year family medicine positions filled by
osteopathic seniors was 24%, with a combined fill rate of 62.8%.

An increasing number of U.S.-citizen seniors/graduates from foreign medical schools are participating in
the Texas Match, and most are from schools in the Caribbean or Mexico. In the 2020 Match, 41% of the
38 international medical graduates (IMGs) who matched to a Texas residency program were U.S.
citizens. For both U.S.-citizen IMGs and foreign-born IMGs, the top three medical specialties matches
were internal medicine (36%), family medicine (18.5%), and pediatrics (10.7%). U.S. citizen- IMGs were
three times more likely to match to family medicine than foreign-born IMGs (30% vs. 10%). Foreign-
born IMGs were slightly more likely to choose pediatrics (10.7%) than U.S.-citizen IMGs (7.1%).

Number of unmatched Texas medical school graduates dropped
Since 2014, the council has partnered with Texas medical school deans to monitor the number of Texas
medical school graduates who do not match to a residency position. An annual average of 36 (2%) Texas
medical school graduates were unable to match to a residency position in the year of their graduation
during 2014-19. In 2020, there were only 13 unmatched Texas graduates – one-third the average for
the prior six years. Why the number dropped so sharply is unclear, but lowering the number of unmatched
graduates is a shared goal between the medical schools and the council.

State support has grown GME capacity, more is needed
Texas legislators have shown strong support for expanding and maintaining the state’s GME capacity. In
2015, Texas passed landmark legislation to provide state grants to GME sponsors with the goal of
achieving the target ratio of 1.1 to 1. This legislation also established the state’s first-ever state GME
permanent fund, seeded with $300 million. The fund provides $11 million a year to the state GME
Expansion Grant Program.

Meeting the target ratio of 1.1 to 1 has been championed by Sen. Jane Nelson (R-Flower Mound), the
longstanding chair of the Senate budget committee. Since 2014, the state appropriated a total of $321.5
million for GME expansion grants (note: a small state GME grant program preceded the 2015 landmark
legislation). These funds enabled the creation of a total of 410 first-year GME positions since 2014
(Table 5). Funds were not available to support new positions in 2018.

### Table 5

<table>
<thead>
<tr>
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<th></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>25</td>
<td>63</td>
<td>71</td>
<td>78</td>
<td>0</td>
<td>38</td>
<td>115</td>
<td>20</td>
<td>410</td>
</tr>
</tbody>
</table>

*2021 subject to verification.

**Source:** Texas Higher Education Coordinating Board. Prepared by: TMA.

In addition, grants of $75,000 each were provided in 2020-21 to support an estimated 1,867 second- and
third-year GME positions created through the program, for a total of 2,002 supported GME positions
(Table 6) with a total of $150.15 million in grants.

### Table 6

<table>
<thead>
<tr>
<th></th>
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<th></th>
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<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2014</td>
<td>25</td>
<td>125</td>
<td>278</td>
<td>458</td>
<td>583</td>
<td>702</td>
<td>895</td>
<td>1,107*</td>
<td>4,173</td>
</tr>
</tbody>
</table>

*2021 subject to verification.

**Source:** Texas Higher Education Coordinating Board. Prepared by: TMA.
The Texas Higher Education Coordinating Board, which administers the state GME Expansion Grant Program, has placed a high priority on primary care and psychiatry, and this is reflected in the grant awards for 2021, shown in Table 7. Of the total 1,107 GME positions funded through the grant program in 2021, 63% are in primary care, 16% are in psychiatry, and 1% are in a primary care/psychiatry combined program for a combined primary care/psychiatry total of 80%. Only 20% of funded positions were nonprimary care (excluding psychiatry).

Table 7
% GME Positions (All Post-Graduate Years) Funded With State GME Expansion Grants, 2021*

<table>
<thead>
<tr>
<th>Specialty Category</th>
<th>2021 # Funded GME Positions</th>
<th>% of Funded GME Positions</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>698</td>
<td>63%</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>178</td>
<td>16%</td>
</tr>
<tr>
<td>Primary Care and Psychiatry (Medicine-Psychiatry)</td>
<td>5</td>
<td>1%</td>
</tr>
<tr>
<td>Other Non-Primary Care Specialties</td>
<td>226</td>
<td>20%</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td><strong>1,107</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>

*2021 subject to verification.
Source: Texas Higher Education Coordinating Board. Prepared by: TMA

Distribution of the grant funds by specialty for the 2020-21 state biennium is shown in Table 8, in order by amount of funding. Internal medicine received the largest amount of grant funding, followed closely by family medicine. For nonprimary care specialties, psychiatry received the largest distribution, by far. Although internal medicine is included in the tabulations of primary care residency programs in tables 7 and 8, it is recognized that a portion of physicians who train in internal medicine will likely go on to train in fellowships in nonprimary care specialties. This also applies to pediatrics, to a lesser degree. For this reason, the percentage of residents who ultimately enter primary care practices is likely to be lower than the summaries shown.

Texas has a shortage of primary care physicians, as presented in Report 4 2021 Texas Physician Workforce Update prepared by the TMA Committee on Physician Distribution and Health Care Access. It is also recognized that Texas has a shortage of many other medical specialties, including a maldistribution in many areas of the state.
Table 8  
GME Positions Funded with State GME Expansion Grants, by Specialty, in 2020-21  
In Order by Total Funding

<table>
<thead>
<tr>
<th>Number of Programs</th>
<th>Program Specialty</th>
<th>Positions Funded 2020</th>
<th>Positions Funded 2021*</th>
<th>Total Funding</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>19</td>
<td>Internal Medicine</td>
<td>222</td>
<td>293</td>
<td>$38,625,000</td>
</tr>
<tr>
<td>20</td>
<td>Family Medicine</td>
<td>215</td>
<td>258</td>
<td>$35,475,000</td>
</tr>
<tr>
<td>8</td>
<td>Pediatrics</td>
<td>73</td>
<td>80</td>
<td>$11,475,000</td>
</tr>
<tr>
<td>5</td>
<td>Obstetrics/Gynecology</td>
<td>33</td>
<td>41</td>
<td>$5,550,000</td>
</tr>
<tr>
<td>3</td>
<td>Internal Medicine-Pediatrics</td>
<td>25</td>
<td>26</td>
<td>$3,825,000</td>
</tr>
<tr>
<td>Primary Care Total</td>
<td></td>
<td>568</td>
<td>698</td>
<td>$94,950,000</td>
</tr>
<tr>
<td>Psychiatry</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>14</td>
<td>Psychiatry</td>
<td>135</td>
<td>178</td>
<td>$23,475,000</td>
</tr>
<tr>
<td>Primary Care and Psychiatry</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>Internal Medicine/Psychiatry Combined Program</td>
<td>5</td>
<td>5</td>
<td>$750,000</td>
</tr>
<tr>
<td>Primary Care and Psychiatry Total</td>
<td></td>
<td>708</td>
<td>881</td>
<td>$119,175,000</td>
</tr>
<tr>
<td>Other Non-Primary Care Specialties</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6</td>
<td>Neurology</td>
<td>38</td>
<td>44</td>
<td>$6,150,000</td>
</tr>
<tr>
<td>3</td>
<td>Emergency Medicine</td>
<td>26</td>
<td>47</td>
<td>$5,475,000</td>
</tr>
<tr>
<td>5</td>
<td>Surgery</td>
<td>33</td>
<td>36</td>
<td>$5,175,000</td>
</tr>
<tr>
<td>3</td>
<td>Anesthesiology</td>
<td>26</td>
<td>28</td>
<td>$4,050,000</td>
</tr>
<tr>
<td>2</td>
<td>Transitional Year</td>
<td>25</td>
<td>26</td>
<td>$3,825,000</td>
</tr>
<tr>
<td>1</td>
<td>Orthopedic Surgery</td>
<td>16</td>
<td>20</td>
<td>$2,700,000</td>
</tr>
<tr>
<td>1</td>
<td>Physical Medicine &amp; Rehab</td>
<td>16</td>
<td>16</td>
<td>$2,400,000</td>
</tr>
<tr>
<td>1</td>
<td>Plastic Surgery-Integrated</td>
<td>6</td>
<td>6</td>
<td>$900,000</td>
</tr>
<tr>
<td>2</td>
<td>Urology</td>
<td>1</td>
<td>3</td>
<td>$300,000</td>
</tr>
<tr>
<td>Other Non-Primary Care Specialties Total</td>
<td></td>
<td>187</td>
<td>226</td>
<td>$30,975,000</td>
</tr>
<tr>
<td>TOTAL All Specialties</td>
<td></td>
<td>895</td>
<td>1,107</td>
<td>$150,150,000</td>
</tr>
</tbody>
</table>

*2021 subject to verification.  
Source: Texas Higher Education Coordinating Board. Prepared by: TMA.
State budget writers are now working on the biennial state proposals for 2022-23. Both the Senate and the House are proposing $150 million in funding for the state GME Expansion Grant Program. The council recognizes there are tremendous pressures on the state budget; however, it should be noted that this funding level will not allow any grants for the creation of new GME positions in 2022 and 2023. In addition, funds would not be available for grants to support the refilling of GME positions previously created through the program as residents progress to the next year of their training program. State authorities estimate an additional $49 million is needed, for a total of $199 million in 2022-23, to sustain the state GME Expansion Grant Program.

Texas legislators also provide funding to other GME programs, such as state formula funding to medical schools, with an overall total of $135 million a year. Cuts of about 5% are proposed for these programs in 2022-23.

To maintain the target ratio of 1.1 to 1, as noted in Table 2 on page 6, Texas needs to create an additional 250 first-year GME positions by 2024, 300 additional by 2025, 400 additional by 2026, and 500 more by 2027. To reach a ratio of at least 1 to 1 (instead of 1.1 to 1) and have a first-year position for each Texas medical school graduate, Texas needs to create 36 additional positions by 2024, 86 by 2025, 163 by 2026, and 237 by 2027.

Summary

During the 45 years from 1971 to 2016, only one medical school opened in Texas. Since then, six medical schools opened and another is in development. Considering the high rate of population growth during that considerable time span, the recent opening of new medical schools represents a delayed response to the robust growth in the state’s population. There is strong interest in a study of the future demand for more medical schools in the state to evaluate whether Texas is on track to meet future physician workforce needs and to ensure sufficient clinical clerkship capacity for Texas medical students and clinical training space for other Texas health professional educational programs.

In 2020, both medical school matriculants and first-year GME positions saw a sudden jump in numbers. And, in both cases, the numbers represented historic gains. Through the state’s GME Expansion Grant Program, a total of 410 first-year GME positions have been created since 2014 with a large majority in primary care and psychiatry. Initial 2022-23 state budget proposals of $150 million for this program will not be sufficient to fund grants for the creation of additional GME positions and also are not sufficient to fund residency positions created through the program that become available as residents progress to the next year in their training. State authorities estimate an additional $49 million, for a total of $199 million, is needed to sustain the program in 2022-23.

Unless the state’s GME capacity continues to grow incrementally, the state will fall short of the target 1.1 to 1 ratio and even a 1 to 1 ratio. Texas needs to create 250 additional first-year GME positions by 2024 to maintain the 1.1 to 1 ratio; 300 by 2025; 400 by 2026; and 475 by 2027. Without additional GME growth, there will not be enough first-year GME positions to retain Texas graduates beginning in 2024, and Texas will lose graduates to other states. Given the state’s investment in the education of these physicians and the ongoing physician workforce shortage in the state, this would be a tremendous loss for Texas.

There is a need for continued growth of the state’s GME capacity and sustained state support to achieve that goal. This report was prepared to inform the TMA House of Delegates, TMA’s members, and state policymakers of that need, as demonstrated through recent data analysis and TMA surveys. TMA will continue to place a priority on advocating for growth in the state’s GME capacity during the 2021 state legislative session.
Subject: Recognizing Charles E. Cowles, Jr., MD

Presented by: Kevin W. Klein, MD, Chair, Council on Medical Education

Charles E. Cowles, Jr., MD, lost his life on Dec. 26, 2020, due to a tragic automobile accident while on vacation with his wife and three young sons. His love for medicine began as a young man, when he worked as an EMT and firefighter. With those experiences, he decided to pursue a career in medicine and eventually, to work and teach in anesthesiology.

Dr. Cowles was a devoted son of Houston. He was born at Hermann Hospital on April 19, 1968 and grew up in the Houston area. He earned a bachelor’s degree in sports medicine from the University of Houston, followed by a medical degree and anesthesiology specialty training from The University of Texas Medical School at Houston. And, at the time of his death, Dr. Cowles worked as a neuro-anesthesiologist and a professor at The University of Texas MD Anderson Cancer Center.

Organized medicine was an important part of Dr. Cowles’ life. He joined the Texas Medical Association early in his career, remaining a member for 20 years. He served in multiple leadership positions in the Harris County Medical Society, Texas Society of Anesthesiologists, and TMA. He received the Distinguished Educator in Anesthesiology Award from the American Society of Anesthesiologists. At the time of his death, Dr. Cowles held the position of chair of the TMA Council on Medical Education; was a member of the TMA Interspecialty Society; and served as Secretary-Treasurer of Harris County Medical Society. His prior service included appointments to the TMA Committee on Membership, including tenure as chair, and the TMA Committee on Emergency Medical Services. He was a graduate of the TMA Leadership College. At Harris County Medical Society, he was Vice Chair of the HCMS Delegation to TMA, a member of the Gulf Coast Regional Blood Center Board, and a past member and chair of the Board of Ethics. He also served on the TMA Insurance Trust Board.

Additional information from his obituary:
Charles used his accumulated knowledge and wisdom as a first responder throughout his anesthesia career. He served on multiple institutional safety committees and was ultimately named the chief safety officer for the Anesthesiology Division in 2016. Charles was an international expert in operating room fire safety and traveled worldwide teaching from his unique experience as both a firefighter and anesthesiologist. He served on multiple committees for local, state, and national medical societies. Not wanting to limit his contributions solely to anesthesia, Dr. Cowles also served as the Tactical Medical Director of the Pasadena Police Department and the Local Health Authority for the City of Pasadena during the COVID-19 pandemic.

Inside and outside of work, his family and his faith were essential. He was very involved at First Baptist Church of Pasadena, as a deacon and the medical committee director. He served as a board member of the First Baptist Christian Academy, where his three sons attended elementary and middle school. Charles served on the board of Youth Reach Houston, a home for troubled boys.

Dr. Cowles’ legacy remains with all who were privileged to know him. He left his mark on organized medicine and he will not be forgotten.
Subject: 2020-21 Board Officers and Committees

Presented by: Gary W. Floyd, 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 September 2020, the board elected Gary W. Floyd, MD, as chair; Richard W. Snyder, as vice chair; and Michelle A. Berger, MD, as secretary. The board approved codifying its executive committee to the following officers: TMA President Diana L. Fite, MD; President-Elect E. Linda Villarreal, MD; Immediate Past President David C. Fleeger, MD; board chair; vice chair; Speaker of the House of Delegates Arlo F. Weltge, MD; and secretary/treasurer for the House of Delegates and Board of Trustees. The board welcomed Kimberly E. Monday, MD, as an at-large member and M. Brett Cooper, MD, as the young physician member for 2020-22.

Board committees for 2020-21 are:

- Finance and Investments (Dr. Berger, chair; Keith Bourgeois, MD; G. Ray Callas, MD; Dr. Fleeger; Bradford W. Holland, MD; Dr. Monday; Dr. Snyder; Dr. Villarreal; Dr. Floyd as board chair liaison; and TMA Foundation liaison Craig Norman, RpH);
- Educational Scholarship and Loan (Sue S. Bornstein, MD, chair; Dr. Cooper; Dr. Fite; Cynthia A. Jumper, MD; Jayesh B. Shah, MD; Joseph S. Valenti, MD; Dr. Weltge; resident trustee Kayla Riggs, MD; student trustee Vamsi K. Potluri; Dr. Floyd as board chair liaison; Dr. S.E. Thompson Scholarship Fund Trustee John M. Zerwas, MD; Resident and Fellow Section representative Justin W. Holmes, MD; Medical Student Section (MSS) representative Syed Rizvi; MSS alternate representative Brittany Ikwuagwu; and TMA Alliance representatives Pam Abernathy and James P. Davis.

Drs. Bourgeois, Callas, Fite, Fleeger, Floyd, Villarreal, and Weltge represent the board on the TMA/Texas Osteopathic Medical Association/TMF Health Quality Institute Liaison Committee. Drs. Bornstein, Bourgeois, Callas, Curran, Fite, Fleeger, Monday, 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; Muriel Mendell; Ann Morales; Beverly Ozanne; George Peterkin III, MD; and Shirley Sanders. Dr. Floyd 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; J. Patrick Walker, MD; and Larry Wilson, MD. J.J. Waller, MD, serves as the TMA Alliance 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. Jennifer Fan, MD, serves as the Resident and Fellow Section representative and Pranati Pillutla as the MSS representative.
Subject: Disclosure of Affiliations

Presented by: Gary W. Floyd, MD, chair

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.
BY ORGANIZATION:

AllCare Physicians Group Board of Directors
   G. Ray Callas, MD (D)

American Academy of Ophthalmology
   Keith A. Bourgeois, MD

American Academy of Pediatrics
   Gary W. Floyd, MD (C and D)

American Board of Anesthesiology
   G. Ray Callas, MD

American Board of Medical Specialties
   Cynthia A. Jumper, MD

American College of Cardiology, Texas Chapter
   Richard W. Snyder, MD

American College of Emergency Physicians
   Diane L. Fite, MD
   Arlo F. Weltge, MD

American College of Hyperbaric Medicine
   Jayesh B. Shah, MD

American College of Physicians
   Sue S. Bornstein, MD
   Cynthia A. Jumper, MD

American Medical Response
   Arlo F. Weltge, MD

American Society of Anesthesiologists
   G. Ray Callas, MD

Anesthesia Associates
   G. Ray Callas, MD (D)

Austin Ear, Nose and Throat Clinic
   Michelle A. Berger, MD (D)

Bailey Square Surgery Center
   Michelle A. Berger, MD
   David C. Fleeger, MD

Baylor University
   Bradford W. Holland, MD
Beaumont Chamber of Commerce
    G. Ray Callas, MD

Blue Cross and Blue Shield of Texas
    G. Ray Callas, MD (D)
    Richard W. Snyder, MD (D)
    Linda Villarreal, MD (D)

Cardiovascular Provider Resources, Inc.
    Richard W. Snyder, MD

Caring for Women, PA
    Joseph S. Valenti, MD

Central Texas Colon & Rectal Surgeons
    David C. Fleeger, MD

CHI Patients Medical Center, Pasadena, Texas
    Kimberly E. Monday, MD

Emerus Community Hospital
    Diana L. Fite, MD

Employees Retirement System of Texas
    Cynthia A. Jumper, MD

Extraco Banks
    Bradford W. Holland, MD

Fish Pond Surgery Center
    Bradford W. Holland, MD (D)

Harris County Hospital District
    Kimberly E. Monday, MD

HeartPlace, PA
    Richard W. Snyder, MD

Houston Community College
    Diana L. Fite, MD
    Arlo F. Weltge, MD

Houston Neurological Institute
    Kimberly E. Monday, MD

Jefferson and Orange County Board of Pilot Commissioners
    G. Ray Callas, MD

Kare Infusion Center
    G. Ray Callas, MD (C and D)

Keith A. Bourgeois, MD, PA
    Keith A. Bourgeois, MD (A, B, C, and D)
Lone Star Alliance Board of Directors
  Joseph S. Valenti, MD

Mallinckrodt Pharmaceuticals
  G. Ray Callas, MD (D)

Medical Care Advisory Committee
  Cynthia A. Jumper, MD

Memorial Hermann Health Care System
  Kimberly E. Monday, MD

Memorial Hermann Physician Network
  Kimberly E. Monday, MD

Memorial Medical Clinic
  E. Linda Villarreal, MD

Mission Trail Baptist Hospital/Tenet
  Jayesh B. Shah, MD

Northwest Surgery Center
  Michelle A. Berger, MD

PathAdvantage Associated
  Sue S. Bornstein, MD

Physicians Foundation Board of Directors
  Joseph S. Valenti, MD

South Texas Wound Associates, PA
  Jayesh B. Shah, MD

Southwestern Medical Foundation
  Richard W. Snyder, MD

Specialty Physician Assurance Company
  Richard W. Snyder, MD

St. Joseph Medical Center
  Keith A. Bourgeois, MD (D)

Surgicare of South Austin
  David C. Fleeger, MD

Tarrant County Emergency Physicians Advisory Board
  Gary W. Floyd, MD

Texas Association of Otolaryngology
  Bradford W. Holland, MD

Texas College of Emergency Physicians
  Diana L. Fite, MD
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| Texas Medical Association PracticeEdge, LLC                         | Gary W. Floyd, MD (C and D) |
| Texas Medical Association Specialty Services, LLC                   | Richard W. Snyder, MD |
| Texas Medical Foundation Health Quality Institute                    | Gary W. Floyd, MD (C and D) |
| Texas Medical Home Initiative                                        | Sue S. Bornstein, MD |
| Texas Medical Liability Trust                                        | Keith A. Bourgeois, MD (D) |
|                                                                     | G. Ray Callas, MD (D) |
|                                                                     | Joseph S. Valenti, MD |
| Texas Neurological Society                                           | Kimberly E. Monday, MD |
| Texas Pediatric Society                                              | Gary W. Floyd, MD |
| Texas Society of Anesthesiologists                                  | G. Ray Callas, MD (C and D) |
| Texas Tech University Health Sciences Center-Lubbock                | Cynthia A. Jumper, MD |
| TIMEO2 Healing Concepts, LLP                                         | Jayesh B. Shah, MD |
| McGovern Medical School at UTHealth                                  | Arlo F. Weltge, MD |
|                                                                     | Kimberly E. Monday, MD |
| UT Southwestern Medical School                                       | M. Brett Cooper, MD |
| Waco Otolaryngology, PC                                              | Bradford W. Holland, MD (C) |
| Wound Care Alliance                                                 | Jayesh B. Shah, MD |
| **BY MEMBER:**                                                      |                 |
| Michelle A. Berger, MD                                               |                 |
| Austin Ear, Nose and Throat Clinic (D)                              |                 |
| Bailey Square Surgery Center                                         |                 |
Northwest Surgery Center

**Sue S. Bornstein, MD**
- American College of Physicians
- PathAdvantage Associated
- Texas Medical Home Initiative

**Keith A. Bourgeois, MD**
- American Academy of Ophthalmology
- Keith A. Bourgeois, MD, PA (A, B, C, and D)
- St. Joseph Medical Center (D)
- Texas Medical Liability Trust (D)

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- American Board of Anesthesiology
- American Society of Anesthesiologists
- Anesthesia Associates (D)
- Beaumont Chamber of Commerce
- Blue Cross and Blue Shield of Texas (D)
- Jefferson and Orange County Board of Pilot Commissioners
- Kare Infusion Center (C and D)
- Mallinckrodt Pharmaceuticals (D)
- Texas Department of Licensure and Regulations
- Texas Medical Liability Trust (D)
- Texas Society of Anesthesiologists (C and D)

**M. Brett Cooper, MD**
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- Emerus Community Hospital
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- Texas College of Emergency Physicians

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- Surgicare of South Austin

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- Tarrant County Emergency Physicians Advisory Board
- Texas Medical Association PracticeEdge, LLC (C and D)
- Texas Medical Foundation Health Quality Institute (C and D)
- Texas Pediatric Society

**Bradford W. Holland, MD**
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- Extraco Banks
- Fish Pond Surgery Center (D)
- Texas Association of Otolaryngology
- Waco Otolaryngology, PC (C)
Cynthia A. Jumper, MD
American Board of Medical Specialties
American College of Physicians
Employees Retirement System of Texas
Medical Care Advisory Committee
Texas Tech University Health Sciences Center-Lubbock

Kimberly E. Monday, MD
CHI Patient’s Medical Center, Pasadena, Texas
Harris County Hospital District
Houston Neurological Institute
Memorial Hermann Health Care System
Memorial Hermann Physician Network
Texas Neurological Society
McGovern Medical School at UTHealth

Jayesh B. Shah, MD
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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 Board of Directors
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
McGovern Medical School at UTHealth
REPORT OF BOARD OF TRUSTEES

BOT Report 3 2021

Subject: TMA Insurance Trust, TMF Health Quality Institute, and Texas Medical Liability Trust

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). In September 2020, Dr. Noel cast the proxy vote to elect Lan Le, DO, of Fort Worth to fill the open position vacated by the term expiration of Russ Juno, MD (immediate past chair). TMAIT board member Charles E. Cowles Jr., MD, passed away in December 2020. His position on the board will be filled at the next TMAIT Annual Meeting of Subscribers in September.

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.

Nominations for positions on the TMFHQI board to be filled by MDs are solicited from TMA. In addition, a general notice is sent to TMFHQI members, who may offer nominations. The election, by those attending and by proxy, is held during the institute’s annual meeting in August.

Currently TMA members on the TMFHQI board are the following: Gary W. Floyd, MD, Fort Worth; Kevin H. McKinney, MD, Galveston; Lisa L. Ehrlich, MD, Houston; Ronald S. Walters, MD, Bellaire; and Erick Santos, MD, PhD, Corpus Christi. In June 2021, the term of one physician serving in a MD position expires, Gary W. Floyd.

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.

Current TMA members on the TMLT board are the following: Gerald “Ray” Callas, MD, Beaumont; Michelle Harden, MD, San Antonio; Russell Krienke, MD, Austin; Luis M. Benavides, MD, Laredo; A. Compton Broders, MD, Dallas-Fort Worth; William Fleming, III, MD, Houston; Lindsey Harris, MD, Houston; Herb Singh, MD, Austin; and Tim West, MD, Lubbock.
REPORT OF BOARD OF TRUSTEES

Subject: Medical Student and Resident Physician Loan Funds

Presented by: Gary Floyd, MD, chair

Overview
The medical student and resident physician loan program originated in 1952 with trust donations set up in endowed funds at the Texas Medical Association. 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, 2020, TMA disbursed 23 loans totaling $118,922 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. Three resident loans totaling $13,000 were disbursed from July 1 through Dec. 31, 2020.

2021-22 Allocation
In January 2021, the board approved allocations for the 2021-22 school year (June 1-May 31) totaling $736,000, including $38,000 for residents. The loan allocations to the 15 medical schools are based on availability of funds, history of each school’s utilization, and the current pandemic reducing borrower needs.
REPORT OF BOARD OF TRUSTEES

BOT Report 5 2021

Subject: Minority Scholarship Program

Presented by: Gary Floyd, MD, chair

Since 1998, the Texas Medical Association Minority Scholarship Program has given 164 scholarships to underrepresented minority medical students in Texas for a total of $1,127,500. Fifteen Texas medical schools have received an award. As of Jan. 27, 2021, the TMA Foundation has collected $35,835 in cash and pledges for the 2021 scholarships. All shortfalls will be covered by 2016 donations received from two private donors: Robert J. Bayardo, MD, and Patrick Leung, MD.

The 2021 program will award 15 $10,000 scholarships to students matriculating at:

- Baylor College of Medicine,
- Sam Houston State College of Osteopathic Medicine (new 2020),
- Texas A&M University College of Medicine,
- TCU and UNTHSC School of Medicine (new 2019),
- Texas Tech University Health Sciences Center El Paso Paul L. Foster School of Medicine (new 2013),
- Texas Tech University Health Sciences Center School of Medicine Lubbock,
- 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 March 25, 2021. The Board of Trustees’ Educational Scholarship and Loan Committee members review qualified applications and make the selection of winners. Scholarship recipients are notified virtually in April, and recipient information will be shared during TexMed 2021 in May.

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), recent news articles indicate that Texas medical schools received 700 more applications this year than last – an increase of 33%, according to the Texas Health Education Service. (This does not mean medical schools are accepting more students.) TMA’s scholarship program is 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 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: Gary W. Floyd, 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 11th year, boasts 238 alumni with numerous graduates serving in TMA leadership via councils, committees, and sections and 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 thanks to a grant from The Physician Foundation, but scholars are responsible for their own travel expenses.

Instruction for the TMALC Class of 2021 has been conducted entirely online this year, with plans to reinstate in-person courses for future classes as soon as possible. The curriculum continues to highlight critical leadership topics including advocacy, media training, communication skills, and team development. In addition, an emphasis on physician wellness and self-care has been incorporated into the course. In 2020, TMA had planned to launch a second cohort of the program known as the Lifelong Leadership cohort, a fee-based option targeting more experienced physicians and advanced leadership topics. However, the launch was delayed because of COVID-19. In its stead, TMA has started the Lifelong Leadership virtual series – quarterly webinars on advanced leadership topics offered to members free of charge. It is hoped the series will generate further interest in leadership development and serve as a springboard for the eventual launch of the second cohort.

In response to concerns regarding the application and selection process, the TMALC Executive Committee passed a series of changes in early 2021 to help ensure a diverse, representative class of scholars and increase transparency in the process for all stakeholders:

- Under the current process, county medical societies and specialty societies are asked to rank the top three applicants from their organization. These rankings are incorporated into applicants’ scores with an applied weight. The committee acknowledged the value in county medical and specialty societies’ input and knowledge of prospective candidates and so voted to increase the weight of the county medical societies’ and specialty societies’ submitted rankings.
- In addition, any candidate ranked as No. 1 by his or her society will receive a bonus point at the increased weight.
- The committee voted to allocate one guaranteed TMALC participant slot for each of the five caucuses, with the understanding that each class has space for 25 participants. Capitation at 25 participants is considered ideal to ensure sufficient resources, staffing, and engagement for all members of the cohort. Candidates for each caucus slot will still be evaluated and scored according to the criteria – as a result, candidates ranked No. 1 by their society may not always be chosen to fill their caucus slot.
- While the Class of 2021 achieved a diverse set of candidates (see attached historical demographic information), the committee agreed to meet following the initial round of scoring to review the makeup
of each proposed class and make any adjustments necessary to ensure a good demographic mix, including geography, specialty, and the like.

- To increase transparency, committee names and roles will be added to the TMA Leadership College webpage. In addition, the descriptions of application criteria on the TMALC website will be revised for clarity prior to soliciting applications for the Class of 2022.
- The committee also requested that year-over-year historical demographic data for TMALC participants be included in its reports to the Board of Trustees moving forward.

Now Accepting Applications for 2022

Applications for the 2021-22 program are due by June 11, 2021. Visit www.texmed.org/Leadership for more information and to access the online application. For questions, contact Melanie Fossett at melanie.fossett@texmed.org.

Congratulations Class of 2021!

Twenty-six scholars are slated to graduate at TexMed 2021 on Saturday, May 2.

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<thead>
<tr>
<th>Scholar</th>
<th>Specialty</th>
<th>Practice Location</th>
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<tr>
<td>Bradley Barham, DO</td>
<td>PD</td>
<td>Buffalo Gap</td>
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<td>Fatimah Bello, MD</td>
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<td>Edinburg</td>
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<td>Joy Chen, MD</td>
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<td>Emily George, MD</td>
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<td>Vijay Giridihar, MD</td>
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<td>Techcia Idowu, MD</td>
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<td>CCM</td>
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<td>Emily Kuo, DO</td>
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<td>Awungjia Leke-Tambo, MD</td>
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<td>Graham Machen, MD</td>
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<td>Marte Martinez, MD</td>
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<td>Haley Newton, DO</td>
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<td>Ikeneefuna Okwuwa, MD</td>
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<td>Evan Perez, MD</td>
<td>FSM</td>
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<td>Emily Petersen, MD</td>
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<td>Carolyn Riley, MD</td>
<td>GYN</td>
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<td>Stephanie Savory, MD</td>
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<td>Srikanth Sridhar, MD</td>
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<td>Rebeccca Teng, MD</td>
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<td>Nathan Trayner, MD</td>
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<td>Melanie Vettimattam, MD</td>
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<td>Brandon Williamson, MD</td>
<td>FM</td>
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<tr>
<td>Karla Wyatt, MD</td>
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<td>Houston</td>
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Urban & Rural CMS Participation by Class Year

Alumni Member Retention
REPORT OF BOARD OF TRUSTEES

BOT Report 7 2021

Subject: Pending Lawsuits Involving Texas Medical Association and Audit Trail

Presented by: Gary W. Floyd, chair

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

1. 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 §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 section 201.002(b) of the Texas Occupations Code, 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 which 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, neurologist Sara Austin, MD, testified on behalf of TMA. TBCE voted to adopt the rule, without any debate whatsoever. 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 the Government Code, Section 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 Richard Kemper, MD, for deposition, and both did an excellent job testifying.

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 its amended petition, 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 or not 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 December 8, 2014, the Third Court of Appeals court affirmed denial of the Plea, and on February 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 from 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 Texas Legislature included only the musculoskeletal system and spine in the definition of chiropractic, TMA argued, the VON testing rule exceeds the scope of chiropractic. The 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 of 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 Jan. 2017, TBCE filed an appeal with the Third Court of Appeals. In its appeal, TBCE argued three main points:

1. That nerves are associated with subluxation complexes and are an integral part of chiropractic treatment and correction of biomechanical problems affect nerves, which means that 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 they offered uncontradicted evidence that VON testing is useful in chiropractic evidence. And,

3. The term “diagnosis” in the challenged rule was within the statutory scope of chiropractic practice and that 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 November 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 that 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, Section 201.002 of the Occupations Code was amended to provide that a person practices chiropractic if 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 February 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 Mar. 26, 2019.

The court requested additional briefing as to whether it should grant the Petition for Review. On August 21, 2019, TCBE filed its brief, and TMA filed its response on September 25, 2019. On March 13, 2020, the court granted the petition for review. Oral argument was heard on September 16, 2020. As of January 2021, the court has not released 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); Michael Macris, MD; and Keith Alexander (CEO of MH) in their official capacities. Dr. Gomez alleges tortious conduct on the part of MH and that anticompetitive actions were taken by the defendants.

Dr. Gomez seeks documents that purport to measure his quality and efficiency as compared to 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 that Dr. Gomez had applied for privileges at a competing facility that was 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 the privileges of Dr. Gomez 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 of the issue 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
or not 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. There is neither an anticompetitive nor a civil rights exception included in that medical
committee provision.

On June 19, 2014, TMA filed an amicus curiae brief in the case. TMA’s brief argued that the
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

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 section 161.032(a) than they do under section 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 March 17--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 over $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 anti-competitive 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 October 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.
Dr. Gomez filed a response on March 11, 2020, and MH filed a reply on April 27, 2020. On May
29, 2020, the Court requested the parties submit briefing on the merits. MH’s brief was filed on
Aug. 28, 2020. Dr. Gomez’s response was filed Nov.18, 2020, and MH’s reply is due Feb. 3,
2021. The TMA Board Chair has authorized the filing of a third brief in this case now before the
Texas Supreme Court. The Petition for Review is still pending.
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 and 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 another 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 Fourteenth 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 that 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 from a wrongful prosecution that cause 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 together 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 2021, no new decisions have been issued by district court.

3. 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 (the “Firm”) entered into a letter of protection (“LOP”) agreement with UCC to provide certain health care services at UCC for the 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.

The Firm entered into an 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 Firm agreed to pay a $40 fee to UCC per client referred for his services and entered in to 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. The Firm, 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.

The Firm filed a motion to dismiss UCC’s claims under the Texas Citizen’s Participation Act (the “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 has to meet a higher evidentiary threshold to avoid dismissal of his case.
In its motion to dismiss, the Firm argued several reasons that the TCPA should apply to UCC’s claims. First, the Firm argued that the LOP involved the Firm’s right to petition. Specifically, the Firm claimed the LOP “pertains to” a judicial proceeding, i.e., the Firm’s participation in litigating the BP case. Second, the Firm claimed that the 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.” The Firm argued that the 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 market place.”

UCC responded to the Firm’s motion to dismiss. Regarding the TCPA claim, UCC argued that 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 the Firm 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 Firm’s motion to dismiss. The Firm appealed the trial court’s decision to Houston’s First Court of Appeals.

On Jun. 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 the Firm’s motion to dismiss. On March 26, 2020, the Firm filed a motion with the Texas Supreme Court requesting an extension of time to file a petition for review, which the court granted. On May 4, 2020, the Firm filed its petition for review. UCC filed its response to the petition on July 31, 2020. On Aug. 17, the Firm filed its Reply. On October 2, 2020, the Texas Supreme Court denied the Firm’s petition for review.

4. **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)

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

On March 13, 2013, DWC issued its Medical Fee Dispute Resolution Findings and Decision. The DWC found the Respondent had failed to provide the required notice of its intent to access an informal or involuntary network. It accordingly reviewed the claim and determined reimbursement under the DWC Outpatient Hospital Fee Guideline. DWC determined Petitioner was entitled to additional reimbursement in the amount of $20,495.78. Dissatisfied with the DWC’s decision, Respondent demanded a contested-case hearing at the State Office of Administrative Hearings (SOAH) before an administrative law judge (ALJ) to challenge the DWC order. The SOAH judge found that Respondent had the burden of proof in the contested case, and after a hearing, the SOAH judge found that Respondent failed to meet its burden of proof and affirmed the DWC order.

Respondent appealed to Travis County district court. The court found that Decision and Order of the ALJ was supported by substantial evidence and affirmed the SOAH decision, consequently affirming the DWC order. Respondent appealed again to the Third Court of Appeals, Austin, Texas.

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 ALJ should have placed the burden of proof on the Petitioner. On Aug. 23, 2019, Petitioner filed a petition for review with the Supreme Court.

On November 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 ALJ’s decision to assign the burden of proof to the Respondent. Second, the Third Court’s ruling creates bad public policy by giving insurance companies significantly more power in DWC’s medical reimbursement 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 reimbursement through DWC’s process and encourage insurance companies to continually under-reimburse providers for their services. Ultimately, the workers’ compensation system itself, and Texas’s patients in the system, may suffer because practitioners choose not to participate.

On Jan. 17, 2020, though noting that the petition for review was still under consideration, the Supreme Court requested that the parties file briefs on the merits. On March 13, Patients Medical Center filed its brief. Respondent filed its brief on April 23, 2020. On May 29, 2020, the court granted the petition for review. Oral argument was held on Oct. 27, 2020. As of January 2021, the court has not released a decision.
5. Lewis v. Cook Children’s Medical Center
   (Regarding the Texas Advance Directive Act)

Ms. Lewis is the mother of a ten-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 that she has no hope of recovery and there are no possible surgical interventions that 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 Directive Act (TADA), Cook Children’s submitted the issue to its ethics committee, which concluded that 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 October 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 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 the Tarrant County Medical Society, filed an amicus brief in support of TADA, setting forth how it provides families and physicians with a framework for resolving difficult end-of-life decision.

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.

Ms. Lewis filed her brief on January 16, 2019, Cook Children’s filed its response on Jan. 22, 2019. The joint amicus brief, in which TMA joined 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 Texas, and Tarrant County Medical Society, was filed on Jan. 29, 2020.

The Second Court of Appeals released its decision on July 24, 2020, reversing the trial court’s denial of an injunction. The court of appeals decision was based on finding that Cook Children’s is a “state actor”, for purposes of Ms. Lewis’s claim of violation of due-process rights under 42 U.S.C.A. § 1983 (“§ 1983”). One justice dissented on finding that medical decisions were state
actions, explaining that the “treatment decision regarding [the patient] turned on professional medical judgments made by private parties, which were not dictated by standards established by the state.”

On Aug. 20, 2020, Cook Children’s filed a petition for review to the Texas Supreme Court. The petition argued that the Second Court of Appeals’ decision is contrary to binding U.S. Supreme Court and Fifth Circuit precedent. Under this precedent, medical judgment by private actors does not qualify as state action. As such, the requested injunction fails to meet the requirements of a § 1983 claim. On Aug. 31, 2020, TMA and fellow amici filed a brief in support of Cook Children’s petition. On Oct. 16, 2020, the Texas Supreme Court denied Cook Children’s Petition for Review.

On Nov. 10, 2020, Cook Children’s filed a Petition for Writ of Certiorari with U.S. Supreme Court. TAPA, the AMA, and several other organizations that joined to file the amicus briefs at the district court, court of appeals and/or Texas Supreme Court, filed a supporting amicus brief on Dec. 14, 2020. On Jan. 11, 2021, the U.S. Supreme Court denied the petition. The case has been returned to the district court for final disposition.

6. Regent Care of San Antonio v. Robert Detrick

   (Regarding awarding periodic payments of future medical expenses for a health care liability claim)

In 2013, Respondent Robert Detrick was admitted to Petitioner Regent Care, a skilled nursing facility, to receive treatment for a rash that was preventing surgery. He left suffering from permanent paraplegia and incontinence, resulting from a tumor on his thoracic spine that caused a compression fracture and neurological injury. A jury found that Regent Care’s nurses were negligent in failing to notify Detrick’s treating physicians of a change in his condition, resulting in a delay in the diagnosis and treatment of the spinal tumor.

The jury awarded Detrick $3,000,000 for future medical expenses. Initially, the court declined to order that any portion of the future medical expenses be paid be in installments. It subsequently modified its judgment, ordering that $256,358 of the award for future medical expenses be paid in periodic payments.

Regent Care appealed to the Fourth Court of Appeals San Antonio. It argued, *inter alia*, that the trial court abused its discretion in ordering that only $256,358 of the $3,000,000 in future medical expenses be paid in periodic payments. In November 2018, the court of appeals rejected this argument. In support of awarding the bulk of the award as a lump sum, the court cited the plain language of the periodic payment statute and a similar case decided by the Houston Court of Appeals.

In affirming the evidentiary basis of the $3,000,000 award for future medical expenses, the court of appeals noted that Respondent’s expert had opined that his life expectancy was 6–8 years, and that his annual medical expenses would be around $350,000. Petitioner died two weeks after the court of appeals decision.
Regent Care then filed a Petition for Review to the Texas Supreme Court, which was granted in November 2019. On Jan. 20, 2020, TMA joined an amicus brief with Texas Alliance for Patient Access, Texas Hospital Association, TMLT, Texas Osteopathic Medical Association, and ProAssurance Corporation in support of Regent Care. The brief argued that the periodic payment amounts are to be based on the evidence of future medical expenses presented at trial, and that burden of proof on providing these damages belongs to the claimant.

Oral argument was heard by the Texas Supreme Court on Jan. 29, 2020. On May 8, 2020, the court issued a decision in favor of Respondent Detrick. The court agreed in part with the TMA’s joint amicus brief in that the amount of periodic payments must be based on evidence at trial or post-trial, and that the $256,358 for periodic payments was not supported by the evidence at trial. However, the court ruled that the party requesting periodic payments bears the burden of identifying to the trial court the evidence supporting the periodic payments. The court found that Regent Care had failed to do so. Therefore, although the trial court’s $256,358 in periodic payments was not supported by the evidence, it was not reversible because Regent Care had not identified what should have been allocated instead. On May 22, 2020, Regent Care filed a motion for rehearing, which the Texas Supreme Court denied on Oct. 2, 2020.

7. Van Boven v. Freshour

(Regarding TMB notification of the NPDB when a physician prevails at SOAH)

This case arises from an *ultra vires* dispute between Robert Van Boven, MD, and Texas Medical Board (TMB) officials. Dr. Van Boven sued the Board Chair, Sheriff Zafran, MD, Board members Margaret McNeese, MD, and Timothy Webb, as well as attorney employees Scott Freshour, Amy Swanholm, and Chris Palazola. They are being sued in their individual capacities as officers of the Board (the “officers”). Dr. Van Boven argues that these officers acted without legal or statutory authority.

In February 2016, a three-person disciplinary panel of the Board issued an Order of Temporary Restriction (OTR) against Dr. Van Boven’s medical license, following a Temporary Suspension and Restriction Hearing (TSRH). The suspension arose from an alleged retaliatory complaint filed in bad faith by a hospital owner/board manager of a financially imperiled, private, for-profit hospital after Dr. Van Boven reported incidents of patient deaths and harm. (These incidents were independently verified by federal and state investigators as violating state and federal law.) After the TSRH, TMB reported the OTR against Dr. Van Boven to the National Practitioner Data Bank (“NPDB”).

TMB’s case was heard before the State Office of Administrative Hearings (SOAH). After a five-day trial, the ALJ issued a proposal for decision (PFD) on October 18, 2017. The PFD found that TMB failed to meet its burden to prove Dr. Van Boven committed any violations. Subsequently, TMB issued a Final Order finding that Dr. Van Boven was not subject to any sanctions. The Final Order dismissed the matter, “superseding” the OTR.

TMB subsequently filed a Revision-to-Action Report (RTAR) with the NPDB. A RTAR, however, does not remove the initial adverse report of the OTR, but updates the initial adverse report. Dr. Van Boven claims that TMB should have filed a “Void Report,” which would have voided the reported initial adverse action and eliminated any mention of the matter at the NPDB.
A Void Report carries out the Final Order superseding the OTR, whereas, as Dr. Van Boven claims, the RTAR has the effect of a sanction and is not the proper corrective action (the RTAR leaves the complaint and OTR information on the NPDB website).

Dr. Van Boven alleged that TMB’s actions harm his reputation as a physician and interfere with his ability to practice medicine, including participating in payer networks, obtaining hospital medical staff privileges, obtaining employment, and attracting patients and patient referrals. Consequently, Dr. Van Boven filed suit. On October 26, 2018, Dr. Van Boven filed his second amended petition against certain Board officers claiming that they acted *ultra vires*, or without legal authority. TMB officers filed a Plea to the Jurisdiction challenging the trial court’s jurisdiction over all of Dr. Van Boven’s claims. Ultimately, the trial court granted in part, denied in part, the Plea to the Jurisdiction regarding its jurisdiction over certain officers, and also denied Dr. Van Boven’s request for a temporary injunction.

Defendants Scott Freshour, Dr. McNeese, Mr. Webb, and Dr. Zaafran appealed the trial court’s ruling denying their Plea to the Jurisdiction. In relevant part, TMB officers alleged the trial court’s decision finding that it has subject matter jurisdiction over Dr. Van Boven’s *ultra vires* claim was incorrect.

Plaintiff Dr. Van Boven cross-appealed based on, in relevant part, the trial court’s ruling granting in part Defendants’ Plea to the Jurisdiction and denying Dr. Van Boven’s *ultra vires* claims against TMB officers (attorneys) Mr. Palazola and Ms. Swanholm.

On January 9, 2020, the Third Court of Appeals rule in favor of the Board officers. The court reversed the trial court’s denial of Freshour, McNeese, Webb, and Zaafran’s Pleas to the Jurisdiction, and affirmed the dismissal for Palazola and Swanholm. In finding that Dr. Van Boven’s claims did not fall within the *ultra vires* exception to sovereign immunity, the court reasoned that there was not clear authority requiring TMB to submit a Void Report instead of a RTAR.

Dr. Van Boven filed a petition for review to the Texas Supreme Court on May 8, 2020. TMA filed an amicus brief in support of Dr. Van Boven’s petition on June 10, 2020. On Oct. 2, 2020, the Supreme Court requested that the parties provide briefs on the merits. On Dec. 2, 2020, Dr. Van Boven filed his brief on the merits. TMB’s response brief is due Jan. 21, 2021, and Dr. Van Boven’s reply is due Feb. 5, 2021.

8. **Leonard v. Texas Medical Board**

(Regarding the retroactive application of a Texas Medical Board rule)

On June 15, 2018, the Texas Medical Board (TMB) entered a final order against Philip J. Leonard, MD, revoking his medical license based on a boundary violation and his drug prescribing and documentation practices involving one male patient. Dr. Leonard maintains that the patient filed his complaint with TMB because Dr. Leonard refused to prescribe the schedule II drugs the patient demanded. Dr. Leonard believes the patient had access to the previous order of the TMB and knew how to get him in trouble.
The TMB decision to revoke Dr. Leonard’s medical license was based, in part, on findings that he violated the applicable standard of care, found under 22 Texas Administrative Code §170.3 (Minimum Requirements for the Treatment of Chronic Pain). However, much of the language used to establish the standard of care in §170.3 did not exist at the time of the treatment at issue (May 2011 through May 2015). The rule was initially adopted in 2007. It was later amended in August 2015 and July 2016. The 2007 version of the rule – the version in existence at the time the services at issue were rendered – was viewed more as guidelines (i.e., what a physician should do). In the 2015 amendment, the title was changed, over a dozen uses of the word “should” were replaced with “must”, and the following language in subsection (b) was deleted:

“(b) It is not the board's policy to take disciplinary action against a physician solely for not adhering strictly to these guidelines if the physician's rationale for the treatment indicates sound clinical judgment documented in the medical records. Each case of prescribing for pain will be evaluated on an individual basis. The physician's conduct will be evaluated by considering:

(1) the treatment objectives, including any improvement in functioning,
(2) whether the drug used is pharmacologically recognized to be appropriate for the diagnosis as determine by a consensus of medical practitioners in the State or by recognized experts in the field for which the drug is being used,
(3) the patient's individual needs, and
(4) that some types of pain cannot be completely relieved.”

The current version now states that a “physician’s treatment of a patient’s pain will be evaluated by considering whether it meets the generally accepted standard of care and whether the following minimum requirements have been met: […]” (emphasis added).

Dr. Leonard appealed the TMB’s decision to the Travis County District Court, arguing that the TMB improperly applied newer, more stringent rules defining the standard of care for pain management to him retroactively. On June 10, 2020, TMA filed an amicus brief in support of Dr. Leonard. TMA’s amicus brief argues that TMB’s decision has serious implications for Texas physicians, as well as being arbitrary and capricious, unconstitutional, and incorrect in that it applied a rule on a physician’s conduct that occurred before the rule was adopted.

On Oct. 6, 2020, the trial court denied Dr. Leonard’s appeal. Dr. Leonard then appealed to the Third Court of Appeals in Austin, which transferred the case to the Eighth Court of Appeals in El Paso. As of January 2021, the court of appeals has not set a briefing schedule for the parties.

9. **R.J. Reynolds Tobacco Co. v. United States Food and Drug Administration**

(Regarding warning images and text on cigarette packs and cartons)

Plaintiffs are tobacco manufacturers, distributors, sellers, and advertisers. Plaintiffs challenge the First Amendment constitutionality of a U.S. Food and Drug Administration (“FDA”) rule that requires placement of warning language and images on cigarette packs and cartons.
On Aug. 16, 2019, the FDA issued a proposed rule requiring cigarette packs and cartons to display one of 13 images, paired with one of 12 textual warnings (one of the textual warnings can be paired with two images).

FDA released the final rule on March 18, 2020. On April 3, 2020, Plaintiffs filed a Complaint in the U.S. District Court for the Eastern District of Texas, in Tyler. The Complaint requested that the district court declare the Final Rule unconstitutional and enter an injunction enjoining its enforcement.

The Campaign for Tobacco-Free Kids requested that TMA join its amicus brief in support of the constitutionality of the FDA’s Final Rule. On July 17, 2020, the amicus brief was filed, supported by TMA and 16 other organizations, including the AMA. On Dec. 11, 2020, the district court heard the parties’ competing motions for summary judgment. As of January 2021, the district court has not released a decision.

10. Folosade Ojo, MD, v. James Mason

(Regarding the duty owed by a physician to third parties living with the physician’s patient)

This is a professional liability claim brought against a physician by a homeowner for injuries and damages caused by a fire. The fire was set accidently by the physician’s patient, who lived with the homeowner.

In 2015, AMed-Health Inc. (AMed) and its medical director, Folasade Ojo, MD, provided hospice care to Charles Vance. The care was provided to Mr. Vance in the home of James Mason and several of his relatives, with whom Mr. Vance lived. Mr. Vance’s treatment included narcotic pain medications and receiving oxygen. Because of the risk of fire, Vance, a longtime smoker, was admonished by AMed staff and Mr. Mason to not smoke indoors. However due to cold weather, one night Vance decided to smoke indoors and forgot to turn off the oxygen. In the ensuing fire, the Masons home and personal possessions were damaged, and Mr. Vance and Mr. Mason sustained burns requiring medical treatment.

The Masons and Mr. Vance sued AMed and Dr. Ojo for medical negligence and gross negligence. They claimed that AMed and Dr. Ojo breached the duty of care owed to them by failing to properly educate them about the dangers of smoking while on oxygen, and that Dr. Ojo deviated from the standard of care by not offering a nicotine replacement.

At the trial court, both AMed and Dr. Ojo moved for summary judgment. They argued, inter alia, that they owed no duty to the Masons. The trial court granted both motions, disposing of all claims. On appeal, the First Court of Appeals in Houston reversed the trial court. Among other reasons for reversal, the court of appeals held that AMed and Dr. Ojo had a duty to warn the Masons of the dangers posed by the oxygen and to lessen their risks, such as by providing a nicotine substitute to Vance.

On Nov. 15, 2019, AMed and Dr. Ojo filed petitions for review to the Texas Supreme Court. On March 13, 2020, the court requested the parties submit briefs on the merits of the case. AMed then settled its case with the Masons and Mr. Vance. On June 12, 2020, Dr. Ojo filed her brief on the merits. Vance and the Masons’ response was filed on August 3, 2020. Dr. Ojo’s reply brief
was filed Aug. 18, 2020. On Oct. 27, 2020, TMA and fellow amici filed a brief in support of Dr. Ojo. The brief argues that Texas law generally does not impose a duty to control one person’s conduct to prevent harm to third parties, and imposition of such a duty on physicians would result in an impossible burden.

As of January 2021, the Texas Supreme Court has not released a decision.

11. **Columbia Valley Healthcare v. A.A., by and through his mother, Anna Ramirez**

   (Regarding the evidence that must be considered in determining a lump sum award under the periodic payment statute)

This is a health care liability claim brought against a hospital as result of injuries suffered during childbirth. In 2014, Anna Ramirez was hospitalized at defendant Columbia Valley’s hospital prior to giving birth to her son, plaintiff A.A. During the hospitalization, when A.A.’s heart rate began deaccelerating, Columbia Valley’s nurses did not call the obstetrician. Half an hour later, after the nurses could not detect A.A.’s heartbeat, they called the obstetrician, who arrived and ordered a c-section be performed. When A.A. was delivered, the obstetrician observed the umbilical cord wrapped around A.A.’s neck, resulting in oxygen and blood loss to his brain. A.A. was later diagnosed with cerebral palsy and requires 24-hour care.

In 2018, a jury returned a verdict in favor of A.A., finding that the hospital’s nurses were negligent in not calling the obstetrician when A.A.’s heart rate deaccelerated, and that the delay in calling the obstetrician caused A.A.’s injuries. The jury awarded A.A. $62,000 in past health care expenses; $9,060,000 in future medical expenses until A.A. is 18 years old; and $1,208,000 for medical expenses after age 18, for a total award of $10,330,000 in medical expenses.

Prior to the 2018 trial, Columbia Valley requested that the court order the medical expenses be paid in periodic payments. After the trial, the judge ordered the award be paid in one lump sum payment of $7,310,000, plus five years of $604,000 periodic payments ($3,020,000 total).

Columbia Valley appealed the verdict and award to the Thirteenth Court of Appeals in Corpus Christi. On appeal, Columbia Valley argued, *inter alia*, that the trial judge erred in applying the periodic payment statute, Civil Practice and Remedies Code §74.503, in two ways. First, that the trial court erred in not allowing the question of A.A.’s life expectancy to be submitted to the jury. Second, that the trial court abused its discretion by ordering a lump sum payment amount that was not supported by the evidence. Columbia Valley argued that any ambiguity in §74.503 be interpreted as requiring the jury to consider life-expectancy and for the judge’s lump sum determination be supported by the evidence.

On July 30, 2020, the Court of Appeals released a decision affirming the verdict and judgment of the trial court. On Oct 29, 2020, Columbia Valley filed a petition for review to the Texas Supreme Court. The TMA Board Chair has authorized TMA to join TAPA and other amici in a brief supporting Columbia Valley’s petition.

12. **In re K&L Auto Crushers, LLC and Thomas Gothard, Jr.**

   (Regarding the amount of billing information a personal-injury defendant can subpoena from the plaintiff’s treating physicians)
This case involves a discovery dispute over access to medical billing records in a personal injury lawsuit. It is currently pending before the Texas Supreme Court.

The driver and passenger of one of the vehicles involved in an automobile crash (the “Plaintiffs”) filed a personal injury lawsuit against the other driver and his employer, (the “Defendants”). One of the Plaintiffs filed billing affidavits from several physicians and physician practices (collectively referred to herein as the “Physicians”) as proof of damages from medical services. The treatment was provided under Letters of Protection, which guarantee payment for medical bills from any settlement or other recovery, as specified by the attorney and the physician or practice (versus billing insurance or the patient directly).

Defendants served nonparty subpoenas on the Plaintiffs’ treating Physicians to obtain certain additional billing information. Specifically, the subpoenas sought to obtain, among other things:

- The amounts charged private insurance companies, generally, for the services and materials listed in the Physicians’ bills as of the billing dates for the last 10 years;
- The amounts charged federal insurance programs (i.e., Medicare and Medicaid), for the last 10 years, for the services and materials listed in the Physicians’ bills as of the billing dates;
- The amounts billed to the Physicians or paid by them to the manufacturers, sellers and distributors of the materials/devices charged for in the Physician’s bills;
- 10 years of documents regarding billing pursuant to a letter of protection;
- 10 years of documents relevant to amounts charged to self-pay patients for the services/devices provided to one of the plaintiffs;
- 10 years of documents that evidence write-offs;
- Documents showing the selling of accounts receivable for 10 years; and
- Documents revealing how charge master rates are set.

The Physicians’ attorney filed a motion to quash the subpoenas, objecting to the subpoenas as overly broad, unduly burdensome, and as seeking irrelevant and/or confidential information (including physician-patient privileged materials, trade secrets, and other state and federal privacy laws protecting the documents). Plaintiffs also filed objections, arguing that, in part, the Defendants did not need the discovery because Defendants filed counter-affidavits from their own medical experts. Defendants responded the discovery was proper under In re North Cypress Medical Center.

In North Cypress, the Texas Supreme Court in a 6-3 majority decision ruled that certain billing information, including negotiated contracts with insurers and Medicare/Medicaid reimbursement rates for certain devices and services, were discoverable to demonstrate whether emergency room charges were reasonable based on a statute that expressly states a valid hospital lien may not secure charges that exceed a reasonable and regular rate.

At the hearing on the Motion to Quash the subpoenas, among other things, the Physicians’ attorney and Plaintiffs argued North Cypress does not apply to personal injury cases and that the objections asserted stand. The trial court ultimately granted the Physicians’ and Plaintiffs’ Motions to Quash the subpoenas.
Defendants motioned for the trial court to reconsider certain requests: (1) what all other private and government insurance providers might hypothetically pay for medical services provided to other patients under different circumstances; and (2) all agreements and communications with and payments made to the manufacturers, sellers, and distributors of various medical devices and equipment used in Plaintiffs’ treatment. The trial court denied the motion.

On Sept. 3, 2019, the Defendants filed a Petition for Writ of Mandamus – an order from a higher court finding that a lower court abused its discretion in its decision making – to the Fifth Court of Appeals. The court of appeals denied the petition on Oct. 29, 2019. Defendants then filed a Petition for Writ of Mandamus with the Texas Supreme Court. The Texas Supreme Court granted the petition on Oct. 2, 2020.

On Dec. 27, 2020, TMA and the Texas Hospital Association (THA) filed a joint amicus brief (prepared by TMA) in favor of the Physicians. TMA and THA’s brief argued that the trial court did not abuse its discretion in applying North Cypress and in finding that the information requested was irrelevant to the personal injury case. Oral argument was held on Jan. 5, 2021. As of January 2021, the court has not released a decision.

D. COMMENTS TO ADMINISTRATIVE AGENCIES

Texas Health and Human Services Commission Draft Rules Concerning Medicaid
Telemedicine Requirements, 1 Tex. Admin. Code §§ 354.1430 and 354.1432

In April 2018, the Health and Human Services Commission (HHSC) released and solicited comments on draft rules intended to implement Senate Bill 1107, 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, the Texas Academy of Family Physicians, and the Texas Pediatric Society, commented that the rules should adhere to the bill’s provisions. TMA’s comments included again reiterating that Texas statute requires HHSC to pay for telemedicine under Medicaid for services that otherwise satisfy applicable requirements. The comments also stated that 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 to do so.

As of January 2021, HHSC has not officially proposed these rules. TMA staff will continue to monitor the progress of these rules.


In May 2018, the Texas Office of the Inspector General (IG) published a solicitation for feedback regarding its current rules relating to the criteria the IG uses to determine administrative sanctions or actions to impose provider violations, as found in 1 Tex. Admin.
Code § 371.1603(f)-(h). In June 2018, TMA provided comments for improvements that could be made to those considerations. Generally, TMA’s comments focused on making the process more fair and ensuring that 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, the IG proposed draft rules relating to administrative actions and sanctions, including criteria the IG uses to determine administrative actions or sanctions to impose for alleged provider violations. TMA provided a comment letter in response and met with the IG’s office in August 2019. The 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 these rules. See below for further information on TMA’s comment letter to the OIG following its 2019 proposed draft rules.

1. **TMA Comments to the Texas Medical Board Regarding the Corporate Practice of Medicine and Unauthorized Practice of Medicine**

In conjunction with the Texas Medical Board’s public comment period in association with its December 2018 full board meeting, TMA submitted written comments relating to 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) violation of certain laws prohibiting interference with a physician’s professional judgment. TMA noted that there is a complaint form for licensees, but 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.

During the 2019 legislative session, TMA supported successful legislation to require the changes urged in TMA’s earlier letter (H.B. 1532). As of January 2021, TMB has not yet taken steps to implement the legislation. On the TMB website, the complaint form only contemplates a complaint about a practitioner. As of January 2021, the TMB has not responded to TMA’s comments. Also, TMB has neither proposed nor adopted rules on this subject.

2. **Joint Comments to Health and Human Services Commission Relating to Medicaid Reimbursement for Telemedicine Medical Services**

In January 2019, TMA along with the Texas Association of Health Plans, the Texas Hospital Association, the Texas Association of Community Health Plans, and the Texas Pediatric Society submitted joint comments to the Health and Human Services Commission 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 reimbursement policies in line with state law by allowing reimbursement for all services that could be provided through telemedicine. TMA staff had been told by HHSC that 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 in order 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 2021, HHSC has not proposed rules to implement this legislation.

Texas Medical Board Proposed Rules Relating to Reporting of Unregulated Professionals and Delegation of Radiological Procedures, 22 Tex. Admin. Code §§ 193.5 and 193.21

In January 2019, the Texas Medical Board (TMB) 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 the proposed rules are not in compliance with statutory authority, leave many questions unanswered, lack an adequate framework, and may have unintentional consequences.

TMA explains 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 have a responsibility to “report” the professionals. The rules do state that the reporting obligation would be relating to discipline or termination of the professional, but it is not clear whether this is the only thing that is to be reported, nor is it clear what type of discipline should be reported. TMA further explains that because the proposed rule would impose such a significant burden, that it would have the consequence of either discouraging disciplining 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 the TMB to hold a stakeholders meeting to ensure that the proposed rules would not disrupt collaborative team-based practice.

As of March 2019, TMB has not finalized these proposed rules. Prior to the submission of TMA’s comments, TMB did notify TMA that it would be holding a stakeholders meeting on the second set of rules relating to delegation of radiological procedures. The Board held a stakeholders meeting on Jun. 4, 2019. After the stakeholders meeting, the Board 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 Aug.
2019.

TMB held another stakeholder meeting on Sept. 20, 2019, and formal proposed rules were
published on Nov. 8, 2019. TMA responded with a comment letter in December 2019. TMA’s
comments noted several issues with the proposed rules. Among other things, that the rules are
unnecessary in light of existing delegation rules, would increase physician liability, add to
existing administrative burdens, and are confusing in their language regarding levels of training
and scope of practice. On May 8, 2020, TMB withdrew these rules.

Department of State Health Services Draft Rules Relating to Epinephrine Auto-Injectors in
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 and 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 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 applicable underlying legislation (Senate Bill 1367) requires that public institutions of
higher education get prescriptions for epinephrine auto-injectors from only physicians.
In its draft rules, the Department of State Health Services failed to note this distinction. TMA
submitted brief comments to encourage the department to ensure that its rules were in
accordance with applicable state law. The draft rules were never published as official proposed
rules.

During the 2019 session, the Legislature passed House Bill 4260, allowing a physician, or
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.

On March 20, 2020, DSHS published the adopted rules. In response to TMA’s comment, DSHS
declined to make the proposed clarification. The agency stated that the prescriptive authority
under SB 1367 could be read to include those who have been delegated prescriptive authority by
a physician.

3. Texas Medical Association Comments to the Centers for Medicare & Medicaid Services
Regarding Due Process Protections in the Conditions of Participation
The Texas Medical Association submitted comments to the Centers for Medicare & Medicaid
Services 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 after thorough consideration and examination, it determined that there is insufficient evidence that addressing TMA’s issues would directly or adversely impact the health 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 that 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.


The Texas Health and Human Services Commission, Office of Inspector General (HHSC-OIG) 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 the draft rules, TMA noted and expressed support for the improvements, and made further suggestions as to how the rule could be improved. These further suggestions included allowing any provider 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 December 13, 2019, HHSC-OIG published proposed rules for §§371.1603 and 371.1715. Among other changes, the proposed rules add provisions setting forth interest and penalties for repayment plans, additional remedial measures that may be considered as mitigating factors, and statutory due process protections.

TMA submitted comments on the proposed rules on Jan. 13, 2020. In general TMA, requested that HHSC-OIG provide the specific statutory authority for the proposed rules and to clarify potentially unclear language. TMA also commented on specific proposed provisions. For the proposed repayment plan interest and penalties, TMA recommended clarifying that these additional payments only apply in the event of late or missed payments, and that HHSC-OIG include the possibility of a good cause exception. For the HHSC-OIG’s sanctions and factors considered, TMA recommended that HHSC-OIG not exceed the statutory authority contained in Government Code § 531.102 and Human Resources Code § 32.039.

On May 15, 2020, HHSC-OIG published the adopted rules without changes.
4. **Texas Department of Insurance Solicitation for Comments on Issues for Discussion Regarding Senate Bill 1264 and Subsequent Rulemaking**

In June 2019, the Texas Department of Insurance (TDI) 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, along with 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 some information on the arbitration system in New York and provided comments on opportunities to rebut information in arbitration and on arbitrator fee issues. TMA continued to comment that HMOs should hold enrollees harmless in situations resulting from gaps in its coverage. TMA also contended that the department should develop rules requiring health plan issuer/administrator submission of claims to the benchmarking database selected by the commissioner, and also that 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. Following up with the stakeholders meeting, on Aug. 8, 2019, TMA submitted additional briefing to the 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 (as well as 11 other societies) submitted a joint 71-page letter, expressing general concerns that the Department’s rule proposal: (1) omitted details necessary to make the arbitration and meaningful and workable process for Texas’ physicians and (2) included language that would unnecessarily increase the costs/burden of arbitration and/or reduce access to the arbitration process. Additionally, TMA’s joint comment letter contained numerous specific objections to the rule proposal 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 its adoption order, 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 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.

On Dec. 18, 2019, the TMB issued “TMB Guide Statement on TDI Rules Related to Senate Bill 1264,” which explains, among other things, that “Physicians 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 the TMB’s enforcement authority related to violations of SB 1264 and notes that the “TMB will work on development of rules consistent with TDI’s rules.”

On Feb. 10, 2020, TMA, the American College of Obstetricians and Gynecologists District XI, the Texas Society for Gastroenterology and Endoscopy, and the American College of Physician Services, Texas Chapter, submitted joint comments to TDI on the emergency rules.

At the outset, the joint letter reiterated TMA’s prior comments on the lack of TDI’s authority to adopt rules on SB 1264’s out-of-network disclosure exception and its prohibition on balance billing. TDI’s authority to implement SB 1264 is limited to those provisions regulating the arbitration process and health benefit plan issuers and administrators (TDI’s traditional scope of regulation). It does not include regulating the practice of medicine, which is the purview of the TMB.

For section 21.4903 as a whole, the comments noted several inconsistencies between the rule’s language and the statute; the comments recommended that the rules use language consistent with the statute. The comments also recommended that the rules reflect that for the election of treatment by an out-of-network provider, that language reflect that this choice may be made by the enrollee’s legal representative or guardian.

For subsection 21.4903(b)(1), the joint comment letter noted that for SB 1264’s exception for permissible balance billing, TDI’s inclusion of a “meaningful choice” requirement adds an additional condition not supported by the statute. The satisfaction of this condition would also be dependent on parties outside of the out-of-network provider’s control, such as the health plans or health facility. The language of subsection (b)(1) – particularly “a meaningful choice” – is also vague and as such could lead to unintentional violations of the rule. Due to these issues, the joint comments proposed that subsection (b)(1) be omitted from the rule.

For subsection 21.4903(b)(2), the joint comments opposed the inclusion of certain language invalidating the permissible balance billing exception if the patient is “coerced by a provider or health benefit plan issuer or administrator when making the election.” The reasons for opposing
this language were similar to those raised for (b)(1). First, as the “coerced” language is
overbroad and vague, a provider could have difficulty knowing what conduct is proscribed.
Second, as the coercion may be by the health benefit plan, the satisfaction of the condition is
again outside of the control of the of out-of-network provider.

For subsection 21.4903(c), the comments noted that the proposed requirement to provide the
notice and disclosure prior to scheduling the procedure is not supported by the statute. It would
also be difficult for indirect access physicians, such as radiologists and pathologists, who
generally would have little or no interaction with the patient prior to scheduling the procedure.
TMA proposed that if TDI does go forward with this provision, it be tied to a timeframe after the
scheduling of the procedure (three business days).

Additionally, for subsection (c)’s 10-business-day requirement, the comments noted the potential
negative impacts on patient care and patient freedom of choice. While recommending that the
10-day requirement be removed altogether, the comments suggested that if the requirement
remains, it be shortened to three days. Similarly, the five business days for the patient to rescind
acceptance should be shortened to one day. The comments also recommended that TDI add two
exceptions to the day requirement, for where the patient expressly waives the requirement, or in
urgent care scenarios.

For subsection 21.4903(d), the joint comments noted several issues with the responsibility for
maintaining the signed notice and disclosure form. First, that the current rule could be construed
to require an out-of-network provider to personally maintain a copy of the signed documentation,
which is inconsistent with the rule’s other language that allows other requirements to be satisfied
by the out-of-network provider’s agent or assignee. Second, that the current language of the rule
could be read to require the out-of-network provider to retain a copy of the form even if the
procedure is not ultimately performed, an unnecessary administrative burden. Third, that the rule
requires the out-of-network provider to provide the enrollee with a copy of the signed notice and
disclosure on the date it is signed, which may not be within the provider’s control.

To address these concerns, the comments recommended adding language to allow maintenance
of the documentation by an agent or assignee, limiting the subsection’s applicability to when
balance billing occurs, and allowing a signed copy to be provided to the enrollee as soon as
practicably possible. The comments also recommended adding language to the subsection to
indicating that failing to meeting its requirements does not disqualify an out-of-network provider
from balance billing.

For subsection 21.4903(f), the comments noted concerns regarding the absolute prohibition of
utilizing the independent dispute resolution process if the out-of-network provider obtained a
signed notice and disclosure form. This language does not take into account situations where the
enrollee signs the form but is ultimately not balance billed by the out-of-network provider. The
comments also noted subsection (f) is very broadly drafted and not limited to the services and
supplies for which an out-of-network provider balance bills.

The comments recommended that the language in subsection (f) be amended to reflect that the
disqualification from the dispute resolution process be based on the provider having balance
billed the enrollee – not obtaining the signed documentation – and the language be appropriately
narrowed to apply to the services or supplies for which an out-of-network provider balance bills. The comments also recommended adding a subsection (g), which would allow a provider to participate in the independent dispute resolution process if the out-of-network provider obtained the disclosure statement in good faith but the documentation is later determined to be defective due to the actions of another person.

For section 21.4904, the comments noted issues with the cost information a party — out-of-network provider or health benefit plan — is required to provide to the enrollee, relative to their access to that information. The proposed rule imposes demanding obligations on the out-of-network provider, without a corresponding obligation for the health benefit plan. However, the latter determines its payment and coverage information. To address this imbalance, the comments recommended additional language for the proposed rule, requiring the health benefit plan to facilitate the out-of-network provider’s completion of the notice and disclosure form by providing its coverage and payment information, as well as an estimate of the enrollee’s total financial responsibility. The comments also recommended that an exception for the out-of-network provider’s obligation to provide cost information where the provider has made a good faith attempt to obtain the benefit plan payment information but was unable to do so.

Lastly, for the TDI Proposed Notice and Disclosure Statement Form, for areas corresponding to TDI’s proposed rules, the comments recommended changes to the form consistent with the comments’ recommendations for the corresponding proposed rules. The comments also recommended removing language indicating that the enrollee is waiving his or her legal rights, as the enrollee is exercising an exception set forth in the underlying statute. The comments also recommended changes to the form to reflect that information supplied by the out-of-network provider is estimated based on the scheduled services and supplies and that the actual date and costs may vary.

The initial expiration date for TDI’s emergency rule was April 30, 2020. On April 17, 2020, citing to authority under of Government Code §2001.034(c), TDI renewed the rule for 60 days to June 28, 2020.

On June 19, 2020, TDI published its adopted rules (28 Tex. Admin. Code §§21.4901-4904). Sections 21.4901, 21.4902, and 21.4904 were adopted without substantive changes. TDI also declined to make any changes to the Proposed Notice and Disclosure Statement Form. In §21.4903, TDI adopted changes to subsections 21.4903 (d) and (f) in line with TMA’s recommended changes. For subsections (b) and (c) though, TDI declined to make any changes from the original proposed language.


In October 2018, TMA, the Texas College of Emergency Physicians, the Texas Neurological Society, and the Texas Society of Anesthesiologists (collectively, Associations) provided joint comments to the Texas Department of State Health Services (DSHS) 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.

On June 23, 2020, the Texas Department of State Health Services (DSHS) held a webinar
stakeholder meeting to discuss stroke facility designation rules. TMA, the Texas Society of
Anesthesiologists, the Texas College of Emergency Physicians, and the Texas Neurological
Society submitted joint follow-up comments on July 10, 2020. The comments thanked DSHS for
making certain changes consistent with the 2018 and 2019 recommendations, though noting that
several of the addressed concerns still remained. The comments also made several
recommendations regarding drafting errors, surveyor conflicts of interest, notification
requirements for a facility experiencing a temporary interruption in its capabilities, and public
advertising and communication. As of January 2021, DSHS has not officially published
proposed rules for § 157.133.

Texas Medical Board Guidance Letter Regarding House Bill 2174’s 10-day Limit on Opioids

In August 2019, the Texas Medical Board (TMB) offered initial guidance related to the state’s
new 10-day limit on opioid prescriptions for acute pain, which was created by House Bill 2174
in the 86th Texas Legislature. On Sept. 21, 2019, TMA submitted jointly with the Texas
Orthopaedic Association a request for additional clarification to TMB. While noting that TMB’s
guidance was helpful in that it answered the question as to whether or not a follow-up
prescription could be written for an episode of care, it also implied that a follow-up prescription
could only be written if the patient sees the physician in person, contradicting HB 2174. TMA
again noted this issue in the Feb. 28, 2020 joint follow-up letter to the February TMB
stakeholder meeting, discussed below. As discussed more fully below, on April 3, 2020, TMB
published proposed rules amending the Pain Management definitions in 22 Tex. Admin. Code
§170.2, which were adopted on July 10, 2020. The amendments added to the definition of “acute
pain”, limiting its duration to no more than 30 days from the date of the initial opioid
prescription.

As of January 2021, TMB has not published additional proposed rules or guidance on this
subject.

6. Texas Department of State Health Services Request for Feedback on Informal Rule
    Proposals regarding MEDCARES Grant Program, 25 Tex. Admin. Code, Ch. 36.

In September 2019, the Texas Department of State Health Services (DSHS) requested
stakeholder feedback on draft rules for the MEDCARES Grant Program. On Oct. 7, 2019, TMA
jointly responded with the Texas Pediatric Society. The joint comments notes 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 with the statute and report. As of January 2021, DSHS has not
published proposed rules or otherwise responded to the comments.
7. **Texas Board of Chiropractic Examiners Proposed Rule Relating to Questions About Scope of Practice, 22 Tex. Admin. Code § 78.10**

On October 4, 2019, the Board of Chiropractic Examiners (TBCE) published proposed rules allowing the Board 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. On April 6, 2020, the proposed rule was withdrawn.

8. **Texas Medical Board, TMA Comments on Topics Discussed at Oct. 9, 2019, Opioid Workgroup**

On Oct. 9, 2019, the Texas Medical Board (TMB) held an Opioid Workgroup meeting, which TMA representatives attended. Following the meeting, on Oct. 24, 2019, TMA submitted its recommendations, in three areas: (1) recommendations on defining acute, chronic, and post-operative pain; (2) recommendations on interpreting and enforcing the Prescription Monitoring Program (PMP) checks and e-prescriptions; and (3) recommendations on interpreting and enforcing opioid CME legislation.

For the opioid CME requirements, TMB released initial guidance on February 6, 2020, and proposed rules on March 27, 2020. As discussed more fully below, TMA submitted comments on May 26, 2020, and TMB published the adopted rules on July 3, 2020. For the PMP check requirements, TMB released initial guidance on Feb. 7, 2020, updated guidance on Feb. 21, 2020, and proposed rules on April 3, 2020. On that date, TMB also released proposed rules addressing definitions for the types of pain. As discussed more fully below, for the pain definitions and PMP requirements, TMA submitted comments on May 28, 2020, and TMB published the adopted rules on July 10, 2020.


On Nov. 8, 2019, the Texas Medical Board (TMB) 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 MPA 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. On May 8, 2020, TMB withdrew the proposed rules.
9. **Texas Medical Board Proposed Amendment to Nonsurgical Medical Cosmetic Procedures**  

On Nov. 8, 2019, the Texas Medical Board (TMB) 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 non-surgical cosmetic procedures in medspas. TMA and the Texas Society of Plastic Surgeons (collectively, Associations) responded jointly on Dec. 6, 2019. Though thanking TMB for holding several stakeholder meetings on different informal versions of the proposed rules, the Associations noted their 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, the Associations 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 carefully review the rule to correct drafting errors. On May 8, 2020, TMB withdrew the proposed rules.

10. **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 (DSHS) held a meeting to present its recently released Texas State Plan for Alzheimer’s Disease 2019 – 2023 (State Plan) and receive stakeholder input. TMA representatives attended the meeting, and TMA submitted a comment letter on Dec. 19, 2019. TMA raised its concerns with the language in the State Plan regarding “best practices,” “validated standards” and stakeholder responsibility for implementation of the State Plan. TMA also noted that 2019 Legislature set forth specific instructions for the State Plan, which the State Plan does not include or contradicts.

On Jan. 21, 2020, DSHS responded to TMA’s concerns. Though not addressing the effect of the 2019 legislation, DSHS explained that the current State Plan had been developed based upon stakeholder feedback gathered in 2018, of which TMA had been provided the opportunity to participate.

11. **Texas Department of Insurance, Division of Workers’ Compensation Proposed Amendment for Work Status Reports, 28 Tex. Admin. Code § 129.5**

On Oct. 11, 2019, the Texas Department of Insurance, Division of Workers’ Compensation (DWC) proposed amendments to conform § 129.5 to the changes made by House Bill 387 (86th R.S.). 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 the DWC clarify an introductory clause. Specifically, to clarify whether the authorization of the delegation is governed the licensing statute of the physician or the delegate.

On Feb. 28, 2020, DWC published adopted rule § 129.5. Though the adopted language remained the same as proposed, the agency’s comments accompanying the adopted rule clarified that authorization of the delegation is governed by the licensing statute of the physician.
12. **Centers for Medicare & Medicaid Services Proposed Amendments to the Stark Law**

In October 2019, the Centers for Medicare & Medicaid Services (CMS) published proposed rules amending the physician self-referral law (Stark Law). The stated purpose of the changes is to adapt the rules to healthcare’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. CMS’ final rule was published on Dec. 2, 2020. The main result of the rule amendments is to except “value-based arrangements” from the Stark Law’s prohibition on physician self-referrals.


In October 2019, the Health and Human Services Office of Inspector General (HHS-OIG) published proposed rules amending the Anti-Kickback Statute (AKS). The stated purpose of the changes is to adapt the rules to healthcare’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 August 2020, HHS-OIG has not published adopted rules. HHS-OIG’s final rule was published on Dec. 2, 2020. The main result of the rule amendments is to create “safe harbors” from AKS enforcement for “value-based” arrangements.


On Jan. 27, 2020, the Texas Health and Human Services Commission (HHSC) released draft standards for HHSC’s review and approval of the human trafficking training courses required by House Bill 2059. On Jan. 31, 2020, TMA submitted informal comments. TMA recommended that the review process include notifying the submitter of a training course of any deficiencies that resulted in disapproval, so that the deficiencies could be addressed and the course resubmitted.

Sometime in April or May of 2020, HHSC’s website was updated to include a document that sets forth the training course review process (titled “HHSC Human Trafficking Training Review Process”). The review process set forth therein includes TMA’s recommendation that if a submitted training course is denied, HHSC will provide the submitter with a detailed explanation of the denial reasons.
15. **Texas Health and Human Services Commission Draft Rules on Human Trafficking**

*Training Requirements, 26 Tex. Admin. Code § 370.1*

On Jan. 8, 2020, the Texas Health and Human Services Commission (HHSC) released draft rules for human trafficking training required by House Bill 2059. TMA submitted informal comments on Jan. 21, 2020. TMA’s comments recommended the draft rule be amended to be consistent with the underlying statute. Specifically, that physicians be excluded from HHSC’s training requirements. TMA noted that H.B. 2059’s amendment of the Chapter 156 of the Occupations Code placed training in human trafficking prevention within a physician’s CME requirements, and thus this training fell within the purview of the Texas Medical Board, not HHSC. TMA also requested clarification of the “identification” and “assessment” components in the training courses to ensure that they did not exceed the scope of practice of some of the course’s intended participants.

On Aug. 14, 2020, HHSC published its proposed rule for §370.1. TMA submitted comments on Sept. 4, 2020, again recommending that HHSC amend the proposed rule to be consistent with the rulemaking framework established by the legislature in House Bill 2059, 86th R.S. (2019), with the Texas Medical Board having authority over physician training, not HHSC. TMA also recommended that § 370.1 be amended to clarify the breadth of the “identification” and “assessment” components of a training course, to avoid unintended scope expansion.

HHSC published the adopted rule on Nov. 27, 2020. The adopted rule reflected TMA’s recommendation that physicians be excepted from HHSC’s course requirements. However, the adopted ruled did not incorporate TMA’s suggested revisions regarding the rule’s required training course components.

16. **Texas Department of Licensing and Regulation Proposed Rule on Opioid Prescription Limits to Treat Acute Pain, 16 Tex. Admin. Code § 130.59**

On Jan. 3, 2020, the Texas Department of Licensing and Regulation (TDLR) published a proposed rule for podiatrists to prescribe opioids. The proposed rule was nearly identical to Health and Safety Code § 481.07636, and the former included the latter’s exception for prescriptions for treatment of substance abuse. On Jan. 30, 2020, TMA submitted comments to TDLR on the proposed rule. TMA’s letter noted that treatment of substance abuse addiction contemplated by § 130.59(c) is outside of a podiatrist’s scope of practice and recommended that this language be removed to avoid confusing a podiatrist’s appropriate scope of practice.

On June 26, 2020, TDLR published adopted rules, stating that it agreed with TMA’s comment and deleting subsection (c).


On Jan. 8, 2020, the Texas Department of State Health Services (DSHS) released draft rules that would repeal the current rules in Texas Administrative Code Title 25, Chapter 37, Subchapter S in their entirety in order to propose a new framework for operation of the newborn screening program. On Jan. 23, 2020, TMA responded with informal comments to DSHS. In the comment...
letter, TMA noted that there are areas of the draft rules that differed from the structure and terminology of the previous rules and underlying statute. TMA’s letter recommended that DSHS holding a stakeholder meeting followed by an opportunity for additional comment could help address these concerns.

On Aug. 7, 2020, DSHS published proposed rules, on which TMA submitted comments on Sept. 4, 2020. TMA recommended amendments to the proposed rules in three areas. First, that the required reporting section be amended to account for when a parent does not consent to disclose personally identifying information. Second, that the section addressing sharing clinical results be amended to ensure that this information will ordinarily be provided to the patient’s primary care physician. Lastly, that the language on the timeframes for proving the follow-up screening and diagnostic evaluation be amended to reflect that appointment scheduling and attendance is outside of the practitioner’s control.

DSHS published adopted rules on Dec. 18, 2020. DSHS addressed TMA’s first recommendation – regarding reporting when a parent declines to consent to disclosure – by modifying the language of the applicable subsection. DSHS did not make any changes in response to TMA’s second and third recommendations.


On March 10, 2020, the Texas Health and Human Services Commission (HHSC) held a public stakeholder meeting on psychoactive medication consent requirements for hospitals. Representatives from TMA attended the meeting. At the meeting, two differing interpretations of the rules were put forward, with various stakeholders interpreting the rules to only apply to psychiatric hospitals or licensed mental health units within hospitals, and HHSC interpreting the rules to apply to hospitals generally.

TMA submitted a follow-up comment letter on March 25, 2020. TMA’s comment letter noted that TMA’s physician members uniformly disputed the proposed rule’s separate process or promulgated form for consent to treatment with psychoactive medication outside of inpatient mental health settings. The letter explained that the draft rules could complicate informed consent conversations between physician and patient, delay patient care, introduce excessive administrative burden, and inappropriately stigmatize mental health treatment.

As of January 2021, HHSC has not responded to TMA’s comments or published proposed rules.

19. Texas Medical Board, February Opioid Workgroup Meeting

On Feb. 18, 2020, the Texas Medical Board (TMB) held a stakeholder meeting, which representatives from TMA attended. On Feb. 28, 2020, TMA, the Texas College of Emergency Physicians, the Texas Orthopaedic Association, and the Texas Academy of Family Physicians jointly submitted follow-up comments.

The joint letter made recommendations in two areas. First, for a 10-day prescription for acute pain, the letter recommended that the TMB allow a post-operative follow-up visit be conducted
via telecommunications, as set forth in Chapter 111 of the Texas Occupations Code. Second, the letter recommended that TMB implement two prior recommendations on opioid CME requirements: (1) that the rules be tailored to the types of physicians specified by the underlying legislation; and (2) that the rules clarify that physicians need not to take the same course each time.

For the opioid CME requirements, TMB released initial guidance on Feb. 6, 2020, and proposed rules on March 27, 2020. As discussed more fully below, TMA submitted comments on May 26, 2020 and TMB published the adopted rules on July 3, 2020.

Also discussed more fully below, on April 3, 2020, TMB published proposed rules amending the Pain Management definitions in 22 Tex. Admin. Code §170.2, which were adopted on July 10, 2020. The amendments added to the definition of “acute pain”, limiting its duration to no more than 30 days from the date of the initial opioid prescription.

20. Texas Department of State Health Services, Draft Rule on Maintenance and Administration of Asthma Medicine, #20R019, Title 25, Chapter 40, Subchapter D

On March 9, 2020, the Texas Department of State Health Services (DSHS) released draft rules on the maintenance and administration of unassigned asthma inhalers at schools. TMA submitted informal comments on March 31, 2020. TMA’s comment letter recommended that DSHS amend the draft rules to clarify the responsibilities for obtaining a renewed prescription and for issuing the standing order. Specifically, that the rules clarify (1) which practitioner is responsible for providing the standing order, and (2) that is the responsibility of the campus—not the prescribing physician—to obtain the annual prescription.

On Oct. 16, 2020, DSHS published proposed rules, which incorporated TMA’s recommended revisions. As of January 2021, DSHS has not published the adopted rules.

Texas Department of State Health Services, Draft Rule on Control of Communicable Diseases, #20RO59, Title 25, Chapter 97, Subchapter A

On April 8, 2020, the Texas Department of State Health Services (DSHS) released draft rules amending its rules on the identification and reporting of communicable diseases and notifiable conditions. TMA submitted an informal comment letter on April 18, 2020. TMA’s letter supported the inclusion of “syphilis infection in pregnant women” as beneficial to addressing Texas’s increase in congenital syphilis morbidity. Also, TMA’s comments recommended that a multidrug-resistant bacteria not be removed from the notifiable conditions list, and that DSHS consider adding more multidrug resistant organisms to the list. Additionally, given the current pandemic, TMA stressed the importance of current reporting requirements related to significant respiratory pathogens. Lastly, for the draft rule’s deletion of “practitioner name” in the minimal reporting requirements, TMA requested that DSHS provide an explanation of its rationale for removal and remedy the potential inadvertent removal of “name.”

On Sept. 11, 2020, DSHS published proposed rules, which addressed TMA’s concern regarding the draft rule’s deletion of “practitioner name,” but did not change the diseases added and removed. DSHS published the adopted rules on January 1, 2021, without substantive changes.
Pursuant to House Bill 3184 (86th, 2019), on April 22, 2020, the Texas Department of State Health Services (DSHS) released draft rules amending the informed consent form rule for investigational stem cell treatment. TMA submitted an informal comment letter on May 1, 2020. TMA’s comments encouraged DSHS to clarify the intent and language of draft §1.462 (as well as the draft DSHS informed consent form). TMA also requested that DSHS hold a stakeholder meeting to discuss the proposed rules and consent form prior to formal publication of the proposal in the Texas Register. Such a stakeholder meeting would (1) foster a better understanding of DSHS’s intended operation of the draft rules and form; and (2) enable more meaningful comments at the formal rulemaking stage.

On Sept. 11, 2020, DSHS published proposed rules. The proposed rules addressed some but not all of the issues raised in TMA’s informal comment letter. On Oct. 9, 2020, TMA submitted comments on the proposed rules, again recommending changes for the proposed rule and draft consent form to make clearer the requirements of the proposed rule and underlying statute (Chapter 1003 of the Texas Health and Safety Code), as well as again requesting a stakeholder meeting. As of January 2021, DSHS has not responded to TMA’s letter or published adopted rules.

On April 3, 2020, the Texas Medical Board (TMB) published proposed rules amending 22 Tex. Admin. Code §§ 170.2, 170.3, and 170.9. The rulemaking preamble indicated that the proposed rules incorporated stakeholder input from the October 2019 and February 2020 opioid workgroup meetings (discussed above). TMA, Texas Pain Society, Texas Society of Anesthesiologists, Texas Academy of Physicians, Texas Chapter of the American College of Physician Services, American College of Obstetricians and Gynecologists, Texas Association of Obstetricians and Gynecologists, and the Texas College of Emergency Physicians submitted joint comments on May 28, 2020. The joint comments noted the lack of consensus and other issues regarding the pain definitions in § 170.2 and requested the TMB reconvene the opioid workgroup to continue discussions on the issue. The joint comments also recommended changes to §§ 170.2 and 170.3 to be consistent with other statutes and rules. This included striking mandatory PMP review documentation and making an integrated electronic health record system to conduct PMP checks automatically compliant. Lastly, the joint comments proposed several minor drafting revisions to § 170.9.

TMB published adopted rules on July 10, 2020. Sections 170.2 and 170.3 were adopted without any changes. For § 170.9, TMB incorporated the joint comment’s suggested drafting revisions into the adopted rules.

On March 27, 2020, the Texas Medical Board (TMB) published proposed amendments to 22 Tex. Admin. Code §§ 166.2 (Continuing Medical Education) and 172.13 (Conceded Eminence). TMA submitted comments on May 26, 2020.

For §166.2, TMA’s comments included six recommendations. First, that the CME requirements apply only to prescribing and direct-patient-care physicians. Second, that TMB permit extra opioid CME credit hours to roll over to the next renewal period. Third, that TMB extend the new CME deadline to be consistent with TMB’s extension on license renewals (due to the COVID-19 Disaster). Fourth, TMA recommend adding language to clarify the ability to dually use opioid and human trafficking CME required hours for the medical ethics and/or professional responsibility requirement. Fifth, that TMB clarify unclear and possibly mistaken language in §166.2(d)(1). For §172.13, TMA recommended that TMB consider whether some portion of the 10-year practice requirement occur in the U.S., as well as several recommendations addressing inconsistent, unclear, and/or possibly unintended language throughout the proposed rules.

TMB published adopted rules on July 3, 2020, adopting both with non-substantive changes consistent with several of TMA’s recommendations.

Texas Department of Insurance, Comments on Reporting Requirements under SB 1264 (i.e., Tex. Ins. Code § 38.004)

On March 26, 2020, the Texas Department of Insurance (TDI) held a webinar meeting for input on data reporting requirements in Senate Bill 1264. Per TDI’s request, TMA and the Texas Society of Anesthesiologists submitted written comments in advance on March 25, 2020. For data collected by TDI, the joint comments included several recommendations regarding the breadth, applicability, accuracy, verification, and sources of data collected by TDI. The joint comments also requested clarification of two similarly worded reporting requirements in the statute. Lastly, the joint comments requested the opportunity provide supplemental comments after completion of the webinar to address a Draft SB 1264 Data Reporting Form released by TDI on the morning of March 25, 2020.

On April 3, 2020, TMA, Texas Society of Anesthesiologists, Texas College of Emergency Physicians, Texas Radiological Society, and Texas Society of Pathologists submitted joint comments addressing the draft Data Reporting Form released by TDI on March 25, 2020. Similar to the earlier comments, the April 3 joint comments raised several general concerns regarding the data reporting. The comments noted that the Data Reporting Form, as currently drafted, appears to be reliant solely on health plan reported data without any clear mechanism for vetting the data. Also, the data reporting form is not accompanied by a directions sheet that would clearly explain the terms and categories/columns in the form in order to ensure that health plans are submitting data uniformly. Additionally, that the data breakdown is too generalized to provide meaningful data for the purposes of evaluating the impact of SB 1264.

On July 7, 2020, TDI released a Commissioner’s Bulletin to all health benefit plan issuers and administrators, issuing a mandatory data call under § 38.004. The data call directed health
benefit plan issuers to a revised Reporting Form, available on TDI’s website. The revised Reporting Form reflected changes to address some of the issues raised by TMA’s joint comments in March and April. For example, complaints regarding balance billing are collected through a separate report form from licensing boards, not health benefit plans. However, the revised Reporting Form, and accompanying FAQ, do not fully address TMA’s concerns about the source, accuracy, and verification of the data collected by TDI.

As of January 2021, TDI has not released additional information on the data reporting requirements under § 38.004.

Texas Department of Insurance, Informal Comments on Draft Rule on Consumer Choice of Benefit Plan Disclosure Rules

On July 1, 2020, the Texas Department of Insurance (TDI) released an informal working draft and request for informal comments on consumer choice benefit plan disclosure rules. TMA submitted comments on July 14, 2020. Generally, TMA’s comments supported changes that would increase consumer information about the plans being purchased. TMA opposed changes that would decrease or impede consumer access to plan information, allow plans to create their own disclosure forms instead of the standardized TDI form, and reduce requirements for plan reporting on costs and coverage.


Texas Department of Insurance, TMA Recommendations for Biennial Report

On June 1, 2020, the Texas Department of Insurance (TDI) invited submissions of suggested statutory changes, to be considered for inclusion in TDI’s biennial report to the Texas Legislature. TMA submitted seven recommendations. First, amend Tex. Ins. Code §1455.004 to enact telemedicine coverage and payment parity policies, like those found in emergency rule 28 Tex. Admin. Code §35.1. Second, amend Tex. Ins. Code Subchapter B, Chapter 541 to add specific violation and enforcement measures against a health benefit plan that violates the prudent layperson standard for emergency care. Third, amend Tex. Ins. Code §1467.084(e)(1) to increase the statutory limit on bundling claims for arbitration under Senate Bill 1264. Fourth, amend Tex. Ins. Code §1467.082 to ensure SB 1264 arbitrator fees are reasonable. Fifth, amend Tex. Ins. Code Chapters 843, 1301, and 4201 to give TDI explicit statutory authority to audit health plans’ compliance with prior authorization timeframes. Sixth, amend Tex. Ins. Code §4201.206 to require a peer-to-peer discussion, with a Texas-licensed physician of the same or similar specialty, before a utilization review agent issues an adverse determination. Seventh, amend Tex. Ins. Code Chapter 4201 to create an automatic approval, on an individual physician basis, that waives prior authorization requirements for a specific procedure/service that is ordinarily approved for that physician.

In December 2020, TDI released its biennial report to the Texas Legislature. The report did not include any of TMA’s recommended statutory changes.
Texas Health and Human Services Commission, Informal Comments on Standards of Care and Treatment in Psychiatric Hospitals, Draft Rule #20R008, Title 26, Chapter 568

On June 25, 2020, the Texas Health and Human Services Commission (HHSC) released draft rules on standards of care and treatment in psychiatric hospitals. TMA submitted informal comments on July 7, 2020. TMA’s comments recommended that HHSC reconsider proposed “face-to-face” training requirement in draft §568.490(a)(1), given that the ongoing COVID-19 pandemic and that the underlying statute does not contain an in-person requirement. TMA also suggested several technical corrections for consistency with Texas statutes.

On Jan. 1, 2021, HHSC has published proposed rules, which reflected TMA’s recommended technical corrections, but did not alter the “face-to-face” training requirement.

Texas Health and Human Services Commission, Informal Comments on Preadmission Screening and Resident Review (PASRR), Draft Rule #20R049, Title 26, Chapter 303

On June 12, 2020, the Texas Health and Human Services Commission (HHSC) released draft rules on screening and review of individuals with intellectual and developmental disabilities. TMA and the Federation of Texas Psychiatry jointly submitted informal comments on June 24, 2020. The joint comments made four recommendations including: recommending that HHSC remain cognizant of scope of practice issues when revising the rules; requesting that HHSC explain or remove the additional training requirements for licensed practitioners of the healing arts than for providers with lower qualification levels; for background purposes and to inform any future comments at the formal rulemaking stage, the comments noted that it would be helpful if HHSC further elaborated on the impetus for the changes it its draft rules. As of January 2021, HHSC has not published proposed rules.

Texas Office of the Governor, Comments on Regulatory Compliance Division Proposed Rules, 1 Tex. Admin. Code §§ 5.201-5.213

On April 24, 2020, the Office of the Governor (OTG) released proposed rules related to its review of certain state agencies’ proposed rules’ effects on market competition, 1 Tex. Admin. Code §§ 5.201-5.213. TMA submitted comments on May 24, 2020. First, for §5.204(a)(2), TMA recommended adding “has reason to believe” language for consistency with the underlying statute. Second, for §5.213’s provisions regarding rule information publicly available on OTG’s website, TMA recommended that the rule specify that any submission memorandum attachments or supplemental documentation be available as well. Lastly, for an agency claiming exigent circumstances to waive §5.208’s 30-day comment period, TMA recommended at least a 10-day comment period in those circumstances.

On Oct. 9, 2020, OTG published adopted rules. OTG revised the adopted rules in accordance with TMA’s recommendations regarding the addition of “has reason to believe” language and a 10-day minimum comment period, but declined to revise its website rule to include the availability of attachments or supplemental materials.
Texas Health and Human Services Commission Proposed Rules for Child Care Regulation, 
Title 26, Part 1, Chapters 744, 746, and 747

On Nov. 20, 2020, the Texas Health and Human Services Commission (HHSC) published proposed rules regulating family homes, before and after-school programs, childcare centers, and childcare homes. TMA submitted a comment letter on Dec. 18, 2020. TMA’s comments recommended that the meal substitution provisions in proposed 26 Tex. Admin. Code §§ 744.2411, 746.3311, and 747.3111 be amended to remain consistent with the nutrition standards of the federal Child and Adult Care Food Program (CACFP), specifically, that any meal substitution for a child with a disability be supported by written approval from a physician or other health care professional with prescriptive authority. As of January 2021, HHSC has not published adopted rules.

Texas Department of Insurance Proposed Amendments and Repeals Regarding Preferred Provider Benefit Plans (PPBPs), Exclusive Provider Benefit Plans (EPBPs), and Health Maintenance Organizations (HMOs)


TMA submitted comments on Oct. 26, 2020. The comments noted that TMA supported TDI’s intent of incorporating the requirements of House Bill 3911 and Senate Bill 174— which TMA supported during the last legislative session — into the proposed rules. However, TMA opposed the proposed rules’ elimination of certain network adequacy requirements for a benefit plan written by an insurer or HMO for a contract with the Health and Human Services Commission to provide services under CHIP, Medicaid, or with the State Rural Health Care System. TMA’s comments also offered technical corrections to various portions of the proposed rule.

As of January 2021, TDI has not published adopted rules.

Texas Department of Pharmacy Proposed Rules Regarding Mandatory E-Prescribing Exceptions and Waivers, 22 Tex. Admin. Code §315.3

On Oct. 2, 2020, the Texas State Board of Pharmacy (Pharmacy Board) published proposed amendments to 22 T.A.C. § 315.3, pertaining to the implementation of the exceptions and waivers for mandated e-prescribing in House Bill 2174 (86th R.S. 2019).

TMA submitted comments on Oct. 30, 2020, addressing two areas of the proposed rules. First, that there are seven additional exceptions in the underlying statute (Health and Safety Code §481.0755) that are not included in subsection (c)(2) of the proposed rule. To prevent potential confusion, TMA requested the Pharmacy Board either list all of the exceptions or cross reference the relevant statutory provisions. Second, TMA urged the Pharmacy Board to use its discretion to add three additional waivers: (1) for physicians who prescribe fewer than 100 controlled substances a year; (2) for compound medications; and (3) based on a reasonable request by a
patient. TMA’s letter also noted that HB 2174 requires the Board to define emergency situations where electronic prescribing may not be appropriate.

The Pharmacy Board published adopted rules on Dec. 11, 2020. For TMA’s first issue, the Pharmacy Board added a reference to in the adopted rule to the additional exceptions in Health and Safety Code §481.0755. For the second issue, the Pharmacy Board declined to add the additional waivers, on the grounds that it lacked the discretion to do so. The Pharmacy Board did not address TMA’s comments regarding defining emergency situations.

**Texas Department of Insurance, Division of Worker’s Compensation, Proposed Rules**  
Regarding Electronic Submission of Requests for Medical Fee Dispute Resolution, 28 Tex. Admin. Code § 133.307

On Oct. 9, 2020, the Texas Department of Insurance, Division of Worker’s Compensation (TDI-DWC), published proposed amendments to 28 Tex. Admin. Code §133.307. Currently, the methods of submitting a request are limited to mail, hand-delivery, and fax. The proposed rule amendments would allow requests to be submitted electronically.

On Nov. 4, 2020, TMA and the Texas Orthopaedic Association submitted joint comments, expressing support for the proposed amendments, which would ease the administrative burdens associated with mail and personal delivery. As of January 2021, TDI-DWC has not published adopted rules.


On Oct 23, 2020, the Texas Department of Insurance (TDI) published proposed rules regarding utilization review for health care provided under a health benefit plan or health insurance policy. TMA submitted comments on Nov. 23, 2020. The comments noted that TMA had strongly supported the underlying legislation – Senate Bill1742, House Bill1584, and House Bill 3041 – and offered several technical comments and recommendations for the proposed rules.

As of January 2021, TDI has not published adopted rules.

**Texas Medical Board Proposed Rules Regarding the Implementation of the Memorandum of Understanding between the Board and the Texas Physician Health Program, 22 Tex. Admin. Code §161.11.**

On Nov. 6, 2020, the Texas Medical Board (TMB) published a proposed a new rule, 22 T.A.C. § 161.11, pertaining to the implementation of the Memorandum of Understanding between the Board and the Texas Physician Health Program (TXPHP).

TMA submitted comments on December 4, 2020, addressing two areas of the proposed rule. First, for legal counsel provided to TXPHP by a TMB attorney under proposed 161.11(b)(5), TMA expressed concern regarding access to TXPHP information of physician under TMB investigation. TMA recommended that TMB develop internal safeguards to preserve
confidentiality of TXPHP materials. Second. TMA requested that TMB modify proposed § 161.11(e)(2) to be consistent with the underlying statute. Specifically, that the TXPHP’s reporting of information relating to physician impairment is permissive, not mandatory.

TMB published adopted rules on Dec. 25, 2020, declining to make any changes for either issue. However, for the first issue, the Board’s response to TMA’s comment stated that “TMB general counsel has protections in place to ensure that TXPHP information remains separate and confidential from TMB information.”

**Texas Medical Board Proposed Rules Regarding Mandatory E-Prescribing Exceptions and Waivers, 22 Tex. Admin. Code §170.10.**

On Nov. 12, 2020, the Texas Medical Board (TMB) published proposed amendments to 22 T.A.C. §170.10, pertaining to the implementation of the exceptions and waivers for mandated e-prescribing in House Bill 2174 (86th R.S. 2019).

TMA submitted comments on Dec. 4, 2020, addressing three areas of the proposed rules. First, that proposed rule preamble only addresses the e-prescribing waivers and but not the automatic exception. As the latter are also included in the rule (in subsection (b)), their omission from the preamble could confuse readers into thinking that a waiver is required for the automatic exceptions. Second, that there seven additional exceptions in the underlying statute (Health and Safety Code §481.0755), which are not included in subsection (b). To prevent potential confusion, TMA requested TMB to either list all of the exceptions or cross reference the relevant statutory provisions. Third, TMA urged TMB to use its discretion to add three additional waivers: (1) for physicians who prescribe fewer than 100 controlled substances a year; (2) for compound medications; and (3) based on a reasonable request by a patient.

TMB published adopted rules on Dec. 25, 2020. For TMA’s first and second issues, the Board modified the adopted rule preamble language and added a reference to in the adopted rule to the additional exceptions in Health and Safety Code §481.0755. For the third issue, TMB declined to add the additional waivers, on the grounds that the Board lacked the discretion to do so.

**Texas Board of Nursing Proposed Rules Regarding Balance Billing Dispute Resolution (SB 1264), 22 Tex. Admin Code § 217.23**

On Nov. 27, 2020, the Texas Board of Nursing (BON) published proposed rules regarding balance billing dispute resolution. TMA submitted comments on Dec. 24, 2020. The comments noted that TMA supported the proposed rules tracking the corresponding rule language used by the Texas Department of Insurance. However, for one exception in the proposed rules where BON added an additional term to the underlying statutory definition, TMA requested BON provide the basis and intent for this change.

As of January 2021, BON has not published adopted rules.

On Dec. 4, 2020 the Texas Department of Insurance (TDI) published proposed rules, which amended and repealed provisions of Chapter 21 relating to the required notices for consumer choice health benefit plans. TMA submitted comments on Jan. 4, 2021, which addressed multiple aspects of the proposed rules. Generally, TMA opposed changes in the proposed rules that would reduce the information plans would be required to disclose to consumers, or that could make that information more difficult for consumers to understand. TMA also opposed changes in the proposed rules that would reduce the information carriers must provide to TDI.

As of January 2021, TDI has not released adopted rules.

E. LETTER BRIEFS TO THE TEXAS ATTORNEY GENERAL


On July 17, 2020, State Rep. James White requested an Attorney General Opinion on the application of Educ. Code § 38.001 and 25 Tex. Admin. Code § 97.62. For students not immunized due to reasons of conscience – who normally are exempt from school immunization requirements – the statute and rule allow for the exclusion of these students “in times of emergency or epidemic” declared by the Commissioner of the Department of State Health Services. The Opinion Request asked for clarification on whether the lack of vaccination must be related to the declared epidemic for the exclusion to apply.

On August 7, 2020, TMA submitted a letter brief to the Attorney General. The brief noted that during an epidemic, public health considerations, as well as the language of the statute and rule, support allowing the exclusion of students who – for reasons of conscience – lack a required immunization, even if the disease causing the epidemic is not one for which immunization is required. As of January 2021, the Attorney General has not released an opinion.

2. Texas Department of Insurance Public Information Act Request Regarding Outcomes of Mediations and Arbitrations Authorized by Senate Bill 1264

On Oct. 22, 2020, a reporter with San Antonio News 4 submitted a Public Information Act (PIA) request to the Texas Department of Insurance (TDI). The request asked for TDI’s information on the outcomes of arbitrations and mediations authorized under Senate Bill 1264’s dispute resolution provisions (from May 22, 2020 to Oct. 22, 2020). On Nov. 5, 2020, TDI notified health plans, physicians, and other providers that their records fell within the request and that they had the right to submit arguments to the Office of the Attorney General (OAG) against the release of their information. On Nov 19, 2020, TMA submitted arguments to OAG, explaining that the dispute resolution information provided to TDI under SB 1264 is confidential, pursuant to two sections of the Texas Insurance Code. As such, it falls within the “confidential by law” exception to disclosure under the PIA. Finding otherwise would contravene the Texas
Legislature’s intent, be inconsistent with TDI’s prior comments during the rulemaking process, and discourage participation in SB 1264 dispute resolution process.

As of January 2021, OAG has not released a decision.

3. **Texas Medical Board’s Request for Opinion on Chapter 157 of the Occupation Code Regarding Supervision and Delegation of a Certified Registered Nurse Anesthetist**

On Aug. 12, 2020 the Texas Medical Board (TMB) submitted an opinion request to the Texas Office of the Attorney General (OAG). The Board requested two opinions regarding the Texas Medical Practice Act (MPA):

1. Does the Texas Occupation Code, Chapter 157 et. seq. require any level of physician supervision of a certified registered nurse anesthetists (CRNA)?
2. Is the liability of the delegating physician limited solely to the determination of competency to initially delegate to CRNA under Section 157.060, or does it include liability for all delegated medical acts under Section 157.001?

TMB’s position on the first question is that supervision is required. On the second question, TMB’s position is that both Section 157.060 and Section 157.001 apply to CRNA delegation.

TMA submitted a brief on September 14, 2020. On the first issue, TMA generally agreed with TMB’s position that the MPA requires some level of supervision for medical acts delegated to a CRNA. The level of required supervision is flexible, and the level of physician involvement is based on the physician’s professional judgment in light of other relevant federal and state laws, facility policies, medical staff bylaws, and ethical standards.

TMA also generally agreed that both Section 157.060 and Section 157.001 apply to CRNA delegation. TMA’s brief noted, however, that a physician’s liability in Section 157.060 for certain delegated acts to a CRNA is limited: the physician cannot be held liable for delegated acts based solely on the delegated order unless the physician had reason to believe the CRNA lacked competency to perform the act.

The deadline for OAG to release its opinion is February 2021. As of January 2021, the Attorney General has not released an opinion.

F. **LETTERS TO LEGISLATIVE COMMITTEES**

1. **House Insurance Committee Interim Charge RFI, Interim Charge No. 1**

On Aug. 11, 2020, the Texas House of Representatives, House Committee on Insurance (Committee) requested written submission from interested parties and the public regarding Interim Charge No. 1. Interim Charge No. 1 provides that the Committee will “oversee the implementation of relevant legislation passed by the 86th Legislature” and “[c]onduct active oversight of all associated rulemaking and other governmental actions taken to ensure intended legislative outcome of all legislation.”
On Sept. 8, 2020, TMA and 16 other medical associations (Associations) submitted joint written testimony on four of the bills addressed by the Committee’s Interim Charge No.1:

- House Bill 2536 (requiring certain reporting requirements on certain pharmaceutical practices for drug manufacturers, pharmacy benefit managers, and health insurers);
- Senate Bill 1264 (prohibiting balance billing and creating a dispute resolution system to settle balance bills);
- Senate Bill 1852 (requiring certain disclosures for insurers that offer short-term plans); and
- Senate Bill 1940 (extending to August 31, 2021, TDI’s authority to revise and administer the temporary health insurance risk pool to the extent federal funds are available).

For HB 2536, the Associations recommended that the Committee study the effect of prior authorization on patient access to prescription drugs, as well the potential increase in the practice of “brown bagging” and “white bagging” related to cancer care. For SB 1264, the Associations’ comments emphasized the importance of data collection in evaluating the law’s effect and expressed support for the selection of FairHealth as the benchmarking database. Additionally, to increase access to SB 1264’s dispute resolution system, the Associations recommended legislation to raise the statutory bundling cap for arbitrating multiple claims in one proceeding and to authorize the Texas Department of Insurance (TDI) to set a maximum arbitrator fee by rule. For SB 1852, the Associations recommended insurers offering short-term be required to provide the required disclosures to consumers in writing prior to purchase of a plan. For SB 1940, the Associations recommended pursuing federal 1332 and Medicaid 1115 waivers to reduce the number of uninsured in Texas.

In December 2020, the Committee released its Interim Report (Report). The Report’s recommendations included several of the recommendations included in the Associations’ Sept. 8, 2020 letter. For SB 1264, the Report recommended the Legislature work to improve data collection, as well as providing the TDI with the authority to set a maximum arbitrator fee.

For SB 1852, the Report recommended the expansion of strong up-front disclosure requirements to consumers. And for SB 1940, the Report recommended that the Legislature consider a reinsurance program through a 1332 waiver in order to help reduce the cost of health coverage for Texans. The Report also recommended that the legislature consider the benefits that could be achieved by expanding Medicaid in Texas.

2. House Insurance Committee Interim Charge RFI, COVID-19 Pandemic Questions

On Aug. 11, 2020, the Texas House of Representatives House Committee on Insurance (Committee) requested written submission from interested parties and the public on interim charges relating to the COVID-19 pandemic. On Sept. 8, 2020, TMA and 16 other medical associations (Associations) submitted joint written testimony on four of the interim charges:

- Interim Charge 1: How prevalent is price gouging related to COVID-19 testing? What are state agencies doing in order to monitor price gouging associated with COVID-19 testing?
• Interim Charge 2: What steps are being taken in order to prevent surprise medical billing associated with COVID-19 treatment? What steps can consumers take in order to avoid these surprise medical bills?
• Interim Charge 3: How many business interruption claims have been filed during the COVID-19 pandemic? Did policyholders report issues with being unaware of pandemic-related exceptions to coverage under these policies?
• Interim Charge 4: What is the anticipated impact of the COVID-19 pandemic on health insurance premiums and the health insurance market moving forward?

For Interim Charge 1, the Associations responded that they did not have information specific to the prevalence of price gouging for COVID-19 testing in Texas. However, the Associations expressed their opposition to price gouging, provided information on the existing protections against price gouging, and noted that Committee should remember that not all price variations or higher pricing constitutes price gouging.

For Interim Charge 2, the Associations noted that steps to prevent surprise billing have been taken at both the federal and state level: for the former, through the Families First Coronavirus Response Act and the CARES Act; for the latter, through administrative action by the Texas Department of Insurance and by the recently enacted S.B. 1264. Going forward, the Associations noted that surprise billing could be reduced by strengthening existing laws on network adequacy. The Associations also listed several steps that consumers could take to avoid surprise medical bills.

For Interim Charge 3, the Associations informed the Committee that numerous business interruption claims have been filed, both by physicians and other businesses. However, as many insurers are taking the position that the coverage does not include viruses, litigation will likely be needed to resolve this issue.

For Interim Charge 4, the Associations noted that while COVID-19 has had a significant negative impact on the financial stability of physician practices and hospitals, the same has not been true for payers, which have experienced significantly increased earnings. Additionally, how COVID-19 will affect premiums and the market going forward could depend on many factors. These could include increased health care costs from expanded domestic PPE production, increased costs from care that was delayed in 2020, as well as the costs of COVID care and vaccines.

As of January 2021, the Committee has not released a report addressing these interim charges.

3. **Senate Committee on Business and Commerce Interim Charge RFI, Senate Bill 1264**

In September 2020, the Texas Senate Committee on Business and Commerce (Committee) published a request for information regarding the implementation of Senate Bill 1264. On Oct. 1, 2020, TMA and 16 other medical associations (Associations) submitted joint written testimony. The Association’s comments emphasized the importance of data collection in evaluating the law’s effect. Additionally, to increase access to SB 1264’s dispute resolution system, the Associations recommended legislation to raise the statutory bundling cap for arbitrating multiple claims in one proceeding and to authorize the Texas Department of Insurance (TDI) to set a
maximum arbitrator fee by rule. On Jan. 11, 2021 the Committee released its Interim Report, which concluded that the Committee should continue to monitor the data around surprise medical bills.

4. **House Committee on Public Health Interim Charge RFI on the Continuation of the Texas Medical Board**

On Oct. 5, 2020, the Texas House Committee on Public Health (Committee) released a request for information (RFI) pertaining to implementation of House Bill 1504 (86th R.S., 2019), which continues the Texas Medical Board (TMB) until Sept. 1, 2031. Per the RFI, the committee is to “review and identify any challenges related to the processing of complaints, including due process concerns and the independence of the (Texas Medical) Board. Make recommendations for additional modifications to address these challenges.”

TMA responded on Oct. 16, 2020, asking the Committee to consider TMA’s concerns and recommendations for four areas. First, to allow an expedited licensing process for out-of-state physicians who meet certain parameters. Second, that information on physician’s public profile relating to a complaint be removed promptly when the complaint is dismissed. Also, if TMB reported information related to a complaint to an external entity, and that information was later required to be removed, TMB should be required to inform the entity that the previous information has been voided. Third, for remedial plans, TMA recommended that TMB should be required to remove information about the remedial plan from the physician’s profile if the remedial plan is for a one-time violation that does not involve the delivery of health care. Fourth, TMA asked that legislation be passed requiring TMB, prior to a hearing on a contested case, to share any exculpatory evidence in its possession with the license holder.

As of January 2021, the Committee has not released a report addressing these issues.

5. **Joint Legislative Committee on the Use of Prior Authorization and Utilization Review Processes RFI**

On Dec. 7, 2020, the Texas Legislature Joint Committee on the Use of Prior Authorization (PA) and Utilization Review (UR) Processes (Committee) invited submission of written testimony. On Dec. 17, 2020, TMA and 19 other medical associations (Associations) submitted joint written testimony. The Associations noted changes resulting from legislation in the previous session were important first steps towards improving the PA and UR process in Texas, but additional review and reform is still needed. PA still often imposes an excessive administrative burden that delays access to medically necessary care and negatively affects continuity of patient care. The Associations recommended nine specific PA and UR reforms. The Associations also recommended that the Committee consider the potential increase in the practice of “brown bagging” and “white bagging” related to prescription drugs for cancer care.

As of January 2021, the Committee has not released a report addressing these issues.
REPORT OF BOARD OF TRUSTEES

BOT Report 8 2021

Subject: Audit of 2019 Financial Statements and 2020-21 Operating Budgets

Presented by: Gary W. Floyd, MD, chair

Audit of 2019 Financial Statements

The Audit of 2019 Financial Statements report was presented to the Texas Medical Association Board of Trustees at its Oct. 11, 2020, meeting. Independent auditor Holtzman Partners, LLP, determined the consolidated financial statements “present fairly, in all material respects, the consolidated financial position of Texas Medical Association and 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.

The Audit of 2020 Financial Statements report by Holtzman Partners, LLP, will be completed and presented to the Board of Trustees at its 2021 spring meeting. The board will present the audit report to the House of Delegates in 2022.

2020 Operating Budget

For 2020, operating income was $25,479,920, and operating expenses were $25,183,046. At year-end, total actual operating income for the year was below budgeted operating income by $1,493,080 (5.54%). Total actual operating expenses were under budget by $1,847,454 (6.83%), resulting in an actual net operating surplus of $296,874. This actual net operating surplus exceeded the budgeted net operating deficit by $354,374. An unaudited report on 2020 operations is attached.

2020 Non-Operating Expense

2020 non-operating expense includes $418,986 of compensation and benefits expense for Louis Goodman in his role as EVP emeritus and a $650,000 payment to the estate of Louis Goodman for past contractual obligations.

2020 Net Investment Gain

Net investment gain includes realized investment gains of $295,360, unrealized gains on investments of $3,107,019, and other losses on disposal of assets of $9,239.

2021 Operating Budget

In December 2020, the Board of Trustees approved a 2021 operating budget projecting an income of $25,391,740 and expenses of $25,391,740, with a 2021 capital expenditure budget of $413,000. 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 2021 as follows: TEXPAC request for support totaling $332,570; TMA Alliance request for support totaling $215,000; TMA Foundation request for support totaling $115,000; and Association Management Services request for support totaling $1,104,010. Offsetting these expenses are projected 2021 Association Management Services fees totaling $1,120,860; corporate contributions of $75,000 to TEXPAC; and $15,000 in grant revenue received for TMA Foundation programming.

The 2021 expense budget of $25,391,740 represents a decrease of $1,638,760 from the final 2020 expense budget of $27,030,500. Supporting this expense budget is a projected income budget of $25,391,740. This represents a decrease of $1,581,260 from the final 2020 income budget of $26,973,000. As a result, a break-even budget is projected for 2021.
The 2021 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 2021 operating budget adopted by the board is attached.
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### Return to Info Agenda

### Supplement

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### Texas Medical Association

#### 2021 Operating Budget

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<tr>
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<th>2021 Budget</th>
<th>2020 Budget</th>
<th>Change</th>
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<td><strong>($1,581,260)</strong></td>
<td>(5.9%)</td>
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<p>| <strong>Expense</strong>              |             |             |        |             |
| Communications           | $3,237,900  | $3,278,390  | ($40,490) | (1.2%) | 12.8% |
| Organization and Support Activities | 3,085,140 | 3,768,850   | ($683,710) | (18.8%) | 12.2% |
| Building Operations      | 2,627,980   | 2,378,520   | 249,460  | 10.4% | 10.3% |
| Advocacy and Public Policy | 2,387,110 | 2,608,280   | ($221,170) | (8.5%) | 9.4% |
| Membership Recruitment and Retention | 1,791,980 | 1,781,980   | ($10,000) | (0.1%) | 6.9% |
| Related Organization Administration | 1,650,550 | 1,740,690   | ($90,140) | (5.2%) | 6.5% |
| Information Technology   | 1,631,950   | 1,887,580   | ($255,630) | (14.0%) | 6.4% |
| Association Governance   | 1,431,280   | 1,554,240   | ($123,960) | (7.9%) | 5.6% |
| Legal                    | 1,399,480   | 1,474,580   | ($75,100) | (5.1%) | 5.5% |
| Marketing and Member Services | 1,244,270 | 1,671,260   | ($427,990) | (25.5%) | 4.9% |
| Public Health - Quality - Science | 1,212,490 | 1,198,350   | 14,140   | 1.2% | 4.8% |
| Health Policy - Regulation | 1,033,510 | 964,200     | 69,310   | 7.2% | 4.1% |
| Conference Management    | 938,340     | 893,310     | 45,030   | 5.0% | 3.7% |
| Continuing Medical Education | 327,490 | 343,230     | ($15,740) | (4.6%) | 1.3% |
| Education Center         | 235,630     | 229,220     | 6,410    | 2.8% | 0.9% |
| Non-Cash Depreciation Expense | 1,187,300 | 1,225,800   | ($38,500) | (3.1%) | 4.7% |
| <strong>Total Expense</strong>        | <strong>$25,391,740</strong> | <strong>$27,030,500</strong> | <strong>($1,638,760)</strong> | (6.1%) |</p>
<table>
<thead>
<tr>
<th>Income</th>
<th>Total</th>
<th>Building Fund</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Membership Recruitment and Retention</td>
<td>$15,888,608</td>
<td>$15,888,608</td>
<td>$16,675,000</td>
<td>$786,392</td>
<td>(4.72%)</td>
<td></td>
</tr>
<tr>
<td>Insurance Royalty Income</td>
<td>2,250,514</td>
<td>2,250,514</td>
<td>2,236,950</td>
<td>13,564</td>
<td>0.61%</td>
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<tr>
<td>Building Operations</td>
<td>1,788,187</td>
<td>1,788,187</td>
<td>1,732,220</td>
<td>55,967</td>
<td>3.23%</td>
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<tr>
<td>Related Organization Support</td>
<td>1,310,574</td>
<td>1,310,574</td>
<td>1,288,250</td>
<td>22,324</td>
<td>1.66%</td>
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<tr>
<td>Organization and Support Activities</td>
<td>1,300,162</td>
<td>1,300,162</td>
<td>1,372,150</td>
<td>(71,990)</td>
<td>(5.25%)</td>
<td></td>
</tr>
<tr>
<td>Communications</td>
<td>916,549</td>
<td>916,549</td>
<td>924,850</td>
<td>(8,301)</td>
<td>(0.90%)</td>
<td></td>
</tr>
<tr>
<td>Investment Income</td>
<td>661,163</td>
<td>114,191</td>
<td>547,422</td>
<td>665,000</td>
<td>117,578</td>
<td>(17.68%)</td>
</tr>
<tr>
<td>Marketing and Member Services</td>
<td>526,331</td>
<td>526,331</td>
<td>773,080</td>
<td>(247,349)</td>
<td>(31.97%)</td>
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<tr>
<td>Education Center</td>
<td>412,105</td>
<td>412,105</td>
<td>444,400</td>
<td>(32,295)</td>
<td>(7.27%)</td>
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<tr>
<td>Continuing Medical Education</td>
<td>170,110</td>
<td>170,110</td>
<td>201,500</td>
<td>(31,390)</td>
<td>(15.68%)</td>
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<tr>
<td>Public Health - Quality - Science</td>
<td>123,320</td>
<td>123,320</td>
<td>79,500</td>
<td>43,820</td>
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<tr>
<td>Association Governance</td>
<td>83,143</td>
<td>83,143</td>
<td>76,000</td>
<td>7,143</td>
<td>9.40%</td>
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<tr>
<td>Advocacy and Public Policy</td>
<td>78,975</td>
<td>78,975</td>
<td>67,000</td>
<td>11,975</td>
<td>17.97%</td>
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<tr>
<td>Conference Management</td>
<td>58,039</td>
<td>58,039</td>
<td>421,000</td>
<td>(363,961)</td>
<td>(96.69%)</td>
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</tr>
<tr>
<td>Information Technology</td>
<td>20,258</td>
<td>20,258</td>
<td>19,000</td>
<td>12,258</td>
<td>38.20%</td>
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<tr>
<td>Legal</td>
<td>1,623</td>
<td>1,623</td>
<td>26,500</td>
<td>(24,877)</td>
<td>(93.88%)</td>
<td></td>
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<tr>
<td><strong>Total Income</strong></td>
<td>$25,594,111</td>
<td>$114,191</td>
<td>$25,479,920</td>
<td>$26,873,000</td>
<td>$(1,483,080)</td>
<td>(5.54%)</td>
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<table>
<thead>
<tr>
<th>Expense</th>
<th>Total</th>
<th>Building Fund</th>
<th>Actual</th>
<th>Budget</th>
<th>Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organization and Support Activities</td>
<td>4,416,880</td>
<td>4,416,880</td>
<td>4,490,660</td>
<td>(73,780)</td>
<td>(1.64%)</td>
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<tr>
<td>Communications</td>
<td>3,399,266</td>
<td>3,399,266</td>
<td>3,086,800</td>
<td>313,466</td>
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<tr>
<td>Membership Recruitment and Retention</td>
<td>2,531,808</td>
<td>2,531,808</td>
<td>2,332,970</td>
<td>198,838</td>
<td>8.52%</td>
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<td>Building Operations</td>
<td>2,393,915</td>
<td>53,530</td>
<td>2,340,385</td>
<td>(39,530)</td>
<td>(1.64%)</td>
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<tr>
<td>Information Technology</td>
<td>1,987,136</td>
<td>1,987,136</td>
<td>1,865,050</td>
<td>122,086</td>
<td>6.55%</td>
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<tr>
<td>Related Organization Support</td>
<td>1,714,656</td>
<td>1,714,656</td>
<td>1,928,070</td>
<td>(213,414)</td>
<td>(11.02%)</td>
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<tr>
<td>Advocacy and Public Policy</td>
<td>1,676,716</td>
<td>1,676,716</td>
<td>2,270,650</td>
<td>(593,934)</td>
<td>(26.15%)</td>
<td></td>
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<tr>
<td>Legal</td>
<td>1,333,404</td>
<td>1,333,404</td>
<td>1,474,680</td>
<td>(141,176)</td>
<td>(9.57%)</td>
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<td>Depreciation</td>
<td>1,188,380</td>
<td>1,188,380</td>
<td>1,225,800</td>
<td>(37,420)</td>
<td>(3.05%)</td>
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<tr>
<td>Public Health - Quality - Science</td>
<td>1,131,478</td>
<td>1,131,478</td>
<td>1,111,630</td>
<td>19,848</td>
<td>1.79%</td>
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<tr>
<td>Conference Management</td>
<td>673,471</td>
<td>673,471</td>
<td>1,685,400</td>
<td>(812,929)</td>
<td>(48.17%)</td>
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<tr>
<td>Health Policy - Regulation</td>
<td>841,690</td>
<td>841,690</td>
<td>984,200</td>
<td>(122,510)</td>
<td>(12.71%)</td>
<td></td>
</tr>
<tr>
<td>Marketing and Member Services</td>
<td>797,262</td>
<td>797,262</td>
<td>892,590</td>
<td>(95,328)</td>
<td>(7.57%)</td>
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</tr>
<tr>
<td>Continuing Medical Education</td>
<td>472,798</td>
<td>472,798</td>
<td>509,500</td>
<td>(36,702)</td>
<td>(7.20%)</td>
<td></td>
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<tr>
<td>Education Center</td>
<td>261,652</td>
<td>261,652</td>
<td>229,220</td>
<td>32,432</td>
<td>14.55%</td>
<td></td>
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<tr>
<td>Association Governance</td>
<td>216,064</td>
<td>216,064</td>
<td>615,950</td>
<td>(399,886)</td>
<td>(64.92%)</td>
<td></td>
</tr>
<tr>
<td><strong>Total Expense</strong></td>
<td>$25,236,576</td>
<td>$53,530</td>
<td>$25,183,046</td>
<td>$27,030,500</td>
<td>$(1,847,454)</td>
<td>(6.83%)</td>
</tr>
</tbody>
</table>

Net Operating Income (Loss) $357,535 $60,661 $296,874 $57,500 $354,374

Non-Operating Expense
EVP Emeritus Compensation and Benefits Expense (418,986) (418,986)
EVP Emeritus Contractual Obligations (660,000) (660,000)
**Total Non-Operating Expense** (1,088,986) (1,088,986)

Investment Gain (Loss)
Realized Investment Gain (Loss) 296,360 99,449 195,911
Unrealized Gain (Loss) on Investments 3,107,019 407,859 2,699,160
Other Gain (Loss) (9,239) (9,239)
Net Investment Gain 3,363,140 507,308 2,855,932

Net Income $2,681,689 $567,969 $2,113,720
REPORT OF BOARD OF TRUSTEES

BOT Report 9 2021

Subject: Investments

Presented by: Gary W. Floyd, MD, chair

TMA and Separate Fund Investments

Members of the Texas Medical Association Board of Trustees also serve as trustees or as the board of trustees for two library funds, two student loan funds, 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 Finance 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 six separate funds and sets policy for the mix of investment media (equities, fixed income, alternative mutual funds, and cash equivalents).

The Dec. 31, 2020, net assets of the funds managed by these investment managers were reported as follows: TMA, $37,449,753; Texas Medical Association Library, $3,167,927; Annie Lee Thompson Library Trust Fund, $4,335,330; May Owen Irrevocable Trust, $3,592,333; Dr. S.E. Thompson Scholarship Fund, $7,082,743; Physicians Benevolent Fund, $5,450,694; and Texas Medical Association Special Funds Foundation, $3,225,716.

Dec. 31, 2020, Investment Manager Performance Report

Since Dec. 31, 1993, the composite annualized performance for all equity investments has been 9.05% versus the equity composite index annualized rate of return of 9.68%. The one-year rate of return was 17.42% versus the equity composite index return of 18.15%. Equity investment allocation by manager is approximately 32% at Luther King Capital Management, 64% in iShares blended mutual funds, 2% 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 5.31% versus the Barclays Aggregate annualized return of 5.53% for the period of June 30, 1992, through Dec. 31, 2020. The one-year rate of return was 6.08% versus the index return of 7.51%. Fixed income investment allocation by manager is approximately 52% at Vaughn Nelson, 21% in the Metropolitan West Intermediate Bond Fund, 14% in the JP Morgan Strategic Income Bond Fund, and 13% in the FPA New Income Bond Fund.

Alternative mutual fund investments have experienced an annualized return of 7.52% versus the HFRI Fund of Funds Composite Index annualized return of 4.87% for the three-year period through Dec. 31, 2020. The one-year rate of return was 11.89% versus the benchmark return of 10.86%. Alternatives investment allocation by manager is 100% in the FPA Crescent Fund.
Subject: The Term Physician Should Be Used Rather Than Provider, Resolution 104-2020

Presented by: Gary W. Floyd, MD, chair

Resolution 104-2020, introduced by the Harris County Medical Society, was referred to the TMA Board of Trustees for action with a report back to the TMA House of Delegates in 2021.

A resolution referred for action gives the body to which it is referred the full power of the house to act on that item, and may decide to adopt it, defeat it, amend it, refer it to still another body for study, or to dispose of it in any other way, and to implement whatever action is taken.

The resolution resolves that (1) 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; (2) that TMA encourage physicians, its local components, and the media to use the term “physician” instead of “provider” when describing physicians; and (3) 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.

The board met Oct. 11 to consider this resolution. In lieu of adopting resolution 104, the board reaffirmed existing TMA policy 245.002, Health Care Provider:

Health Care Provider: The Texas Medical Association recognizes that the term “health care provider” is a generic term that does not communicate the emphasis on education and concern for patients embodied by the traditional term “physician” or “doctor.” Similarly, the term “covered lives” is a dehumanizing phrase that often is used instead of “patients.” Therefore, TMA should refrain whenever possible from the use of such terms as “provider,” “covered lives,” and similar terms in all communications with members, the public, and the media, and “patient” and “physician” should be used in place of these terms.
Subject: Flu Vaccinations in Immigrant Holding Facilities at the Border, Resolution 329-2020

Presented by: Gary W. Floyd, MD, chair

Resolution 369-2020, introduced by the Medical Student Section, was referred to the TMA Board of Trustees for action with a report back to the TMA House of Delegates in 2021.

A resolution referred for action gives the body to which it is referred the full power of the house to act on that item, and this body may decide to adopt it, defeat it, amend it, refer it to still another body for study, or to dispose of it in any other way, and to implement whatever action is taken.

The resolution resolves that (1) the Texas Medical Association support legislation increasing vaccine availability in immigrant holding facilities; and (2) that our TMA acknowledge the importance vaccinations for the health of immigrants in 33 holding facilities on the border, which can also directly affect the health of Texas citizens.

The board met Oct. 11 and referred this resolution for further study to the Council on Science and Public Health with a report back to the board at Winter Conference. The council further requested feedback from and incorporated the expertise of TMA’s Committee on Infectious Diseases.

At the board’s Winter Conference meeting Jan. 31, the Council on Science and Public Health submitted the following background information with recommendations that the board adopt the second resolve and that the TMA Delegation to the American Medical Association support AMA’s efforts calling for better federal oversight of appropriate infectious disease prevention and control, including vaccinations for immigrants in holding facilities. The board approved these recommendations.

Background

During fiscal year (FY) 2019 (Oct. 1, 2018, through Sept. 30, 2019), the U.S. Border Patrol apprehended 851,508 non-U.S. citizens along the southwest U.S. border. This was a 115% increase from the previous year and the highest number over the past 10 years. The sheer increased volume of immigrants, especially family units (which saw an increase of 340% compared with FY 2018), led to both a humanitarian and a border security crisis that overwhelmed U.S. federal agencies involved in immigrant detainment.

The U.S. Border Patrol falls within U.S. Customs and Border Protection (CBP), which is the primary federal law enforcement agency for border management and control under the U.S. Department of Homeland Security (DHS). Along the southwest U.S. border, CBP agents are typically the ones who begin the initial processing of non-U.S. citizens apprehended by border patrol. CBP is required, “except in the case of exceptional circumstances,” to transfer any detainees within 72 hours to either:

- U.S. Immigration and Customs Enforcement (ICE), which is also under DHS; or
- Office of Refugee Resettlement (ORR), which is within the U.S. Department of Health and Human Services (HHS). ICE is in charge of holding adult detainees processed by U.S. Customs and Border Protection. Alternatively, ORR holds detained children under 18 years of age after CBP processing.

The heavy influx of immigrants stretched resources, prolonged detention, and caused overcrowding, with CBP being unable to adhere to the 72-hour requirement of appropriately transferring detainees to ICE or ORR. In June 2019, the U.S. Office of Inspector General issued a management alert calling on CBP to
address dangerous overcrowding and prolonged detention of children and adults in the Rio Grande Valley. The report listed a number of concerns at some facilities, including both adult and child detainees being held well beyond 72 hours (some more than a month), limited to no access to showers or clean clothes, no hot meals, and standing room only spaces for a week, among others. The report called to attention that CBP is not responsible for long-term detention of detainees and urged for implementation of sufficient measures to address the prolonged detention and overcrowding. Inquiries with TMA physicians at the border indicate the heavy influx and migration decreased significantly during 2020, with detainees no longer being held within CBP facilities for longer than the 72-hour limit.

CBP disclosed to members of Congress that border facilities do not require influenza vaccination for staff nor offer influenza vaccinations to detainees. CBP also issued statements explaining the logistical challenges for its border patrol agency, whose function is law enforcement, to be given the responsibility of implementing a comprehensive detainee vaccination program. This includes complex systems and processes for supply chains, storage, quality control, documentation, and consent, as well as addressing adverse reactions, poor health literacy, language barriers, and mistrust of medical services. Though CBP does not provide vaccinations, the other two agencies that hold migrants for extended periods – ICE and ORR – do provide vaccines. ICE has an annual mass flu vaccination program, where children are offered vaccines “appropriate for their age” and adults are offered varicella vaccinations as needed to avoid chickenpox. ORR also provides vaccinations, including flu shots, according to federal guidelines. Further, under former administration policy, migrants were sent back to Mexico to wait in border camps instead of going to ICE or ORR. CBP has also pointed out the 200 medical personnel (a 10 times increase from the previous year) who were engaged along the border to provide medical care to detainees, including medical personnel on site available 24/7 to provide medical diagnosis and treatment, address infectious disease issues and coordinate referral for further care off site as necessary. With the recent change in federal administration, changes in these immigration policies are highly likely; however, this may result once again in greater influxes of immigrant migration.

Public Health Considerations

Immigrant holding facilities left detainees vulnerable to infectious diseases due to an overcrowded, stressful environment; poor hygiene; and limited access to nutritious food, health care, and other basic needs. Forty-one influenza outbreaks occurred in 13 detention centers from Jan. 1, 2017, to March 22, 2020, and at least three children died of influenza from December 2018 to May 2019 while in the custody of CBP. Other infectious diseases including varicella and mumps were reported, and of all infections, 44.7% occurred in the South Texas Family Residential Center.

The Centers for Disease Control and Prevention (CDC) recommends most people in the U.S. aged 6 months and older receive an influenza vaccination annually, as it is the primary preventive measure against a potentially severe illness. CDC conducted an investigation of respiratory illnesses in CBP facilities and provided recommendations to DHS.

Select CDC recommendations to DHS regarding respiratory illnesses in CBP facilities are as follows:

3. Influenza Vaccination of Facility Staff
   a. We recommend that all staff at all facilities who are not yet vaccinated this season and who have no contraindications to vaccination be offered an age-appropriate influenza vaccine according to current CDC/ACIP [Advisory Committee on Immunization Practices] recommendations. Ideally, influenza vaccination should be offered to staff each season.

8. Influenza Vaccination of Migrants
   a. Annual influenza vaccination for all persons ≥6 months of age is recommended (no influenza vaccines are licensed for children <6 months).
b. In facilities with medical infrastructure, all migrants present for sufficient time for vaccination who do not have contraindications should be offered an age-appropriate influenza vaccine.
   i. All migrants should be presumed unvaccinated unless records indicating vaccination are available.
   ii. For persons with moderate or severe acute illness, with or without fever, due to any cause, vaccination should be deferred until the acute illness has resolved.

c. Priority groups for vaccination include children aged 6 months through 18 years and pregnant women.
   i. All children 6 months to <9 years should receive the first dose of vaccine at the border patrol station and a second dose ≥4 weeks later.

d. Vaccination may be considered for adults >18 years of age if feasible.

AMA sent and published a letter to DHS and HHS in September 2019 calling for asylum seekers to receive all medically appropriate care, including vaccinations:

We believe that the current living conditions facing many children and families detained in CBP custody may aggravate the spread of infectious diseases such as the flu. The flu season will begin shortly, and we believe that it is in the best interest of public health for vaccinations to be given as soon as possible. As you know the flu can be particularly dangerous for very young children, pregnant women, and individuals with chronic medical conditions. Additionally, we believe that providing vaccinations to unaccompanied children as soon as possible will not only help in preventing the spread of flu in the Office of Refugee Resettlement shelters but, will keep our nation healthier as a whole.

Of note, additional considerations regarding influenza vaccination of immigrants in holding facilities include these, among others:

- Infectious disease outbreaks at migrant detention facilities stress both border patrol staff and community medical infrastructure.
- If a detainee was previously immunized, a second administration will have no negative impact on the individual.
- Vaccinating detainees will lead to lower costs associated with care of infected patients. An influenza vaccine costs CDC approximately $1-$2 per dose compared with the cost of an emergency department visit to treat someone who is severely sick with flu.

**Discussion and Recommendations**

Resolution 329 addresses an issue highly relevant to Texas, which is a state that has both the largest border with Mexico and the highest number of immigrant holding facilities in the U.S. The resolution calls for the need to protect migrant populations seeking asylum from preventable and potentially deadly influenza virus. Preventing outbreaks of infectious diseases such as influenza requires appropriate infectious disease prevention and control measures, especially to prevent infectious diseases from overwhelming local health care systems and spreading throughout surrounding communities outside of the facility.

The state of Texas has limited oversight and authority over federal detention facilities and entities. Thus state legislation to address influenza and infectious disease control and prevention within these facilities may be less effective. However, at the federal level, AMA strongly calls for medically appropriate care for asylum seekers, including flu vaccinations. The council supports the stance of both AMA and CDC calling for influenza vaccines to be made available to immigrant holding facility staff and detainees. Further, the cost of vaccine doses at a few dollars per person pales in comparison with the hundreds, if not
thousands, of dollars spent on emergency department visits. Therefore the council supports flu vaccine access to migrant detainees not only for the public health of Texas but also for the overall lower economic costs.

The council supports the overarching goal of Resolution 329 and its second resolve for TMA to acknowledge the importance of vaccinations for the health of immigrants in holding facilities on the border, which can also directly affect the health of Texas citizens. For the first resolve, the council believes there may be more effective strategies in support of AMA’s efforts at the federal level to better address the issue.

Conclusion
After careful consideration from the council’s report, in lieu of adopting Resolution 329 in its entirety, the board approved adopting the second resolve of Resolution 329, “That our TMA acknowledge the importance of vaccinations for the health of immigrants in holding facilities on the border, which can also directly affect the health of Texas citizens.”

The board approved also that the TMA Delegation to the AMA support AMA’s efforts calling for better federal oversight of appropriate infectious disease prevention and control, including vaccinations for immigrants in holding facilities.

Related TMA Policy:
- 135.005 National Vaccine Plan
- 135.012 Immunization Rates in Texas
- 135.013 Universal Influenza Vaccination
- 260.005 Community and Migrant Health Centers
- 260.088 United States-Mexico Border Health Commission

Related AMA Policy:
- H-440.851 Influenza Vaccine Availability and Distribution
- D-350.983 Improving Medical Care in Immigrant Detention Centers
- H-440.876 Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients
- H-350.955 Care of Women and Children in Family Immigration Detention
- D-65.992 Medical Needs of Unaccompanied, Undocumented Immigrant Children
- H-350.957 Addressing Immigrant Health Disparities
- H-60.906 Opposing the Detention of Migrant Children
- H-60.905 Mental Health Issues and Use of Psychotropic Drugs for Undocumented Immigrant Children
- H-65.955 Oppose Mandatory DNA Collection of Migrants

References:
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<th>Reference</th>
<th>Details</th>
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Subject: Placing Medicaid Expansion on a Statewide Voting Ballot, Resolution 419 2020

Presented by: Gary W. Floyd, MD, chair

Resolution 419 2020, introduced by the Medical Student Section, was referred to the TMA Board of Trustees for action with a report back to the TMA House of Delegates in 2021.

A resolution referred for action gives the body to which it is referred the full power of the house to act on that item, and this body may decide to adopt it, defeat it, amend it, refer it to still another body for study, or to dispose of it in any other way, and to implement whatever action is taken.

The resolution resolved that the Texas Medical Association (1) advocate for the inclusion of Medicaid expansion initiatives on a statewide ballot to allow eligible Texas voters to decide, and (2) encourage a reopened dialogue on the topic of Medicaid expansion as an avenue to reduce the high rate of uninsured individuals in Texas.

The board met Oct. 11 to consider this resolution. Regarding placing Medicaid expansion on a statewide voting ballot: Texas law does not allow voters to bring ballot initiatives forward for consideration. Instead, the Texas Legislature must pass a constitutional amendment for voters to have the opportunity to consider the question.

Considering these restrictions on statewide ballot initiatives in Texas, the board approved that TMA continue its advocacy on Medicaid expansion, and that Resolution 419 not be adopted.
REPORT OF BOARD OF TRUSTEES

Subject: Prior Authorizations, Resolution 411 2020

Presented by: Gary W. Floyd, MD, chair

Resolution 411 2020, introduced by the Bexar County Medical Society, was referred to the TMA Board of Trustees for action with a report back to the TMA House of Delegates in 2021.

A resolution referred for action gives the body to which it is referred the full power of the house to act on that item, and that body may decide to adopt it, defeat it, amend it, refer it to still another body for study, or to dispose of it in any other way, and to implement whatever action is taken.

The resolution addresses the burden and negative impact of prior authorizations. The resolution resolves that the Texas Medical Association work to limit the use of prior authorizations to only treatments not supported by the medical literature.

The board met Oct. 11, 2020, and referred this resolution to the Prior Authorization Task Force.

The task force met twice in 2020 to discuss the need for a wide variety of prior authorization reforms (which encompass issues related to and raised in Resolution 411). The most recent meeting of the task force was on Dec. 1, 2020. At that task force meeting, members:

- Provided and reviewed recommendations for TMA legislative efforts related to prior authorization during the 87th (regular) session of the Texas Legislature (2021);
- Discussed TMA comments on interim charges related to prior authorizations, including the request for information to the Joint Committee on the Use of Prior Authorizations and Utilization Review Processes;
- Reviewed physician survey data collected by TMA and other sources regarding the burden and impact of prior authorization; and
- Recommended strategies and support needed for success in prior authorization reforms.

The task force’s legislative recommendations have been incorporated into TMA’s legislative agenda for the 87th session of the Texas Legislature and into multiple TMA comment letters to the Texas Legislature in response to interim charges:

1. Require health benefit plan issuers to “gold card” certain physicians from prior authorization (i.e., create an automatic approval or exemption, on a physician-by-physician basis, that waives prior authorization requirements if that physician is approved for a specific procedure/service the vast majority – e.g., 80% – of the time);
2. Require the Texas Department of Insurance to audit health plan compliance with statutory prior authorization timelines for approvals and denials;
3. Require health benefit plan issuers and benefit managers that require prior authorizations to have staff available to process approvals 24 hours a day, 365 days a year, including holidays and weekends;
4. Strengthen Texas law to better prevent payment denials once patient care has been approved;
5. Require peer-to-peer discussions under Tex. Ins. Code §4201.206(b) to be with a Texas-licensed physician who is of the same or similar specialty; for example, for a cancer treatment ordered by an
oncologist, a Texas-licensed oncologist should conduct the peer-to-peer call on behalf of the utilization review agent, not a physician in an unrelated specialty.

6. Heighten enforcement and penalties when a health benefit plan issuer or its agent (1) knowingly violates the prudent layperson standard for emergency care; (2) deters enrollees from seeking care consistent with the prudent layperson standard for emergency care; or (3) engages in a pattern of wrongful denials of claims for emergency care, including denials related to application of the prudent layperson standard;

7. Prohibit prior authorization for health care services that are state-mandated benefits: mammography, mastectomy and breast reconstruction or prosthesis, diabetes management, low bone-mass test for osteoporosis prevention, and prostate cancer screenings; as health benefit plan issuers are required to cover these, prior authorization is an unnecessary barrier to patient care and a misuse of physician time better dedicated to patient care; and

8. “Support continuity of care for medical services and prescription medications for patients on appropriate, chronic, stable therapy through minimizing repetitive [prior authorization] requirements.”

The task force and the Council on Legislation are working to move these legislative agenda items forward. TMA Office of the General Counsel staff drafted new bill language on the first five recommendations and drafted bill amendment language and/or reviewed existing bill language to incorporate the last three task force recommendations. TMA Advocacy staff worked to obtain bill authors for the first five recommendations and to get TMA’s recommended language into currently filed or soon-to-be refiled bills for the last three task force recommendations.

Thus, while the task force has not directly pursued the resolve in Resolution 411 (i.e., to limit the use of prior authorizations to only treatments not supported by the medical literature), it has taken a multipronged approach directed at reducing the number and burden of prior authorizations in Texas.

At the board’s Jan. 31 meeting, the board approved that in lieu of Resolution 411, TMA continue to pursue these ongoing legislative reforms formulated by the Prior Authorization Task Force to decrease the burden and negative impact of prior authorization related to state-regulated health plans.
REPORT OF BOARD OF TRUSTEES

BOT Report 15 2021

Subject: Interstate Medical Liability Tort Protection for Physicians Treating Patients in Neighboring States, Resolution 416 2020

Presented by: Gary W. Floyd, MD, chair

Resolution 416 2020, introduced by the Medical Student Section, was referred to the TMA Board of Trustees for action with a report back to the TMA House of Delegates in 2021.

A resolution referred for action gives the body to which it is referred the full power of the house to act on that item, and may decide to adopt it, defeat it, amend it, refer it to still another body for study, or to dispose of it in any other way, and to implement whatever action is taken.

The resolution resolves that the Texas Medical Association (1) recognize that the appropriate forum for medical liability suits against physicians is the state in which care is rendered; and (2) that the Texas Delegation to the American Medical Association take this resolution with the added language to the 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.

The board met Jan. 31 and referred this resolution to the Council on Socioeconomics with a report back at the March Board of Trustees meeting.

The Council on Socioeconomics convened Feb. 9, 2021 to discuss this resolution. The council discussed how this resolution applies nationally and recommended rewording the language in the second to call on the AMA to take action and create a model bill for other states to consider. The council also recommended rewording the language in the first resolve for readability.

Therefore, the council unanimously recommended to the board that the TMA adopt this resolution as amended:

RESOLVED, The Texas Medical Association recognize that the appropriate legal forum for medical professional liability claims is in the state where the patient received the medical care rendered; and be it further 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 create model legislation and support corrective legislation to assure that the appropriate legal forum for medical liability claims is in the state where the patient received the medical care rendered. 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.
Acting upon the recommendation of the Council on Socioeconomics, the board approved adopting the resolution language as amended.

**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
REPORT OF BOARD OF TRUSTEES

BOT Report 19 2021

Subject: Incorporating Helmet Safety Education Into Texas Elementary Schools, Resolution 331-2020

Introduced by: Gary W. Floyd, chair

Resolution 331-2020, introduced by the Medical Student Section, was referred to the TMA Board of Trustees for action with a report back to the TMA House of Delegates in 2021.

A resolution referred for action gives the body to which it is referred the full power of the house to act on that item, and that body may decide to adopt it, defeat it, amend it, refer it to still another body for study, or to dispose of it in any other way, and to implement whatever action is taken.

Resolution 331 calls for a modification of current TMA Policy 55.021 on bicycle helmets. The resolution provides support for the proposed resolve with the following statistics and arguments:

- 857 bicyclists were killed in traffic accidents in the U.S. in 2018;
- Children 5-14 years old have the highest rates of bicycle injuries in the U.S.;
- The greatest risk of death and disability to bicyclists is from head injuries;
- 12,789 crashes in Texas from 2007 to 2012 resulted in 12,132 injuries and 297 fatalities, and 27% of the victims were under age 15;
- A meta-analysis of 55 studies between 1989 to 2017 found that wearing a helmet 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%;
- Children in states without helmet laws were 3.5 times more likely to not wear helmets consistently;
- According to a survey of schoolchildren, the strongest correlates of not using a helmet were the belief of not needing a helmet and wishing to use a hat instead;
- Children who receive bicycle helmet safety instruction are more knowledgeable on safe bicycling behaviors than those who do not receive instruction and are less likely to be involved in a cycling accident; and
- Children living in suburbs that use a combination of helmet legislation and education reported higher helmet use than children living in suburbs with helmet legislation alone.

The specific language of the resolve is as follows:

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.

The board referred this Resolution 331 to the Council on Science and Public Health with a report back at the March Board of Trustees meeting.

Background

In Texas, from 2010 to 2016, there were 16,807 crashes involving bicycles, resulting in 9,769 injuries and 362 fatalities, out of which more than one-quarter (11%) of cyclists involved in crashes were younger than 15-years-old.¹
TMA has established policy on bicycle helmets since 1996, with the adoption of TMA Policy 55.021 Bicycle Helmets, which currently reads:

55.021 Bicycle Helmets: The Texas Medical Association supports the use of bicycle helmets certified by the U.S. Consumer Products Safety Commission, by Texans of all ages and passage of a law mandating approved helmet use for all cyclists (Substitute Committee on Emergency Medical Services and Trauma and Medical Student Section, p 155, A-96; reaffirmed CPH Rep. 3-A-10; amended CM-CAH Rep. 1-A-14).

The policy has been retained since, reaffirmed in 2010, and amended in 2014.

TMA has also prioritized child helmet use and safety via its Hard Hats for Little Heads program, a helmet giveaway program created to help reduce head injury among Texas children. TMA supports the data that suggests a properly fitting helmet can prevent up to 85% of head injuries, which are the most common causes of disability or death in bicycle crashes. Since the program’s inception in 1994, TMA has given away more than 350,000 helmets to Texas children. The program has also developed bike helmet fitting guides in English and Spanish and educational videos for children on the importance of wearing a helmet while bicycling, skateboarding, inline skating, and riding a scooter. As more Texans get vaccinated in the coming months, TMA encourages event hosts to seek out local events/opportunities in the fall and during the holidays to safely give helmets.

Federal, State, and Local Bicycle Helmet Laws
No federal law requires the use of bicycle helmets, nor does any statewide law in Texas require bicyclists to wear helmets. However, some local jurisdictions in Texas have established helmet safety laws, particularly for children:

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<thead>
<tr>
<th>Jurisdiction</th>
<th>Age (in yrs)</th>
<th>Effective since</th>
</tr>
</thead>
<tbody>
<tr>
<td>Arlington</td>
<td>&lt; 18</td>
<td>1997</td>
</tr>
<tr>
<td>Austin</td>
<td>&lt; 18</td>
<td>1996/97</td>
</tr>
<tr>
<td>Bedford</td>
<td>&lt; 16</td>
<td>1996</td>
</tr>
<tr>
<td>Benbrook</td>
<td>&lt; 17</td>
<td>1996</td>
</tr>
<tr>
<td>Coppell</td>
<td>&lt; 15</td>
<td>1997</td>
</tr>
<tr>
<td>Dallas</td>
<td>&lt; 18</td>
<td>1996/2014</td>
</tr>
<tr>
<td>Fort Worth</td>
<td>&lt; 18</td>
<td>1996</td>
</tr>
<tr>
<td>Houston</td>
<td>&lt; 18</td>
<td>1995</td>
</tr>
<tr>
<td>Southlake</td>
<td>&lt; 15</td>
<td>1999</td>
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Public Health Considerations
The importance of wearing a helmet while riding a bicycle in preventing head injuries and fatalities has been well documented by the science. Helmets have been found to provide a 63% to 88% reduction in the risk of head, brain, and severe brain injury for all ages of bicyclists. They provide equal level of protection in crashes involving motor vehicles (69%), and facial injuries are reduced by 65%. The Centers for Disease Control and Prevention (CDC) does highlight how bicycle helmet laws are only as effective as the laws’ implementation, and legislation effectiveness is strengthened when in conjunction with education campaigns and supportive publicity. Role modeling through parents is also encouraged, where parents wear a helmet despite the lack of a helmet law for adults. CDC also suggests that promotional events such as free or discounted helmet distribution, parent/child education on helmet fitting.
and the importance of wearing a helmet for every bicycle ride, and school campus helmet requirements all
may be effective strategies to encourage greater uptake of youth helmet use.

Regarding the public health costs of helmets versus potential indirect medical costs due to injury, the
National Highway Traffic Safety Administration (NHTSA) states that to be effective:

[a] helmet law should be supported with appropriate communications and outreach to parents,
children, schools, pediatric health care providers, and law enforcement. NHTSA has a wide range
of material that can be used to educate and promote the use of a helmet every ride, demonstrate
helmet effectiveness, and educate and demonstrate how to properly fit a helmet. While helmets
that meet safety requirements can be purchased for under $20, States may wish to provide free or
discounted helmets to some children. When considering the costs of providing helmets, agencies
should consider the benefits. A NHTSA summary of helmet laws reported that “every dollar
spent on bicycle helmets saves society $30 in indirect medical and other costs” 4

Discussion and Recommendations
Resolution 331 highlights an opportunity to strengthen TMA’s current bicycle helmet policy. TMA
already has strong established policy supporting mandatory bicycle helmet use, and through its Hard Hats
for Little Heads program, the association also promotes parent/child education and distributes free
helmets to children. TMA’s multifaceted approach to encouraging bicycle helmet use, especially among
children, is an effective strategy supported by scientific research. A modification of the current policy
would be supportive of the efforts already underway by TMA but would also call for strengthened
physician involvement in helmet safety education for schoolchildren in elementary schools.

After careful study and consideration of the resolve of Resolution 331 calling for a modification of
current TMA policy, the Council on Science and Public Health recommended to the board amending
TMA Policy 55.021 as follows:

Recommendation: Amend as follows:

TMA Policy 55.021 Bicycle Helmets: The Texas Medical Association supports the use of
bicycle helmets certified by the U.S. Consumer Products Safety Commission, by Texans of all
ages and passage of a law mandating approved helmet use for all cyclists. TMA
encourages physicians to be informed about the benefits of helmet use, particularly for
elementary school-age cyclists, and to promote evidence-based, best practices regarding helmet
safety education to school and community safety advisory committees.

The board reviewed the recommendation of the Council on Science and Public Health in March. Acting
upon the council’s report, the board approved amending TMA Policy 55.021 Bicycle Helmets.

Related TMA Policy:
55.019 Comprehensive School Health Education
55.027 Public School Education
260.074 All-Terrain Vehicles

Related AMA Policy:
Bicycle Helmets and Safety H-10.985
Helmets for Riders of Motorized and Non-motorized Cycles H-10.964
Motorcycles and Bicycle Helmets H-10.980
Helmets and Preventing Motorcycle- and Bicycle-Related Injuries H-10.977
Use of Helmets in Bicycle Safety H-10.987
References:
Background
Social media discourse has become more volatile. The Texas Medical Association (TMA) has seen more people on its social media channels posting hostile content about Texas’ elected leaders and/or about TMA. Acknowledging how harmful this content is to constructive dialogue, the TMA Board of Trustees adopted a process for warning and removing these individuals (TMA members and/or the general public) from TMA’s social media channels when its social media policy is not followed. Below is the social media policy and warning process to offenders.

TMA’s Social Media Conduct Policy
The Texas Medical Association is active on various social media channels. These channels are platforms for followers to communicate and interact with TMA members and stakeholders. To maintain a friendly and informative environment, we ask that users of TMA’s social media platforms do not post any links, comments, photos, or videos that:

- Abuse, harass, threaten, or otherwise violate the legal rights of others;
- Are defamatory, indecent, misleading, anticompetitive, or unlawful;
- Violate state or federal privacy laws or rules or show protected health information (PHI);
- Are unkind toward fellow community members;
- Contain spam or are intended to cause disruptions to the page;
- Violate another’s copyright, trademark, or other intellectual property rights;
- Are overtly promotional in nature;
- Are irrelevant to page content; or
- Violate any local, state, federal, and/or international laws or regulations.

We reserve the right to remove any posted content and/or block any user that fails to adhere to these rules.

The views expressed in comments on any of our social media channels are those of the author. Please note that TMA does not endorse opinions or content not posted or originally created by TMA. You are fully responsible for everything that you post.

All content provided is for informational purposes only, and no representations are made as to the accuracy or completeness of any information found on TMA’s social media channels or found by following any link on one of these pages. Further, TMA does not endorse and is not responsible for the content of third-party websites accessed through any of our social media pages.

For questions regarding TMA, you may contact the TMA Knowledge Center at (800) 880-7955.
Warning Process

- TMA has posted its social media policy on its Facebook, Twitter, Instagram, and LinkedIn channels to remind people to be respectful of others when posting their comments.
- If TMA staff identifies someone who is posting disrespectful, mean-spirited comments on a TMA social media channel, TMA will contact that individual via a direct message on that channel. They will be pointed to TMA’s social media policy and be given a warning. TMA staff will notify the appropriate chair of the board, council, committee, or section at that time.
- If the person continues to post harmful content, the appropriate TMA board, council, committee, or section chair will contact the individual via email to say such behavior will not be tolerated and include TMA’s social media policy. The chair also will let the individual know that if such behavior continues, TMA will block them from the social channel where the offense occurred.
- If the individual continues to post negative, mean-spirited content, TMA will block the person from the channel with approval from the chair of the TMA Board of Trustees.

Related TMA Policy:
295.017 Online Communications Policy for TMA Physician Leaders

Related AMA Policy:
Policy on Conduct at AMA Meetings and Events H-140.837
Over the past year, the Committee on Medical Home and Primary Care focused on helping primary care physicians stay informed on the latest COVID-19 resources as well as providing resources to help them improve patient care. The committee collaborated with the Texas A&M Rural and Community Health Institute and Project ECHO to develop and promote CME for primary care physicians seeking to serve rural communities. In addition, the committee is represented on the Steering Committee for the Texas Coalition of Healthy Minds, which promotes the integration of mental health services into the medical home and advocates for parity in the treatment of medical and mental health conditions.

**Pandemic response**

The committee responded to the SARS-CoV-2 pandemic by promoting innovation and collaboration among other TMA components and working to advance and improve primary care. It held three educational events with CME together with the TMA Committee on Rural Health and the Value Based Payment Workgroup to help TMA better identify COVID-19’s impact on primary care physician practice viability and develop potential legislative and regulatory interventions, including new primary care payment models and telemedicine payment parity.

**Texas Primary Care Consortium**

The committee collaborated with the Texas Primary Care Consortium, an organization facilitating communication among primary care leaders and advancing the medical home, to develop its 2021 virtual summit and subsequent report, Making Primary Care Primary: A Prescription for the Health of all Texans. Report recommendations include strengthening the health care safety net, prioritizing value-based care delivery, and optimizing health care spending through investment in primary care.
REPORT OF COMMITTEE ON RURAL HEALTH

CM-RH Report 2 2021

Subject: Rural Health Activities Update

Presented by: Lucia L. Williams, MD, Chair

Over the past year, the Committee on Rural Health focused on helping rural physicians stay informed on the latest COVID-19 resources and safeguarding the rural facilities in which they serve. The committee collaborated with the Texas A&M Rural and Community Health Institute and Project ECHO to develop and promote training for physicians seeking continuing medical education to serve rural communities.

Pandemic response
The committee responded to the SARS-CoV-2 pandemic by promoting coordination and collaboration to advance and improve rural health. It held three educational events with CME together with the TMA Committee on Medical Home and Primary Care and the Value Based Payment Workgroup to help TMA better identify COVID-19’s impact on practice viability and develop potential legislative and regulatory interventions, including telemedicine payment parity. The committee also expresses interest in virtual networking opportunities for rural physicians to aid in vaccine rollout and pandemic response.

Rural communities and hospitals
In pursuit of the recommendations in the committee’s report, Studying Financial Barriers of Rural Hospitals, adopted by the House of Delegates in 2020, the committee collaborated with the Texas Organization of Rural and Community Hospitals on policy priorities for Texas’ 2021 legislative session. In addition, the committee is involved in discussions to revitalize the Rural Community Health System, an innovative delivery system established by the legislature in 1997.
Financial and Organization Affairs Reports and Resolutions
AGENDA
REFERENCE COMMITTEE ON FINANCIAL AND ORGANIZATIONAL AFFAIRS
Saturday, May 8, 2021

3. Board of Councilors Report 1 – Emeritus Nominations (Updated 5.7.2021)
4. Board of Councilors Report 2 – Honorary Nominations (Updated 5.7.2021)
6. Council on Constitution and Bylaws Report 1 – Amendment to Bylaws to Remove “Spring” Requirement for the Annual Session
7. Council on Constitution and Bylaws Report 2 – Amendments to Bylaws to Establish an Application and Appeal Process for At-Large Members, and to Clarify the Disciplinary Process for Small County Medical Societies
8. Council on Constitution and Bylaws Report 3 – Amendments to Bylaws to Allow Two-Year Terms for County Medical Society Officers
9. Council on Constitution and Bylaws Report 4 – Amendment to Bylaws to Tie Council Meeting Requirements to the TMA Session Year
10. Council on Constitution and Bylaws Report 5 – Amendments to Bylaws to Allow Sections to Determine Members’ Right to Vote and Hold Office
11. Council on Constitution and Bylaws Report 6 – Amendments to Bylaws to Update and Clarify Existing Language
12. Council on Constitution and Bylaws Report 7 – Amendments to Bylaws to Allow Use of Virtual Platforms, In-Person Voting
13. Council on Constitution and Bylaws Report 8 – Amendments to Article V of the TMA Constitution
16. Board of Trustees Report 10 – Sunset Review of TMA Standing Committees
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<thead>
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<th>Number</th>
<th>Title</th>
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<tbody>
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<td>17.</td>
<td>Board of Trustees Report 16 – Establish a Coalition of Medical Societies to Protect Competition and Sustainability in the Health Insurance Marketplace, Resolution 106-A-19 (Tabled BOT Report 10 2020)</td>
</tr>
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<td>19.</td>
<td>Board of Trustees Report 20 - Nominations for Board of Governors, Texas Medical Liability Trust</td>
</tr>
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<td>21.</td>
<td>LGBTQ Health Section Report 1 – LGBTQ Health Section Update</td>
</tr>
<tr>
<td>23.</td>
<td>Resolution 102 – Expansion of the Texas Medical Association Ambassador Program (Tabled Res 102 2020)</td>
</tr>
<tr>
<td>25.</td>
<td>Resolution 104 – 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 (Tabled Res 108 2020)</td>
</tr>
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<td>26.</td>
<td>Resolution 105 – Virtual Option for Delegates at Future Meetings</td>
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<td>Resolution 106 – Creation of Ad Hoc Committee to Study and Make Recommendations Concerning Non-Compete Agreements in Physician Employment Contracts</td>
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<td>29.</td>
<td>Resolution 108 – Paid Sick Leave Policies</td>
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<td>31.</td>
<td>Resolution 110 – Encouraging ADA Compliance on Virtual Platforms</td>
</tr>
<tr>
<td>32.</td>
<td>Resolution 111 [THIS RESOLUTION WAS REMOVED BECAUSE IT WAS A DUPLICATE FOR RES. 106]</td>
</tr>
<tr>
<td>33.</td>
<td>Resolution 112 – One Hundredth Anniversary of the Texas Pediatric Society</td>
</tr>
<tr>
<td>34.</td>
<td>Resolution 113 – Composition of Hospital Ethics Committees</td>
</tr>
<tr>
<td>35.</td>
<td>Resolution 114 – Noncompete Clauses Within Physician Contract</td>
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</table>
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

SPKR Report 1 2021

Subject: Amending Policy 295.013 Election Process

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

Referred to: Reference Committee on Financial and Organizational Affairs

For the election of officers and other positions by the House of Delegates, Section 7.41 of the TMA Bylaws provides that nominations be made in accordance with the TMA Election Process:

Nominations shall be by members of the House of Delegates and shall be made in accordance with the TMA Election Process as adopted by the House of Delegates.
Nominating speeches shall conform to protocols established by the Speaker of the House of Delegates.

The TMA Election Process currently allows nominations from the floor. However, such nominations would be incompatible with the intended virtual meeting structure of the 2021 elections, whereby electors vote electronically for candidates whose nominations were received by the established deadline. For a virtual meeting, the proposed amendments below would generally not allow nominations after the established deadline.

However, during a virtual meeting where a vacancy arises after the established deadline, there may be a need to allow nominations so the vacancy may be filled. Accordingly, the proposed amendments also set forth how to address this situation, based on whether there are sufficient nominations to fill the position.

Lastly, the current TMA Election Process requires that elections be held on the second day of the annual session. This would be incompatible with intended virtual meeting structure of the 2021 elections. The proposed amendments would remove this requirement.

Recommendation: Amend Policy 295.013 Election Process as follows:

295.013 Election Process

The Texas Medical Association recognizes the following election process:

The Texas Medical Association House of Delegates holds at-large elections for the association’s president-elect (who serves the following year as president and the year after as immediate past president), secretary/treasurer, speaker and vice speaker of the house, the nine at-large members and the young physician member of the Board of Trustees, a councilor for each district, and delegates and alternate delegates to the American Medical Association. The house confirms district elections of vice councilors. The process may be guided by adopted House Standing Rules.
Nominations

Members of the house and county medical societies receive advance information on elective positions to be filled at the next annual session and the protocol for nominations. Candidates and/or those who will nominate candidates will notify House of Delegates staff at TMA headquarters as soon as possible so that the names of candidates seeking election or reelection can be distributed to members of the house and county medical societies by the deadline established by the speakers of the House of Delegates.

Where electors vote by rules established for a remote or “virtual” meeting using electronic ballot, nominations received after the announced deadline will not be considered, except where a vacancy occurs during the course of the House of Delegates meeting and there is an insufficient number of nominees to fill the open positions and the vacancy. In this event, the speakers of the House of Delegates will announce a deadline for nominations to fill the vacancy.

Where electors vote during an on-site, in-person meeting by ballots, nominations may be accepted on the floor of the house whether or not prior notification of intent to seek election has been received or published by the established deadline. All candidates nominated from the floor must complete the required candidate information as stated in the TMA Election Process. Candidates are encouraged to complete this information in advance and send it to House of Delegates staff at TMA headquarters at least one week before the opening session of the meeting at which the election is to be held. Candidates nominated from the floor will complete the requisite information on site and provide the information as soon as practicable to be distributed to the house prior to the election.

Guidelines

The intent of the following guidelines is to encourage fair, open, and equitable campaigning by: (1) specifying permitted and prohibited election related activities; (2) fostering opportunities for candidates to educate their colleagues about the issues; (3) informing voters about candidate experiences and views; (4) keeping costs down; and (5) maintaining dignified and courteous conduct appropriate to the image of the medical profession. The TMA Election Process with campaign guidelines is will be posted on the TMA House of Delegates website at http://www.texmed.org/HOD or in adopted House Standing Rules.

Campaigns are often spirited and your House of Delegates speaker and vice speaker expect candidates to state their positions and plans for TMA directly and positively.

Campaign expenditures and activities should be limited to prudent and reasonable levels necessary for adequate candidate exposure to delegates. Mindful that access to resources is not equal, candidates and their sponsoring organizations should exercise restraint in campaign spending.

The nominating county society, caucus, or individual should send a candidate announcement to house members by email or U.S. mail before annual session rather than distribute announcement cards to delegate seats at the meetings. Candidates may make personal phone calls and send letters. Including the initial announcement and one follow up, a maximum of two mass communications (an impersonal, one-way email or mail
communication to all or part of the house membership, sponsored by or on behalf of a candidate) may be used for campaign purposes.

Candidates may make use of personal websites, blogs, social media, videos, etc. One of the two permitted mass communications may be used to communicate links to a candidate’s electronic campaign material; this an email must start with “TMA Campaign” in the subject line. TMA will post links to candidate websites on its website.

For on-site, in-person meetings, candidates may display one 24”x36” poster in the Credentials Committee area at the entrance to the House of Delegates meeting; TMA provides easels. Candidates may not distribute any other campaign materials at the meeting.

Candidates will provide information as requested by the speakers including a candidate profile form. TMA publishes candidate information in the Handbook for Delegates and on the TMA website, eliminating the need for campaign literature. TMA will send an announcement indicating where house members can find candidate information.

Any candidate for at-large trustee or any office that includes an ex officio seat on the TMA Board of Trustees (president, president-elect, secretary/treasurer, and speaker and vice speaker of the House of Delegates) shall provide full disclosure of affiliations on a form developed by the speaker of the house by the time of the election.

TMA will host a forum for candidates in contested races during or before at the annual session.

Candidates for TMA office should not attend meetings of county medical societies unless officially invited. Candidates may accept reimbursement of travel expenses by the county society in accordance with the policies of the society.

Compliance

Each candidate is provided a copy of these guidelines and is expected to abide by them. Candidates are to inform those involved in their campaign efforts about the guidelines by sending a copy or by calling attention to the guidelines in the Election Process posted on the TMA website.

When candidates or their supporters are unclear about whether an intended campaign action is permitted, before taking action, they should seek the opinion of the speaker of the House of Delegates by contacting house staff at TMA headquarters. The speaker, in consultation with the vice speaker and the association’s immediate past president, will respond with a ruling concerning the proper interpretation of the guidelines and inform all candidates in order to maintain a level playing field.

Any violation by a candidate or supporter of which the speaker becomes aware will be investigated. Should the speaker, vice speaker, and immediate past president rule that a violation has occurred, the speaker will make an announcement at the house meeting.
Elections

TMA elections are held during the second day of the annual session at a time(s) determined and published by the speakers in advance.

As provided in TMA Bylaws, all elections are by secret ballot and a majority of the votes cast are necessary to elect. When there are three or more nominees for a single position, the candidate 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.

Where electors for a remote or “virtual” meeting vote by electronic ballot, and a vacancy occurs during the course of the House of Delegates meeting, the process will be as follows:

- If there is a sufficient number of nominees to fill the open positions and the vacancy, and the number of nominees equals the number of open positions, including the vacancy, the vote may be by acclamation.

- If there is a sufficient number of nominees to fill the open positions and the vacancy, and the number of nominees exceeds the number of open positions, including the vacancy, the election shall proceed as set forth in Sections 7.421, 7.422, and 7.423 of the TMA Bylaws.

- If there is an insufficient number of nominees to fill the open positions and the vacancy, the election for the vacancy will be held during the annual session at a time determined and announced by the speakers, consisting of the nominees submitted by the deadline announced by the speakers.

For both an on-site, in-person meeting and a remote or “virtual” meeting using electronic elections, the house will hold a run-off election to fill any vacancy that cannot be filled because of a tie vote.

With the exception of delegates and alternate delegates to AMA, elected candidates assume office at the adjournment of the House of Delegates meeting at the annual session. AMA delegates and alternate delegates assume office on Jan. 1 of the year following their election except those who are elected to fill vacancies, in which case they assume office at the adjournment of the annual session.
Several recent past speakers of the Texas Medical Association House of Delegates have not served as TMA president. Having past speakers serve as voting members in the house would ensure their experience in TMA parliamentary affairs will continue to benefit membership and the business sessions of the house.

Adoption of the recommended amendment to Chapter 3 of the Bylaws would take effect once laid over a day and approved at the 2021 House of Delegates. However, to amend the TMA Constitution, the proposed change must be approved at two consecutive TMA annual sessions. Past speakers would not have membership in the house – unless serving in another role that would give them membership under the constitution – until the recommended constitutional amendment to Article V is approved a second time at the 2022 House of Delegates.

Recommendation 1: Amend TMA Constitution Article V. House of Delegates 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 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 and past speakers 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.

Recommendation 2: Amend TMA Bylaws, Chapter 3. House of Delegates as follows:

3.12 Voting Rights. (12) past presidents and past speakers of the association who are active or emeritus members.

3.45 Quorum. A majority of voting members shall be required to officially transact business. Past presidents and past speakers who are active or emeritus members shall not be included in the quorum calculation.
REPORT OF BOARD OF COUNCILORS

Subject: Emeritus Nominations

Presented by: Steven Petak, MD, JD

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 (BOC), 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 BOC has approved the nominations of Lyle Thorstenson, MD, and Gregory M. Kronberg, MD, for Emeritus membership and recommends their election by the House of Delegates. A brief sketch for Drs. Thorstenson and Kronberg follows.

Summary of Qualifications:

Lyle Thorstenson, MD

Dr. Thorstenson received his medical degree from Baylor College of Medicine in Houston. He completed post-graduate training in ophthalmology at UT Southwestern Medical School in Dallas. He is an American Board of Ophthalmology certified ophthalmologist.

He has been a member of the Texas Medical Association for 40 years and has served 25 years on the Texas Delegation to the AMA House of Delegates. He served 14 years on the executive committee including four years as chair. Nominated by TMA, he also served eight years on the AMPAC Board of Directors, including two years as chair.

In addition to serving multiple reference AMA committees representing TMA, Dr. Thorstenson chaired the first AMA Task Force for the Retention and Recruitment of Members. He served three years on the AMA Reference Committee on Governance and Finance, including one year as chair.

He has served in nearly every office position within the Texas Ophthalmological Association (TOA), including president.

Dr. Thorstenson is a six-term past president of the Nachogdoches-San Augustine county medical society.

He was Chief of Staff at the Memorial County Hospital and their representative to the Organized Medical Staff Section (OMSS) to TMA and AMA House of Delegates for three terms.

Dr. Thorstenson was also a founding member and past president of the Nachogdoches Area Physicians Association, American Academy of Ophthalmology Committees, and past vice president of the Association of Veterans Affairs Ophthalmologists.

He has received many honors, including the TMA “Young at Heart” Award, TOA Distinguished Service Award, American Academy of Ophthalmology Achievement Award, and the UT Southwestern Department of Ophthalmology Distinguished Alumnus Award.

Gregory M. Kronberg, MD
Dr. Kronberg received his medical degree from the University of California, San Francisco in 1973 and served in the U.S. Air Force from 1965-77. After completing his anesthesiology residency in 1977, he did a Fellowship in intensive care anesthesiology, before joining Capital Anesthesiology Association in Austin where he practiced until his retirement in 2017.

Dr. Kronberg has held numerous leadership positions within the Texas Society of Anesthesiologists over the last 25 years including as its president in 2010-11. He has served continuously as a Travis County delegate to the TMA and has been a mainstay on the Society’s Medical Legislation Committee since 2002.

Dr. Kronberg’s devotion to and tireless efforts on behalf of his chosen profession amply qualify him for this honor.

Recommendation:

The BOC recommends that the House of Delegates approve the nominations of Drs. Thorstenson and Kronberg to Emeritus member status.
REPORT OF BOARD OF COUNCILORS

Subject: Honorary Nominations

Presented by: Steven Petak, MD, JD

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 (BOC), may elect a member of the association who has rendered outstanding service to organized medicine or made noteworthy contributions to scientific medicine, and who have reached a point of comparative inactivity in the practice of medicine as determined by the county society, to the status of member Honorary.

The BOC has approved the nominations of Stephen B. Greenberg, MD, Eric J. Haufrect, MD, Robina Poonawala, MD, and Richard S. Ruiz, MD, for Honorary membership and recommends their election by the House of Delegates. A brief profile for these three members follows.

Stephen B. Greenberg, MD
Dr. Greenberg received his medical degree from the University of Maryland in Baltimore. His postgraduate training includes an internship and residency with the University of Maryland Hospital and a fellowship in infectious disease at Baylor College of Medicine.

He has been a member of the Texas Medical Association and Harris County Medical Society for 46 years. In addition to serving on TMA’s Committee on Public Health and Health Care Quality Committee, he also served on TMA’s Council on Medical Education. He has received many awards and recognitions, including awards for his teaching services at Baylor College of Medicine, such as the John P. McGovern Outstanding Clinical Teacher Award and the Baylor Alumni Award. Dr. Greenberg was also awarded Baylor’s Barbara and Corbin J. Robertson Jr. Presidential Award for Excellence in Education. His many awards and honors also include membership in the Alpha Omega Alpha honor society, Master of the American College of Physicians, American College of Physicians Texas Chapter Laureate, and fellow of the Infectious Diseases Society of America. He has also been listed among the Best Doctors in America in 1997, 1998, 2002, 2005-2006, 2007-2008, 2009-2010, and 2012.

Eric J. Haufrect, MD
Dr. Haufrect received his medical degree from Baylor College of Medicine in Houston. He completed a residency in Obstetrics and Gynecology with Baylor College of Medicine.

He has been a member of TMA and Harris County Medical Society for 47 years. Dr. Haufrect has held many leadership and service positions within TMA and Harris County Medical Society (HCMS), including serving as a delegate to TMA’s House of Delegates, previous Board of Ethics chair, officer of the HCMS Executive Board, and a member of the TMA Health Care Quality Committee and Membership Committee. He has also served the medical community in other leadership roles, including as a Fellow, American College of Obstetrics and Gynecology and American Fertility Society, as well as a Board Member with The Immunization Partnership.

Dr. Haufrect is board certified by the American Board of Obstetrics and Gynecology. He has held many teaching positions focused on obstetrics and gynecology, including most recently a professorship with
Houston Methodist Academic Institute teaching clinical obstetrics and gynecology. He has also contributed to many medical publications, participated in speaking engagements before the medical community, and has received awards and honors in recognition of his services to the medical community, including the John Overstreet Lifetime Achievement Award.

Robina Poonawala, MD
Born in Hyderabad, Telangana, India, Robina Poonawala, MD, received her medical degree from the University of Bombay in 1978. She served her internship at the MacNeal Memorial Hospital in Berwyn, Illinois from 1980-81 and completed her residency at the same school from 1981-83. Upon completion of her training, Dr. Poonawala moved to Austin, where she was in practice until December 2018.

Dr. Poonawala has been a member of the Travis County Medical Society since 1984 and has held leadership positions at both the state and local level, including as chair of the TMA’s Patient-Physician Advocacy Committee in 2003-04. She has served on the Travis County Medical Society’s Public Relations, Advance Care Planning, Communications and Public Health Committees, was an at-large member of its Executive Board 2002-06 and served on its Delegation to TMA from 2005-13.

Dr. Poonawala was also involved with her specialty society and has been an active member of the Texas Indians Physicians Society – Southwest Chapter since 2007.

The 35 years of Dr. Poonawala’s career have been marked by devotion to her profession and her patients. She is superbly qualified for recognition as an Honorary Member of the Texas Medical Association.

Richard S. Ruiz, MD
Richard S. Ruiz, MD, received his medical degree from The University of Texas Medical Branch School of Medicine (UTMB) in Galveston. He interned at Hermann Houston Hospital, completed his residency at the Kresge Eye Institute in Detroit, and then completed a fellowship to the Massachusetts Eye and Ear Infirmary of the Harvard Medical School.

He has been a member of TMA and Harris County Medical Society for 63 years.

He is a professor and chairman in the Department of Ophthalmology at McGovern Medical School at UTHealth and he belongs to many medical organizations, including the American College of Surgeons, American Medical Association, and the Texas Ophthalmology Association. He has also contributed to a substantial number of medical publications and presentations.

Dr. Ruiz was also awarded the Ashbel Smith Distinguished Alumnus Award from UTMB.

**Recommendation:** The BOC recommends that the House of Delegates approve Drs. Greenberg, Haufrect, Poonawala, and Ruiz’s nominations to Honorary member status.
Subject: Licensure Status on TMA Membership Applications, Resolution 109-A-19
(Tabled BOC Report 4 2020)

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, 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, the Tarrant County Medical Society 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 Texas Medical Association 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.

In light of the need to reschedule the 2020 House of Delegates due to the COVID-19 pandemic, there have been discussions about giving the House of Delegates and the Board of Trustees greater flexibility in scheduling future sessions. Flexibility is currently limited by the requirement in the TMA Bylaws that the annual session be held in spring.

Recommendation: To allow the annual session to be held at any time of the year, the Council on Constitution and Bylaws recommends amending Chapter 8 of the Texas Medical Association Bylaws, as set forth below:

CHAPTER 8. ANNUAL SESSION

8.10 Time and place

The association shall hold an annual session in the spring of each year at such time and place as may be established by the House of Delegates or the Board of Trustees. The Board of Trustees shall have the authority to change the annual meeting time and place to meet unforeseen emergencies.
REPORT OF COUNCIL ON CONSTITUTION AND BYLAWS
C-CB Report 2 2021

Subject: Amendments to Bylaws to Establish an Application and Appeal Process for At-Large Members, and to Clarify the Disciplinary Process for Small County Medical Societies

Presented by: William Gilmer, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

At its TMA House of Delegates Virtual Annual Meeting 2020, the TMA House of Delegates approved bylaw amendments relating to county medical societies with fewer than 50 members (small societies) and inactive societies. These amendments were the result of recommendations from the Ad Hoc Committee on Inactive County Medical Societies, which studied the organizational challenges of small- to medium-sized county societies. The amendments allowed small societies to be governed by a smaller number of officers, and for the TMA Board of Councilors to determine a medical society to be “inactive” if it did not meet certain requirements.

A result of the amendments may an increase in the number of TMA “at-large” members or applicants (due to the medical society in their county being deemed inactive). The TMA Bylaws do not currently address the application or discipline process for at-large members or the organizational requirements for the participation of the at-large member group.

Additionally, for small county medical societies, though the amendments in 2020 addressed the process and appeals for a member’s application, they did not address those areas for member discipline.

Recommendation: The Council on Constitution and Bylaws recommends amending Chapters 1, 3, 5, and 12 of the TMA Bylaws, as set forth below, and renumbering them accordingly, to (1) add an application, discipline, and appeal process, as well as the operating requirements for at-large members, and (2) add a disciplinary process for small county medical societies.

CHAPTER 1. MEMBERSHIP

1.13 Ethics. A physician or medical student applying for membership in a county medical society or at large shall subscribe to the AMA Principles of Medical Ethics and the ethics opinions of the Board of Councilors.

1.202 At-large. Physicians against whom no charges of unethical or unprofessional conduct that could lead to denial of membership as provided in 1.11 are pending shall be eligible for at-large membership provided that they reside or work in a county where the county medical society is an inactive society, as described in Section 12.113, or no county society charter exists (see Section 5.203). At-large members shall have all rights and privileges of membership.

1.80 Application and appeal for at-large membership

1.81 Application for at-large membership. For a physician eligible for at-large membership as provided in 1.202, the application for membership shall be made to the district councilor and vice councilor of the county in which the applicant resides or works. With respect to an application for at-large membership, the district councilor and vice councilor act as the board of censors.
The application shall contain the following information: full name and address, place and date of birth, medical education and degree received, locations and dates of residencies, and such other information as the association or the district councilor may require.

The district councilor shall retain any original applications the councilor receives and forward copies to the executive vice president of the association. Copies of any original applications the association receives shall be forwarded to the district councilor and vice counselor.

1.82 District councilor examination. The district councilor and vice counselor who receive a completed application for at-large membership shall perform the examination under this section within 60 days of receipt. Upon the examination of the applicant’s qualifications and decision to approve the applicant’s membership, the district councilor and vice councilor shall declare the applicant a member.

The executive vice president shall be notified if the district councilor and vice councilor do not reach a unanimous decision. The executive vice president will then appoint a member of the Board of Councilors to resolve the impasse.

1.83 Disapproval of membership. Within 10 business days of a denial of membership by the district councilor and vice councilor, the district councilor shall notify the applicant of the decision as well as the applicant’s right to appeal the denial to the Board of Councilors. A copy of the notice to the applicant shall be sent to the Board of Councilors.

The applicant then must give written notice of appeal to the Board of Councilors within 30 days of the notice of denial. If the applicant does not request a hearing, or after the hearing is complete, the Board of Councilors shall vote to deny or accept the applicant for membership. The Board of Councilors shall notify the applicant promptly of its decision to approve or deny membership.

1.84 Appeal and reapplication. If the district councilor takes no action on a completed application within these specified periods of time, the applicant may appeal to the Board of Councilors.

If an application for at-large membership is rejected, the physician may not reapply for a period of one year from the date of rejection.

CHAPTER 3. HOUSE OF DELEGATES

3.23 At-large members. At-large members shall be entitled to delegate representation in the House of Delegates and shall have the authority 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. An alternate delegate shall be selected for each delegate and may serve as provided in 3.32. A meeting for at-large members shall be hosted at least twice a year between the end of one annual session and the end of the following annual session of the association.

A meeting may be held in person, or by telephone conference or similar means by which all meeting participants can hear each other; or by other electronic communications system, including videoconferencing technology. Meetings shall 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 at-large member group.

CHAPTER 5. BOARD OF COUNCILORS

5.211 Publish *Hearings Procedures Manual*. The board shall publish a manual describing procedures that county medical societies and the board shall use in conducting disciplinary investigations, hearings, and appeals.

5.212 Serve as Board of Censors. The board shall constitute the association’s Board of Censors. The board shall receive and hear appeals of individual members from the disciplinary action taken by component county medical societies pursuant to the provisions of the *Hearings Procedures Manual*. The board also shall receive and hear those appeals provided for in 1.40. The board, in those instances in which local action has not or cannot be taken or in questions involving two or more component county medical societies, may, after due notice and investigation, take original jurisdiction in any matter involving any TMA member for violating this Constitution and Bylaws, for violating the AMA Principles of Medical Ethics, or for violating the ethical policies of the Texas Medical Association.

With the exception of the rules of procedure set forth in the *Hearings Procedures Manual*, governing the appeal of a member from the disciplinary action or denial of membership by a component county medical society, all other appeals or hearings before the board shall be governed by such rules of procedure as may be adopted or provided for in 5.212.

The decision of the board in all such cases shall be final, except that a member, applicant, or a component county society may appeal to the Council on Ethical and Judicial Affairs of the American Medical Association in accordance with the bylaws of that organization.

Complaints of members against each other or component county societies coming before the House of Delegates shall be referred to the Board of Councilors without debate. The board shall report to the House of Delegates on all such matters so referred as promptly as circumstances permit.

5.219 Responsibilities for certain counties. The district councilor and vice councilor of a county where the county medical society is an inactive society or no county society charter exists shall perform the duties of the board of censors described under Section
12.433. Where the district councilor and vice councilor determine that disciplinary action against a member is warranted, a notice of proposed disciplinary action will be sent to the member, as prescribed by the *Hearings Procedures Manual*. Appeal may be made to the Board of Councilors of the association, as provided in Section 5.213, and the district councilor and vice councilor will recuse themselves, in accordance with Section 5.44.

With respect to the denial of a membership application or disciplinary process for a county electing officers in accordance with Section 12.4211, the district councilor and vice councilor act as the executive board.

For this section, where the district councilor and vice councilor do not reach a unanimous decision, the executive vice president will appoint a third member of the Board of Councilors to resolve the impasse.

5.44. *Recusal*. Councilors who decided matters brought on appeal to the Board of Councilors that a component county medical society brings on appeal to the councilors, including the appeal of the disapproval of membership under Section 1.16 or 1.81 or disciplinary proceedings under Section 12.434 or 5.219, must recuse themselves if the appeal is passed on to the Board of Councilors.

**CHAPTER 12. COUNTY SOCIETIES**

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.

With respect to the disciplinary process for a county electing officers in accordance with Section 12.4211, the district councilor and vice councilor act as the executive board. The chair of the Board of Councilors shall be notified if the district 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.
REPORT OF COUNCIL ON CONSTITUTION AND BYLAWS

C-CB Report 3 2021

Subject: Amendments to Bylaws to Allow Two-Year Terms for County Medical Society Officers

Presented by: William Gilmer, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

County Medical Societies (CMSs) have requested the flexibility to elect their officers to two-year terms. According to TMA Bylaws §12.412, a CMS must elect a minimum of five officers: a president, a secretary/treasurer, and three members of the board of censors. In an incorporated CMS, other members of the CMS executive board may also be elected as officers. For a CMS with less than 50 members (small CMS), the CMS may forego a board of censors, but must elect a president-elect.

The TMA Bylaws specify that members of the board of censors are elected to three-year terms and allow the term of the secretary/treasurer to be extended to two or three years. All other officers – a president, a president-elect, or other executive board members elected as officers – are limited to a one-year term. Therefore, a bylaw amendment is necessary for officers other than the secretary/treasurer or a member of the board of censors to serve for a term longer than one year.

However, if the TMA Bylaws are amended to allow other officers to serve two-year terms, this could conflict with the current TMA Bylaw §12.45 language indicating that a small CMS holds an election every year. As discussed above, the TMA Bylaws allow a small CMS to choose to elect only three officers: president, president-elect, and secretary/treasurer. If the terms of office for all small CMS officers were extended, there could be years when no election is needed. As such, if the TMA Bylaws are amended to allow two-year terms, then the annual election requirements for small CMSs should be amended to apply only when there are vacant positions.

To allow CMSs the flexibility to elect officers to two-year terms, while not requiring an election if there are no expiring terms, the Council on Constitution and Bylaws recommends amending Chapter 12 of the Texas Medical Association Bylaws, as set forth below.

Recommendation: Amend Texas Medical Association Bylaws as stated below:

CHAPTER 12. COUNTY SOCIETIES

12.422 Term of office. The term of office for all officers, except 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. The term of the office of other officers may be extended to two years. An amendment to a society’s bylaws to extend a term of office requires approval by the Board of Councilors, in accordance with Section 5.209.

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. In each subsequent year, the society shall annually elect a president-elect and secretary/treasurer unless there are no expiring terms that year, in accordance with Section 12.422. 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.
Subject: Amendment to Bylaws to Tie Council Meeting Requirements to the TMA Session Year

Presented by: William Gilmer, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

The Board of Councilors, pursuant to its authority to interpret the TMA Bylaws, as stated in TMA Bylaws §5.202, has interpreted the “once a year” meeting requirement for councils in §9.40 to refer to a calendar year. As such, under the language of the current TMA Bylaws, a council could theoretically go an entire TMA session year without holding a meeting. For example, a council could hold a meeting in January 2020, but not meet again until August 2021. Although the chair appointed after the TMA annual session in May 2020 would never have held a meeting, this would not run afoul of the current bylaw language.

In contrast, the bylaw provisions for the Board of Councilors and Committees avoid this possibility by tying their meeting requirements to TMA’s annual session per TMA Bylaws §5.60 and §10.214.

To tie the council meeting requirement to the annual session, the Council on Constitution and Bylaws recommends amending Chapter 9 of the TMA Bylaws, as set forth below.

**Recommendation:** Amend Texas Medical Association Bylaws as follows:

**CHAPTER 9. COUNCILS**

9.40 **Meetings, attendance, and quorums**

A council shall meet upon call of its chair, at least once a year between the end of one annual session and the end of the following annual session of the association.
REPORT OF COUNCIL ON CONSTITUTION AND BYLAWS

C-CB Report 5 2021

Subject: Amendments to Bylaws to Allow Sections to Determine Members’ Right to Vote and Hold Office

Presented by: William Gilmer, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

Prior to the 2020 elections for the Women Physicians Section and the LGBTQ Health Section, a question arose among section members and TMA staff as to whether medical student and resident members of the sections had the right to vote and run for elected positions. Generally, TMA Bylaws limit those rights for these two member categories.

Those limitations make sense for overall TMA governance, as a means of ensuring organizational decision-making is predominantly in the hands of more experienced physicians. That rationale is less compelling for sections though, which participate in a more limited range of organizational governance, and whose stated purposes include encouraging member involvement and representation.

To allow Sections to determine – through their operating procedures – the rights of their medical student and resident members to vote and hold elected positions, the Council on Constitution and Bylaws recommends amending Chapter 1 of the Texas Medical Association Bylaws, as set forth below.

Recommendation: Amend Texas Medical Association Bylaws, as follows:

CHAPTER 1. MEMBERSHIP

1.208 Resident. Physicians serving internships, residencies, and fellowships in hospitals located within the geographical boundaries of a county society, who are not in private practice, shall be eligible for resident membership in that county society. Resident membership shall cease with the completion of the internship, residency, or fellowship.

Resident members shall have all rights and privileges of membership except the right to vote and hold elective or appointive positions. However, resident members may serve as voting delegates or alternate delegates to the TMA House of Delegates, may be elected to the designated position on the association’s AMA delegation, may be appointed to the designated member position on the Board of Trustees and the Committee on Membership, and may serve as special appointees to councils and committees (see Sections 9.38 and 10.30). Resident members also may be granted voting privileges on committees of a county medical society, at the discretion of the county society. Resident members may be granted the right to vote and hold elective or appointive positions in a section, if provided for in its operating procedures.

1.209 Student. Full-time students pursuing a course of study in a Texas medical school recognized by the Texas Medical Board that leads to the degree of Doctor of Medicine or Doctor of Osteopathy shall be eligible for student membership in the county society in which the medical school or satellite campus where they are enrolled is located. Student membership shall cease upon termination or change of enrollment status.
Student members shall have all the privileges of membership except the right to vote and hold elective or appointive positions. However, student members may serve as voting Medical Student Section delegates or alternate delegates, may be elected to the designated position on the association’s AMA delegation, may be appointed to the designated member position on the Board of Trustees and the Committee on Membership, and may serve as special appointees to councils and committees (see Sections 9.38 and 10.30). Student members also may be granted voting privileges on committees of a county medical society, at the discretion of the county society. Student members may be granted the right to vote and hold elective or appointive positions in a section, if provided for in its operating procedures.
REPORT OF COUNCIL ON CONSTITUTION AND BYLAWS

C-CB Report 6 2021

Subject: Amendments to Bylaws to Update and Clarify Existing Language

Presented by: William Gilmer, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

As listed below, there are sections in the TMA Bylaws that could be updated to reflect recent amendments or would benefit from minor clarifications.

- **3.12, Voting Rights.** The 2021 House of Delegates will consider the final approval of an amendment to the TMA Constitution to allow delegate representation for the Women Physicians Section, the LGBTQ Health Section, and the At-Large member group. If approved, the section of the TMA Bylaws addressing voting rights – Section 3.12 – should be updated to reflect the constitutional amendment.

- **Bylaws Section 3.251, Section Communications and Relationships.** The TMA Bylaw language addressing Sections – TMA Bylaws §§ 3.251 to 3.259 – was modeled after similar language in the American Medical Association (AMA) bylaws. When drafted, the intent was to replace references to the “AMA” with “TMA”. This was done in all instances except one: TMA Bylaws Section 3.251(3). In that subsection, the replacement was inadvertently omitted, and the subsection was adopted with the original “AMA” reference. Amending this subsection to reference “TMA” would be consistent with the original drafting intent.

- **Bylaws Section 9.40, Quorum for Council Meeting.** The current TMA Bylaw language on quorum for councils does not read clearly: “A majority of voting members to include medical student, Resident and Fellow Section (RFS), and Texas Medical Association Alliance (TMAA) special appointees, if present, (see Section 10.30), shall be required to officially transact business.” Non-substantive changes in wording and punctuation could make it clearer.

- **Bylaws Section 10.214, Quorum for Committee Meetings.** The issue discussed above for councils is also present in the language on quorum for committees. It could be addressed with the same non-substantive changes in wording and punctuation.

- **Bylaws Section 12.434, Board of Censors Allowed.** For a county medical society (CMS) with less than 50 members, the TMA Bylaws allow the CMS’s president, president-elect, and secretary/treasurer to serve as the CMS’s board of censors. The intent of this language was to allow those officers to serve in that role if the CMS was unable to fill those positions with separate candidates, due to the CMS’s limited membership. However, if the CMS were able to fill its board of censors’ positions with separate candidates, the current bylaw language could be read to only allow president, president-elect, and secretary/treasurer to act in that role. An amendment could clarify that for CMS groups with less than 50 members, the president, president-elect, and secretary treasurer serve as the board of censors if no board of censors has been elected.
**Recommendation 1:** Amend Texas Medical Association Policy 3.12 Voting rights as follows:

3.12 **Voting rights.** Voting privileges are reserved exclusively to (1) delegates, elected in accordance with this Constitution and Bylaws; (2) the president, president-elect, immediate past president, secretary/treasurer; (3) councilors; (4) nine members elected at large to the Board of Trustees plus the young physician, resident, and student members of the board; (5) speaker of the House of Delegates; (6) vice speaker of the House of Delegates; (7) Texas delegates and alternate delegates to the American Medical Association; (8) chairs of standing councils and members of the Council on Legislation; (9) delegates from the International Medical Graduate Section, LGBTQ Health Section, Resident and Fellow Section, and Young Physician Section, and Women Physicians Section; (10) delegates representing the Medical Student Section from each approved and active Medical Student Section Chapter; (11) delegates of medical specialty societies selected in accordance with the provisions of the Bylaws; and (12) past presidents of the association who are active or emeritus members; and (13) delegates representing at-large members. An individual is entitled to only one vote, regardless of the number of positions held.

**Recommendation 2:** Amend TMA Policy 3.251 Missions of the sections as follows:

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 TMA 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.

**Recommendation 3:** Amend TMA Policy 9.40 Meetings, attendance, and quorums as follows:

9.40 **Meetings, attendance, and quorums**

A council shall meet upon call of its chair, at least once a year.

If any member fails to attend two consecutive scheduled meetings, the position shall be declared vacant.

A majority of voting members, including Medical Student, Resident and Fellow Section (RFS), and Texas Medical Association Alliance (TMAA) special appointees, if present, (see Section 10.30), shall be required to officially transact business.
Recommendation 4: Amend TMA Policy 10.214 Meetings and quorums as follows:

10.214 Meetings and quorums. Should any standing committee meet less than twice during the entire year between the end of one annual session and the end of the following annual session of the association, the committee shall be abolished.

A majority of voting members, including [to include] Medical Student, Resident and Fellow Section (RFS), and Texas Medical Association Alliance (TMAA) special appointees, if present (see Section 10.30), shall be required to officially transact business.

Recommendation 5: Amend TMA Policy 12.434 Board of censors responsibilities for certain counties as follows:

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 if no board of censors has been elected. 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, if no board of censors has been elected.
Because of the COVID-19 pandemic, TMA transitioned from in-person to virtual meetings and elections, often through videoconferencing technology, e.g., Zoom. While born of necessity, many council and committee members have expressed enthusiasm for conveniences inherent to virtual meetings, such as not having to travel. TMA members have expressed interest in allowing virtual meetings to remain an option when the pandemic subsides. Though nowhere prohibited in TMA’s bylaws, no specific provisions allow for virtual meetings.

Also, several provisions in TMA’s bylaws about voting do not explicitly include in-person voting. Including this language is not strictly necessary, as Texas law explicitly allows a member to vote in-person. However, adding language to that effect would avoid having to read outside TMA’s bylaw to determine how voting may be conducted.

To specifically allow virtual meetings and in-person voting, the Council on Constitution and Bylaws recommends amending Chapters 4, 5, 9, 10, and 14 of the Texas Medical Association Bylaws, as set forth below.

Recommendation: Amend the Texas Medical Association Bylaws as follows:

**CHAPTER 4. BOARD OF TRUSTEE**

**4.60 Meetings**

The board shall hold regular meetings. Special meetings of the board may be called at any time by the chair, the TMA president, or by four members of the board upon written or personal notice at least five days before such meeting is to be held.

A majority of voting members shall be required to transact business.

A trustee vote on any matter may be conducted in person, 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.

**CHAPTER 5. BOARD OF COUNCILORS**

**5.60 Meeting and quorums**

The board shall hold such meetings as it may deem necessary, provided that at least one meeting is held during each annual session of the association, at which meeting any physician who has a proper grievance shall be allowed to appear and be heard by the board.
A majority of councilor districts being represented by either a councilor or a vice councilor voting as a meeting shall be required to officially transact business.

Voting members include councilors, vice councilors, and Resident and Fellow Section (RFS) and Medical Student Section (MSS) special appointees.

A councilor, vice councilor, or special appointee vote on any matter may be conducted in person, 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.

CHAPTER 9. COUNCILS

9.40 Meetings, attendance, and quorums

A council shall meet upon call of its chair, at least once a year.

If any member fails to attend two consecutive scheduled meetings, the position shall be declared vacant.

A majority of voting members to include medical student, Resident and Fellow Section (RFS), and Texas Medical Association Alliance (TMAA) special appointees, if present, (see Section 10.30), shall be required to officially transact business.

A council member vote on any matter may be conducted in person, 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.

CHAPTER 10. COMMITTEES

10.214 Meetings and quorums.

Should any standing committee meet less than twice during the entire year between the end of one annual session and the end of the following annual session of the association, the committee shall be abolished.

A majority of voting members to include medical student, Resident and Fellow Section (RFS), and Texas Medical Association Alliance (TMAA) special appointees, if present (see Section 10.30), shall be required to officially transact business.

A committee member vote on any matter may be conducted in person, 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.
CHAPTER 14. RULES OF ORDER

14.10 Parliamentary Procedure

The *American Institute of Parliamentarians Standard Code of Parliamentary Procedure* shall govern the association in all cases to which it is applicable and is not inconsistent with this constitution and bylaws and standing rules of the association.

14.20 Meetings

Unless otherwise provided in these bylaws, association meetings and other association activities may be held in-person; by telephone conference or similar means; or through another suitable electronic communications system, including videoconferencing technology or the internet; or any combination, if the telephone or other equipment or system permits each person participating in the meeting to communicate with all other persons participating in the meeting.

14.30 Voting

Unless otherwise provided in these bylaws, a member vote on any matter may be conducted in person, by mail, by facsimile transmission, by electronic message, or by a combination of those methods.
Subject: Amendments to Article V of the TMA Constitution

Presented by: William Gilmer, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

Proposed revisions to the Texas Medical Association Constitution to add delegate representation in the House of Delegates for the LGBTQ Health Section were approved at first reading by the TMA Disaster Board, acting in lieu of the delayed House of Delegates on May 17, 2020 (C-CB Report 3 2020).

Similarly, the TMA Disaster Board approved proposed revisions to the TMA Constitution to add delegate representation in the house for the Women Physicians Section and the at-large physicians (C-CB Report 1 2020).

As required, the proposed amendments to the Constitution were published in the March 2021 issue of *Texas Medicine*, and are being submitted at this meeting for final House of Delegates approval. The TMA Constitution in its entirety is attached.

**Recommendation:** Amend the Texas Medical Association Constitution as follows:
CONSTITUTION

All references in this document to “articles” shall refer to articles in this Constitution; all references to “chapters” shall refer to chapters in these Bylaws; and all references to “the association” shall refer to the Texas Medical Association.

ARTICLE I. NAME.

The name of this organization is the Texas Medical Association.

ARTICLE II. PURPOSES.

The purposes of the association are to (1) serve the people of Texas in matters of medical care, (2) federate members of the profession practicing medicine and surgery, (3) provide effective representation for its members, (4) unite with similar state associations to form the American Medical Association, (5) promote unity and cooperation among its members and component organizations, (6) secure the enactment of appropriate medical and health care legislation, (7) extend medical knowledge and advance medical science, and (8) strive for the prevention and cure of disease and the improvement of public health.

The association shall have the authority to regulate ethical conduct among its members, to maintain and advance the standards of medical care, and to enact bylaws regulating such matters.

ARTICLE III. COMPOSITION.

Sec. 1. This association shall be composed of members of duly chartered county medical societies and affiliate and at-large members of the association.

Sec. 2. Those eligible for membership in the association are physicians holding the degree of Doctor of Medicine and/or Doctor of Osteopathy, and full-time students pursuing a course of study in a Texas medical school recognized by the Texas Medical Board that leads to the degree of Doctor of Medicine or Doctor of Osteopathy. Deans of these medical schools and presidents of health science centers of which these medical schools are component schools also shall be eligible for membership in the association provided they hold doctoral degrees.

Sec. 3. All members shall subscribe to the Principles of Medical Ethics of the American Medical Association and shall not hold themselves out as practitioners of sectarian medicine.

Sec. 4. All physician members shall be licensed to practice medicine in Texas; a temporary license, certificate, or permit shall not be deemed adequate. The exceptions to this licensure requirement for membership are:

(1) House staff physicians serving in training programs approved by the Accreditation Council for Graduate Medical Education who hold institutional permits from the Texas Medical Board.

(2) Physicians who are military medical officers, employees of governmental entities, and those with academic and administrative appointments in medical schools who are not required to register under the Medical Practice Act of Texas, and who are residents of the State of Texas.

(3) Physicians who are fully retired from the practice of medicine.
ARTICLE IV. OFFICERS.

The officers of the association shall be the president, president-elect, immediate past president, secretary/treasurer, and speaker and vice speaker of the House of Delegates. Their election, responsibilities, and terms of office shall be as provided in the Bylaws.

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, LGBTQ Health 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.

ARTICLE VI. BOARD OF TRUSTEES.

The Board of Trustees shall be composed of at-large members elected as provided in the bylaws and, ex officio, with vote, the president, president-elect, immediate past president, secretary/treasurer and speaker and vice speaker of the House of Delegates; one young physician who shall be elected as provided in the bylaws, and one resident and one student member, who shall be appointed annually. This board shall establish interim policy of the association. All policies established by the Board of Trustees shall be subject to ratification by the House of Delegates. The Board of Trustees shall perform other duties as defined in the Bylaws and as may be established by the House of Delegates. The board shall meet at intervals between meetings of the House of Delegates.

The Board of Trustees shall manage the business and financial affairs of the association. All association funds shall be subject to the exclusive control of the Board of Trustees except as otherwise provided in the Bylaws. The Board of Trustees shall serve in general as a board of directors within the meaning of the corporate laws of the State of Texas.
ARTICLE VII. BOARD OF COUNCILORS.

The Board of Councilors shall consist of one member from each councilor district. All questions of medical ethics shall be referred to this board, as provided in the Bylaws. The Board of Councilors shall supervise component county societies.

ARTICLE VIII. COMPONENT COUNTY SOCIETIES.

Component county societies shall be chartered by and organized under the direction of the Board of Councilors. Component county societies shall have general jurisdiction over the medical affairs within their geographical boundaries, as provided in the Bylaws.

ARTICLE IX. COUNCILOR DISTRICTS.

The House of Delegates shall divide the state into councilor districts for the primary purpose of electing councilors and vice councilors and to promote the best interests of the public and the profession.

ARTICLE X. ANNUAL SESSION.

The association shall hold an annual session for the presentation of general and scientific programs.

ARTICLE XI. FUNDS, DUES, AND ASSESSMENTS.

Funds may be raised by annual dues and by assessments of members of the association, as provided in the Bylaws.

ARTICLE XII. INCORPORATION.

The association shall have the authority to take out papers of incorporation under the corporate laws of the State of Texas. The association shall have a common seal with power to break, change, or renew the same at pleasure. Component county societies shall have the authority to take out papers of incorporation, provided that said incorporation does not remove the said component county societies from the jurisdiction of the association.

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.
Sunset Policy Review

Presented by: Susan B. Hudson, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

House of Delegates policies in the association’s Policy Compendium are reviewed periodically for relevance and appropriateness. Following are policies reviewed by the council with recommendations for amendment.

This policy was reviewed by TMA’s Health Information Technology Committee, which made several updates, edits for redundancies, and editorial clarifications.

Paragraphs 11 and 12 were added to address changes that have occurred in the health care environment since the policy was last reviewed in 2011. The rationale for these additions is as follows:

1. Direct-to-consumer genetic testing is a growing increasingly common with many consumers ordering tests without understanding how the data and results may be used.

2. Patient-facing health tools such as computer or phone-based applications (“apps”) are being increasingly used by patients to request data from covered entities such as physicians, hospitals, and labs. One technology used by these tools is called an application programming interface (APIs). The vendors and companies that own and operate these apps, APIs and other tools often are not covered entities nor business associates and as such do not have to comply with HIPAA laws and regulations.

Paragraph five was updated to reflect changes in privacy laws regarding the responsibility of the patient to pay for services if the patient refuses to release information to an insurer.

Original paragraph eight was felt to be redundant with paragraph two, so they were consolidated.

The committee debated whether to add this paragraph:

Patients have the right to withhold their health information from sharing, to the extent allowed by law. Until better technology exists for withholding specific health information, the patient should take responsibility for sharing the record.

Ultimately, the majority determined to not include it for now, but it should be considered in future policy development.

It is recommended that this policy be approved as amended:

105.019 Principles for Protection of Medical Record Privacy

In developing privacy legislation, the Texas Medical Association adheres to the following principles for protection of medical record privacy. The central focus should be on the best interests of the patient:
(1) Medical information privacy protections should follow the information. Any Privacy
requirements for medical records the handling, including transmission, of medical information
should apply to any entity in possession of, or with access to, the contents of these records such
information regardless of the form in which the information content exists, or is transmitted
(paper, electronic, etc.)

(2) Any pPenalties for the misuse of such medical record information also shall should apply to
any specific entity violating privacy laws or regulations. These penalties should be (1) strong
and enforceable so as to deter malicious use of medical record information or negligent care and
(2) fair, so as to avoid placing unnecessary or excessive burdens on physician practices.
Consideration should be given to mitigating factors when assessing breaches or administering
penalties.

(3) Employers should not have access to individually identifiable medical information
regarding employees, except for legitimate employee health and safety purposes, with
appropriate privacy safeguards. While it is reasonable for employers to may receive aggregate
information regarding their employee health care utilization and expenditures, they should not
have access to individually identifiable information regarding the health care conditions or
treatments of their employees, except for legitimate employee health and safety purposes with
appropriate privacy safeguards.

(4) Medical information should not be used for nonmedical purposes without the informed
and non-coerced consent of the individual involved. The increasing horizontal and vertical
integration of our financial services sector of the economy may provide nonmedical entities
with access to individual’s medical records. These organizations, (e.g. such as financial
institutions, and credit reporting entities, and third-party research facilities) should not use
individuals’ medical records without their informed written consent.

(5) Treatment through or membership in a particular health plan should not be contingent upon
release of such medical information against a patient’s will, however, the patient should be
prepared to pay for services provided if they refuse release of their information to an insurer.

(6) Medical information should be carefully defined and should include prescription drug
information. Records made through the purchase of prescription medications can reveal the
medical condition of an individual. For this reason, legislation should clarify that prescription
drug records are considered protected medical information.

(7) Consideration should be given to special protections for “sensitive health information.”
Certain conditions, such as HIV, sexually transmitted diseases, psychiatric conditions, and
domestic violence, are particularly sensitive and may require special protections. Such protections
may include complete prohibition of disclosure outside certain circumstances or additional
consent for disclosure. Those special protections may be limited by the current lack of
functionality of many electronic health record systems to filter this information in a reliable way.
Health information technology vendors should develop products that allow physicians to easily
comply with handling of sensitive health information protected by law.

(8) When consent is required by law, it should be understandable and clearly communicated
to the patient, for the use or release of medical information should meet specific standards.
Individuals, and in some cases treating health care professionals, should be required to provide
informed consent regarding the use or transfer of medical information. Standards should be
established to ensure such consent is understandable and clearly communicated. Individuals should be required to give consent in order to purchase insurance coverage or receive medical treatment or payment for that treatment.

(7) Research activities should be protected, but not at the expense of individual privacy. Information used for research should be required to be de-identified in an acceptable manner, unless documented informed consent has been obtained, to support legitimate clinical research without unnecessary risk to the patient’s privacy.

(8) Penalties should be severe and readily enforceable. Databases are extremely valuable in today’s marketplace. Given the potential financial gains from selling medical information, penalties must be severe to deter these lucrative activities. There should be clear enforcement directives and the ability of an individual to seek redress in the courts should enforcement measures prove inadequate.

(9) Patients should have the right to the information in their medical records. Patients should have the right to inspect and obtain copies of their medical records to the extent allowed by law, except for that information which, in the opinion of the health care professional, would cause harm to the patient or to others

(10) Genetic and genomic testing results should be classified as protected health information.

(11) Application programming interface (API) vendors and companies accessing patient health information on behalf of patients should have nationally standardized terms of service with strong patient privacy provisions. (TF Rep. 1-A-01; reaffirmed CSE Rep. 8-A-11).

Recommendation: Retain as amended.
REPORT OF PATIENT-PHYSICIAN ADVOCACY COMMITTEE

CM-PPA Report 2 2021

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:

160.013 Medical Expert Witness Standards. The Texas Medical Association supports efforts to hold medical expert witnesses accountable for their actions (Amended Res. 108-A-01; reaffirmed CSE Rep. 8-A-11)


225.019 Criteria for Physicians Conducting Peer Review. The Texas Medical Association advocates that physicians who conduct review for health care decisions in Texas should (1) be in an active practice; (2) possess a nonrestricted license to practice in Texas; and (3) be experienced in the procedures or treatment under review. (For example, not all orthopedic surgeons perform spinal surgery.) (Res. 410-A-11)

Recommendation 1: Retain.

The Patient-Physician Advocacy Committee recommends deletion of the following policy:

95.035 Distribution of Donated Medications. The Texas Medical Association supports state and federal legislation to allow charity, county, and other gap clinics, as well as other physicians who receive pharmaceuticals that are not controlled substances or insulin, from patient assistance programs, to dispense these drugs, free of charge, with proper documentation to their own patients who are in need of such assistance (Res. 304-A-11).

Recommendation 2: Delete.

The Patient-Physician Advocacy Committee recommends amending the following policy:

170.001 Good Samaritan and Charitable Immunity Laws. The Texas Medical Association continues to support the Good Samaritan Law, which provides immunity from civil
liability for physicians and others who allows persons including physicians, to render aid in
good faith during a bonafide in an emergency free from liability when such aid it is not
provided for or in expectation of remuneration compensation. The Texas Medical
Association continues to support the Charitable Immunity Law which provides immunity
from civil liability for allows any volunteer health care provider who voluntarily provides
medical or health care on behalf of a charitable organization, within their appropriate legal
scope of practice, so long as certain written acknowledgements are obtained and except for
an act or omission that is intentional, willfully negligent, or done with conscious indifference
or reckless disregard for the safety of others, to the needy free of charge to be free of liability
risks. These laws increase access to necessary care for Texas’ patients in charity, emergency,
and disaster situations allow semi-retired and retired health care professionals to participate
in providing health care to those in need without having to purchase professional liability
insurance. TMA continues to support legislative efforts to dissolve roadblocks to access to
medical care by the needy. (Res. 27DD, p 181K, I-90; reaffirmed CSE Rep. 5-I-01; amended

Recommendation 3: Amend.
Subject: Sunset Review of TMA Standing Committees

Presented by: Gary W. Floyd, MD, chair

Referred to: Reference Committee on Financial and Organizational Affairs

TMA Bylaws provide that standing committees of the association shall be discharged at the expiration of three years unless the parent council or board petitions the Board of Trustees. The House of Delegates then acts on the recommendations of the board.

At the 2016 Winter Conference, the Board of Trustees (BOT) approved a report detailing the findings and recommendations of a BOT Task Force on TMA Committee Sunset Review Process. The task force’s report was in response to Resolution 106-A-15, TMA Sunset Review of Councils, Committees, and Sections, referred to the board for study.

Upon review and deliberation of the issues raised in Resolution 106-A-15, the board discerned the need for greater collaboration of all parties involved in and affected by sunset recommendations. The board further recognized the importance of transparency of criteria and inclusive communication of process prior to sunset recommendations coming before the House of Delegates. The BOT task force report contained five recommendations:

1. That, as part of their appointment, council and committee members be provided with annual objectives and goals and how they align with TMA’s overall strategic efforts.
2. That criteria for sunset review align with TMA strategic goals and objectives and that the criteria be communicated to councils and committees in a transparent and efficient manner at the beginning of each year with ongoing collaboration with the Board of Trustees as the year progresses.
3. That sunset review be accomplished as reasonably and efficiently as possible and that for any major change (discharge, reorganization), the Board of Trustees actively participate and collaborate with all affected councils or committees and, if necessary, seek external member input prior to forwarding recommendations to the House of Delegates.
4. That TMA provide (1) an orientation of council and committee chairs as to their roles and the association’s organizational structure; and (2) a mechanism for better communication between council chairs and the Board of Trustees and between council chairs with each other.
5. That the Council on Constitution and Bylaws be asked to consider issues identified in this report in light of options for alternatives to standing committees such as use of subcommittees to allow organizational effectiveness and efficiency.

TMA’s Council on Constitution and Bylaws Report 1-A-17 found that, as a supplement to TMA Bylaws, parliamentary procedure provides a good deal of direction concerning the functions of committees, subcommittees, and special groups. The council recommended adoption of the new American Institute of Parliamentarians Standard Code of Parliamentary Procedure (AIP) to ensure TMA is following the most up-to-date parliamentary procedures (SPKR and CCB Joint Report 1-A-17, Adopted A-17).

In further response to these recommendations, an orientation video was created and shared with all council and committee members and posted to the TMA website. It clearly describes the functions and work products expected of TMA councils and committees, as well as other general requirements including attendance. This video discusses the TMA governance process, and the process of committee sunset review. The board also approved the use of a simple, one-page form for use by all councils to evaluate standing committees reporting to them.
**Board of Trustees**

The Interspecialty Society Committee provides its member societies and other specialty societies an entity to which legislative, social, economic, and professional concerns may be presented and transmitted to the House of Delegates or other appropriate bodies of the association. The committee has been recognized as the conduit for specialty concerns and offers specialty societies a voice within TMA.

The Committee on Membership provides physician-led guidance in the development of annual and long-term membership recruitment and retention programs. County society staff serve as consultants to the committee. The committee is instrumental in providing guidance on proposed marketing strategies, ideas for new and emerging membership segments, removing barriers to membership, a local physician view of TMA policies and procedures, and direction and assistance for local market activities. Its efforts contribute directly to membership recruitment and retention, which continues to increase every year, contributing to a 2020 annual dues revenue of $15.89 million, which represents 62.47% of actual operating revenue.

**Recommendation 1:** Continue the Interspecialty Society Committee and Committee on Membership for three years.

**Board of Councilors**

The Committee on Physician Health and Wellness (CM-PHW) reports to the Board of Councilors. The committee’s copious and multidimensional duties include (1) promoting healthy lifestyles to Texas physicians, residents, and medical students; (2) providing education focused on the prevention of impairing conditions, including by liaising with the Texas Medical Board (TMB) and Texas Physician Health Program (TXPHP); (3) advising the Council on Legislation when there are needed changes in the laws relating to physician health and wellness; and (4) providing general education on physician health and wellness topics.

These duties are very important to TMA’s 2025 goal of engaging in legislative, regulatory, and legal advocacy to improve the environment in which Texas physicians care for their patient.

These important duties have led to many accomplishments by CM-PHW over the years, including: the production of numerous programs and brochures to educate physicians, residents, and medical students about wellness, stress, and potentially impairing conditions. For example, CM-PHW was integral to the evolved Physician Benevolent Fund Wellness Fund that provides financial assistance to licensed Texas physicians who cannot afford treatment for depression, substance use disorders, or other potentially impairing conditions. Assistance may also be available for household expenses while the physician is receiving treatment. The committee also surveils activities involving physicians reported for suspected impaired conditions and connects with TMB and TXPHP as needed.

**Recommendation 2:** Continue the Committee on Physician Health and Wellness for three years.

**Council on Medical Education**

The Committee on Continuing Education serves a unique role both within and outside of TMA. Not only does the committee develop policy for consideration, but also conducts research that is used by others within TMA and in the legislative arena. This research is not conducted by any other group in the state and fills a gap. Furthermore, the committee’s work supports a uniform, national system of CME accreditation helping to assure physicians, state legislatures, CME providers and the public that all CME programs are held to the same high standards; and enables Texas physicians to maintain their license and board certification. The committee’s work has also gained national recognition; TMA has been asked to provide services to other state medical societies that are struggling with their accreditor programs. TMA’s CME Program has maintained its status of Accreditation with Commendation.
The Committee on Physician Distribution and Health Care Access serves in a unique role of monitoring  
and reporting on dominant trends in the physician workforce and other health professions and identifying  
research on the state’s workforce needs. The committee’s work has gained national and state-level  
recognition and fills a gap in national and state workforce planning. During the COVID-19 pandemic, the  
committee assessed the impact of the pandemic on the physician workforce. These outcomes provide a  
foundation for the formulation of policy recommendations by the Council on Medical Education and  
inform TMA’s advocacy activities, both in congress and with the Texas Legislature.

**Recommendation 3:** Continue the Committee on Continuing Education and Committee on Physician  
Distribution and Health Care Access for three years.

### Council on Practice Management Services

The Committee on Health Information Technology provides a valuable service to the association, as it  
informs on numerous issues related to the safe and effective use of technology for practice efficiency and  
quality of care. The committee monitors and influences state and federal laws and regulations through  
numerous comment letters. The committee strengthens TMA’s advocacy through various state and  
national collaborations and works to oversee the development of education and resources for members.

It is further recommended that the parent council for CM-HIT be reassigned to the Council on  
Socioeconomics to align with the division staffing within the association. Effective Jan. 1, 2021, the HIT  
Department is now part of the Division of Medical Economics, as this department has evolved to assume  
a stronger role in policy and advocacy.

**Recommendation 4:** Continue the Committee on Health Information Technology for three years.

**Recommendation 5:** Amend the TMA Bylaws to reassign the Committee on Health Information  
Technology from the parent Council on Practice Management Services to the parent Council on  
Socioeconomics and renumber the bylaws accordingly.

### Council on Science and Public Health

Five standing committees report to the Council on Science and Public Health: Committee on Cancer;  
Committee on Child and Adolescent Health; Committee on Emergency Medical Services and Trauma;  
Committee on Infectious Diseases; and Committee on Reproductive, Women’s, and Perinatal Health.  
Overall, the council commends each of the committees’ activities and accomplishments. Each of the  
committees met the necessary meeting and attendance requirements. These committees submitted  
numerous reports to the House of Delegates, created physician education, worked closely with other  
committees, and advocated on numerous issues.

The Committee on Cancer has worked tirelessly to provide TMA members with research, education, and  
policy recommendations to benefit all Texans on cancer – those who require diagnosis and treatment, and  
those who can benefit from prevention. Members of the committee represent the main specialties and  
many of the vitally important subspecialties who work so hard to reduce the morbidity and mortality of  
cancer in all its forms. In the past three years the committee has developed (CME for physicians with  
specialty in oncology and prevention; supported HPV vaccination promotion efforts; collaborated with  
the Texas Public Health Coalition on issues related to cancer prevention; developed TexMed Cancer  
Track CME sessions and enduring CME sessions; collaborated with fellow committees and TMA leaders  
on HPV vaccination efforts through continuing education; and most recently completed the report on  
Addressing Cancer Health Disparities.

The Committee on Child and Adolescent Health (CM-CAH) is an important advocate for pediatrics and  
child health in Texas. CM-CAH provides input and expertise regarding public health and its impact on  
child health. CM-CAH serves to review, advise, and advocate for legislative issues in Texas that impact  
child health and pediatrics. CM-CAH provides resources for TMA on pediatric issues, pediatric providers,
immunization practices, and funding for pediatric care. The committee advocates for fragile populations involving children and provides input on the epidemiology of childhood illnesses. CM-CAH has contributed to the TMA COVID-19 response through its participation in the TMA COVID-19 Task Force, TMA School Reopening Workgroup, and roundtable meetings on TMA Telemedicine/Telehealth Flexibilities. As TMA continues to assess the long-term impact of emerging diseases on children and adolescents, the committee is ready to serve the membership by sharing critical clinical recommendations, providing consultation on unique issues facing Texas children, and supporting public health initiatives to make Texas equitably healthier for young Texans.

The Committee on Emergency Medical Services and Trauma’s charge is to: (1) work with all parties in the formulation, initiation, and maintenance of community plans for emergency medical services leading to statewide coverage; (2) liaison between the Texas medical community and government agencies concerned with emergency medical care; (3) educate and inform Texas physicians on the developments in emergency medical services at national and state levels; (4) identify and review state health programs relating to emergency medical services, injury prevention, and trauma care; (5) participate in, and provide physician input to, these state health programs; (6) maintain liaison with government agencies devoted to preparation and execution of plans in the event of any occurrence of catastrophic proportions, and educate Texas physicians about plans for medical care in disaster situations; (7) study, evaluate, and make recommendations regarding trauma and related problems, including accidents and physical abuse resulting in trauma; and (8) study, evaluate, and make recommendations regarding the development and funding of a statewide trauma system.

The Committee on Infectious Diseases has played a large and active role in TMA’s response to the COVID-19 pandemic. In addition to its members serving on TMA’s COVID-19 Task Force and TMA’s School Reopening Workgroup, the committee directly helped develop TMA’s COVID-19 Risk Chart as well as contributing to dozens of resources, podcasts, and interviews developed during the pandemic. During the review period, the Committee has also developed CME on HIV Screening and Antimicrobial Stewardship and a TMA/THA joint Health Advisory on the increasing threat of a measles outbreak. Legislatively, the committee testified on behalf of passed bills relating to first responder access to their vaccination status and records and to establishing infection control advisory councils for long-term care facilities.

The Committee on Reproductive, Women’s, and Perinatal Health has played a significant role carrying forward state-level initiatives to improve maternal and newborn care, improving review of maternal mortality and severe maternal morbidity, promoting the use of Long-Acting Reversible Contraception access and use, improving management of women with a stillbirth during pregnancy, and increasing awareness of emerging and resurging perinatal infectious concerns such as Zika, COVID-19, and congenital syphilis. Key areas identified for future committee focus are 1) enhanced postpartum awareness and management of women with preeclampsia; 2) provider education related to stillbirth workup/management; 3) heightened awareness of long-term cardiovascular risks in women with preeclampsia in pregnancy; 4) educating health care professionals on new paradigms for postpartum care; 5) expansion of continuing health care access for women with mental health conditions; and 6) increased collaboration of health care professionals with birthing centers.

Recommendation 6: Continue the Committee on Cancer; Committee on Child and Adolescent Health; Committee on Emergency Medical Services and Trauma; Committee on Infectious Diseases; and Committee on Reproductive, Women’s, and Perinatal Health for three years.

Council on Socioeconomics
Three standing committees report to the Council on Socioeconomics: Committee on Medical Home and Primary Care, Patient-Physician Advocacy Committee and Committee on Rural Health. The council recommends their continuation. Each of these committee’s respective duties are integral to TMA’s 2025 goal of engaging in legislative, regulatory, and legal advocacy to improve the environment in which
Texas physicians care for their patients. Additionally, each contributes to TMA’s 2025 goal of strengthening physicians’ trusted leadership role.

The work of the Committee on Medical Home and Primary Care (CM-HPC) has led to many accomplishments. The committee participated in the planning for the last three annual Texas Primary Care and Health Home Summits. The committee conducted joint meetings with the TMA Committee on Rural Health and Value-Based Payment Workgroup to identify COVID-19’s impact on primary care physician practice viability and develop potential interventions, including new primary care payment models and telemedicine payment parity. CM-HPC has produced educational materials to better inform primary care physicians about community resources to address the needs of autistic patients.

The Committee on Rural Health (CM-RH) has advocated that TMA take a leadership role to advance legislative initiatives to expanding broadband internet to rural and other communities, contributing to legislative wins in 2019. The committee wrote the report *Studying Financial Barriers of Rural Hospitals*, adopted by the House of Delegates in 2020, that evaluated the impact of hospital closures on Texas communities and developed policy recommendations to mitigate it. CM-RH conducted joint meetings with the TMA Committee on Medical Home and Primary Care and Value-Based Payment Workgroup to identify COVID-19’s impact on primary care physician practice viability and develop potential interventions, including new payment models and telemedicine payment parity. The meetings provided CME for participants.

The Patient-Physician Advocacy Committee reviewed multiple peer review cases on behalf of TMA members and advocated before the Texas Medical Board to achieve improvements, reviewed several physician-specific peer review cases that resulted in submission of amicus briefs to the courts on behalf of TMA members, and provided an important outlet and resource for physicians who seek TMA assistance to confront challenges related to the practice of medicine.

**Recommendation 7:** Continue the Committee on Medical Home and Primary Care, the Committee on Rural Health, and the Patient-Physician Advocacy Committee for three years.
Subject: Establish a Coalition of Medical Societies to Protect Competition and Sustainability in the Health Insurance Marketplace, Resolution 106-A-19 (Tabled BOT Report 10 2020)

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 Texas Medical Association 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 (PAI) 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** 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.

Recognizing 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 specialty 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 toward 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 employers
- Market to upper management on the 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 2022.

**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;
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- 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 employers**
- 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.
REPORT OF BOARD OF TRUSTEES

BOT Report 20 2021

Subject: Nominations for Board of Governors, Texas Medical Liability Trust

Presented by: Gary W. Floyd, MD, chair

Referred to: Reference Committee on Financial and Organizational Affairs

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 are also given the opportunity to nominate other eligible candidates. These nominations also are reported to the House of Delegates.

Beginning with elections in 2007, places on the TMLT board are staggered so that only a portion of places 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 2021:

Place 7: Gerald Callas, MD, will fulfill his term and board tenure at the end of 2021. The TMLT Governing Board recommends nominating Leah Jacobson, MD, Pediatrics, San Antonio, for a three-year term beginning in 2022.

Place 8: A. Compton Broders, MD, will fulfill his second term and board tenure at the end of 2021. The TMLT Governing Board recommends nominating Sarah Way, MD, JD, Emergency Medicine, Dallas, for a three-year term beginning in 2022.

Place 9: Tim West, MD, will fulfill his second term at the end of 2021. The TMLT Governing Board recommends that Tim West, MD, be reelected for an additional three-year term beginning in 2022.

Recommendation: Approve Leah Jacobson, MD; Sarah Way, MD, JD; and Tim West, MD; nominees of the TMLT Governing Board, to be placed before TMLT policyholders for election.
REPORT OF COMMITTEE ON MEMBERSHIP

CM-M Report 1 2021


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
Currently, 573 physicians who live in 34 states hold an active Texas telemedicine license.

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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 (two 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 (150 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: That 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.
The Lesbian, Gay, Bisexual, Transexual, Queer/Questioning (LGBTQ) Health Section was established by the House of Delegates to address important issues of interest to LGBTQ medical students, residents and fellows, physicians, and patients through LGBTQ Health Section member participation in TMA activities and through representation in the TMA House of Delegates.

The section approved its final operating procedures, attached to this report for adoption by the house (Attachment A, below).

A TMA webpage (www.texmed.org/LGBTQ_HealthSection/) has been established to make announcements and provide resource materials to the membership.

**Elections.** The section held its first two business meetings on Oct. 13, 2020, and Dec. 1, 2020, to discuss organizational steps and complete the election of the interim executive council.

The following executive council was elected to interim terms that will conclude at TexMed 2021:

- Interim chair: G.S. Massingill, MD;
- Interim chair-elect: John Carlo, MD;
- Interim secretary: Maria Monge, MD;
- Interim TMA delegate: Emily Briggs, MD;
- Interim TMA alternate delegate: Kelly Bennett, MD; and
- Interim medical student representative: Daniel Bradford, JD.

**Priorities.** The section will review and develop future activities based on the following five objectives in the House of Delegates charge:

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;
4. Communicate association policy and expertise on LGBTQ health; and
5. Educate policymakers and advocate for policies addressing the medical spectrum of gender identity to improve access to quality health care.
Workgroups. The executive council will establish ad hoc workgroups at regular meetings of the section to address priority objectives.

Next steps. The section is committed to leveraging its current momentum and expanding opportunities for members to engage and address important issues of interest to LGBTQ medical students, residents, fellows, and physicians, and to support efforts to improve the health of the LGBTQ patients. The section plans to meet regularly during TMA conferences with the meeting format to be a combination of section business, an educational presentation, and opportunities for networking.

Recommendation 1: Adopt the LGBTQ Health Section’s operating procedures.
1.10 **NAME.** The name of the organization shall be LGBTQ Health Section of the Texas Medical Association.

2.10 **PURPOSE.** The purpose of the LGBTQ Health Section is to address important issues of interest to LGBTQ medical students, residents and fellows, physicians, and patients through LGBTQ Health Section member participation in TMA activities and through representation in the TMA House of Delegates.

3.10 **MEMBERSHIP.** The membership shall consist of any TMA medical students, residents and fellows, and physicians who request to join the section.

4.10 **EXECUTIVE COUNCIL.** An executive council of the LGBTQ Health 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 medical student representative shall compose the Executive Council. Should a member of the Executive Council cease to be an LGBTQ Health Section 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. Except as set forth in 6.12, members of the Executive Council shall not serve for consecutive terms in the same position.

4.12 **ELECTION.** Elections shall be held at the section’s annual meeting unless otherwise specified. Except as set forth under 7.10, any LGBTQ Health Section physician member shall be eligible for election to the Executive Council. Approval by a simple majority of the physician member votes cast, via ballot in person, via email, or by other reliable electronic means 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 LGBTQ Health Section and Executive Council. The immediate past chair shall participate in section Executive Council meetings and advise the chair. In the event of an impasse on a vote by the Executive Council, the immediate past chair shall cast a vote to resolve.

For the first Executive Council elected under these operating procedures, the chair-elect of the prior interim Executive Council shall serve as chair. The interim chair shall serve as the immediate past chair. This provision will expire at the conclusion of the first Executive Council’s term and be removed from these operating procedures. This amendment will not require approval by the TMA House of Delegates to become effective.

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. The chair, chair-elect, and secretary shall be elected at the section’s annual meeting.

5.13 **VACANCY.** In the event of a vacancy in the position of chair, the chair-elect shall serve as chair and an election shall be held to elect a new chair-elect at the next section meeting. In the event of a vacancy in the office of chair-elect, secretary, or medical student representative, an election shall be held to fill the position at the next section meeting. In the event of a vacancy in the position of TMA delegate or alternate, the chair shall appoint a temporary replacement until the vacant position is filled by election at the next section meeting. The terms of these succeeded, elected, or appointed positions 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 consecutive 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.

For the first Executive Council elected under these operating procedures, the delegate and alternate delegate of the prior interim Executive Council shall continue to serve in those positions for a second year. This provision will expire at the conclusion of the first Executive Council’s term and be removed from these operating procedures. This amendment will not require approval by the TMA House of Delegates to become effective.

6.13 **QUALIFICATION.** Any LGBTQ Health Section member in good standing may be elected to serve as a delegate or alternate delegate from the section.
7.10 MEDICAL STUDENT REPRESENTATIVE.

7.11 DUTIES. The medical student representative shall represent the LGBTQ Health Section medical student members and have voting rights on the Executive Council.

7.12 TERM. The term of the medical student representative shall be one year. Tenure shall not exceed one term, except that election to an unexpired term shall not be regarded as tenure in office.

7.13 QUALIFICATION. Any LGBTQ Health Section medical student member who will not graduate from medical school before or during the term of office shall be eligible for election to the medical student representative position.

7.14 ELECTION. Election of the medical student representative shall be held at the section’s annual meeting. Approval by a simple majority of the medical student member votes cast, via ballot in person, via email, or by other reliable electronic means, shall be required to elect the medical student representative. Vacancies shall be handled by the procedure set forth in 5.13.

8.10 MEETINGS. The section shall meet upon call of its chair, at least once a year. A meeting may be held in person, by telephone conference, or similar means by which all meeting participants can hear each other, or by other electronic communications system, including videoconferencing technology.

A section member vote on any matter may be conducted by mail, by facsimile transmission, by electronic message, by reliable electronic means, or by a combination of these 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, except as set forth in 4.12, 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 or the LGBTQ Health 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.** These operating procedures may be amended by a two-thirds vote of the members present and voting at a section meeting. As provided in the TMA Bylaws, amendments must be approved by the TMA House of Delegates to become effective.
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.

Fiscal Note: $150,000/year

Related TMA Policy: None.

Related AMA Policy: None.
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 102
2021

Subject: Expansion of the Texas Medical Association Ambassador Program
(Tabled Res 102 2020)

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 TMA’s strength; and

Whereas, TMA depends on local county medical societies to recruit and retain members to grow the organization and provide more influence with government leaders when advocating on behalf of physicians and patients; and

Whereas, Many county medical societies find attracting good attendance at their meetings – by members and potential members – an increasing challenge; and

Whereas, Many county medical societies have found CME presentations on topics of interest to physicians are a good way to boost meeting attendance; and

Whereas, Such presentations help county medical societies remind members and potential members of benefits of TMA membership; and

Whereas, The Texas Medical Association has helped county medical societies since 2006 through its Ambassador Program, which arranges for speakers to present a variety of CME topics during county medical society meetings without charging a speaker’s fee; and

Whereas, Many county medical societies have found that offering CME 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 TMA allocate additional resources so the Ambassador Program can add at least two new CME topics each year.

Related TMA Policy:
None.

Related AMA Policy:
None.
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 103
2021

Subject: A Systematic and Precise Method for AMA Public Endorsements of Proposed Legislation (Tabled Res 103 2020)

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 conflict directly 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 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; and

Whereas, having no guiding policy regarding endorsements of omnibus legislation, the American Medical Association has been pressured in the past to publicly support incomplete and imperfect legislation under threat of being left out of negotiations; therefore, be it

RESOLVED, that the Texas Delegation to the American Medical Association introduce a resolution to the AMA House of Delegates that calls upon our 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 likely to be detrimental to the quality or sustainability of our health care system and 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
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 104
2021

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 (Tabled Res 108 2020)

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, and incremental, and should 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 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 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 that calls upon AMA to support the aforementioned permanent, physician-led, independently funded public outreach entity.

Fiscal Note: $1.5-$2.5 million/year

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
Whereas, The Texas Medical Association House of Delegates represents all Texas physicians and gives all Texas member physicians a voice; and

Whereas, The TMA House of Delegates has seen declining participation in recent years from county medical societies that are outside the “Texas Triangle” (Houston, Dallas-Fort Worth, San Antonio, and Austin); and

Whereas, Lack of participation in the TMA House of Delegates by some county medical societies has led to reduced interest in those counties in TMA advocacy activities, thereby leading to missed opportunities for those physicians to educate their local legislators on the legislative priorities of Texas physicians and their patients; and

Whereas, House of Delegates meetings historically have been held in the Texas Triangle, thereby forcing delegates from West Texas, the Texas Panhandle, the Rio Grande Valley, and northeast Texas to miss more time from their practices and incur greater travel expenses than other delegates (as exemplified by El Paso physicians, who face an 11-hour drive each way to attend sessions in Houston); and

Whereas, Many physicians in remote parts of Texas have felt disenfranchised by TMA due to House of Delegates sessions requiring in-person voting at locations they cannot reach easily; and

Whereas, Some physicians would have been interested in joining TMA and in serving as delegates but are unable to do so because of the travel requirement; and

Whereas, The COVID-19 pandemic has proven that virtual House of Delegates meetings can be effective and can greatly increase participation by delegates from outlying counties; and

Whereas, Last year’s House of Delegates virtual elections were well received by delegates throughout the state and gave TMA members in remote parts of the state a sense that their voices finally could be heard and that TMA election results were a legitimate reflection of all its members; and

Whereas, Return to in-person voting for elections would result in the disenfranchisement of physicians in counties where the distance from the meeting is a significant barrier to participation; and

Whereas, County medical societies within the Texas Triangle also would suffer from a return to in-person voting, as many of these societies would have a much easier time recruiting delegates if virtual attendance is an option because many physicians who are willing to serve are in a specialty or practice setting that prevents them from traveling to an in-person meeting; therefore, be it
RESOLVED, That the Texas Medical Association House of Delegates affirm its commitment to representing all physicians and ensuring that geography, income, specialty, practice type, and health status are not barriers to participation in the TMA House of Delegates; and be it further

RESOLVED, That the TMA House of Delegates, to fulfill this commitment, will make virtual elections a permanent part of House of Delegates meetings rather than a temporary change intended for the duration of the current public health emergency; and be it further

RESOLVED, That the TMA House of Delegates will continue to offer a virtual option during House of Delegates sessions for delegates to give testimony and vote on resolutions if they are unable to attend the meeting in person.

Fiscal Note: $65,000/year

Related TMA Policy:
None.

Related AMA Policy:
None.
Subject: Creation of Ad Hoc Committee to Study and Make Recommendations Concerning Noncompete Agreements in Physician Employment Contracts

Introduced by: Bexar County Medical Society

Referred to: Reference Committee on Financial and Organizational Affairs

WHEREAS, A noncompete agreement, also known as a covenant not to compete, is a contractual provision in a physician’s employment contract that grants an employer unilateral authority to restrict a physician’s ability to practice medicine once the parties’ employment relationship has ended; and

WHEREAS, Preventing a physician from practicing medicine for the commercial advantage and economic benefit of an employer is contrary to the public interest because it may deny patients access to care, particularly in medically underserved areas; disrupt continuity of care; interfere with the patient-physician relationship; limit patient choice; and undermine confidence in the health care system; and

WHEREAS, Noncompete agreements often result from unfair negotiations characterized by disproportionate bargaining power and asymmetrical information that favor employers and burden physicians, particularly new physicians who have few resources, significant debt, and little professional standing or reputational capital; and

WHEREAS, Texas has a long history of attempting to protect patients and physicians from the corporate practice of medicine, while at the same time recognizing and upholding employers’ legitimate business interests; therefore be it

RESOLVED, That the Texas Medical Association establish an ad hoc committee to study noncompete agreements in physician employment contracts and evaluate the impact of noncompete agreements on physicians and patients in Texas; and be it further

RESOLVED, that the ad hoc committee assess whether means other than noncompete agreements might suffice to protect physician employers’ legitimate interests.

Fiscal Note: $2,500

Related TMA Policy:
115.017 Protections of Non-employment Physicians Extended to 501 (a)s
185.019 Rural Physician Workforce Policy

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
1 Related AMA Policy:
2 Utilization Review by Physicians H-320.973
3 Principles of Drug Utilization Review H-120.978
4 Medical Necessity and Utilization Review H-320.942
Whereas, The United States is one of only a few developed countries that does not have a national mandate for paid sick leave (PSL), forcing approximately 30% of full-time workers and 80% of part-time and low-income workers to continue to work when ill or injured to avoid losing wages; and

Whereas, Currently, the U.S. federal government provides the Family Medical Leave Act (FMLA), which enables employees who have worked at a qualified employer for more than 1,250 hours in the previous year to take up to 12 weeks of unpaid leave under specific circumstances; and

Whereas, Hispanic, Black, and American Indian/Alaska Native working adults and parents are less likely to be eligible for and able to afford to take FMLA unpaid leave; and

Whereas, Texas does not mandate private-sector employers to provide paid or unpaid sick leave of any kind, though unpaid leave may be considered necessary for employees with disabilities, who are pregnant, or who have medical conditions protected under some other statute; and

Whereas, As of 2017, approximately 40% of the total workforce in Texas lacked PSL, which disproportionately affects lower-wage workers in private industries; and

Whereas, Workers without PSL are more likely to delay or forgo medical care for themselves and their family members to avoid losing wages; and

Whereas, Workers without PSL are more likely to suffer nonfatal occupational injuries than those with PSL; and

Whereas, U.S. health care workers with health insurance and PSL were more likely to use outpatient care services rather than emergency services, which not only saves money for workers but also decreases business health insurance expenditure; and

Whereas, The federal government enacted the Families First Coronavirus Response Act (FFCRA), which required qualified employers in both the private and the public sectors to provide each qualified employee with at least two weeks of PSL to help mitigate the effects of shutdown or quarantine by providing relief for specific reasons related to COVID-19; and

Whereas, Researchers at Cornell University and the KOF Swiss Economic Institute confirmed that the FFCRA helped “flatten the curve” of COVID-19 infection at the time of its enactment; and

Whereas, A 2018 meta-analysis on the economic impacts of PSL concluded that if all U.S. employers offered PSL, they likely would have saved $630 million to $1.88 billion in influenza-related employee absentee costs alone between 2007 and 2014; and
Whereas, PSL provides numerous benefits to businesses, without profit loss, as a result of reduced employee turnover, increased productivity, decreased presenteeism and absenteeism, and employees pursuing timely health care services; and

Whereas, PSL has been shown to promote timely use of health care services among employees; and

Whereas, least 13 states and 22 jurisdictions, including Washington D.C., have implemented PSL laws; and

Whereas, In New York City and Seattle, the enactment of PSL laws increased economic and employer growth respectively; and

Whereas, Connecticut’s 2011 mandatory PSL policy led to a decrease in the aggregate rate of sick leave taken for illnesses; and

Whereas, In states and jurisdictions with existing PSL laws, the majority of employers support the law and report not having to change their policies to be in compliance; and

Whereas, A large national study revealed that Americans widely support enactment of new paid sick and family leave policies and expansion of preexisting policies; therefore be it

RESOLVED, That our Texas Medical Association promote awareness and education for physicians, legislators, and the public on the benefits and barriers of creating and expanding paid sick leave policies in Texas to improve health outcomes and the well-being of our families and workforce; and be it further

RESOLVED, That our TMA support studies on the barriers to expanding paid sick leave in Texas in collaboration with, but not limited to, the Texas Department of State Health Services, Texas Health and Human Services Commission, and state higher education institutions.

Relevant TMA Policy:
- Employee Sick Leave 60.001
- Parental Leave 260.104

Relevant AMA Policy:
- Policies for Parental, Family and Medical Necessity Leave H-405.960
- Paid Sick Leave H-440.823

References:
17. The bottom line on earned sick time: In Minnesota, A cost and benefit analysis of earned paid sick days. The Main Street Alliance of Minnesota. Published in 2016.
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 109
2021

Subject: Physicians’ Salary Survey (Tabled Res 406 2020)

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Financial and Organizational Affairs

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 considers 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.

Fiscal Note: $150,000/year

Related TMA Policy:
None found
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 110
2021

Subject: Encouraging ADA Compliance on Virtual Platforms

Introduced by: Medical Student Section

Referred to: Reference Committee on Financial and Organizational Affairs

Whereas, Telemedicine has existed throughout the United States for years; and

Whereas, Due to the COVID-19 pandemic, physicians’ adoption and use of telemedicine has increased exponentially over the past year, with telemedicine visits increasing by an estimated 154% in March 2020 alone; and

Whereas, The rapid growth of telemedicine users has brought enormous positive change in patient-physician relationships by providing greater access to services, but the lack of oversight of telemedicine products has the potential to increase the existing inequality gap for people with disabilities; and

Whereas, Within the U.S., nearly 61 million people (26% of adults) live with a disability, and prior to the pandemic, people with disabilities who required custom solutions to access medical appointments could seek them in a physical space; and

Whereas, Since the pandemic, state, federal, and local governments have been racing to make telemedicine HIPAA compliant, with little to no focus on its compliance with the Americans with Disabilities Act (ADA), putting patients at risk of going without treatment because of potential barriers posed by telemedicine software; and

Whereas, Some potential barriers are communication barriers for those who are deaf and blind, and infrastructure barriers for those who have manual dexterity or physical mobility disabilities that interfere with their ability to interact during telemedicine visits; and

Whereas, Because the federal Medicaid statute does not recognize telemedicine as a health service distinct from face-to-face physician visits, telemedicine should therefore afford patients the same ADA protections received in a face-to-face physician interaction; and

Whereas, The ADA was passed before the wide proliferation of the internet as a public service, and therefore the law does not outline in legally enforceable terms the standards and scope for accessibility on virtual platforms; and

Whereas, Telemedicine also remains unregulated by the ADA because the standards of accessibility, called W3C recommendations, remain voluntary and unenforceable; and

Whereas, This could leave a large portion of Texans who have disabilities without equal access to health care because telemedicine platforms are all designed differently; and

Whereas, While the National Association of the Deaf has outlined the challenges telemedicine poses and published guidelines for using telemedicine with deaf and hard of hearing patients, the barriers faced by
people with disabilities are not solely faced by individuals with hearing disabilities and these guidelines are not mandatory; and

Whereas, In March of 2019, the National Federation of the Blind sued Epic, a telehealth company, alleging the company’s software was inaccessible to blind employees; and

Whereas, Today, telemedicine appointments are largely replacing in-person appointments without an option for the alternative, and this trend is set to continue even after the pandemic ends; and

Whereas, Without accessibility requirements for virtual platforms, it is imperative that the Texas Medical Association promote following the ADA even in virtual spaces; therefore be it

RESOLVED, That our Texas Medical Association support the compliance of telemedicine platforms with the Americans with Disability Act; and be it further

RESOLVED, That TMA take the position that technology companies that produce telemedicine software/products should be regulated, as they and their software/products should be held to the standards of health care organizations and products; and be it further

RESOLVED, That TMA encourage hospitals and clinics in Texas to adhere to guidelines that maintain ADA standards within telemedicine; and be it further.

RESOLVED, That TMA collaborate with relevant stakeholders to encourage the creation of equally accessible telemedicine services.

Related TMA Policy:
290.007 Telemedicine and Confidentiality
290.005 Telemedicine
290.003 Telemedicine Use As Supportive Mechanism in Delivery of Care
290.008 Telemedicine Use in Protecting the Health and Welfare of Citizens

Related AMA Policy:
1.2.12 Ethical Practice in Telemedicine
The Promotion of Quality Telemedicine H-160.937
COVID-19 Emergency and Expanded Telemedicine Regulations D-480.963

References:


Subject: One Hundredth Anniversary of the Texas Pediatric Society

Introduced by: Valerie Borum Smith MD, MPH, FAAP

Referred to: Reference Committee on Financial and Organizational Affairs

WHEREAS, The Texas Pediatric Society was founded on May 12, 1921 in Dallas, Texas; and

WHEREAS, The Texas Pediatric Society is an organization which deems that the most important resource of the State of Texas is its children; and

WHEREAS, The Texas Pediatric Society pledges its efforts to promote the health and welfare of the children of Texas; and

WHEREAS, The Texas Pediatric Society is an organization whose members’ goal is that all children in the State attain their full potential for physical, emotional, and social health; and

WHEREAS, The Texas Pediatric Society dedicates its talents and resources to ensure that children in Texas are safe and healthy; and

WHEREAS, The Texas Pediatric Society works to ensure that its members are well informed and supported; and

WHEREAS, The Texas Pediatric Society commits to maintaining the fulfilling and economically viable practice of pediatrics in Texas; therefore be it

RESOLVED, That the Texas Medical Association extends its congratulations to the Texas Pediatric Society on the occasion of its one hundredth anniversary; and be it further

RESOLVED, That TMA and its members participate in the year-long opportunity to commemorate, educate, and celebrate the accomplishments of the Texas Pediatric Society; and be it further

RESOLVED, That TMA wishes the Texas Pediatric Society continued success in prioritizing the physical, emotional, and social health of the children of the state of Texas.
Subject: Composition of Hospital Ethics Committees

Introduced by: Stuart Pickell, MD; Steve Brotherton, MD; Kendra Belfi, MD; Ed Furber, MD; Daniel Casey, MD; Ken Hopper, MD; and David Capper, MD

Referred to: Reference Committee on Financial and Organizational Affairs

WHEREAS, Most clinical scenarios in which treatment withdrawal is a consideration occur in hospital settings; and

WHEREAS, Hospital ethics committees are tasked with reviewing and making recommendations regarding the continuation or withdrawal of life-sustaining interventions; and

WHEREAS, Hospital ethics committees may be perceived as being vehicles through which hospital policy is conducted; and

WHEREAS, Hospitals are anchor institutions for community health and well-being; and

WHEREAS, There are no guidelines in Texas regarding community participation on hospital ethics committees; therefore be it

RESOLVED, That the Texas Medical Association study and report back to the House of Delegates regarding the current composition of hospital ethics committees around the state, and be it further

RESOLVED, That TMA collaborate with the Texas Hospital Association and other relevant stakeholders to draft recommendations for the composition of hospital ethics committees.

Fiscal Note: $25,0000

Related TMA Policy:
- 115.017 Protections of Non-employment Physicians Extended to 501 (a)s
- 185.019 Rural Physician Workforce Policy
- 185.020 Principles for Employment Contracts

Related AMA Policy:
- Code of Medical Ethics Opinion 10.7
TEXAS MEDICAL ASSOCIATION HOUSE OF DElegates

Resolution 114
2021

Subject: Noncompete Clauses Within Physician Contracts

Introduced by: Resident and Fellow Section

Referred to: Reference Committee on Financial and Organizational Affairs

Whereas, Noncompete clauses can be defined as “a contract provision in which a physician agrees not to work for a competing practice or hospital within a certain period after leaving a job;” and

Whereas, Exercising of noncompete clauses often affects patient/physician contracts thus limiting or prohibiting patient access to their physician, which can cause patient harm; and

Whereas, the corporate practice of medicine is prohibited in Texas, and

Whereas, noncompete clauses required by health care entities, by limiting or prohibiting patient access to their doctor, influence patient-physician relations; and

Whereas, in smaller communities with a limited number of practitioners in certain specialties, the enforcing of noncompete clauses can cause or contribute to a lack of patient access to these specialists; and

Whereas, the American Academy of Emergency Medicine (AAEM) is opposed to use of noncompete clauses; and

Whereas, an increasing number of states have passed laws prohibiting noncompete clauses, including Massachusetts, Delaware, Colorado and Rhode Island, and for example:

- Oklahoma favors the right of individuals to work in the profession of their choice over the rights of an employer. Most noncompete clauses are simply void in the state
- New Mexico prohibits noncompete clauses that prevent physicians from providing clinical health care services.
- Florida prohibits noncompete clauses between a physician who practices a medical specialty and an entity that employs or contracts with all physicians who practice that specialty in the county; and

Whereas, in many other states, noncompete clauses are generally considered unenforceable; and

Whereas the percentage of employed physicians increased nationally from 4% in 2012 to 8% in 2016, and this percentage will likely continue to increase; and

Whereas, the time and geographic limitations of noncompete clauses can make it financially impossible for a physician to maintain a viable practice. Contracts often contain noncompete clauses because hiring a new physician can require a substantial investment by the health care entity. However, other methods can be used to recoup this investment in the event the health care entity and hired physician sever their relationship; and
Whereas, younger physicians often have great debt from obtaining their education and have few resources, with few options but to enter into contracts with noncompete clauses, resulting in severe financial hardship, as they may be required to move and start over to establish a new patient basis; therefore be it

RESOLVED, That the Texas Medical Association adopt policy in opposition to the use of noncompete clauses in physician contracts, and be it further

RESOLVED, That TMA strongly advocate for the Texas Legislature to prohibit the use of noncompete clauses in physician contracts with any hospital association or other health care entity.

Related TMA Policy:
185.020 Principles for Employment Contracts
Medical Education and Health Care Quality Reports and Resolutions
AGENDA
REFERENCE COMMITTEE ON MEDICAL EDUCATION AND HEALTH CARE QUALITY
Saturday, May 8, 2021

5. Council on Medical Education Report 3 – Status of Graduate Medical Education Capacity in Texas
6. Council on Medical Education Report 5 – Opposition to Nonphysician Practitioners Serving as Attending Physicians of Residency and Fellowship Programs
7. Council on Medical Education Report 6 – Support for Acceptance of DACA Recipients to Texas Medical Schools
8. Council on Medical Education Report 7 – Update to TMA Policies on Advanced Practice Registered Nurses
9. Committee on Physician Distribution and Health Care Access Report 1 – Requiring All Texas Licensed Physicians to Pass Texas Medical Jurisprudence Exam
12. Committee on Physician Distribution and Health Care Access Report 4 – Renewed Effort to Increase Diversity Among the Texas Physician Workforce
13. Resolution 201 – Admission of Deferred Action for Childhood Arrivals (DACA) Students in Texas Medical Schools (Tabled Res 202 2020)
16. Resolution 204 – Defining What Constitutes Proper Use of the Terms “Residency” and “Fellowship” When Referring to Specialty Training
17. Resolution 205 – Skin of Color Representation in Medical Education and Research
19. Resolution 207 – Suicide Prevention Education in Medical School (Tabled Res 305 2020)

20. Resolution 208 – Facilitating Brain and Other Postmortem Tissue Donation for Research and Educational Purposes (Tabled Res 306 2020)

21. Resolution 209 – Promoting Careers in Geriatrics Among Medical Students (Tabled Res 204 2020)

22. Resolution 210 – Amending the Mental Health Question on the Physician Licensure Application to Reflect Current Impairment (Tabled Res 206 2020)

23. Resolution 211 – Medical School Compliance with the Americans With Disabilities Act

24. Resolution 212 – Support Addressing, Screening, and Providing Healthy Coping Mechanisms for Burnout
REPORT OF COUNCIL ON HEALTH CARE QUALITY

C-HCQ Report 2 2021

Subject: Sunset Policy Review

Presented by: Chelsea I. Clinton., MD, Chair

Referred to: Reference Committee on Medical Education and Health Care Quality

House of Delegates policies in the association’s Policy Compendium are reviewed periodically for relevance and appropriateness. Following are policies reviewed by the council with recommendations for retention, amendment, and deletion.

The council recommends amending the policy as follows:

30.019 **Federal Physician Care Compare Website**: Federal “Physician Care Compare Website”: That the Texas Medical Association will monitor Centers for Medicare & Medicaid Services’ development of the Physician Care Compare Website to ensure that physicians currently in clinical practice are involved in the development of the standards to evaluate physician performance, that the measures and methodology used for the website are transparent and valid, and that physicians are provided with an opportunity to challenge a rating through a fair process (CSE Rep. 3-A-11).

**Recommendation 1**: Retain as amended.

The council recommends deletion of the following policy as they are no longer relevant:

115.011 **Disease Management**: Disease management is a multidisciplinary, continuum-based approach to health care delivery that proactively identifies populations with, or at risk for, established medical conditions that supports the physician/patient relationship and plan of care; emphasizes prevention of complications utilizing cost-effective, evidence-based practice guidelines and patient empowerment strategies, such as self-management education; and continuously evaluates clinical, humanistic, and economic outcomes with the goal of improving overall health.

The decision to participate or not participate in a disease management program should be a coordinated decision between the patient and the patient’s physician based on discussion of the various elements of the disease management program (Amended CSA Rep. 5-A-01; amended CSPH Rep. 3-A-11).

**Recommendation 2**: Delete.
REPORT OF COUNCIL ON HEALTH CARE QUALITY

C-HCQ Report 3 2021

Subject: Initial Assessment and Treatment Recommendation by Specialists, Resolution 108-A-19

Introduced by: Chelsea I. Clinton., MD, Chair

Referred to: Reference Committee on Medical Education and Health Care Quality

Background

The 2019 Texas Medical Association House of Delegates considered Resolution 108-A-19, Initial Assessment and Treatment Recommendation by Specialists, from the TMA Young Physician Section. 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. Further testimony at the House of Delegates, however, called for a thorough review of the resolution’s language for inclusivity of primary care physicians as well as physician specialists. Therefore, the House of Delegates recommended referral for study with report back at TexMed 2020, and the resolution was referred to the Council on Health Care Quality and Interspecialty Society Committee. Per the 2020 Joint Report of the Council on Health Care Quality and Interspecialty Society Committee, Resolution 108-A-19, Initial Assessment and Treatment Recommendation by Specialists, was referred again for further study to the Council on Health Care Quality and the Interspecialty Society Committee (ISC) with a report back at TexMed 2021.

Discussion

As part of its due diligence on this controversial topic, the Council on Health Care Quality surveyed the members of the Council and the ISC, consulted with TMA’s Office of General Counsel, and held several Zoom meetings with the Council and ISC to thoroughly discuss Resolution 108. Included in these meetings were legal topics of antitrust, setting a precedent for standard of care and physician practice autonomy in delegating patient care. These conversations were rigorous, thoughtful, and impassioned, but consensus supporting adoption of Resolution 108 was not achieved. Instead, the Council and the ISC support reaffirmation of physician-led, team-based care in lieu of adopting Resolution 108.

REPORT OF COUNCIL ON MEDICAL EDUCATION

C-ME Report 1 2021

Subject: Sunset Policy Review

Presented by: Kevin W. Klein, MD, Chair

Referred to: Reference Committee on Medical Education and Health Care Quality

House of Delegates policies in the association’s Policy Compendium are reviewed periodically for relevance and appropriateness. Following are policies reviewed by the council with recommendations for retention, amendment, and deletion.

The council recommends retention of the following policy:

205.005 Funding Levels for Research and Medical Education:
The Texas Medical Association supports legislative initiatives and continued funding levels for mandated research and medical education at the state and national levels and legislative initiatives and funding requests for programs that encourage physicians to practice in underserved areas (CME, p 80, A-91; amended CME Rep. 2-A-01; reaffirmed CME Rep. 2-A-11).

185.015 Addressing Workforce Issues:
The Texas Medical Association (1) encourages the American Medical Association to actively support adequate federal funding of the National Health Service Corps Loan Repayment Program; (2) supports state funding for graduate medical education programs; (3) encourages Texas medical schools with rural missions to periodically evaluate their student admission criteria to ensure that the most appropriate criteria are utilized for identifying students most likely to select careers in rural medicine; (4) supports funding from the federal Health Resources and Services Administration of the U.S. Department of Health and Human Services for state-based health professions workforce planning activities; and (5) encourages the Texas Medical Board to conduct an ongoing survey of physicians seeking state licensure who are relocating from other states or countries to identify the primary reasons why physicians are moving to Texas for use in projecting future physician supply (CME Rep. 4-A-01; amended CME Rep. 2-A-11).

Policy 290.001 makes a direct reference to the TMA Knowledge Center and was reviewed by center staff and recommended for continuation, as written.

290.001 Academic Libraries:
The Texas Medical Association urges the American Medical Association to address and support federal funding of the Information Technology Research and Development Programs, including the National Research and Education Network, and similar computer networks that link universities, national libraries, non-profit institutions, government organizations, and private companies to consolidate and build upon existing interconnected telecommunications networks. TMA supports legislation establishing and funding statewide library networks that enhance the ability of physicians and students to access information in support of the delivery of quality health care. TMA agreed to participate in the planning of statewide information-sharing networks that benefit TMA membership.
TMA encourages medical libraries in Texas to promote the efforts of state and federal
government agencies, such as the Texas Department of State Health Services, the Centers for
Disease Control and Prevention, the National Library of Medicine, the National Institutes of
Health, and the National Cancer Institute that provide free access to authoritative medical
information on their Web sites and the Texas State Library and Archives Commission's
TexShare Consortium that provides remote access to online indexes and full-text materials to
participating libraries. TMA supports state laws that allow nonprofit libraries, including the
TMA Knowledge Center, to qualify for participation in the TexShare Consortium and
adequate state funding of this collaborative program (CME, pp 78-79, A-91; amended CME

**Recommendation:** Retain.
Subject: Referral of Resolution 202-A-18 Addressing Gender Bias in Undergraduate Medical Education and Implicit Bias Training

Presented by: Kevin W. Klein, MD, 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 of Delegates in 2018. Testimony for and against the resolution prompted the house to refer the resolution. Some testimony asked that the scope of the policy be expanded beyond gender to also include training on bias related to race and ethnicity.

To evaluate the merits of the resolution, the council conducted extensive research on implicit bias and engaged in several in-depth discussions. While the decision was not unanimous, the overwhelming majority of council members support bias training for learners, faculty, and staff at academic health centers. The council also concurred with the testimony that supported the expansion of this policy to include training on racial and ethnic biases. Further, the council recognizes the potential benefit of mentorships for medical students, residents, and fellows in medical specialties with significant underrepresentation by gender and/or race/ethnicity. An example is women in surgical specialties.

The resolution proposed that TMA (1) support implementation of implicit bias training for 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 policies. While several related policies were identified, none fully covered the topics in the resolution, such as the following policy:

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 male and female TMA members. TMA’s Women Physicians Section selected Unconscious Bias in Medicine, an online CME program offered by Stanford University School of Medicine, as the recommended training program in response to this resolution.

In the 24 years since the adoption of TMA Policy 185.012 on the recruitment of a diverse physician workforce, minimal change has occurred in the racial and ethnic diversity of the state’s physicians. Currently, far less diversity exists among Texas physicians than among the Texas population. The following statistics demonstrate the state’s far more diverse population than the state’s physician workforce:

**Race/Ethnicity**
- Five times more Hispanic Texans than Hispanic physicians,
- Twice as many Black/African American Texans than physicians, and
- 1.4 times more white Texas physicians than white Texans.

(Also, see Committee on Physician Distribution and Health Care Access Report 1 Renewed Efforts to Increase Diversity among the Texas Physician Workforce)

**Gender**
- Women make up 50.3% of Texans, and only 35% 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, the council found numerous prominent studies that showed:

- 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, disparities in health care in the U.S. exist based on gender and racial/ethnic status.
- Unconscious bias can exist, and most individuals are unaware of their own biases and how they manifest.
- When individuals are made aware of unconscious biases, change is possible.
- Racial/ethnic concordance between patients and their physician is a positive association.
- Diversity of faculty, administration, and medical school enrollments is an important component of learning.
- Training programs about implicit bias at academic health centers have led to institutional changes that resulted in greater diversity in hiring and student admissions.

As proposed in Resolution 202, the council supports mentorship for women during medical school in the medical specialties that have an underrepresentation of women. The council also supports expanding this policy proposal to include underrepresented minorities with the goal of promoting greater diversity in medicine.
Recommendation: Adopt new Texas Medical Association policy as follows in lieu of Resolution 202-A-18:

Support Bias Training for All Texas Medical School Students, Resident Physicians, Staff, and Faculty of Academic Health Centers, and Promotion of Greater Diversity in Medicine. 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 significant underrepresentation by gender and/or race/ethnicity within the physician workforce.
Subject: Developing Best Practices for Educating Medical Students and Residents During a Pandemic or Other Extended Catastrophic Event

Presented by: Kevin W. Klein, MD

Referred to: Reference Committee on Medical Education and Health Care Quality

Medical education and residency training in the state suffered a series of interruptions and serious set-backs as a result of the COVID-19 pandemic. All forms of testing throughout the physician pipeline also were subject to interruptions, delays, and suspensions. This report provides an overview of the impact and offers recommendations for being better prepared for future catastrophic events of this nature.

Medical Education

On March 17, 2020, the Association of American Medical Colleges issued guidance that medical students should not be involved in direct patient care activities unless there was a critical health care workforce need in a particular area. Teaching hospitals, clinics, and community-based physician preceptors asked medical schools to withdraw medical students from in-person educational settings. Soon after, Texas Gov. Greg Abbott issued a series of executive orders that temporarily prohibited in-person educational programs, which shut down preclinical classes at the medical schools. Across the country, in-person testing was suspended for licensing board exams and medical specialty board certification.

In the early stages of the pandemic, medical students were treated in the same manner as visitors to teaching hospitals and facilities. In looking back, the question arises whether this was the best policy. In contrast, in some states such as New York, new medical school graduates were hired by hospitals as health care workers before starting their residency training. In retrospect, many academic leaders recognize medical students, with the proper precautions, can continue serving in their usual roles by taking patient histories and vital signs, organizing lab tests and data, issuing communications including some levels of interactions with family members of hospitalized patients, and engaging in many other organizational activities. Rather than being a hindrance or a liability, medical students can provide invaluable service as part of the medical team.

To be clear, no one questions the motivation for the action taken to remove medical students from training institutions in March 2020. It is not difficult to reconstruct the unknowns of those early days of the pandemic, such as the lack of knowledge about the epidemiology of the virus; the severe shortage and uncertainties about replenishment of personal protective equipment (PPE) and viral testing; and the need to focus all hospital staffing and other resources on saving lives.

Medical schools were nimble in responding to the changes. In-person preclinical courses were converted to online formats, and educational experts were consulted to guide this conversion. Students quickly became involved in virtual medicine in lieu of in-person clinical clerkships. Electives on the pandemic were quickly developed to enable students to earn academic credit for learning about current conditions. While some clinical training is conducive to virtual formats, other clerkships such as surgery are not a good fit at all. The Liaison Committee on Medical Education, the accrediting body for allopathic medical schools, made clear that the curriculum could not be 100% virtual; some education and training must be provided in person.
“Away” rotations were largely halted for fourth-year medical students. This hampered the ability of medical students to make in-person assessments of potential future training programs and facilities. Residency program and medical school interview processes were also converted to virtual formats.

The suspension of in-person U.S. Medical Licensing Exams and Comprehensive Osteopathic Medical Licensing Exams resulted in delays throughout the physician educational pipeline. Eventually, all Texas medical schools restarted in-person clinical training. The combined effects of all of these changes created significant pressures on medical education deans, administrators, faculty, their clinical partners, and learners. The full effects of the various disruptions and extensive amount of virtual learning on the educational and training experience of medical students and residents are not yet known.

**Interruptions to Graduate Medical Education**

Residents and fellows had the opposite experience of medical students, with great demands being placed on them in response to various surges in hospitalizations and spikes in demand for emergency and critical care services. In some cases, residents and fellows were temporarily reassigned from their training programs to fill gaps in staffing for areas in highest demand. Residents, fellows, and clinical faculty faced unprecedented levels of stress. These changes were disruptive to their training as well as their personal lives. Given their roles in delivering care, it is difficult to imagine how critical staffing needs could have been met without them.

Examples of disruptions to graduate medical education training:

- When patient clinics closed, clinical activities moved to telemedicine formats.
- Low patient volumes at times presented challenges to meeting clinical training requirements for some specialties, e.g., primary care, ophthalmology, and surgical specialties.
- Some hospitals temporarily limited operating room activities to essential residents to conserve PPE.
- Emergency medicine residents in San Antonio were temporarily removed from obstetrical rotations due to concerns about their potentially higher exposure rate as staff in emergency departments.
- Residents transitioned to elective research projects, as needed.
- Those participating in global health training programs were brought back to Texas.
- High-risk residents were reassigned from certain practice settings.
- Some residents in community-based preceptorships were reassigned to other clinical settings.

In the post-pandemic period, it is recommended that ALL involved in the teaching of medical students, residents, and fellows evaluate the policies in place for teaching and training during a pandemic or other extended catastrophic events. The emergency policies in place were primarily developed with a short-term and localized catastrophic event in mind, such as a hurricane. These policies were not designed to respond to an international pandemic of an extended and uncertain duration.

Questions to be addressed in a post-pandemic assessment:

- What have we learned?
- What were the best practices?
- What needs to be improved?
- What resources are needed?
- Should medical students be treated as if they are “visitors” to hospital and clinic facilities or included in the federal definitions of “essential workers” for their potential role in assisting in the delivery of medical care?
• What are the policies for ensuring medical students and residents have access to PPE, viral testing, and vaccinations?
• What are the policies for scheduling clinical learning activities for medical students or residents who are not candidates for vaccination or who are vaccine-hesitant?

This assessment may be an appropriate activity for the Texas Higher Education Coordinating Board to lead or contract out.

Recommendation: The council recommends the following be adopted as Texas Medical Association policy:

Preserving Medical Education, and Residency and Fellowship Training During a Pandemic or Other Extended Catastrophic Event

The Texas Medical Association supports a post-pandemic assessment of the policies that affect ALL involved in the teaching of medical students, residents, and fellows to evaluate policies in place for preserving education and training during a pandemic or other extended catastrophic event. The evaluation should consider what has been learned, identify best practices and needed improvements, and identify resources required for future improvements. TMA encourages the Texas Higher Education Coordinating Board to consider leading this post-pandemic assessment.

TMA encourages consideration of the following during the assessment:

1. Whether medical students should be treated in the same manner as visitors to teaching facilities – or treated differently, with recognition given to the role of learners in health care delivery at teaching facilities;
2. The need for a commitment to securing adequate supplies of personal protective equipment (PPE) and viral tests for all learners, within reason, recognizing frontline workers should receive the highest priority, and the need for appropriate training in the use of PPE;
3. Developing policies to preserve the ability of medical students to experience hands-on learning, including in-person clerkship experiences, with consideration given to alternative learning sites if needed to avoid high exposure to contagions;
4. Appropriate roles for medical students to contribute to a crisis response, with proper precautions and at a level appropriate for their education, experience, and training; and
5. More flexible policies, as needed, for unavoidable absences by students, residents, and fellows.

TMA should work with the American Medical Association to encourage federal authorities such as the U.S. Centers for Disease Control and Prevention and the U.S. Department of Homeland Security to reconsider how medical students are defined in official policies on “essential workers,” e.g., in publications such as the Cybersecurity and Infrastructure Security Agency’s Guidance on Essential Critical Infrastructure Workers.

TMA also supports an evaluation of the emergency policies enacted for residency training programs during the pandemic, including the impact on the length of training and qualifications for board certification for program completers.
A physician training in a residency program in Texas contacted the council to ask for assistance. Her residency program had designated a physician assistant to serve as the attending physician for her program, and she questioned whether this met national residency program accreditation standards. The resident physician also questioned whether the physician assistant’s education and training qualified that person to serve as the attending physician of a residency program. This concern is not limited to Texas. In fact, residents and fellows have formed various national groups to share common experiences and seek policy changes.

After reviewing the Accreditation Council for Graduate Medical Education (ACGME) Common Requirements for the accreditation of residency programs, council staff contacted ACGME to inquire about the eligibility of physician assistants to serve as “attending physicians.” The following common accreditation standard is applicable:

1. **VI.A.2. Supervision and Accountability VI.A.2.a)(1)**
   - Each patient must have an identifiable and appropriately-credentialed and privileged attending physician (or licensed independent practitioner as specified by the applicable Review Committee) who is responsible and accountable for the patient’s care.

A physician staff member at ACGME provided the following comment:

There are a handful of specialty-specific requirements that allow individuals other than physicians to supervise residents in very specific circumstances. Clearly, though, there is a difference between being allowed to supervise a resident for a given process/procedure and being an attending physician.

The Council on Medical Education recommended that the resident report her concerns to ACGME. In addition, the council reached out to the dean of graduate medical education at the institution that sponsored the residency program to discuss the resident’s concern.

**Role of Nonphysician Practitioners in Residency and Fellowship Training**

The concern brought to the council was not about nonphysician practitioners, including physician assistants, serving as faculty at residency and fellowship programs. The concern was about their serving as the attending physician. The council recognizes many different types of health professionals are highly skilled and are excellent educators, and supports these successful staffing arrangements. In this case, the physician assistant was serving as the attending physician, which carries primary responsibility for the training of the residents in the program as well as the care they provide.

ACGME has 25 review committees that determine the standards for certain specialty areas. In combination with the ACGME Common Requirements, these form the guidelines for residency training. Each review
committee has discretion under Standard VI.A.2 (above) to specifically identify “licensed independent practitioners” who can have a role in supervising residents during certain phases of training. Council staff reviewed the program requirement FAQs for the 25 review committees and summarized the specific provisions for nonphysicians as supervisors by review committee (see attachment).

Of the 25 review committees, nine recognize independent practitioners (nonphysicians) in the role of supervisor of residents and fellows; 13 do not recognize independent practitioners in that role; and three are not known at this time – program requirement FAQs are under revision and temporarily unavailable.

Of the nine review committees that recognize the role of nonphysicians in teaching and supervising, most clarify that their level of supervisory responsibility is secondary to the attending physician. Emphasis is placed on physicians serving in the role as the attending physician, which means they retain the ultimate responsibility for the supervision of residents. An example is from the Review Committee on Ophthalmology:

> While the attending physician may delegate an appropriately-qualified non-physician to assist or teach a resident in a specific aspect of an eye exam (e.g., refraction, low vision, contact lens, orthoptics, and optics), the ultimate responsibility for resident supervision remains the responsibility of the attending physician.

The council supports this degree of clarity in review committee policies for residency and fellowship training.

**Recommendation:** The council recommends the following be adopted as Texas Medical Association policy:

**Opposition to Nonphysician Practitioners Serving as Attending Physicians of Residency and Fellowship Programs**

The Texas Medical Association encourages graduate medical education programs in Texas to designate physicians as supervisors in the clinical training environment for residents and fellows. TMA also continues to encourage interprofessional clinical training for residents and fellows.
<table>
<thead>
<tr>
<th>RECOMMEND COMMITTEE</th>
<th>RESPONSE TO QUESTION:</th>
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<tbody>
<tr>
<td>Allergy and Immunology</td>
<td>Clinical psychologists, clinical social workers, nurse practitioners, physician assistants, and registered dieticians, for example, may supervise residents’ clinical activities when the program director determines that their special expertise will promote education and provide a level of supervision equivalent to that provided by an attending physician. During these situations, there must also be direct or indirect supervision by a physician faculty member.</td>
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<tr>
<td>Anesthesiology; Colon and Rectal Surgery; Dermatology</td>
<td>No reference to a role for non-physician clinical staff in supervising residents.</td>
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<tr>
<td>Emergency Medicine</td>
<td>The Review Committee will accept licensed or certified individuals on occasion to supervise residents in unique educational settings within the scope of their licensure or certification. Examples may include physician assistants, nurse practitioners, clinical psychologists, licensed clinical social workers, certified nurse midwives, certified registered nurse anesthetists, and doctors of pharmacy. Oversight by a faculty physician member during these situations is required.</td>
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<tr>
<td>Family Medicine</td>
<td>No reference.</td>
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<tr>
<td>Internal Medicine</td>
<td>Not known; FAQs are being revised and are not available at this time.</td>
</tr>
<tr>
<td>Neurological Surgery</td>
<td>No reference.</td>
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<tr>
<td>Neurology</td>
<td>Licensed practitioners [that may contribute to a residents’ education] include health care professionals who are licensed in the state and have appropriate credentials to provide patient care. These may include advanced practice providers or psychologists, for example.</td>
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<tr>
<td>Obstetrics/Gynecology</td>
<td>No reference.</td>
</tr>
<tr>
<td>Ophthalmology</td>
<td>Although the Review Committee believes that it is important for residents to acquire experience in leading and participating in health care teams, including those with nonphysicians (e.g., optometrists, orthoptists, or ophthalmic technicians), supervision of all clinical care rendered by residents is the responsibility of physician faculty members. Non-physicians are not permitted to independently supervise residents. While the attending physician may delegate an appropriately-qualified non-physician to assist or teach a resident in a specific aspect of an eye exam (e.g., refraction, low vision, contact lens, orthoptics, and optics), the ultimate responsibility for resident supervision remains the responsibility of the attending physician.</td>
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<tr>
<td>Orthopedic Surgery</td>
<td>Each program is responsible for having clear policies for supervision. Direct supervision requires the supervising individual to be physically present. Appropriately credentialed and privileged nonorthopaedic attending physicians, as well as licensed independent practitioners (this may include non-physician faculty members working in conjunction with the orthopaedic surgery department) with whom the program has a clearly defined relationship outlined in the supervision policy, may directly supervise PGY-1 residents. The clinical care supervised by a...</td>
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<tr>
<td>Specialty</td>
<td>Supervision Details</td>
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<tr>
<td>Otolaryngology</td>
<td>While other care providers are expected to be part of interprofessional teams that provide patient care, only appropriately-credentialed and privileged attending physicians may supervise residents.</td>
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<tr>
<td>Pathology</td>
<td>Although pathologist’s assistants are not licensed independent practitioners, they may be authorized by a department to provide supervision or oversight of dissection of surgical specimens and autopsies.</td>
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<tr>
<td>Pediatrics</td>
<td>Physician assistants, nurse practitioners, psychologists, physical and occupational therapists, speech and language pathologists, dieticians/nutritionists, counselors, and audiologists are just some of the providers who see their own patients and may serve as teachers and/or supervisors for residents as appropriate in ambulatory (i.e., school-based health centers, child development clinics) and inpatient (i.e., neonatal intensive care unit (NICU)) settings. Some states may have regulatory rules that won’t allow licensed independent practitioners to supervise residents.</td>
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<tr>
<td>Physical Medicine and Rehab</td>
<td>Advanced nurse practitioners and psychologists may supervise residents, as appropriate.</td>
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<tr>
<td>Preventive Medicine</td>
<td>PM-1 and PM-2 residents may be supervised by licensed allied health professionals who are identified as faculty members, provided that:</td>
</tr>
<tr>
<td></td>
<td>• the clinical care is within their scope of practice expertise;</td>
</tr>
<tr>
<td></td>
<td>• the level of clinical care is low risk;</td>
</tr>
<tr>
<td></td>
<td>• physician faculty members are available by telephone; and,</td>
</tr>
<tr>
<td></td>
<td>• the program director has approved the supervision with respect to the educational experience.</td>
</tr>
<tr>
<td></td>
<td>Allied health professionals cannot substitute for physician faculty members to meet the 24-hour requirement for on-site supervision of resident care.</td>
</tr>
<tr>
<td>Psychiatry</td>
<td>No reference.</td>
</tr>
<tr>
<td>Radiation Oncology</td>
<td>No. The Review Committee’s opinion is that it is not relevant to our specialty to have other licensed independent practitioners supervise residents. Physician extenders may be present in some clinics, but the Review Committee does not view them as primarily responsible for patient care delivered by residents.</td>
</tr>
<tr>
<td>Radiology-Diagnostic</td>
<td>No reference.</td>
</tr>
<tr>
<td>Sports Medicine – review committees for Emergency Medicine, Family Medicine, Pediatrics, and Physical Medicine and Rehabilitation</td>
<td>While there is an expectation that fellows and faculty members have ultimate responsibility for the overall care of each patient, there may be circumstances where a licensed independent practitioner or physician extender may also be involved in a supervisory role for the fellow. In such instances, the non-physician is expected to provide that supervision within the legal limits of his or her particular license.</td>
</tr>
<tr>
<td>Surgery and Thoracic Surgery</td>
<td>Not known; FAQs are under revision at this time.</td>
</tr>
<tr>
<td>Transitional and Urology</td>
<td>No reference.</td>
</tr>
</tbody>
</table>

Prepared by: TMA Medical Education Department.
Subject: Support for Acceptance of DACA Recipients to Texas Medical Schools

Presented by: Kevin W. Klein, MD

Referred to: Reference Committee on Medical Education and Health Care Quality

TMA’s Medical Student Section submitted a resolution to the House of Delegates in 2020 for new TMA policy in support of the acceptance of DACA recipients to Texas medical schools. DACA refers to the Deferred Action for Childhood Arrivals program, a federal executive branch program created by President Barack Obama in 2012. This action was taken after the Development, Relief, and Education for Alien Minors Act of 2011 (DREAM Act of 2011) did not pass in Congress. The bill would have provided a pathway for citizenship for DACA eligibles. Similar bipartisan legislation, the Durbin-Graham Dream Act of 2021, is currently pending in Congress, but its passage is uncertain.

The DACA program was established to allow a narrow group of young individuals to gain temporary legal status if they entered the U.S. illegally before their 16th birthday, were less than 32 years of age in 2012, and have lived in the U.S. consistently since 2007. Individuals can receive a two-year, renewable authorization to remain and work in the U.S. through an Employment Authorization Document (or work permit) and can apply for a Social Security number. To be eligible, applicants must pass a background check, either be enrolled in school or have graduated or earned a GED, and be enrolled in the U.S. military or honorably discharged, and cannot have been convicted of a felony. An overwhelming majority of Americans (73%) support legalizing students who are undocumented. There are an estimated 230,000 DACA recipients in Texas.

The council researched current policies for DACA recipients at Texas medical schools and residency programs as well as Texas licensing laws. The council learned DACA recipients are eligible for:

- Admission to Texas undergraduate colleges and universities and in-state tuition,
- State financial aid for higher education but not federal financial aid,
- Participation in the National Resident Matching Program and acceptance to Texas residency programs,
- Clinical rotations through U.S. Department of Veterans Affairs health care facilities,
- Medicare graduate medical education payments to hospitals and facilities while in residency training,
- Physician-in-Training permits for residents and fellows in training from the Texas Medical Board,
- Board certification from member boards of the American Board of Medical Specialties and American Osteopathic Association Bureau of Osteopathic Specialists,
- Texas Medical Board medical licensing, and
- Employment on the basis of an Employment Authorization Documents or work permit and Social Security number.

While researching this topic, the council recognized there may be misunderstandings among medical school leadership about what a DACA recipient can and cannot do. Some expressed their understanding to TMA that DACA students are not eligible for a Texas residency training permit or a medical license. Others thought a work or education visa was required or certification from the Educational Commission for Foreign Medical Graduates. None of those restrictions are applicable, and the council recognized the need for educational programs within academic health centers to promote a greater understanding. Several medical schools noted
that TMA policy on the acceptance of DACA recipients to Texas medical schools would likely be useful in
the formulation of state admission policies.

Status of DACA Recipients at Texas Medical Schools
Currently, only one of the state’s 15 medical schools – Texas College of Osteopathic Medicine (TCOM) at
the University of North Texas Health Science Center in Fort Worth – accepts DACA recipients (see
attachment). Fewer than five DACA students are currently enrolled at TCOM. That school plans to stop
accepting applications from non-U.S. citizens, including DACA recipients, beginning in 2022. This change is
being made to align with the admission policies of other Texas medical schools.

Texas has a centralized medical school application program, the Texas Medical and Dental Schools
Application Service, that processes applications for 14 of the state’s 15 medical schools, including TCOM.
TCU and UNTHSC School of Medicine in Fort Worth is the only Texas medical school that does not
participate in the Texas application service. The advisory council for the application service held discussions
on DACA admissions policies in recent months and provided the following statement to TMA in January
2021 regarding these activities:

The Texas Health Education Service oversees administration of the Texas Medical and Dental
Schools Application Service (TMDSAS) and the service’s advisory council [has] been evaluating
policies related to DACA recipients. There has been interest among TMDSAS member institutions
to ensure policies and practices on DACA reflect the reality of the situation, particularly in regard
to recent legislation and other opportunities in the educational and state medical licensure
processes. TMDSAS would like to provide educational opportunities in 2021 to ensure all
participating institutions have accurate and shared understanding of the policies related to DACA.

Background for Current DACA Admission Policies
The council has long held the position that medical school admission policies are best determined by
admissions committees, not entities external to a medical school, with the exception of medical school
accrediting bodies. Certainly, medical schools are required to meet the standards defined by their national
accrediting bodies. However, neither the Liaison Committee on Medical Education nor the American
Osteopathic Association Commission on Osteopathic College Accreditation has standards that disqualify
DACA recipients from applying to an accredited medical school.

The council reached out to the admission deans at Texas medical schools to ask about the background for
their DACA policies. Two reasons were cited most often, as listed below, but there was not agreement on
these policies.

1. Ability of DACA recipients to afford medical school tuition.
   • Because DACA recipients are not eligible for federal student aid, some medical school leaders
     thought this could be an impediment to their success in medical school. Some admission deans
     strongly disagreed with this rationale: DACA students are eligible for state student aid and loans from
     banks and private sources.
   • Some questioned why a different admission criterion would be applied for medical schools than
     colleges and universities, recognizing DACA students are accepted to these schools and
     undergraduate degrees are required for application to medical school.
   • Other admission deans felt this policy excludes an applicant pool based on an assumption rather than
     a fact and expressed concerns about selective application of this criterion.
2. Concerns about the acceptance of DACA recipients by Texas residency programs.

In an outreach to graduate medical education programs, none reported formal policies prohibiting the acceptance of DACA physicians.

The institutions below sponsor the majority of the state’s residency programs, and each reported to TMA their general acceptance of residency position applications from DACA recipients.

- Baylor College of Medicine, Houston;
- Houston Methodist;
- Texas Tech University Health Sciences Center, Lubbock;
- UT Southwestern Medical Center, Dallas;
- UTHealth Houston;
- UT Health San Antonio and University Health System San Antonio; and
- UT Medical Branch, Galveston.

**Potential Benefits of DACA Medical Graduates**

In a research study reported in *Academic Medicine* in 2017, a high percentage (95%) of DACA recipients reported being bilingual, and the largest number spoke Spanish. DACA physicians could potentially help meet the medical needs of Hispanic, non-English-speaking patients in Texas.

Although an exceptionally small number of DACA recipients apply to medical schools (estimated to be less than 1%), research shows those who complete medical education and residency training are likely to have an interest in serving medically underserved populations as a result of life experiences and cultural interests. Studies have found that Hispanic physicians have a greater tendency to serve medically underserved patients, and patient-physician race/ethnic concordance has been shown to yield favorable patient outcomes and lower medical costs. Examples of these studies are listed on page 6 of the TMA Committee on Physician Distribution and Health Care Access’ Report 3 – Renewed Effort to Increase Diversity Among the Texas Physician Workforce.

**Other Considerations**

The DACA program is not open-ended to include every undocumented young person in the U.S. The program is narrowly defined; for example, the individual must have lived continuously in the U.S. since 2007. DACA status does not provide long-term legal protection to recipients and does not provide a pathway for citizenship. Some DACA recipients are able to qualify for citizenship status through other routes.

The council gave careful consideration to the state mandate for every public Texas medical school that limits the acceptance of non-Texas residents (as classified for the purposes of in-state tuition) to no more than 10% of their admissions each year. In other words, 90% of the schools’ admissions must be students classified as Texas residents. As noted, DACA recipients are eligible to be classified as Texas residents for the purposes of qualifying for in-state tuition. This results from a state law passed in 2001 and signed into law by Texas Gov. Rick Perry. This status is applicable to students who graduated from a high school in Texas or completed a GED in Texas and meet certain residency requirements. For this reason, DACA recipients from Texas would not be counted as part of the 10% nonresident admission cap. This status was considered by the council as it debated the issue of potentially accepting non-U.S. citizens into a Texas medical school.

**Related AMA Policy**

Recognizing that DACA is a national program, the council evaluated relevant American Medical Association policies and determined that AMA supports DACA recipients, as follows:
D-350.986 Evaluation of DACA-Eligible Medical Students, Residents and Physicians in
Addressing Physician Shortages: Our AMA will issue a statement in support of current U.S. health
care professionals, including those currently training as medical students or residents and fellows,
who are DACA recipients. (Reaffirmation A-19)

Recent Court Rulings
To evaluate the status of the DACA program, the council looked at recent court actions. In September 2017,
the Trump administration announced a halt to the acceptance of applications to the DACA program and a
wind-down process for existing recipients. The U.S. Supreme Court ruled in June 2020 that justification had
not been provided to end the DACA program and that the Trump administration’s termination of the program
was unlawful. The DACA program was reactivated on Dec. 7, 2020.
The Association of American Medical Colleges, joined by 32 other organizations, in October 2019 filed an
amicus brief in the U.S. Supreme Court case in support of the DACA program. The 19 organizations related
to medicine that joined the amicus brief are listed below. About 200 corporations also filed amicus briefs.

- Academy of Child and Adolescent Psychiatry,
- American Academy of Family Physicians,
- American College of Obstetricians and Gynecologists,
- American College of Physicians,
- American College of Preventive Medicine,
- American Medical Association,
- American Medical Student Association,
- American Psychiatric Association,
- American Society of Hematology,
- American Society of Nephrology,
- American Thoracic Society,
- Association of Academic Health Centers,
- Association of American Indian Physicians,
- California Medical Association,
- Greater New York Hospital Association,
- National Council of Asian Pacific Islander Physicians,
- National Hispanic Medical Association,
- National Medical Association, and
- Society of General Internal Medicine.

U.S. District Court Hearing, Dec. 23, 2020
A hearing on the legality of the DACA program was held Dec. 23, 2020, in the U.S. District Court in
Houston, and the case was left pending. President Joseph Biden has expressed support for continuation of the
DACA program or congressional action on an immigration pathway.

Recommendation: The council recommends the following be adopted as Texas Medical Association policy:
Acceptance of Applications to Texas Medical Schools From Deferred Action for Childhood
Arrivals (DACA) Recipients
The Texas Medical Association recognizes admissions policies are best determined by medical school admissions committees. TMA encourages Texas medical schools to evaluate their individual policies on the acceptance of applications from Deferred Action for Childhood Arrivals (DACA) recipients and supports schools that make the decision to accept them.

DACA recipients are eligible to apply to colleges and universities for undergraduate and graduate degrees, and TMA supports the same consideration for application to medical schools.

It is recognized that (1) DACA recipients are eligible for in-state tuition at higher education institutions and therefore would not be part of the state’s 10% cap on the acceptance of non-Texas residents to Texas public medical schools, and (2) DACA physicians are eligible to apply for Physician-in-Training permits, residency training, Texas medical licenses, employment in the state, and medical specialty board certification.

TMA supports communications by Texas medical schools to inform faculty, residency program directors, administrators, and other staff of the unique status of DACA recipients to promote better understanding.
ATTACHMENT

Excerpt from Texas Medical and Dental Schools Application Service website:

“The following medical schools will only review and consider for admissions applicants who are U.S. citizens or legal Permanent Residents of the U.S.:

“University of Texas Southwestern Medical School
UT Medical Branch at Galveston
Long School of Medicine, UT Health San Antonio
McGovern Medical School (formerly The University of Texas HSC at Houston Medical School)
UT Austin Dell Medical School
UT Rio Grande Valley School of Medicine
Texas A&M Health Science Center, College of Medicine
Texas Tech University Health Sciences Center School of Medicine
Texas Tech University Health Sciences Center - Paul L. Foster School of Medicine at El Paso

“The medical school listed below will review and consider for admissions international applicants, U.S. citizens and legal Permanent Residents of the U.S.:

“University of North Texas - Texas College of Osteopathic Medicine”

Source: Texas Medical and Dental Schools Application Service
Accessed Jan. 17, 2021

References:
Texas has 34,000 licensed advanced practice registered nurses (APRNs). These health care professionals are recognized as valuable members of the health care team, and many Texas physicians participate in delegation agreements with APRNs. Twenty-two states and the District of Columbia allow independent practice for APRNs. House Bill 2029 (Rep. Stephanie Klick, R-Fort Worth) was filed in late February 2021, seeking legislative approval of independent practice for APRNs in Texas. Similar legislation has been filed in the past several legislative sessions.

Full practice authority is defined by the American Association of Nurse Practitioners as “the authorization of nurse practitioners [NPs] to evaluate patients, diagnose, order and interpret diagnostic tests and initiate and manage treatments – including prescribe medications – under the exclusive licensure authority of the state board of nursing.” TMA has policy in opposition to independent practice for APRNs.

While physician assistants (PAs) function in similar roles as APRNs, the primary focus of this report is APRNs in response to physician concerns. It is less common for PAs to seek independent practice; however, many principles in this report are also applicable to PAs.

Physicians recognize the importance of nurses in advanced practice to our current health care system, as defined in TMA Policy 30.15. This policy documents TMA’s strong support for the state’s current laws that reflect the importance of team-based care based on clinical linkages with physicians through integrated practice, as follows:

30.015 Nurses in Advanced Practice: The Texas Medical Association acknowledges the importance of nurses in advanced practice to our current health care system. TMA strongly supports current Texas law that requires advanced practice nurses to maintain clinical linkages to physicians through integrated practice (Council on Medical Education, p 97, I-94; reaffirmed CME Rep. 4-A-04; reaffirmed CM-PDHCA Rep. 2-A-14).

The American Association of Family Physicians has policy similar to TMA’s, as follows:

The AAFP encourages health professionals to work together as multidisciplinary, integrated teams in the best interest of patients. Patients are best served when their care is provided by an integrated practice care team led by a physician.

This spring, proponents of APRN independent practice are saying APRNs are distinct from physicians in that they have a strong interest in practicing in rural medically underserved areas. Current physician delegation requirements do not prevent APRNs from practicing in these areas. Further, it is not a lack of interest that prevents from physicians from practicing in isolated, underserved areas but challenges to practice viability in sparsely populated, less resourced geographic areas.
Proponents of independent practice promote APRNs as being more cost efficient in practice, resulting in lower health care costs. Research studies show that APRNs prescribe more, order more tests, and make more referrals than physicians. All of these can be expected to result in greater health care costs, not less, as cited in research studies referenced later in this report.

It is critically important to fully understand the distinctions between the practice of medicine and the practice of nursing, including the considerable differences in educational preparation and training requirements between the two professions. Each brings important expertise and skills to health care. A physician’s extensive education and tens-of-thousands of hours of clinical training and experience prepare them for the critical thinking, informed by science, needed to diagnose, treat, manage, and supervise the medical care for all patient population groups. Advanced practice nursing places an emphasis on prevention and wellness, patient education, care coordination, and holistic evaluations.

Members have expressed concerns to TMA regarding APRN education and training, including:

- Small amount of hands-on clinical training received by APRNs and the need for extensive “on-the-job” training.
- APRN programs that did not take responsibility for securing clinical training sites for their students, requiring students to hunt for their own. (More on page 10)
- Lack of direction to physician preceptors of intended outcomes for the preceptorship and lack of rigor in the process to be used by preceptors in evaluating APRNs in training. (Page 10)
- Proliferation of APRN education programs that are 100% online, with no requirement for in-person didactic education. (Page 9)

In researching the APRN profession in Texas, the council learned or confirmed the following:

- An APRN’s authority to provide medical aspects of patient care and to prescribe medications in Texas is only through delegation by a physician.
- Physicians receive a minimum of 30 times more clinical training than an APRN. (Page 10)
- A physician’s extensive training enables the physician “to generate broad differential diagnoses and provide comprehensive care to medically complex patients.” (Page 5)
- The number of APRNs grew more than six times faster than physicians during the past decade. (Page 8)
- It is not known how many APRNs want to practice independently in Texas. Anecdotally, many APRNs report no interest in changing their current delegation arrangements. This uncertainty raises questions about the impact of such legislation, particularly for rural underserved areas as is promoted by APRN advocacy groups. (Page 6)
- APRNs do not need independent practice to practice in rural underserved areas. (Page 7)
- Texas is projected to have an oversupply of nurse practitioners and certified registered nurse anesthetists (CRNAs) each year from 2018 to 2032. (Pages 9 and 14) Independent practice laws are not needed to recruit more of these types of APRNs to the state or to retain graduates for practice in the state.
- APRN curricula are not standardized. (Page 9).
- While APRNs have added qualifications and responsibilities over registered nurses, they remain part of the nursing profession, which is rooted in a highly compatible but distinct philosophy from medicine. (Page 3)
- A recent survey found most Texans do not support nurses, PAs, and other nonphysician health care professionals in the role of diagnosing and treating patients, or prescribing without the oversight of a licensed physician. (Page 6)
Updates to TMA policy
TMA has not adopted new policies on APRNs for many years, and the council offers this report with new policy proposals for consideration by the House of Delegates.

BACKGROUND

Differences in state definitions of physicians and APRNs
APRNs and physicians represent professions rooted in distinct philosophies of their unique roles in providing health care. While APRNs have added qualifications and responsibilities over registered nurses, they remain part of the nursing profession and are licensed and regulated by the Texas Board of Nursing not the Texas Medical Board (TMB).

Definition in the Texas Medical Practice Act:
“‘Practicing medicine’ is defined as the diagnosis, treatment, or offer to treat a mental or physical disease or disorder or a physical deformity or injury by any system or method, or the attempt to effect cures of those conditions.”

Definitions from the Texas Nursing Practice Act
“Professional nursing means the performance of an act that requires substantial specialized judgment and skill, the proper performance of which is based on knowledge and application of the principles of biological, physical, and social science as acquired by a completed course in an approved school of professional nursing. The term does not include acts of medical diagnosis or the prescription of therapeutic or corrective measures.”

Related definitions from Texas Board of Nursing rules, §221.1
“(3) The advanced practice nurse is prepared to practice in an expanded role to provide health care to individuals, families, and/or groups in a variety of settings including but not limited to homes, hospitals, institutions, offices, industry, schools, community agencies, public and private clinics, and private practice. The advanced practice nurse acts independently and/or in collaboration with other health care professionals in the delivery of health care services.

“(12) Protocols or other written authorization – Written authorization to provide medical aspects of patient care which are agreed upon and signed by the advanced practice nurse and the physician, reviewed and signed at least annually, and maintained in the practice setting of the advanced practice nurse. Protocols or other written authorization shall be defined to promote the exercise of professional judgment by the advanced practice nurse commensurate with his/her education and experience. Such protocols or other written authorization need not describe the exact steps that the advanced practice nurse must take with respect to each specific condition, disease, or symptom and may state types or categories of drugs which may be prescribed rather than just list specific drugs.”

Texas APRN scope of practice
An APRN’s authority to provide medical aspects of patient care and to prescribe medications in Texas is only through delegation by a physician. (See TMA’s white paper Delegation of Duties by a Physician to a Nonphysician, TMA Office of General Counsel, 2017.)

As noted by the Texas Board of Nursing, historically this delegation occurred through a protocol or other written authorization for medical acts and a separate written agreement for prescriptive authority. If agreeable to the delegating physician and the APRN, both can be reflected in the prescriptive authority agreement, as documented in this excerpt from the Texas Board of Nursing website:
APRNs and PAs are required to have delegated authority to provide medical aspects of patient care. Historically, this delegation has occurred through a protocol or other written authorization. Rather than have two documents, this delegation can now be included in a prescriptive authority agreement if both parties agree to do so. [See definition of “protocols or other written authorization” on page 3.]

Physician supervision requirements
TMB specifies that physicians who delegate to an APRN or PA must adequately supervise those individuals. Texas laws on physician supervision have changed over the years, which appears to have caused some confusion about the current requirements. In 2013, the Texas Legislature replaced the site-based requirements for the delegation and supervision of prescriptive authority with a framework of delegation and supervision that uses prescriptive authority agreements.

There is no limit to the number of APRNs or PAs a physician can supervise. In addition, there is no limit on the number of physicians an APRN or PA can have supervise him or her. There can be limits on the number of APRNs and/or PAs to whom a physician can delegate prescriptive authority, dependent on the practice setting. For facility-based hospital practices or practices that serve medically underserved populations there is not a maximum number to whom a physician can delegate, but there are other limitations. A physician can delegate prescriptive authority through a facility-based protocol at no more than one licensed hospital and two long-term care facilities. A prescriptive authority agreement can be used, if preferred, but a facility-based protocol is sufficient.

The maximum number to whom a physician can delegate prescriptive authority in practice settings other than facility-based hospital practices or practices serving medically underserved populations is a total of seven combined APRN and PA full-time-equivalents. A prescriptive authority agreement is required in these settings.

In response to the COVID-19 pandemic, Texas Gov. Greg Abbott issued an executive order on April 5, 2020, that allows increased flexibility in the physician delegation requirements for APRNs (and PAs): For the duration of the disaster declaration, the limit on the number of prescriptive delegates has been lifted, and supervisory relationships are not required to be in writing or registered with the Texas Medical Board. The order remains in effect at this writing.

TMB advises that a physician does not have to be physically present at all times to be considered to have adequate supervision, and there are no specific requirements for the geographic proximity of a supervising physician’s practice location and the practice site of an APRN or PA. This means an APRN or PA can practice at a different location from the supervising physician. TMB cautions “(i)n any given case, the distance between a physician’s primary practice and the practice site at which the physician’s delegates provide medical services may be an important factor in determining the quality of the physician’s supervision.”

Supervising physicians and the APRN or PA to whom they delegate are required to have regular meetings, and the supervising physicians is required to review a portion of the patient records. The location, method, and frequency of those meetings, and the number of medical records to be reviewed are to be determined by the physician, APRN or PA. TMB advises that “the number or percentage of charts reviewed may be an important factor in determining the quality of the physician’s supervision.”

There have been reports of APRNs paying exorbitant fees to physicians as a requirement for entering into a delegation agreement. No evidence has been provided, and it has not been possible to quantify or verify these reports.
Discord with Texas laws, staffing policies at Veterans Affairs clinics

In November 2020, the U.S. Department of Veterans Affairs adopted rules that permit APRNs and PAs to practice without the clinical supervision of physicians and without regard to Texas laws requiring physician delegation. In light of the complex health care needs of many veterans, including those with traumatic brain injuries and other serious medical and mental conditions, this new staffing rule is of particular concern. The council supports the state’s delegation laws and does not support different standards for veterans’ medical care.

Compilation of viewpoints: differences between medicine and advanced practice nursing

To promote a better awareness of the core differences between medicine and advanced practice nursing, the council reviewed numerous research studies, surveys, and other references and prepared the compilation below.

<table>
<thead>
<tr>
<th>Differences in Training, Particularly in Preparation for Formulating a Diagnosis</th>
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| “While nurse practitioners are trained to emphasize health promotion, patient education, and disease prevention, they lack the broader and deeper expertise needed to recognize cases in which multiple symptoms suggest more serious conditions. The primary care physician is trained to provide complex differential diagnosis, develop a treatment plan that addresses multiple organ systems, and order and interpret tests within the context of the patient’s overall health condition. This expertise is earned through the deep, rigorous study of medical science in the classroom and the thousands of hours of clinical study in the exam room that medical students and residents must complete before being allowed to practice medicine independently.”

<table>
<thead>
<tr>
<th>A physician’s extensive training enables the physician “to generate broad differential diagnoses and provide comprehensive care to medically complex patients.”</th>
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<tbody>
<tr>
<td>“Nursing is knowing how to take care of patients’ needs, whether they are physical, social, psychological. Medicine is much more scientific; diagnosing the disease, not just the symptoms, weighing risks and benefits of treatment, understanding lab results and what they really mean. Nursing is not medicine. Medicine is not nursing. They overlap but should be separate entities to be best for patient care.”</td>
</tr>
<tr>
<td>“Can a nurse practitioner gain the necessary knowledge to take on this role in an additional two years of training? Physicians who were previously nurse practitioners say no. The biggest reason: nurse practitioner schools did not adequately prepare them to be able to develop an adequate differential diagnosis, the essential list necessary to accurately diagnose disease.”</td>
</tr>
<tr>
<td>“Nurse practitioners do not have the time or in-depth training during a two-year program to learn how to develop a comprehensive differential diagnosis.” “Nurse practitioners are taught pattern-based thinking, and physicians are taught more critical thinking.”</td>
</tr>
<tr>
<td>Results from a 2013 survey published in the New England Journal of Medicine showed 66.1% of physicians reported physicians provide a higher-quality examination and consultation than do nurse practitioners during the same type of primary care visit.”</td>
</tr>
<tr>
<td>“The need for physician training occurs during those rare times when a medical situation is unusual or more complicated — and potentially life-threatening.” “Without additional training on how to perform a differential diagnosis and the fund of knowledge required to expand the potential diagnoses to include the most serious causes of a patient’s symptoms, non-physician practitioners may put patients at risk.”</td>
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Research on APRN practice

Proponents of APRN independent practice commonly emphasize that APRNs have a strong interest in practicing in rural medically underserved areas. Further, APRN organizations promote greater cost savings by APRN practices.

What do the data show about preference for rural practice by APRNs? Table 1 provides a comparison of licensing data for APRNs and physicians in Texas for 2018. APRNs had a higher percentage (54%) located in the state’s five most-populous counties of Bexar, Dallas, Harris, Tarrant, and Travis than physicians (51.8%).

<table>
<thead>
<tr>
<th>Percentage of Physicians and APRNs Practicing in Top Five Most-Populous Counties in Texas, 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians: 51.8%</td>
</tr>
<tr>
<td>APRNs: 54%</td>
</tr>
</tbody>
</table>

Sources: Health Professions Resource Center, Texas Department of State Health Services; and Texas Board of Nursing. Prepared by: TMA.

About 7% of APRNs report a practice location in a rural area, as shown in Table 2. For context, 177 of Texas’ 254 counties are rural.
### Table 2

<table>
<thead>
<tr>
<th>APRNs by Texas Urban and Rural County Location, 2018</th>
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<tbody>
<tr>
<td>Urban County: 93.1%</td>
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</table>

*Source: Texas Board of Nursing. Prepared by: TMA*

#### Challenges of rural practice for any health care practitioner

Of Texas’ 254 counties, 29 have been identified as not having a physician. These areas have a population density of three people per square mile, qualifying for what is often referred to as “frontier” areas (generally, defined as areas with fewer than seven people per square mile). The barriers that prevent physicians from practicing in these areas are typically the same barriers that prevent hospitals, pharmacies, grocers, and other retail businesses from locating to these areas. There is not a sufficient population base or infrastructure to support health care systems and businesses.

As an example, it has been estimated that a patient panel of about 2,500 may be needed to sustain a family physician’s practice. Of the 29 counties without a physician, 17 had a total population less than 2,500.

Because geographic modifiers are used to determine the rates for Medicare payments, rural areas often have lower payment rates than larger population areas. These impediments to a successful physician practice can be expected for other types of health care professionals. Medicare payment policies are of particular significance to rural practices because of the relatively high percentage of Medicare beneficiaries living in rural Texas.

In addition, as noted on page 9, the study of APRN supply/demand commissioned by the Texas Center for Nursing Workforce Studies in 2017 determined the number of nurse practitioners and CRNAs exceeds demand and is projected to continue to do so each year through 2032. Texas has been successful in recruiting and retaining these professions and does not need to change delegation laws to achieve this goal.

Independent practice is also not needed to enable APRNs to practice in rural underserved areas. As an example, federally designated rural health clinics are required by federal law to have an APRN or PA on staff for 50% of the time the clinic is open. This evidences the potential availability of employment positions for APRNs in rural physician shortage areas of the state. Mapping research by the American Medical Association compares actual locations of primary care physicians with that of nurse practitioners who practice independently in other states. AMA found nurse practitioners did not move to rural areas in appreciable numbers but generally continued to practice in the same areas as physicians.

#### Lower cost for APRN care?

The following compilation provides a sampling of research findings published in a variety of professional journals, including nursing. In general, the studies showed APRNs prescribe more medications, including antibiotics and antimicrobials; order more tests and imaging services; and make a larger number of referrals. These practice patterns can be expected to result in greater health care costs. Further, APRNs working in collaborative practice arrangements with physicians can be expected to benefit from the efficiencies of an integrated practice.
APRN workforce in Texas, current and projected
APRNs are among the fastest growing health professions, growing more than 200% in Texas from 2011 to 2020, about seven times faster than physicians, as shown in Table 3. Nurse practitioners (NPs) grew at the fastest rate, by 311%. In comparison, physicians in direct patient care in Texas grew by only 32.9%. The four different types of APRNs are shown in the table.

<table>
<thead>
<tr>
<th>Table 3: Growth in APRN Supply in Texas by Type and Comparison with Growth in Direct Patient Care Physicians, 2011 to 2020</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>APRN Type</strong></td>
</tr>
<tr>
<td>Certified Nurse Midwife</td>
</tr>
<tr>
<td>Certified RN Anesthetist</td>
</tr>
<tr>
<td>Clinical Nurse Specialist</td>
</tr>
<tr>
<td>Nurse Practitioner</td>
</tr>
<tr>
<td><strong>TOTAL APRNs</strong></td>
</tr>
<tr>
<td><strong>Direct Patient Care Physicians</strong></td>
</tr>
</tbody>
</table>

Sources: Texas Board of Nursing, and Health Professions Resource Center, Texas Department of State Health Services Prepared by: Texas Medical Association, 2/21.
In Texas, nursing workforce planning activities are overseen by the Texas Center for Nursing Workforce Studies at the Texas Department of State Health Services. The center commissioned a study in 2017 of the projected supply and demand for APRNs (excluding clinical nurse specialists) for 2018 through 2032. This represents the most recent study of this type available in the state.

The study determined the supply of NPs and CRNAs currently EXCEEDS demand in Texas. This is not expected to change; Texas is projected to continue to have more NPs and CRNAs than projected demand each year through 2032. In contrast, the study found that Texas has a shortage of certified nurse midwives and demand is expected to exceed supply each year through 2032.

With a projected oversupply, independent practice laws are not needed in order to recruit more NPs and CRNAs to the state or to retain graduates for practice in the state. (See Appendix A for detailed projections. Note: This study was based on trends for supply and demand before the COVID-19 pandemic.)

**APRN educational model**

Two national groups accredit APRN educational programs, and there is not a standardized APRN curriculum. In Texas, **35 programs offer APRN education** (see Appendix B). In comparison, **there are 15 Texas medical schools**. NPs are educated and certified in six population-focused areas of practice: family care, neonatal, pediatric acute care, pediatric primary care, psychiatric-mental health, and women’s health (see Appendix C for a detailed list, 2019).

During the pandemic, it is recognized that many educational programs have been converted to virtual formats to promote greater safety. Before the pandemic, however, TMA heard concerns about the proliferation of APRN programs that are 100% online. Unlike preclinical medical education and other types of health professional training during the pandemic, the 100% online format for a considerable number of APRN programs is not a temporary response to the pandemic.

**Comparison, length of training for physician and APRNs**

Some distinctions between medical education and APRN education are well known, such as the following:

**Physician:** Typically a four-year undergraduate degree, then four years of medical school. A medical school’s curriculum is at least 130 weeks and generally encompasses around 170 semester credit hours (source: Texas Higher Education Coordinating Board). Medical school and residency training requires a minimum of six to seven years, and with fellowship training, the total can extend to 12 years.

**APRN:** Typically a four-year undergraduate registered nurse degree, followed by an 18- to 24-month master’s or a post-master’s degree certificate program.

In 2018, the National Organization of NP Faculties issued a position statement that entry-level APRN programs should be elevated to the doctorate level by 2025. A previous proclamation for 2015 was not achieved. CRNAs are making this change, and all four CRNA educational programs in Texas are now at the doctorate of nursing practice (DPN) level. (See Appendix B.)
Comparison, clinical training requirements for physicians and APRNs

Table 4 demonstrates physicians are required to complete 30 times the amount of minimum clinical training as APRNs.

<table>
<thead>
<tr>
<th></th>
<th>Physicians:</th>
<th>APRNs:</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>15,000 hours</td>
<td>500 hours</td>
</tr>
</tbody>
</table>

APRN clinical training model
The APRN clinical training model has not changed in 50 years and is primarily dependent on a one-to-one preceptor-student model. Inconsistencies in clinical training requirements across APRN programs are summarized in the following excerpt from a white paper by the American Association of Colleges of Nursing:

APRN students enter clinical training experiences across the curriculum with varied skill levels. Variability among APRN programs, particularly for nurse practitioners and clinical nurse specialists, exists in the clinical competencies expected at various points throughout the curriculum, varied expectations for student performance across programs, and evaluation processes and tools. This variability may hamper efforts to expand the clinical training opportunities for students.

As noted, despite the heavy reliance on preceptors, including physicians, for clinical training, until recently some APRN educational programs did not take responsibility for securing clinical training sites for their students. Instead, students were required to find their own, and TMA heard concerns from physicians.

The Commission on Collegiate Nursing Education added an APRN accreditation standard in 2019 that makes reference to periodic reviews, but specific responsibility is not assigned to educational programs. Such a requirement was not found for the other accrediting body, the Accreditation Commission for Education in Nursing.

**Standard II-B:** Physical resources and clinical sites enable the program to fulfill its mission, goals, and expected outcomes. Adequacy of physical resources and clinical sites is reviewed periodically, and resources are modified as needed.

Both accrediting bodies have standards that require educational programs to clearly define and communicate the roles and performance expectations for preceptors. TMA has heard from physicians who served as APRN clinical preceptors regarding a lack of communication about the objectives of the preceptorship as well as the lack of an evaluation process.

Curricular differences between medicine, advanced practice nursing
In addition to striking differences in the length of training, there are vast differences in curricular content for the educational preparation of physicians and APRNs. To help demonstrate these differences, a comparison is presented in Appendix D of the curriculum for a family medicine physician, including medical school and a three-year residency, and a family nurse practitioner. This example is based on the curricula for these three different types of programs at The University of Texas Medical Branch (UTMB).

In considering the strength of the comments on page 5 of this report about the lack of training in diagnostic reasoning for APRNs, it is important to note that the curriculum for a family nurse practitioner at UTMB lists only two semester credit hours in nurse practitioner diagnostic reasoning.
Summary: Physician-led, team-based care is what is best for the patient

Texas physicians recognize the valuable role of APRNs as members of the health care team. They also recognize what is best for the patient is physician-led, team-based care. Physicians’ extensive education and tens-of-thousands of hours of clinical training and experience prepare them for the critical thinking, informed by science, needed to diagnose, treat, manage, and supervise the medical care for all patient population groups. Advanced practice nursing places an emphasis on prevention and wellness, patient education, care coordination, and holistic evaluations. The council strongly supports continuation of state requirements for physician supervision and delegation of authority for APRNs and PAs and consistent application of these laws within the state.

Attachments

Recommendation: The Council on Medical Education recommends the following be adopted as Texas Medical Association policy:

Physician-Led Patient Care Teams
TMA will continue to advocate that physicians are uniquely qualified by their extensive and broad education, training, and credentialing to lead the patient care team. TMA opposes the independent practice of advanced practice registered nurses and physician assistants and strongly supports continuation of state requirements for physician supervision and delegation of authority for these health professions.

Physician Supervision and Delegation Responsibilities
TMA supports efforts to ensure physicians are well informed of their responsibility to supervise advanced practice registered nurses and physician assistants to whom they delegate practice and prescriptive authority, including through the required content and updating of practice agreements. Both the Texas Medical Board and TMA should periodically provide reminders to physicians of these responsibilities.

Promoting Accurate Understanding of the APRN Profession, and Length and Content of APRN Training
TMA believes patients should be well informed of the distinct differences between the educational and clinical preparation of physicians and advanced practice registered nurses (APRNs). This will enable patients to make better informed decisions about their health care.

TMA determined it also critically important for state policymakers to be informed of these differences. In particular, they should be knowledgeable of the small amount of training APRNs receive in formulating a diagnosis. It should be made known that physicians are required to complete 30 times the amount of clinical training as APRNs, 15,000 hours vs. 500 hours. Further, it is critically important to understand the fundamental differences in the practice of medicine and the practice of nursing.

TMA supports clear and accurate representation of the role, education, and training of APRNs, including doctor of nursing practice (DNP) registered nurses, in the delivery of patient care, including the use of name tags and other labels. Further, APRNs have the obligation to represent themselves and their role in a clear and accurate manner in all communications with patients and other health care practitioners.

Promoting Quality Training for APRNs
TMA strongly supports assurances of high quality training for advanced practice registered nurses (APRNs). This includes consistent accreditation standards for all APRN education and training programs, and professional certification programs. TMA supports evidence-based studies of the degree of preparedness of APRNs for entry into practice. These studies should evaluate the amount of on-the-
job training by physicians required to prepare APRNs to function in their role on the health care team. TMA supports clear accreditation standards that place the responsibility for securing preceptorship opportunities on the APRN training programs not the APRN student.

Physicians who elect to serve as preceptors to APRN students are strongly encouraged to see that the APRN educational programs provide the necessary guidance to enable them to serve in the role of a preceptor. Further, APRN educational programs that use physicians as preceptors for APRN clinical training should be required to adequately inform preceptors of their training role and the program’s expectations for the training experience.

TMA supports evidence-based studies of the outcomes from APRN education programs that are provided 100% online.

**Different Standards for Veterans Clinics**

TMA opposes a different level of care for Texans who are veterans and receive their care at U.S. Department of Veterans Affairs facilities. TMA believes veterans should be treated equitably, not differentiated through federal policies that allow independent practice for nonphysician health care practitioners despite opposing state laws.

**Related TMA policies:**

- [30.001 CRNA Direct Reimbursement](#)
- [30.012 Nursing and Nurses with Advanced Training](#)
- [30.015 Nurses in Advanced Practice](#)
- [30.035 Federal Prohibition of the Independent Practice of Medicine by Nurse Practitioners](#)
- [170.006 Physician Liability for Acts of Assistants](#)
APPENDIX A

Projections of Supply and Demand of APRNs for Texas, 2018 to 2032

The Texas Center for Nursing Workforce Studies at the Texas Department of State Health Services (DSHS) contracted with IHS, Inc. in 2017, to conduct a projection study of APRN supply and demand for Texas for the years 2018 and 2032. Below are the findings for three of the four types of APRNs; projections were not made for clinical nurse specialists.

This study projected an oversupply by 2032 for two of the three types of APRNs in the study: nurse practitioners (NPs) and certified registered nurse anesthetists (CRNAs). In contrast, a shortage was predicted for certified nurse midwives (CNMs).

NPs

The study projected there will be more NPs than demand in Texas, as shown in the graph below. The number of NPs is projected to grow by 117.3% from 20,922 NP full-time-equivalents (FTEs) in 2018 to 45,462 in 2032. During this period, demand is projected to grow by 35.6% from 19,317 FTEs in 2018 to 26,191 FTEs by 2032.

When you compare projections for NP supply and demand, a surplus of NPs is projected to grow from 1,605 in 2018 to 19,271 in 2032. Supply is expected to exceed demand for every year from 2018 to 2032.

Blue line (top trend line): Projected number of NPs in Texas
Gold line (bottom line): Projected demand for NPs in Texas
Charts showing projections for supply and demand for different types of NPs are available on the DSHS website.

CRNAs
The study also projected there will be more CRNAs than demand in Texas, as shown in the graph below.

The supply of CRNAs in Texas is projected to grow by 45.8% from 4,074 CRNA FTEs in 2018 to 5,938 in 2032. The demand for CRNAs in Texas is projected to increase 30.9% during this period from 2,075 CRNA FTEs to 2,717.

An oversupply of CRNAs is predicted for the entire projected period, growing from 1,999 in 2018 to 3,221 in 2032.

Blue line (top trend line): Projected number of CRNAs in Texas
Gold line (bottom line): Projected demand for CRNAs in Texas
CNMs
The projected supply of CNMs is expected to increase by 43.6% from 432 FTEs in 2018 to 621 in 2032. During this time, demand for CNMs is projected to exceed supply, increasing by 23% from 798 FTEs in 2018 to 981 in 2032.

A shortage of CNMs is projected for every year from 2018 to 2032. The shortage is predicted to gradually improve, starting with 45.9% in unmet need in 2018 and declining to 36.8% of unmet need by 2032.

Blue line (top trend line): Projected number of CNMs in Texas
Gold line (bottom line): Projected demand for CNMs in Texas

Source: Texas Center for Nursing Workforce Studies, Texas Department of State Health Services

Note: This study was based on trends for supply and demand before the COVID-19 pandemic. Workforce experts note that the effects of the pandemic on the supply and demand for health care professionals are not yet known. Post-pandemic projection studies may produce different outcomes based on changes in staffing, practice, and patient care demand.
### APPENDIX B

**Number of Educational Programs for APRNs in Texas, 2019, by Type of Program**

Thirty-five educational programs in Texas offer different types of APRN programs:

<table>
<thead>
<tr>
<th>Type of Program</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nurse Practitioner</td>
<td>42</td>
</tr>
<tr>
<td>Clinical Nurse Specialist</td>
<td>6</td>
</tr>
<tr>
<td>Nurse Anesthetist</td>
<td>4</td>
</tr>
<tr>
<td>Nurse-Midwife</td>
<td>2</td>
</tr>
</tbody>
</table>

*Note: All four of the CRNA programs offered in Texas are at the doctorate of nursing practice (DNP) level.*

*Sources: Texas Center for Nursing Workforce, Texas Department of State Health Services; and Council on Accreditation of Nurse Anesthesia Programs.*

*Prepared by: TMA, December 2020.*
APPENDIX C
Texas Nurse Practitioners by Population-Focused Area of Practice

Nurse practitioners (NPs) are required to be certified in a population-focused area of practice. The overwhelming majority licensed in Texas are certified as family nurse practitioners (69%); the next largest groups are 10% in pediatric fields and 9% in adult care, as shown below.

### Distribution of Licensed Nurse Practitioners in Texas by Area of Recognition, as Identified by Texas Board of Nursing September 2019

<table>
<thead>
<tr>
<th>Texas Board of Nursing Nurse Practitioner Area of Recognition</th>
<th>Number</th>
<th>%</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Adult Care</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adult</td>
<td>934</td>
<td>(4%)</td>
</tr>
<tr>
<td>Acute Care Adult</td>
<td>870</td>
<td>(4%)</td>
</tr>
<tr>
<td>Gerontological</td>
<td>287</td>
<td>(1%)</td>
</tr>
<tr>
<td>Emergency</td>
<td>99</td>
<td>(&lt;1%)</td>
</tr>
<tr>
<td><strong>Family</strong></td>
<td>15,867</td>
<td>(69%)</td>
</tr>
<tr>
<td>Neonatal</td>
<td>713</td>
<td>(3%)</td>
</tr>
<tr>
<td>Perinatal</td>
<td>12</td>
<td>(&lt;1%)</td>
</tr>
<tr>
<td><strong>Pediatrics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pediatric</td>
<td>1,729</td>
<td>(8%)</td>
</tr>
<tr>
<td>Acute Care Pediatric</td>
<td>455</td>
<td>(2%)</td>
</tr>
<tr>
<td>Psychiatric/Mental Health</td>
<td>1,141</td>
<td>(5%)</td>
</tr>
<tr>
<td>School Nurse</td>
<td>9</td>
<td>(&lt;1%)</td>
</tr>
<tr>
<td>Women’s Health</td>
<td>984</td>
<td>(4%)</td>
</tr>
<tr>
<td><strong>TOTAL</strong></td>
<td>23,100</td>
<td>(100%)</td>
</tr>
</tbody>
</table>

Note: These statistics are for NPs only, excluding the other three types of advanced practice registered nurses: certified registered nurse anesthetists, certified nurse midwives, and clinical nurse specialists.

Source: Texas Board of Nursing, September 2019 (most recent data available)
APPENDIX D
Comparison of Education and Training Pathways for Family Medicine Physicians and Family Nurse Practitioners

To help demonstrate the differences between the education and training of physicians and nurse practitioners, the curriculum and training requirements at The University of Texas Medical Branch are used as an example. Below is a summary of the educational and training requirements for medical school and the family medicine residency program, compared with registered nurses training in the family nurse practitioner program.

*Note: In addition, the registered nurse (RN) must have a Texas RN license and have completed at least one year of work experience as an RN.*

<table>
<thead>
<tr>
<th>Medical School/Residency Training</th>
<th>Family Physician</th>
<th>Family Nurse Practitioner (FNP)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical School Year 1</td>
<td>• Gross Anatomy and Radiology</td>
<td>Semester 1: (17 Semester Credit Hours [SCHs])</td>
</tr>
<tr>
<td></td>
<td>• Molecules, Cells, and Tissues</td>
<td>• Theoretical and Research Foundations for Advanced Nursing Practice (3 SCHs)</td>
</tr>
<tr>
<td></td>
<td>• Pathobiology and Host Defense</td>
<td>Semester 2:</td>
</tr>
<tr>
<td></td>
<td>• Neuroscience and Human Behavior</td>
<td>• Advanced Health Assessment (3 SCHs)</td>
</tr>
<tr>
<td></td>
<td>• Practice of Medicine</td>
<td>• Nurse Practitioner Diagnostic Reasoning (2 SCHs)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Semester 3:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Pharmacology (3 SCHs)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Public Policy (3 SCHs)</td>
</tr>
<tr>
<td>Medical School Year 2</td>
<td>• Cardiovascular and Pulmonary System</td>
<td>Semester 4: (26 SCHs)</td>
</tr>
<tr>
<td></td>
<td>• Renal, Fluid, and Electrolytes</td>
<td>• Introduction to Primary Care of Adults (6 SCHs)</td>
</tr>
<tr>
<td></td>
<td>• Gastrointestinal/Nutrition</td>
<td>• Families and Health Promotion (2 SCHs)</td>
</tr>
<tr>
<td></td>
<td>• Endocrine/Reproduction</td>
<td>Semester 5:</td>
</tr>
<tr>
<td></td>
<td>• Dermatology/Hematology/Musculoskeletal</td>
<td>• Primary Care: Children and Comprehensive Prenatal Care (6 SCHs)</td>
</tr>
<tr>
<td></td>
<td>• Great Syndromes</td>
<td>• Informatics/Quality Improvement (3 SCHs)</td>
</tr>
<tr>
<td></td>
<td>• Practice of Medicine</td>
<td>Semester 6:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• FNP Chronic Illness (6 SCHs)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Nurse Practitioner Business and Roles (3 SCHs)</td>
</tr>
<tr>
<td>Medical School Year 3</td>
<td>• Internal Medicine (12 weeks)</td>
<td>Semester 7: (6 SCHs)</td>
</tr>
<tr>
<td></td>
<td>• Pediatrics (8 weeks)</td>
<td>• Public Health Principles in Advanced Practice Nursing</td>
</tr>
<tr>
<td></td>
<td>• Surgery (8 weeks)</td>
<td></td>
</tr>
<tr>
<td>Medical School Year 3 Cont’d</td>
<td>Obstetrics/Gynecology (6 weeks)</td>
<td>Psychiatry (6 weeks)</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>---------------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Medical School Year 4</td>
<td>Neurology Selective (4 weeks)</td>
<td>Emergency Medicine Selective (includes Advanced Cardiac Life Support) (4 weeks)</td>
</tr>
<tr>
<td>Family Medicine Residency Year 1</td>
<td>Three years of post-medical school residency training (15,000 hours)</td>
<td>Continuity Clinic (1 half-day each week)</td>
</tr>
<tr>
<td>Residency Year 2</td>
<td>Continuity Clinic (4 half-days each week)</td>
<td>Behavioral Medicine</td>
</tr>
<tr>
<td>Residency Year 3</td>
<td>Continuity Clinic (4 half-days each week)</td>
<td>Ambulatory Family Medicine</td>
</tr>
</tbody>
</table>
Residency Year 3
Cont’d
• Neurology
• Orthopedics with Sports Medicine
• Practice Management/Research
• Surgical Subspecialties (Urology/ENT)

Optional fellowship training.
Family physicians have the option to continue training in added qualifications through fellowship programs.

Sources: The University of Texas Medical Branch website and Texas Board of Nursing website.

References:
1. Texas Board of Nursing Rules, Rule 221.1 Definitions
2. TMA White Paper Delegation of Duties by a Physician to a Non-Physician, TMA Office of General Counsel
3. Texas Board of Nursing Frequently Asked Questions, APRNs
4. Texas Medical Board Frequently Asked Questions
5. Texas Medical Board Coronavirus Resources
6. Issue Briefing: Collaboration Between Physicians and Nurses Work, Compare the Education Gaps Between Primary Care Physicians and Nurse Practitioners, Primary Care Coalition, Texas.
8. Patients at Risk: The Rise of the Nurse Practitioner and Physician Assistant in Healthcare
10. Perspectives of Physicians and Nurse Practitioners on Primary Care Practice.
14. Texas Interested Citizens 32nd Annual Statewide Survey November 18-23 2020 1,200 Texas Registered Voters Interviewed Conducted by live Landline & Cell Phones plus Online Surveys + 2.9% Margin of Error at 95% Level of Confidence.
16. Outpatient Antibiotic Prescribing Among United States Nurse Practitioners and Physician Assistants
17. Open Forum Infect Dis. 2016 Sep; 3(3): ofw168. 2016 Aug 10. Guillermo V. Sanchez; Adam L. Hersh; Daniel J. Shapiro; James F. Cawley; and Lauri A. Hicks
18. Prescribing Practices by Nurse Practitioners and Primary Care Physicians: A Descriptive Analysis of Medicare Beneficiaries Ulrike Muench, RN, PhD; Jennifer Perloff, PhD; Cindy Parks Thomas, PhD; Peter I. Buerhaus, RN, PhD Journal of Nursing Regulation Volume 8, Issue 1, P21-30, April 01, 2017
20. Comparison of the Quality of Patient Referrals From Physicians, Physician Assistants, and Nurse Practitioners Mayo Clinic Proceedings Robert H. Lohr, MD; Colin P. West, MD, PhD; Margaret Beliveau, MD; Jayawant N. Mandrekar, PhD James M. Naessens, ScD; Thomas J. Beckman, MD. Published: October 11, 2013
<table>
<thead>
<tr>
<th>No</th>
<th>Reference</th>
</tr>
</thead>
<tbody>
<tr>
<td>22</td>
<td>A Comparison of Diagnostic Imaging Ordering Patterns Between Advanced Practice Clinicians and Primary Care Physicians Following Office-Based Evaluation and Management Visits Danny R. Hughes, PhD; Miao Jiang, PhD; Richard Duszak Jr, MD JAMA Intern Med. 2015;175(1):101-107.</td>
</tr>
<tr>
<td>23</td>
<td>Emergency Physician Evaluation of PA and NP Practice Patterns Journal of American Academy of PAs</td>
</tr>
<tr>
<td>24</td>
<td>Nurse Practitioner COVID-19 Survey (aanp.org)</td>
</tr>
<tr>
<td>25</td>
<td>WHITE PAPER Re-envisioning the Clinical Education of Advanced Practice Registered Nurses March 2015, American Association of Colleges of Nursing</td>
</tr>
</tbody>
</table>
Texas law requires a physician, with only few exceptions, to pass the Texas Medical Jurisprudence Exam to protect the citizens of Texas by establishing that newly licensed physicians have demonstrated competent knowledge of law and Texas Medical Board rules related to the practice of medicine. This requirement applies to the following types of medical licenses: full (with limited exceptions), telemedicine, administrative, conceded eminence, and faculty temporary permits.

A legislative bill was filed in the 2021 Texas legislative session that seeks to establish a new medical licensing pathway for certain physicians who are military veterans and commit to practice in a medically underserved area of the state. This licensing pathway would exempt the physician from the requirement to pass the Texas Medical Jurisprudence Exam. Recognizing that the exam was created to protect patient safety and to protect practicing physicians by informing them of state laws relevant to medical practice, the committee does not believe this is good public policy. The committee questions why it would not be beneficial to every physician practicing in the state to know applicable laws. Further, by varying the licensing standards, the implication is that underserved areas do not require or deserve the same licensing standards as other areas of the state. TMA already has policy opposing a lower standard for medically underserved areas, as follows:

175.019 Medical Licensing Exam Passage Attempts and Timeframe Limits: TMA does not endorse a lower medical licensing standard for medically underserved areas (CME Rep. 3-A-14).

TMA does not have policy that supports the requirement that all physicians licensed and engaged in the active practice of medicine in Texas must pass the Texas Medical Jurisprudence Exam. Such policy would facilitate TMA’s lobbying efforts in opposition to legislative bills that seek exemptions for certain licensed physicians.

Recommendation: The committee recommends the following be adopted as new Texas Medical Association policy:

Passage of Texas Medical Jurisprudence Exam by All Texas Licensed Physicians

TMA supports the requirement that all physicians licensed to practice medicine in Texas must successfully pass the Texas Medical Jurisprudence Exam in order to be aware of state laws and administrative rules of the Texas Medical Board related to the practice of medicine, for the protection of the public and the practicing physician.

TMA reaffirms its opposition to lower licensing standards for physicians and other health care professionals practicing in physician shortage and medically underserved areas of the state.
REPORT OF COMMITTEE ON PHYSICIAN DISTRIBUTION AND HEALTH CARE ACCESS

CM-PDHCA Report 2
2021

Subject: Sunset Policy Review

Presented by: Evan Pivalizza, MD, Chair

Referred to: Reference Committee on Medical Education and Health Care Quality

House of Delegates policies in the association’s Policy Compendium are reviewed periodically for relevance and appropriateness. Following are policies reviewed by the committee with recommendations for retention, amendment, and deletion.

The committee recommends retention of the following policy:


Recommendation 1: Retain.

The committee recommends amending the following policy. These updates are based on recommendations provided by a number of rural practice experts, including members and staff of TMA’s Committee on Rural Health.

185.019 Rural Physician Workforce Policy: The Texas Medical Association (TMA) recognizes the following 27 recommendations for improving physician supply in rural Texas:

Practice Incentive/Benefit and Other Recruitment Programs
1. Federal and state rural practice incentive/benefit programs such as loan repayment, rural training track grants, Family Medicine Residency Training Program, and the Statewide Primary Care Preceptorship Program should be sufficiently funded to be successful in recruiting and retaining physicians in rural, underserved communities.

2. Physicians, medical students, residents, and premed students should have easy access to information about rural practice incentive programs. Further, the programs should be widely publicized by state authorities, TMA, Texas Osteopathic Medical Association (TOMA), and application forms readily accessible and user-friendly.

3. Area health education centers need to be adequately funded through federal and state funding sources to: (a) provide recruitment and retention services in rural areas; (b) assist in locating reasonable housing for student and resident preceptorships; and (c) provide practice support services to physicians providers and communities, as referenced in other principles listed herein.
4. Incentives should be developed by state authorities to encourage physicians to add a secondary, part-time practice in rural, underserved communities located within a reasonable distance of their primary practice site. Physicians are encouraged to consider hiring and supervising mid-level practitioners, as appropriate, to augment their secondary practices.

5. Physicians are urged to adopt provide telemedicine services in their practices as outreach to patients in underserved to increase access to health care within their communities when applicable and purposeful in meeting health care needs suited to their practice and needs of their patients.

6. Efforts are needed to ensure adequate specialty referral networks are available for rural physicians with limited access to specialists in their immediate communities. This includes specialty services using telemedicine and specialty outreach programs offered by academic health centers such as Project ECHO and the Children’s Psychiatric Access Network.

7. Physicians should be informed of the potential impact of the employed-practice model on their scope of practice and should seek professional advice before signing hospital employment contracts, including resources provided by TMA, and TOMA professional medical specialty societies.

Promoting Rural Practice

8. Information on rural physician shortage areas should be readily available through coordinated websites of state agencies such as Texas Health and Human Services Commission, Texas Department of State Health Services, Texas Medical Board, area health education centers, and Texas State Office of Rural Health Department of Rural Affairs, to practicing physicians, medical students, and residents seeking rural practice opportunities, as well as to underserved communities.

To assist physicians in selecting practice opportunities, comprehensive community profiles should be compiled to identify characteristics and statistics such as: population demographics (percentage child-bearing [for obstetrical needs], aged [for adult medicine-needs], etc.); insurance status; supply of physicians and other health professionals; degree of physician shortage; socioeconomic status; as well as educational and recreational opportunities.

9. Physicians who locate to rural areas, as well as medical students and residents interested in locating to rural areas, should be informed by state and/or local authorities of benefits and incentives available to strengthen the financial viability of their practice, including Medicare bonus payments, recruitment assistance, publicly funded locum tenens programs, etc. Further, they should be informed of the health information technology and health care infrastructure in their area, including systems of care such as federally qualified health centers, indigent care clinics, rural health clinics, hospitals (including critical access hospitals), long-term care facilities, emergency medical services, and hospice. They also should be informed about the availability of other health providers professionals and services such as nursing, pharmacies, therapists, and medical equipment.
109. Physicians should be informed by state authorities, including Texas Medical Board, of the unique peer review services offered by Knowledge, Skills, Training, Assessment, and Research (KSTAR) Program at Texas A&M University Health Science Center for rural hospitals and physicians.

110. County medical societies, hospitals, and other health facilities (when available) should facilitate communication between new physicians and physicians with established practices in the community to help new physicians be better prepared for entering practice in an underserved community.

114. Physicians who receive benefits through state loan repayment programs also should be informed by state authorities of specialized practice support services, including practice start-up, billing, locum tenens, professional development and CME, staff recruitment and training, telemedicine, and so on.

132. Physician practice reentry programs should be widely publicized and monitored to assess their ability to meet demands by state authorities, TMA, and TOMA. Further, when licensed physicians allow their Texas medical license to lapse, they should be informed by Texas Medical Board (TMB) of the potential obstacles to relicensure should they decide to reenter practice following an extended absence from practice.

143. Outreach should be provided by state authorities to physicians without a full-time medical practice to promote volunteer work or part-time practice at clinics in underserved communities.

154. Federal and state policies that impact rural medicine, e.g., payment policies, and the economic viability of rural hospitals, should be monitored by Texas State Office of Rural Health Department of Rural Affairs for their potential impact on the viability of rural practices. TMA, TOMA, and state medical specialty societies should continue to advocate for reimbursement parity between Medicaid and Medicare beyond the two-year period authorized by the Patient Protection and Affordable Care Act. In addition, TMA opposes reimbursement policies that discount professional services to be delivered in rural communities discourage rural practice and should be addressed.

165. Physicians in practice and those in training programs should be informed by TMB, TMA, TOMA, state medical specialty societies and other state authorities of special state medical licensing provisions applicable for practice in rural, underserved areas, including expedited licensing.

Preparing Physicians for Rural Practice

176. Medical schools and residency programs should be incentivized by state authorities to develop and adequately support rural education and training tracks. Examples include bonuses for medical students or residents who participate in rural training tracks, and additional state formula funding for medical students and residents in rural training tracks.

187. Appropriate screening criteria should be used by medical schools for identifying student-applicants and residents most likely to be successful in rural practice.
198. To measure outcomes, assessments should be conducted to identify whether students and residents who participate in rural educational or training tracks are retained in the state for practice after completion of training.

204. Area health education centers should offer opportunities for community physicians who volunteer as preceptors to access information and knowledge of practices that contribute to a positive clinical learning experience. Further, educational institutions should provide adequate support and incentives to recruit and retain physician preceptors, including appropriate levels of recognition and benefits for their teaching efforts. This will become increasingly important as community physicians face continuing pressures to increase productivity.

219. Medicare GME policies should allow for residency program-specific support rather than institutional support for resident training to allow GME funding to follow the resident throughout their training.

224. Primary Care Residency Review Committees (RRCs) of the Accreditation Council for Graduate Medical Education, and Primary Care Residency Review Committees of the American Osteopathic Association, should consider allowing more flexibility for residents to travel away from their core programs to rural areas in order to achieve established training goals for minimum numbers of procedures or encounters.

232. The impact of changes in resident work duty-hour restrictions should be monitored for the impact on rural training programs and health care delivery in comparison to institution-based residency programs.

24. To help rural physicians successfully participate in value-based payment initiatives implemented by Medicaid, Medicare, or commercial payers, TMA, state medical specialty societies, and the Texas A&M University Rural and Community Health Institute should collaborate to address unique challenges faced by rural practices seeking to participate in these initiatives, including insufficient staffing, training, and health information infrastructure; quality and health performance measurement with small populations, and lack of local social and community resources.

Rural Access to Care

254. TMA and TOMA should continue to advocate for a single standard of care for all Texans in all areas of the state.

264. Discussions are needed to develop solutions, including promotion of the use of telemedicine for providing after-hours care for patients of federally funded health clinics requiring urgent or emergent care to prevent undue burdens on community physicians and rural hospital emergency departments.

275. Periodic research should be conducted by the Texas Health Professions Resource Center at Texas Department of State Health Services to monitor significant changes in rural physician workforce trends, including physician demographics and practice characteristics. (CM-PDHCA Rep. 1-A-11).

**Recommendation 2:** Retain as amended.
This report is submitted for 2021 by the committee in response to TMA Policy 185.001 Physician Workforce Texas, which calls for periodic updates on distribution trends for the state’s physician workforce. The committee is also offering policy recommendations related to the effects of the COVID-19 pandemic with the goal of being better prepared for the next catastrophic event.

Committee Findings on Physician Workforce Trends

The committee assembled the most recent information available on physicians practicing in the state along with the latest data available for the three pipelines into the profession: medical school enrollments, residents in training, and those obtaining their first Texas medical license. Most trends were exceedingly positive, however, Texas continues to run a general deficit of physicians, both at the state level and in many areas of the state.

Findings

Highest number in state’s history for:

- State population. (29 million. No. 1 in the U.S. for numerical growth from 2018 to 2019; gain of 370,000 persons. Percentage increase of 1.3% was more than 2x national growth rate of 0.5%)
- Older Texans. (3.7 million people aged 65+)
- Physicians providing patient care. (56,765)
- Number of Texas medical license applications. (6,288)
- Residents in training. (7,953) Also, see TMA Council on Medical Education’s Report 4 Status of Graduate Medical Education Capacity in Texas in Informational Reports of the Handbook.
- Medical students. (8,029)
- Medical schools. (15)

Highest proportion in the state’s history for:

- Women in medicine. (34.6%)
- Women enrolled in Texas medical schools – more than 50% of total medical school enrollment, for the first time in the state’s history (50.3%). Enrollments by women grew 3x faster than male enrollments over past decade.

Other Findings:

- Texas ranks 12th in a state listing by percentage of international medical graduates, with 26%. That percentage is higher than California’s.
- For newly licensed Texas physicians in 2020, the largest number of graduates from outside of Texas were graduates of Caribbean medical schools (294); more than the number from any state outside Texas.
- For physicians in direct patient care in Texas, there were more graduates from two Caribbean medical schools, Ross University in Barbados (561) and St. George’s University in Grenada (511), than from any state outside Texas.
Women in medicine were 1.4x more likely to be Hispanic, Black/African American, or Asian than men (in terms of proportions for each race/ethnic group).

Men in medicine are far more likely to practice in anesthesiology and more likely to practice in emergency medicine than women (in terms of proportions by specialty). Women are far more likely to practice in obstetrics/gynecology and more likely to practice in pediatrics.

Men in medicine were 1.7x more likely to practice in rural areas and 1.6x more likely to practice in border areas of the state than women.

For the five metropolitan areas with more than 1 million in population, Austin leads in both the ratio of physicians in direct patient care (all specialties) per 100,000 population and for primary care physicians per capita. The other four metro areas in order by ratio of direct patient care physicians per capita are: Dallas, Houston, San Antonio, and Fort Worth.

Positive Trends

- Texas has successfully recruited new physicians to the state at ever-increasing numbers.
- Number of physicians (all specialties) is growing at a faster rate than population (2.2x faster).
- Primary care physicians are also growing at a faster rate than population (1.7x faster).
- State’s ratio of physicians per capita consistently improved each year for the past decade.
- Exceptional record of retaining medical students and residents for practice (ranking 3rd in the nation).
- Set a new record for medical license applicants in 2020, breaking 6,000 for the first time.
- Licensed the second-largest number of new physicians in 2020. That is only seven – or 1% – less than the state’s historic peak in 2019.

Challenges: COVID-19

- National pandemic placed pressures on the Texas physician workforce at unprecedented levels.
- State policies in response to surges in COVID-19 hospitalizations had a destabilizing effect on some physician practices and physician employment.

Challenges: Physician Supply and Distribution

- Texas has 8.8% of the U.S. population but 7.1% of U.S. active physicians.
- State rankings of physicians per capita remain in the lowest national quintiles:
  - 41st in the U.S. for ratio of patient care physicians per 100,000 population.
  - 47th for ratio of primary care physicians in patient care per 100,000 population.
  - 48th for ratio of general surgeons in patient care per 100,000 population.
- Texas continues to have a geographic and specialty maldistribution of physicians.

Goals for Meeting Future Physician Workforce Needs:

- Increasing the number of physicians educated and/or trained in the state that are retained or recruited back to practice in the state.
- Continuing to recruit and retain large numbers of physicians from other states.
- Improving equity in access to care for Texans living in areas with physician shortages and other access barriers.
- Continuing to monitor the effects of the COVID-19 pandemic on the state’s physician workforce, and when the timing is right, conducting post-pandemic assessments of public policies and other market forces that strongly impacted physician practice. (See page 16.)
- Continuing to monitor the progress in meeting the state’s physician needs, including the pipelines for preparing physicians for practice.
- TMA will advocate during the 2021 Texas legislative session for state support of key programs that help to build and sustain the state’s physician workforce, including: Physician Education Loan Repayment Program, State Graduate Medical Education Expansion Grant Program, Medical
Newly Licensed Physicians in 2020

About 6,300 medical license applications were received by the Texas Medical Board in the state fiscal year that ended Aug. 31, 2020 (Figure 1). This marks the first time the number of applicants exceeded 6,000. Applications increased 2.5x since tort reform laws were passed in 2003. The number has exceeded 5,000 since 2014.

The Texas Medical Board issued 4,862 new licenses in fiscal year 2020, just shy (-7, -1%) of the highest number in the state’s history of 4,869, which was reached last year (Figure 2). For context, 14 U.S. states have fewer physicians than the number of newly licensed for Texas.
Texas has steadily attracted physicians to the state at a much higher rate since the adoption of state tort reform laws in 2003. In the 17 years preceding tort reform, Texas averaged 2,095 newly licensed physicians each year. In the 17 years post tort reform, the average was 1.8x greater, at 3,715 newly licensed physicians each year. A cumulative annual total of more than 63,000 new physician licenses have been issued in Texas since 2003.

Three out of 4 of the newly licensed physicians in the past year were graduates of medical schools outside of Texas, with 51% who graduated in other U.S. states or Canada and 25% in other countries (Figure 3).

*Figure 3: Fiscal Year 2020 Newly Licensed Texas Physicians by Medical School of Graduation*

FINDING: For newly licensed Texas physicians in 2020, the largest number of graduates from outside of Texas were graduates of Caribbean medical schools (294); more than the number from any state outside Texas.

When the committee looked at the medical school of graduation for newly licensed Texas physicians in fiscal year 2020, the highest number from schools outside of Texas were graduates of Caribbean medical schools (294) (Figure 4). The second-largest number were graduates of medical schools in India (232), followed by New York (222). Graduates from three The University of Texas medical schools ranked among the schools with the largest number: McGovern Medical School at UTHouston, The University of Texas Medical Branch School of Medicine at Galveston, and the UT Health San Antonio Long School of Medicine. Outside of Texas, the following states had large numbers of medical school graduates among the newly licensed: Illinois, Pennsylvania, Florida, and Missouri.

Medical schools in Pakistan also ranked among the top number of graduates. When graduates from India (232) are combined with those from Pakistan (130), the sum of 362 exceeds the sum of graduates from Caribbean schools (294) and ranks India and Pakistan together with having the highest number of graduates among newly licensed physicians from schools outside of Texas.
FINDING: For physicians in direct patient care in Texas, there were more graduates from two Caribbean medical schools, Ross University in Barbados (561) and St. George’s University in Grenada (511), than from any state outside Texas.

Medical School of Graduation for Total Texas Physician Workforce
When looking at the medical school of graduation for the total Texas physician workforce, it is surprising that two Caribbean medical schools – Ross and St. George’s – had more graduates in the Texas physician workforce than ANY state outside of Texas. In addition, two other foreign medical schools, Dow in Pakistan and Universidad Autónoma de Guadalajara in Mexico, ranked in the top 15 (Table 1).
The relatively large number of Texas physicians who graduated from the four non-U.S. medical schools listed in the table is a new trend. No non-U.S. medical schools were ranked in the top 15 for Texas physicians a decade ago.

**FINDING:** Even with Texas leading the nation in population growth for decades, the physician workforce is growing at a faster rate.

Texas has been leading in population growth in the U.S. for decades. The latest U.S. Census Bureau population estimates demonstrate the strength of recent growth in many metropolitan areas, from 2010 to 2019:

- Six of the 10 counties with the largest population gains this decade in the U.S. were in Texas: Harris, Tarrant, Bexar, Dallas, Collin, and Travis.
- Texas also had the most counties of any state in the top 10 fastest growing since 2010, including Hays, Comal, Kendall, and Williamson.
For metropolitan areas, Dallas-Fort Worth-Arlington had the largest numeric gain since 2010, with an increase of 1,206,599 (19%).

Three of the top 10 metro areas in the U.S. with the largest gains in population between 2010 and 2019 were in Texas: Dallas-Fort Worth-Arlington (noted on previous page); Houston-The Woodlands-Sugar Land (up 19.4%), and Austin-Round Rock-Georgetown (up 29.8%).

Texas was No. 1 in the U.S. for numerical growth from 2018 to 2019, with a gain of 370,000 in population. The percentage increase of 1.3% was more than 2x the national growth rate of 0.5%.

About 80,000 physicians have a current Texas medical license, and of this number, 56,765 report a practice in direct patient care in the state. Physician supply has been growing at a steady rate for decades, and over the past 10 years, the yearly growth ranged from 1% to 3%. As a positive indicator of the potential for improved access to care for Texans, the ratio of physicians per capita grew each year of the past decade (Figure 5), starting at 165 in 2011 and rising to 191.3 in 2020, for an increase of 15.9%.

Figure 5: Texas Ratio of Patient Care Physicians per 100,000 Population, 2011 to 2020

The committee wanted to measure the extent to which the gains in physician supply were exceeding population increases. Looking back over the past decade, physicians (all specialties) grew at 2.2x the rate as population and primary care physicians increased 1.7x faster than population (Figure 6).

Figure 6: Texas Physician Supply Growing Faster Than Population
Comparison of % Change for Population and Physician Supply
2011 to 2020

Texas Population
Primary Care Physician Supply
Patient Care Physician Supply

Source: Health Professions Resource Center, Texas Dept. State Health Services. Prepared by: TMA
To compare recent physician growth with previous years, the committee calculated the rate of change for the ratio of physicians per capita for the past three decades. The most recent decade, 2010 to 2019, had the fastest rate of growth (Table 2) over 30 years, with 13x more than 2000-2009, and 1.3x more than 1990-1999.

**Table 2: Changes in Texas Ratio of Physicians per 100,000 People for Three Decades: 1990 to 1999; 2000 to 2009; and 2010 to 2019**

<table>
<thead>
<tr>
<th>Decade</th>
<th>Ratio of Patient Care Physicians Per 100,000 People for Texas</th>
<th>Net Difference in Ratio</th>
<th>Rate of Change for Ratio</th>
</tr>
</thead>
<tbody>
<tr>
<td>1990 to 1999</td>
<td>1990: 133.7, 1999: 151.8</td>
<td>18.1</td>
<td>13.5%</td>
</tr>
<tr>
<td>2000 to 2009</td>
<td>2000: 156.2, 2009: 158.3</td>
<td>2.1</td>
<td>1.3%</td>
</tr>
<tr>
<td>2010 to 2019</td>
<td>2010: 162, 2019: 189.6</td>
<td>27.6</td>
<td>17%</td>
</tr>
</tbody>
</table>

*Source: Health Professionals Resource Center, Texas Dept. of State Health Services  
Prepared by: TMA.*

Although the committee identified numerous positive trends for the state’s physician workforce, it was also clear that serious challenges remain. Much of the state continues to experience geographic and specialty maldistribution, as demonstrated by the following examples:

- 28 (11%) of the state’s 254 counties do not have a physician;
- 138 (54%) do not have a pediatrician;
- 150 (59%) are without an obstetrician/gynecologist;
- 173 counties (68%) do not have a psychiatrist; and
- 131 (51.6%) counties do not have a general surgeon.

In addition to efforts to expand the state’s physician supply in shortage areas, the committee continues to search for innovative programs to increase access to care for physicians already practicing in medically underserved areas.

**Impact of Pandemic on Texas Physicians**

Beginning in March 2020, the COVID-19 pandemic impacted Texas physicians in myriad of ways. Nearly all physicians in active medical practice were affected, regardless of medical specialty, practice setting, or practice type. Texas has likely not seen this degree of disruption in physician medical practices since World War II.

The demand for physicians to treat COVID-19 varied between specialties (Table 3) with decreased primary care visits. Trends remained erratic with sporadic suspensions of elective surgeries and medical...
procedures causing disruptions to practice and patient access to care. Some physicians lost their jobs, although the specific number is not known, while others saw pay cuts or furloughs.

TMA’s COVID-19 Impact Survey in May 2020 found that 63% of physicians had salaries reduced by 50% or more. A little more than 2 out of 3 Texas physicians (68%) reported a reduction in work hours. There were anecdotal reports of older physicians who changed their practice setting or opted to retire rather than continue practicing in high-risk settings. Economic pressures may continue to challenge the viability of physician practices and health care facilities in the coming months. Also, the full effects of the pandemic on medical practices and the health care delivery system are not known. The committee supports a post-pandemic state study to assess how the state’s physician facility staffing needs were met during the peaks in demand during the pandemic.

Table 3: Numbers of Physicians in Medical Specialties in High Demand During COVID-19 Pandemic

<table>
<thead>
<tr>
<th>Specialty</th>
<th># in Texas</th>
</tr>
</thead>
<tbody>
<tr>
<td>Critical Care Medicine TOTAL</td>
<td>539</td>
</tr>
<tr>
<td>-Other Specialties</td>
<td></td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>3,494</td>
</tr>
<tr>
<td>Blood Banking/Transfusion Med</td>
<td>7</td>
</tr>
<tr>
<td>Cardiovascular Diseases</td>
<td>1,854</td>
</tr>
<tr>
<td>Emergency Medicine</td>
<td>4,222</td>
</tr>
<tr>
<td>-Hospitists</td>
<td></td>
</tr>
<tr>
<td>Hospitists</td>
<td>486</td>
</tr>
<tr>
<td>Infectious Diseases</td>
<td>327</td>
</tr>
<tr>
<td>- Palliative Medicine</td>
<td></td>
</tr>
<tr>
<td>Palliative Medicine</td>
<td>89</td>
</tr>
<tr>
<td>Pathology</td>
<td>1,122</td>
</tr>
<tr>
<td>Pulmonary Diseases</td>
<td>367</td>
</tr>
<tr>
<td>-Radiology</td>
<td></td>
</tr>
<tr>
<td>Radiology</td>
<td>2,360</td>
</tr>
</tbody>
</table>

Source: Texas Medical Board physician licensing file provided by Health Professions Resource Center, DSHS, and analyzed by TMA. Prepared by: TMA

Geographic Distribution of Selected High-Demand Medical Specialties
206 (81%) counties do not have a specialist in critical care medicine.
204 (80%) counties do not have a pulmonary disease specialist.
176 (69%) counties do not have an anesthesiologist.
110 (43%) counties do not have an emergency medicine physician.

Emergency Texas Medical Licensing Processes
The Texas Medical Board has a Temporary Medical Licensing Pathway for Physicians under the Texas Disaster Emergency Rule, and as of October 2020, the board reported 2,236 of the 2,577 physicians issued a temporary license through this provision had listed a telemedicine employer on their application. This rapid increase in out-of-state physicians providing telemedicine in Texas occurred at the time that many Texas physicians switched to or added telemedicine to their practices. It is important to understand how this affected Texas physicians, such as through a post-pandemic analysis by the board.

On March 14, 2020, Texas Gov. Greg Abbott issued an emergency waiver that allows the board to temporarily reactivate medical licenses for physicians in Texas who converted to official retired status in the past four years. In October 2020, the board reported 27 retired or cancelled physicians had completed the emergency reactivation process.
Analysis of Physician Distribution by Gender

FINDING: Women make up 50.3% of Texans, but only 34.6% of Texas physicians. The percentage of women in medicine in Texas tripled from 1987 to 2019.

TMA has multiple policies in support of greater diversity within the physician workforce. The representation of women in Texas medicine has grown every year, in a stair-step pattern since TMA began collecting these data in 1987 (data are not available for some years, as noted in Figure 7). The percentage of women in medicine has \textit{tripled} since then. Women now represent 1 out of 3 Texas physicians.

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure7}
\caption{Growth of Women in Texas Medicine, 1987 to 2019}
\end{figure}

Source: Health Professions Resource Center, Texas Dept. of State Health Services
Prepared by: TMA.

FINDING: For the first time in the state’s history, there are now more women enrolled in Texas medical schools than men.

The steady uptick of women in medicine is expected to continue based on the percentage of women enrolled in Texas medical schools (52.8%) and the percentage of women among the state’s newly licensed physicians (45%). Women make up a little more than half of the \textit{first-year medical students} (52.8%) in 2019--the highest percentage ever for Texas (Figure 8).

\begin{figure}[h]
\centering
\includegraphics[width=\textwidth]{figure8}
\caption{Texas % Female First-Year Medical School Enrollments, 2000 to 2019}
\end{figure}

For the first time ever, the majority of total enrollments at Texas medical schools are women (50.8%) (Figure 9). More women applied to Texas medical schools (51%) in 2019 than men and more women enrolled.

![Figure 9: % Women Among Total Texas Medical School Enrollments, 2010-2019](image)

Proportion of women among the total Texas medical school enrollments increased 3x times faster than for men over the past decade. The percentage of men declined from 54.5% in 2010 to 49.2% in 2019.

Three Texas schools had the highest percentages of women among the 2019 entering class, including two of the newest schools. The University of Texas at Austin Dell Medical School had the highest percentage in the state, at 64.7% (33 women; 18 men). University of the Incarnate Word Osteopathic Medical School in San Antonio followed at 61.4% (102 women; 64 men). And Texas Tech University Health Sciences Center School of Medicine in Lubbock had 57.9% (103 women; 75 men).

Profiles of Texas Physicians

Demographic and practice characteristics for Texas physicians are shown in Tables 4 and 5 below.

**Table 4: Demographic and Practice Profile of Texas Physicians, 2019**

| Gender: Male: 36,145 (65.4%) Female: 19,166 (34.6%) | Average Age: 51 |
| Race/Ethnicity: White 32,086 (58%) Hispanic 4,207 (7.6%) Black/African American 3,380 (6.1%) Other (Including Asian) 15,658 (28.3%) |
| Number and percentage with DO Degree: 4,803 (8.7%) |
| % International Medical Graduates (IMGs): 27% Countries with Highest Number of Graduates for IMGs: India and Pakistan Combined: 5,273 (9.5%) |
| % Who Practice in Metro Area: 95% |
Top 10 Medical Specialties:

1. Family Medicine/General Practice (8,116, 14.7%)
2. Internal Medicine (6,968, 12.6%)
3. Pediatrics (4,303, 7.8%)
4. Emergency Medicine (3,966, 7.2%)
5. Anesthesiology (3,401, 6.1%)
6. Obstetrics/Gynecology (2,697, 4.9%)
7. Psychiatry (2,187, 4%)
8. Radiology (2,063, 3.7%)
9. Orthopedic Surgery (1,452, 2.6%)
10. General Surgery (1,383, 2.5%)

Table 5: Comparison of Demographic and Practice Characteristics for Texas Physicians, by Gender

<table>
<thead>
<tr>
<th></th>
<th>MEN</th>
<th>WOMEN</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Average Age</td>
<td></td>
</tr>
<tr>
<td>Years of age</td>
<td>53.3</td>
<td>46.6</td>
</tr>
<tr>
<td>Race/Ethnicity</td>
<td>1.3x more likely to be Anglo</td>
<td>1.4x more likely to be Hispanic, Black/African American, or Asian.</td>
</tr>
<tr>
<td>Practice Location</td>
<td>1.7x more likely to practice in a rural area and 1.6x more likely to practice in a border area.</td>
<td>Less likely to practice in rural or border areas.</td>
</tr>
</tbody>
</table>

MEN

1. Family Medicine
2. Internal Medicine
3. Emergency Medicine
4. Anesthesiology
5. Pediatrics

WOMEN

1. Family Medicine
2. Pediatrics
3. Internal Medicine
4. Obstetrics/Gynecology
5. Emergency Medicine

Men are FAR more likely to specialize in anesthesiology than women, and more likely to practice in emergency medicine. Women are FAR more likely to practice in obstetrics/gynecology than men, and more likely to practice in pediatrics.

FINDING: Austin continues to have the best ratio of physicians per capita of the state’s five largest metropolitan areas.

In a comparison of physician distribution for the state’s five largest metropolitan areas (with population above 1 million), the Austin Metro Area has the smallest population but the best ratio of physicians per capita, both for total specialties as well as for primary care specialties. The Dallas Metro Area follows Austin in the rankings, then Houston, San Antonio, and Fort Worth, as shown in Table 6 and Figure 10. There was one exception: The Fort Worth Metro Area had a slightly better ratio of primary care physicians per capita than San Antonio.
The most common source for comparing medical education and physician workforce trends among states is through national comparisons. This involves examining data from various sources to understand the distribution of healthcare professionals across different regions. In the context of Texas counties, Table 6 presents a comparison of the ratios of patient care and primary care physicians per 100,000 population, with a special focus on counties with populations above one million.

### Table 6: Ratios of Patient Care and Primary Care Physicians per 100,000 Population for Texas Counties With Population Above One Million, 2019

<table>
<thead>
<tr>
<th>Metro Area with Population Above One Million</th>
<th>Population</th>
<th>No. Patient Care Phys. (All Specialties)</th>
<th>Ratio Patient Care Physicians per 100,000 Pop. (Texas County Ranking)</th>
<th>No. Primary Care Patient Care Physicians</th>
<th>Ratio Primary Care Physicians per 100,000 Pop. (Texas County Ranking)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Austin Metro Area (5 Counties)</td>
<td>2.2M</td>
<td>4,954</td>
<td>226.2 (#21)</td>
<td>1,942</td>
<td>88.7 (#30)</td>
</tr>
<tr>
<td>Bastrop, Caldwell, Hays, Travis, and Williamson Counties</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Dallas Metro Area (7 Counties)</td>
<td>5.1M</td>
<td>11,048</td>
<td>217.9 (#25)</td>
<td>4,182</td>
<td>82.5 (#44)</td>
</tr>
<tr>
<td>Collin, Dallas, Denton, Ellis, Hunt, Kaufman, and Rockwall Counties</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Houston Metro Area (9 Counties)</td>
<td>7.2M</td>
<td>15,188</td>
<td>210.4 (#28)</td>
<td>5,863</td>
<td>81.2 (#45)</td>
</tr>
<tr>
<td>Austin, Brazoria, Chambers, Ft. Bend, Galveston, Harris, Liberty, Montgomery, and Waller Counties</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>San Antonio Metro Area (8 Counties)</td>
<td>2.6M</td>
<td>5,190</td>
<td>201.2 (#30)</td>
<td>1,982</td>
<td>76.8 (#52)</td>
</tr>
<tr>
<td>Atascosa, Bandera, Bexar, Comal, Guadalupe, Kendall, Medina, and Wilson Counties</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fort Worth Metro Area (6 Counties)</td>
<td>2.5M</td>
<td>4,850</td>
<td>191 (#32)</td>
<td>1,980</td>
<td>77.8 (#50)</td>
</tr>
<tr>
<td>Hood, Johnson, Parker, Somervell, Tarrant, and Wise Counties</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Sources: Texas Health Professions Resource Center, Texas Dept. of State Health Services, and U.S. Census Bureau. Prepared by: TMA.

Figure 10: Geographic Comparison of Physician Distribution for Most Populous Texas Counties, >1 Million

Sources: Texas Health Professions Resource Center, Texas Dept. of State Health Services, and U.S. Census Bureau. Prepared by: TMA.
To monitor how Texas compares with other states, the committee monitors the state rankings produce by the Association of American Medical Colleges (AAMC) on a biennial basis. Texas rankings for several key indicators on medical education and the physician workforce for 2019 are shown in Table 7. Texas continued to rank among the highest in the U.S. for the retention of physicians following medical school and residency training. Texas ranked No. 2 in retention of physicians from medical school, No. 3 in retention of physicians from both medical school and residency training, and No. 4 in retention from residency training.

<table>
<thead>
<tr>
<th>Table 7: Texas State Rankings for Medical Education and Physician Workforce Indicators, 2019</th>
</tr>
</thead>
<tbody>
<tr>
<td><em><em>Retention</em> of Physicians in Texas</em>*</td>
</tr>
<tr>
<td>From: Medical School</td>
</tr>
<tr>
<td>From: Residency Training</td>
</tr>
<tr>
<td>From: Both Medical School and Residency Training</td>
</tr>
</tbody>
</table>

Comparisons from 2017 to 2019:

There was no change in the state ranking for Texas between 2017 and 2019 for the majority of indicators. Other changes are highlighted below.

**Ratios of Physicians per 100,000 Population**

Texas continued to rank 41st for patient care physicians (all specialties); 47th for patient care primary care physicians; and 48th for patient care general surgeons. The ratios per capita increased for Texas and at the national level for patient care physicians and patient care primary care physicians. There was a slight decline in the ratio for patient care general surgeons for Texas and the U.S. as a whole.

*Rankings are based on an assessment by Association of American Medical Colleges of medical school and residency history for physicians who were practicing in Texas at one point in time – Dec. 31, 2018. These physicians may have relocated to Texas from other states before that date.

**Only a slight improvement from the ranking of #42 a decade ago.


Prepared by: Texas Medical Association.
Active Female Physicians
The percentage of active female physicians in the Texas workforce increased slightly between 2017 and 2019, from 33.9% to 35.2%. Despite the increase, Texas dropped in the state rankings from No. 23 to No. 24. This happened because the percentage for the state of Hawaii increased more rapidly than in Texas.

Active International Medical Graduates
Texas continued to rank No. 12 for the percentage of international medical graduates (IMGs) and to exceed the national total. The percentage for Texas increased from 25.7% in 2017 to 25.9% in 2019. Texas also has a higher percentage of IMGs than California’s.

Ratio of Medical Students and Residents per 100,000 Population
Texas moved down in the state ranking for ratio of medical students per 100,000 population, from No. 36 in 2017 to No. 37 in 2019. Georgia moved into the No. 36 slot. The ratio for Texas actually increased from 27.4 to 28.3 between the two years.

The biggest change for Texas among the state rankings included in this analysis was for residents per 100,000 population, with Texas dropping three spots from No. 22 to No. 25. The ratio actually increased for Texas from 28.7 to 29.9 between the two years. But the ratio increased more rapidly in Iowa, Kentucky, and Hawaii than Texas during this time period.

Texas ranked No. 2 in the percentage of physicians retained from medical school, the same ranking as in 2017. The Texas percentage actually declined slightly from 59.9% in 2017 to 59.7% in 2019. California remained No. 1 with 62.8%, the same ranking and percentage as 2017. Like Texas, the percentage for the U.S. as a whole saw a slight decline, from 38.5% to 38.2%.

Texas moved up a slot for the percentage of physicians retained from graduate medical education, from No. 5 to No. 4, by having a better percentage than Florida in 2019. California, Alaska, and Montana had better retention rates than Texas in both 2017 and 2019.

Texas also moved up a slot in the percentage of physicians retained from both medical school and residency training, from No. 4 to No. 3, by having a better percentage than Arkansas in 2019. Hawaii and California had a better retention rate than Texas in both 2017 and 2019.

TMA Action During 2021 Texas Legislative Session
During the 2021 Texas legislative session, TMA is advocating for state support of key programs that help to build and sustain the state’s physician workforce, including:

- State Physician Education Loan Repayment Program
- State Graduate Medical Education Expansion Grant Program
- State Medical Student and Graduate Medical Education Formula Funding
- Family Medicine Residency Program
- Statewide Primary Care Preceptorship Program
- Joint Admission Medical Program.

A legislative one-pager has been prepared for this advocacy work and is accessible through this link: TMA 2021 Texas Legislative Session One-Pager on Physician Workforce Needs

Summary
TMA recognizes that good health is dependent on access to medical care. Many positive trends were identified in the committee’s analysis of the state’s physician workforce, as presented in this report that could be signs of improved access to medical care for Texans.

Many milestones were achieved and all pipelines into the physician workforce are at the highest levels in the state’s history. Record-high numbers of physicians are seeking medical licensure in the state and are
being educated and trained in the state. Physician shortages remain, however, as a result of geographic and specialty maldistributions.

The pandemic has had a deleterious impact on many physicians’ practices. Some physicians have worked abnormally long days – and under extremely high levels of stress – for extended periods of time during peak demands for hospital staffing. Physicians in other specialties had diminished patient numbers, and in some cases were periodically idled. Some lost their jobs or were furloughed. The full effects on physicians’ practices and the health care delivery system are not fully known.

Policy Proposals

The committee is offering two policy recommendations for the post-pandemic period. Both recommendations are related to the pandemic and are intended to help Texas be better prepared for future events. The following background information may be helpful to the House of Delegates in considering these policy proposals.

The committee is offering a recommendation that would involve the Texas Statewide Health Coordinating Council (SHCC). This body is a 17-member council staffed by the Texas Department of State Health Services and 13 of the 17 members are appointed by the governor. Two physicians are currently appointed to the council. In addition to the governor’s appointments, four members represent specific state agencies on the council, as defined in state law.

The SHCC makes recommendations on state health planning activities to the governor and the legislature through biennial updates to the Texas State Health Plan. The plan is due to the governor by Nov. 1 of even-numbered years. The committee’s first recommendation also suggests collaboration with schools of public health. Texas has several at various university systems that could potentially be invited to participate in this research activity.

Recommendation: The Committee on Physician Distribution and Health Care Access recommends the following be adopted as Texas Medical Association policy:

1) Recognizing that the COVID-19 pandemic resulted in unprecedented demands for physician staffing at Texas hospitals, TMA supports a post-pandemic research study by the Texas Statewide Health Coordinating Council at the Texas Department of State Health Services, in conjunction with the state’s schools of public health on the success of methods used to meet staffing needs. It is recommended that the study include identification of the most effective methods employed by individual hospital systems in the state and that the study be used to inform state emergency preparedness agencies in amending state emergency preparedness plans to better enable the state to respond to surges in hospital physician staffing needs during future extended catastrophic events.

2) TMA recommends an assessment by the Texas Medical Board of the emergency medical licensing provisions and their effectiveness in meeting the state’s emergency hospital physician staffing needs during the COVID-19 pandemic. The goal would be to determine if changes are needed in preparation for future extended catastrophic events.
Subject: Renewed Effort to Increase Diversity Among the Texas Physician Workforce

Presented by: Evan Pivalizza, MD

Referred to: Reference Committee on Medical Education and Health Care Quality

The Texas Medical Association has longstanding policy in support of increased diversity among the Texas physician workforce, including Policy 185.012, which originated with the committee in 1995 and was reaffirmed by the TMA House of Delegates in 2006 and 2016.

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).

Despite this policy, there continues to be less diversity among Texas physicians than among the state’s population, as shown in Figure 1.

To quantify the differences:

Proportion of Hispanic Texans is **five times greater** than the proportion of Hispanic physicians. And, for Black/African Americans, the proportion is **two times greater** among the Texas population than among Texas physicians.
Population Projections

The Texas Demographic Center projects Hispanic populations in Texas will have the highest growth rate from 2010 to 2030 as shown in the graph in the Attachment. Population projections for individual race/ethnic groups in 2030 are summarized in Table 1:

<table>
<thead>
<tr>
<th>Race/Ethnic Group</th>
<th>Projected Population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic</td>
<td>14.5 million</td>
</tr>
<tr>
<td>Non-Hispanic White</td>
<td>12.8 million</td>
</tr>
<tr>
<td>Non-Hispanic Black</td>
<td>4.3 million</td>
</tr>
<tr>
<td>Non-Hispanic Asian</td>
<td>2.4 million</td>
</tr>
<tr>
<td>Non-Hispanic Other</td>
<td>0.9 million</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>34.9 million</strong></td>
</tr>
</tbody>
</table>

Source: Texas Demographic Center. Prepared by: TMA.

Comparisons of Diversity Among Texas Population, Physicians, Medical Students, and Resident Physicians

When additional comparisons are made between physicians in training, including medical students and residents, and the state’s population, there continues to be less diversity among medical learners than among the Texas population.

As shown in Figure 1, among Hispanic Texans, there is a considerably lower proportion among physicians (7.6%) than among medical students (16.4%) and residents (13.8%). Representation of Hispanic Texans among medical students and among resident physicians is about twice that of Hispanic physicians. All these groups have a much lower percentage than that of Hispanics in the Texas population as a whole, at 39.8%.

There is little difference in the proportion of Black/African Americans among physicians, medical students, and resident physicians. Percentages range from 5.3% for medical students to 6.1% for physicians, and all three groups represent about half the proportion for the Texas population, at 12%.

Figure 1: Comparison of Racial/Ethnic Diversity for Texas Population, Physicians, Medical Students, and Residents in Training, 2019

Sources: Health Professions Resource Center, Texas Dept. of State Health Services, Texas Higher Education Coordinating Board, individual Texas medical schools, American Medical Association, and U.S. Census Bureau. Prepared by: TMA.
The low proportion of underrepresented minorities among medical students and residents in Texas means there are limited opportunities for recruitment within the state. Recruitment of underrepresented minority physicians to the Texas physician workforce must be focused primarily on physicians in other states.

### Diversity Among Texas Medical School Enrollments

For the proportion of underrepresented minority students, The University of Texas Rio Grande Valley Medical School (UTRGV) leads the state for both Hispanic/Latino origin and Black/African-American students, as shown in Table 2.

- **Hispanic/Latino origin**
  
  UTRGV’s percentage of Hispanic/Latino origin students, at 37.3%, is close to equaling the percentage of Hispanic/Latino origin population for Texas (39.8%).

  In numbers of Hispanic/Latino students, UT Medical Branch led the state with 187 (19.7%), followed by the UT Health San Antonio Long School of Medicine with 171 (19.9%).

- **Black/African American**

  UTRGV’s percentage of Black or African American students is 10.8% (22 students). UTHealth McGovern Medical School in Houston had the highest number of students at 73 (7.5%), followed closely by UT Medical Branch at 67 (7.1%). In comparison, the proportion of Black Texans in the state overall is 12%. Once again, the percentage at UTRGV closely approximates the state’s population.

<table>
<thead>
<tr>
<th>Medical School</th>
<th>Hispanic or Latino Origin</th>
<th>Black or African American</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baylor College of Medicine</td>
<td>91</td>
<td>20</td>
</tr>
<tr>
<td>TAMUHSC-College of Medicine</td>
<td>67</td>
<td>20</td>
</tr>
<tr>
<td>Texas College Osteopathic Medicine</td>
<td>89</td>
<td>13</td>
</tr>
<tr>
<td>TtuHsc Foster School of Med El Paso</td>
<td>120</td>
<td>14</td>
</tr>
<tr>
<td>TtuHsc School of Medicine Lubbock</td>
<td>97</td>
<td>35</td>
</tr>
<tr>
<td>University of the Incarnate Word</td>
<td>35</td>
<td>30</td>
</tr>
<tr>
<td>UT Austin Dell Medical School</td>
<td>22</td>
<td>12</td>
</tr>
<tr>
<td>UT Medical School-Galveston</td>
<td>187</td>
<td>67</td>
</tr>
<tr>
<td>UT Medical School-Houston</td>
<td>146</td>
<td>73</td>
</tr>
<tr>
<td>UT Medical School-San Antonio</td>
<td>171</td>
<td>47</td>
</tr>
<tr>
<td>UT Southwestern Medical School</td>
<td>132</td>
<td>47</td>
</tr>
<tr>
<td>UTRGV - Medical School</td>
<td>76</td>
<td>22</td>
</tr>
</tbody>
</table>

**Total for Texas (Excluding TCU and UNTHSC)**: 1,233 (15.5%) and 400 (5.0%

*Note: TMA was unable to obtain data for the TCU and UNTHSC Medical School.*

*Sources: Texas Higher Education Coordinating Board and individual medical schools reported to TMA.*

*Prepared by: TMA.*
Comparison From 1999 to 2019

To gauge whether minority percentages have increased at Texas medical schools in recent years, the committee compared statistics for 1999 and 2019 as presented in Table 3.

Texas had eight medical schools in 1999. Five schools saw improvements for both underrepresented minority groups, one school saw declines for both, another saw an improvement in one but no real change for the other, and one saw an improvement in one and a sharp decline in the other. Some medical schools more than doubled the percentage of underrepresented minority students during this period. At the state level, a greater increase occurred for Hispanic/Latino origin percentages, but the increases for both groups were modest.

- Hispanic/Latino origin
  More progress was made in the proportion of Hispanic/Latino origin medical students for individual medical schools than of Black/African American students over the two decades, with seven of the eight schools showing increases. Only one school, UT Medical Branch, saw a decline.

- Black/African American
  A majority of medical schools saw improved numbers, with increased percentages of Black/African American students at five of the eight Texas medical schools. Two schools had a decline in percentages, and one had no change.

Table 3: Proportion of Underrepresented Minorities Among Texas Medical School Enrollments, 1999 and 2019

<table>
<thead>
<tr>
<th>Medical School</th>
<th>Hispanic or Latino Origin</th>
<th>Black or African American</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1999</td>
<td>2019</td>
</tr>
<tr>
<td></td>
<td>%</td>
<td>#</td>
</tr>
<tr>
<td>Baylor College of Medicine</td>
<td>10.2%</td>
<td>91</td>
</tr>
<tr>
<td>TAMU HSC-College of Medicine</td>
<td>8.9%</td>
<td>67</td>
</tr>
<tr>
<td>Texas College Osteopathic Medicine</td>
<td>8.4%</td>
<td>89</td>
</tr>
<tr>
<td>TTHSC Foster School of Med El Paso</td>
<td>120</td>
<td>29.8%</td>
</tr>
<tr>
<td>TTHSC School of Medicine Lubbock</td>
<td>8.4%</td>
<td>97</td>
</tr>
<tr>
<td>University of the Incarnate Word</td>
<td>35</td>
<td>7.5%</td>
</tr>
<tr>
<td>UT Austin Dell Medical School</td>
<td>22</td>
<td>11.2%</td>
</tr>
<tr>
<td>UT Medical School-Galveston</td>
<td>24.8%</td>
<td>157</td>
</tr>
<tr>
<td>UT Medical School-Houston</td>
<td>14.6%</td>
<td>146</td>
</tr>
<tr>
<td>UT Medical School-San Antonio</td>
<td>15.2%</td>
<td>171</td>
</tr>
<tr>
<td>UT Southwestern Medical School</td>
<td>7.8%</td>
<td>132</td>
</tr>
<tr>
<td>UTRGV-Medical School</td>
<td>76</td>
<td>37.3%</td>
</tr>
<tr>
<td>Total for Texas (Excluding TCU and UNTHSC)</td>
<td>13.2%</td>
<td>1,233</td>
</tr>
</tbody>
</table>

Note: Council staff was unable to obtain data for the TCU and UNTHSC Medical School.
Sources: Texas Higher Education Coordinating Board and individual medical schools.
Prepared by: TMA.
Accreditation Requirements for Diverse Medical Student Body and Faculty

The national accrediting body for allopathic medical schools, the Liaison Committee for Medical Education, has specific standards for diversity among medical school students, faculty, other staff, and partners, as noted below:

Standard 3.3 Diversity/Pipeline Programs and Partnerships

A medical school has effective policies and practices in place, and engages in ongoing, systematic, and focused recruitment and retention activities, to achieve mission-appropriate diversity outcomes among its students, faculty, senior administrative staff, and other relevant members of its academic community. These activities include the use of programs and/or partnerships aimed at achieving diversity among qualified applicants for medical school admission and the evaluation of program and partnership outcomes. (Emphasis added.)

TMA Actions

TMA has written about the lack of progress in diversifying the Texas physician workforce in TMA periodicals, such as Texas Medicine. The TMA Foundation also provides a $10,000 scholarship to an underrepresented minority matriculant (first-year student) every year at each Texas medical school through the TMA Minority Scholarship Program. This program was approved by the TMA House of Delegates in 1998 at the urging of the committee’s parent council, the Council on Medical Education, and has awarded a total of 148 scholarships totaling $967,500 during the program’s history. Texas medical schools have recognized this program as particularly important in recruiting underrepresented minority students as Texas public medical schools are restricted in providing scholarships of this type.

Joint Admission Medical Program

In 2003, the Texas Legislature established the Joint Admission Medical Program (JAMP) to assist economically disadvantaged students to pursue careers in medicine. The program provides mentoring and support to students who likely otherwise would not have attended medical school. This program has been successful and has been described as being the envy of other states.

A total of 1,838 Texas undergraduate students participated in the program, 963 students matriculated into a Texas medical school, and 586 JAMP students completed a medical degree.

The JAMP program receives $5.1 million in state funding per year, and the budget has not increased since the program was started in 2003. Since then, seven medical schools have opened in the state and another is in development. With more students but no additional funding, resources are not available to fully grow the program’s services to meet the need.

In its legislative appropriations request for the 2022-23 state budget, the Texas Higher Education Coordinating Board proposed a budget cut of 5%, from $10.2 million to $9.7 million, a loss of $510,000 for JAMP. This program cannot afford a funding loss in the next state budget.

TMA has policy, adopted in 2004, in support of the JAMP program:

200.040 Joint Admission Medical Program: TMA supports the Joint Admission Medical Program (JAMP) and the goal of increasing the number of economically disadvantaged students enrolled in Texas medical schools, including underrepresented minorities. Ongoing monitoring should be implemented to measure the success of program participants in completing medical school and establishing practice in Texas (CME Rep. 3-A-04; reaffirmed CME Rep. 2-A-14).
Prairie View A&M University Premedical Academy

To promote an increase in the number of Black students who pursue medical careers, the state provides funding to the undergraduate premedical academy at Prairie View A&M University. This school has a higher than average percentage of Black students. The academy offers a mentor cooperative network to foster interest in medicine, dentistry, and veterinary medicine among Black students. TMA has the following policy in support of the academy:


Little information on outcomes from the premedical academy was readily available. Knowing about outcomes from the program would be helpful in assessing existing state resources for Black students.

Underrepresented Minority Student Pipeline Programs

Several medical schools in Texas have partnerships with high schools for the health professions in various parts of the state that are designed to provide pathways for underrepresented minority students to ultimately pursue medical degrees. These programs have yielded positive results.

Racial/Ethnic Health Disparities

Statistics on deaths due to COVID-19 among underrepresented minorities have drawn attention to racial/ethnic health disparities. The Centers for Disease Control and Prevention reports that Black and Hispanic Americans are 2.8 times more likely to die of COVID-19 than white, non-Hispanic Americans. Additional studies point to racial/ethnic disparities in accessing health care. Less access to care and poor health status have been contributing factors to health disparities.

For decades, research studies have consistently shown a positive correlation between patient-physician race/ethnicity concordance and health outcomes. Studies have also found that underrepresented minority physicians have a greater tendency to practice in medically underserved areas or to serve medically underserved populations.

Examples of relevant research with links to journal articles:

- **Patient-Physician Racial Concordance Associated with Improved Healthcare Use and Lower Healthcare Expenditures in Minority Populations**
  
  **Major finding**: Racial concordance contributes to a more effective therapeutic relationship, improved health care, and lower health care costs.  
  

- **The Racial and Ethnic Composition and Distribution of Primary Care Physicians**
  
  **Major finding**: “Racial and ethnic minority physicians are more likely to practice primary care and serve in underserved communities.”  
  

- **Predictors of Primary Care Physician Practice Location in Underserved Urban or Rural Areas in the United States: A Systematic Literature Review**
  
  **Major finding from review of 72 studies**: “Studies found significant relationships between physician race/ethnicity and language and practice in underserved areas.”
There is a greater societal focus at this time on public policies for expanding inclusiveness and equity. TMA’s Council on Medical Education submitted a handbook report to the TMA House of Delegates (C-ME Report 1) that recommends the adoption of new TMA policy in support of bias training for all Texas medical school students and resident physicians, as well as staff and faculty at academic health centers.

In 2016, the Association of American Medical Colleges (AAMC) issued an update on the low numbers of Black men in medical school. A startling finding was that the number of Black men applying to U.S. medical schools had actually declined over 40 years. In 1978, 1,410 applied, while in 2014, the number was 1,337. Black men represent 4% of U.S. physicians. In comparison, 13% of the U.S. population is black.

The academic medicine community must take even more aggressive steps to attract and engage talent from all segments of our society to address public health needs. We are dealing with historically entrenched systems of exclusion and oppression for racial and ethnic minorities in the United States. Systemic changes are necessary to make a lasting change in the representation of Black men in medicine, and this will require us to build a coalition of voices and collaborators across multiple communities.

Focusing solely on increasing compositional diversity along the academic medicine continuum is insufficient. To effectively enact institutional change at academic medical centers and leverage the promise of diversity, leaders must focus their efforts on developing inclusive, equity-minded environments. A shared desire for change, aided by a growing number of resources, will enable medical schools and academic health centers to assess their institutional culture and climate and improve their capacity for diversity and inclusion.

Recommendation: The Committee on Physician Distribution and Health Care Access recommends the following be adopted as Texas Medical Association policy:

Renewed Efforts to Increase Racial/Ethnic Diversity Among the Texas Physician Workforce

The Texas Medical Association recognizes the Texas physician workforce is not sufficiently diverse to reflect the racial/ethnic diversity of the Texas population.

1. Working for Greater Diversity Among Texas Physicians. TMA urges Texas medical schools, as well as residency and fellowship programs, to continue their efforts to increase racial and ethnic diversity among medical students, resident physicians, and fellows training in Texas. This includes continued support for pipeline programs that help foster an interest in careers in medicine among underrepresented minority students such as the high schools for the health professions that are often located in high minority areas of the state. TMA encourages support services that facilitate success for underrepresented minority students through college, medical school, and residency programs. Further, TMA recognizes the benefits of role models among academy leadership and faculty for mentorship of minority students and residents.

Health care institutions and health plans are encouraged to strive for diversity in the physician workforce.
2. Role of Physicians. Every physician, in every type of practice or practice setting, can have a valuable role in mentoring the next generation of physicians. Students of underrepresented minorities often have a greater need for mentoring and support to counter challenges in pursuing the pathway to become a physician. TMA encourages Texas physicians to engage in their communities to guide, support, and mentor high school and undergraduate students with a calling to medicine. Students can be exposed to the physician’s practice, pursue shadowing opportunities, and progress to active roles in the office or as scribes. Each physician can make an impact in building the future workforce that is prepared to meet the needs of Texas’ diverse patient population.

3. Protection of Joint Admission Medical Program From Budget Cuts in 2022-23. TMA supports adequate funding for the state’s Joint Admission Medical Program (JAMP), which reserves medical student positions for qualified students who are economically disadvantaged, recognizing that this includes a high proportion of underrepresented minority students. TMA strongly opposes the proposed budget cut of $510,000 for the JAMP program in the 2022-23 state budget and advocates for consideration of the need to increase resources to accommodate students from the new Texas medical schools.

Attachment
TEXAS MEDICAL ASSOCIATION HOUSE OF DElegates

Resolution 201
2021

Subject: Admission of Deferred Action for Childhood Arrivals (DACA) Students in Texas Medical Schools (Tabled Res 202 2020)

Introduced by: Medical Student Section

Referred to: Reference Committee on Medical Education and Health Care Quality

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, Almost none of the 15 Texas medical schools report willingness to admit DACA students; and
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 Deferred Action for Childhood Arrivals (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 202
2021

Subject: Supporting Implicit Bias Training for Perinatal Physicians (Tabled Res 203 2020)

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, A disproportionate number of pregnancy-related deaths are 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 complications 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 Associate advocate for and support the use of implicit bias training for perinatal physicians 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).
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 203
2021

Subject: Service Animal Assisted Therapy in Health Care (Tabled Res 205 2020)

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 a dog 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 the use of service animals, compared with standard care, decreased the symptoms of post-traumatic stress disorder from a baseline level; and

Whereas, People with epilepsy who have service animals experience 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 policy about service animals and emotional support animals; therefore be it

RESOLVED, That the Texas Medical Association encourage physicians to use the Americans With Disabilities Act material concerning service animals as part of their patients’ therapeutic plans in inpatient and outpatient settings; and be it further

RESOLVED, That TMA support the provision of community resources for individuals with service animals that explain how service animals can be part of a therapeutic treatment plan.

Related TMA Policy:
None.

Related AMA Policy:
H-90.966 Service Animals, Animal-Assisted Therapy, and Animals in Healthcare

References:


TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 204
2021

Subject: Defining What Constitutes Proper Use of the Terms “Residency” and “Fellowship” When Referring to Specialty Training

Introduced by: Lone Star Caucus

Referred to: Reference Committee on Medical Education and Healthcare Quality

Whereas, All physicians pursuing specialty board certification are required to complete standardized and accredited training referred to as “residency,” with the possibility for further subspecialized training referred to as “fellowship”; and

Whereas, The term “resident” historically refers to physician training in the early 20th century, when medical trainees resided in hospitals during their formative years; and

Whereas, Some postgraduate training programs for nonphysician clinicians have started using the same nomenclature and labeling their programs as “residencies” and “fellowships”; and

Whereas, The public has been surveyed and has expressed confusion over which clinicians have medical degrees or degrees of osteopathic medicine and favor transparency of training; and

Whereas, The American Academy of Dermatology has stated that labeling nonphysician training programs as residencies or fellowships is misleading, and that this terminology should only apply to physician training programs; and

Whereas, The American Academy of Emergency Medicine has stated that training programs for physician assistants and nurse practitioners should avoid use of the terms “resident” and “fellow”; therefore be it

RESOLVED, That the Texas Medical Association develop a position statement that highlights the historical value and current nature of the terminology “residency” and “fellowship” to describe physician postgraduate training and addresses the ramifications of nonphysician clinician groups using similar nomenclature.

Related TMA Policy:
245.013 Appropriate Title Nomenclature in Medical Settings

Related AMA Policy:
D-275.979 Non-Physician “Fellowship” Programs

References:
2. AMA. Truth in Advertising Survey results.
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 205
2021

Subject: Skin of Color Representation in Medical Education and Research

Introduced by: Medical Student Section

Referred to: Reference Committee on Medical Education and Health Care Quality

Whereas, Half of all skin-related medical visits are not to dermatologists, yet fewer than 40% of primary care residents feel adequately prepared to manage common skin conditions; and

Whereas, Nearly 50% of dermatologists and dermatology residents in a landmark 2011 study reported that their medical school and/or their residency program provided inadequate training in recognizing dermatological conditions on Black skin; and

Whereas, Only 25.4% of chief residents and 19.5% of program directors report having lectures from a knowledgeable expert on Skin of Color (SoC), representing Fitzpatrick's skin phototypes IV through VI as defined as light brown skin to dark skin; and

Whereas, Dermatological health disparities disproportionately affect patients with SoC, resulting in delayed treatment courses and increased morbidity and mortality; and

Whereas, By 2044, people of color will make up more than half the U.S. population; and

Whereas, According to the 2019 U.S. Census, 58.8% of the population of Texas does not identify as solely white, and that number is expected to grow; and

Whereas, Many systemic diseases have dermatological manifestations, which makes it vital for all specialties to be able to recognize cutaneous changes on all skin tones; and

Whereas, Frequent misdiagnosis of “COVID toes” and other cutaneous manifestations of SARS-CoV-2 on darker skin tones has shed light on longstanding health inequalities in the field of dermatology, particularly in the way physicians are taught to recognize dermatological conditions, with words and pictures that typically describe manifestations on lighter skin; and

Whereas, A systematic literature review of publications describing cutaneous manifestations of COVID-19 included no clinical images representing Fitzpatrick type V or VI skin, which may be a contributing factor to higher rates of mortality and morbidity in people of color; and

Whereas, Knowing the cutaneous manifestations of COVID-19 and being able to identify them has been proven to be invaluable in evaluating otherwise asymptomatic patients in the health care setting, yet current literature fails to provide the tools needed for physicians to evaluate these dermatological manifestations on darker skin tones; and

Whereas, Analysis of medical textbook imagery found that only 4.5% of images represent dark skin tones, and dermatology sections of common United States Medical Licensing Examination (USMLE) preparatory resources showed only 24% of dermatological presentations were on SoC; and
Whereas, Medical students in a 2020 study were shown to be less likely to visually diagnose squamous cell carcinoma, atopic dermatitis, and urticaria correctly when presented on SoC, demonstrating the need for cutaneous manifestations of disease to be presented on both light and dark skin tones in medical education; and

Whereas, Lack of SoC representation in clinical research could exacerbate existing health disparities, with only 60% of dermatologic clinical trials in the U.S. reporting their participants’ race/ethnicity and less than 25% recruiting patients who do not identify as white; and

Whereas, An ongoing study suggests that exposure to dermatological pathology on SoC increases physician and student confidence in diagnosing pathology in patients of color; and

Whereas, A cross-sectional study published in JAMA Dermatology revealed that dermatologists with specialized training in SoC reported higher rates of patient satisfaction among Black patients due to their increased knowledge of SoC, cultural competency, cost-conscious care, and empathetic communication skills; and

Whereas, Current American Medical Association policy H-350.974 recognizes racial and ethnic health disparities as a major public health issue and supports the education of residents of all specialties on addressing these disparities in their fields; and

Whereas, Current Texas Medical Association policy 200.020, says medical schools should incorporate a broad range of educational opportunities and perspectives in their curricula, not exclusively related to the basic sciences; therefore be it

RESOLVED, That the Texas Medical Association advocate for dermatological conditions to be presented on varied skin tones in both pre-clinical curricula and clinical didactic sessions; and be it further

RESOLVED, That the Texas Medical Association supports recruiting more patients with skin of color for dermatologic medical research to better represent the diversity of the patient population.

Related TMA Policy:
200.020 Medical Education Curriculum
60.008 Rejection of Discrimination

Related AMA Policy:
Racial and Ethnic Disparities in Health Care H-350.974
Integrating Content Related to Public Health and Preventive Medicine Across the Medical Education Continuum D-295.327
Increasing Minority Participation in Clinical Research H-460.911

References:
Subject: Develop Guidelines for Proper Oversight of and Collaboration With Midlevel Practitioners by Physicians (Tabled Res 422 2020)

Introduced by: Bexar County Medical Society

Whereas, Patients deserve care led by physicians, as four of five patients prefer having physicians lead their health care team; and

Whereas, Like Texas, many states require physician supervision of midlevel practitioners, and Texas Medical Association 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 educate physicians about the basic tenets of proper physician oversight and supervision of midlevel practitioners, and encourage physicians to notify the Texas Medical Board of physicians who are not providing proper supervision 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 physician oversight of and collaboration with midlevel practitioners.

Related TMA Policy:

1. 100.032 Appropriate Physician Oversight of Emergency Medical Service Medical Practices
2. 30.035 Federal Prohibition of the Independent Practice of Medicine by Nurse Practitioners
3. 30.025 Allied Health Care Professionals
4. 30.029 Physician Extenders in Rural Health Clinics
Resolution 207
2021

Subject: Suicide Prevention Education in Medical School (Tabled Res 305 2020)

Introduced by: Medical Student Section

Referred to: Reference Committee on Medical Education and Health Care Quality

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 surrounding persons with mental illness remains 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% in 2018 compared with 2017; and
Whereas, Universal screening tools for depression and suicidality such as the PHQ-9, while useful predictors, are not used consistently 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 help health care professionals identify suicide risk; and
Whereas, Several administrations, the U.S. Congress, and the U.S. Department of Health and Human Services 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 about suicide prevention and intervention based on recommendations from the 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 about suicide prevention and intervention, impairing their ability to treat individuals with suicidal ideation; and
Whereas, Only 15% of U.S. medical schools formally include suicide prevention in their medical curriculum; and

Whereas, Studies demonstrate that medical students who receive education about risk factors for suicide are more prepared to recognize and emergently respond to individuals who are experiencing suicidal ideation; and

Whereas, Early patient interaction, possibly including some patients with suicidal ideation, during the preclinical curriculum is becoming more common and has been found to improve preparedness for clerkships; 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 competencies for medical students, and Liaison Committee on Medical Education and Commission on Osteopathic College Accreditation standards; and be it further

RESOLVED, That TMA recognize the importance of studying suicide identification and prevention training programs to develop the most efficacious method to prepare 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 208
2021

Subject: Facilitating Brain and Other Postmortem Tissue Donation for Research and Educational Purposes (Tabled Res 306 2020)

Introduced by: Medical Student Section

Referred to: Reference Committee on Medical Education and Health Care Quality

Whereas, Postmortem tissue contains information that can be invaluable in medical research and education 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, post-traumatic stress disorder, autism, and major depression and builds upon advances from neuroimaging, genetic, biomarker, and animal studies; and

Whereas, States have undertaken efforts to raise awareness of and increase donations for organ transplant, including asking individuals if they would like to join transplant donor registries when applying for or renewing their driver’s license; 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 and tissue donation 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 tissue donation, 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 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:
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stimulation of subthalamic nucleus. The FASEB Journal.
5. Francis PT, Hayes GM, Costello H, Whitfield DR. Brains for Dementia Research: The Importance of
7. de Lange GM. Understanding the cellular and molecular alterations in PTSD brains: The necessity of
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13. Donate Life Texas (Texas donor registry). Eye and Tissue Banks Serving Texas. Published Aug.14,
14. Tashjian RS, Williams RR, Vinters HV, Yong WH. Autopsy Biobanking: Biospecimen Procurement,
16. Larner SP, Mcquone B, Schober JM, Loukas M, Terrell M. Perceptions of the living dead: An
assessment of knowledge and opinions about whole body donation, its process, and willingness to
17. Striley CW, Milani SA, Kwiatkowski E, DeKosky ST, Cottler LB. Community perceptions related to
Associated Disorders. 2017;31(2):135-140.
Texas Medical Association House of Delegates

Resolution 209
2021

Subject: Promoting Careers in Geriatrics Among Medical Students (Tabled Res 204 2020)

Introduced by: Medical Student Association

Referred to: Reference Committee on Medical Education and Healthcare Quality

Whereas, The United States has 49 million people over the age of 65, and 12.6% of Texas’ population is made up of people over age 65; and

Whereas, The number and percentage of individuals over age 65 in Texas is expected to more than double by 2050, thereby requiring more physicians and resources for this population; and

Whereas, As many as 30% of these individuals will need the expertise of a geriatrician to manage their care; and

Whereas, Texas had only 405 board-certified geriatricians in 2018 to care for nearly 3.5 million individuals; and

Whereas, The Texas Medical Association and the American Medical Association provide support for primary care specialties, TMA does not have policy to support including geriatric medicine in medical student education; and

Whereas, TMA supports preceptorship programs for some primary care specialties to encourage medical student involvement in these specialties and 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 in Texas by providing medical students with information and opportunities that encourage them to specialize in geriatrics; and it be further

RESOLVED, That TMA support the efforts of medical schools to foster interest in geriatrics through interest groups, shadowing opportunities, and other activities.

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:
H-295.981 Geriatric Medicine
D-295.969 Geriatric and Palliative Care Training For Physicians
H-200.949 Principles of and Actions to Address Primary Care Workforce
H-200.969 Definition of Primary Care
References:
4. Geriatrics Workforce By the Numbers at www.americangeriatrics.org/geriatrics-profession/about-4
   geriatrics/geriatrics-workforce-numbers. (n.d.).
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   www.americangeriatrics.org/sites/default/files/inline-files/Current Number of Board Certified
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 210
2021

Subject: Amending the Mental Health Question on the Physician Licensure Application to Reflect Current Impairment (Tabled Res 206 2020)

Introduced by: Medical Student Section

Referred to: Reference Committee on Medical Education and Health Care Quality

Whereas, previously, any person applying for a medical license in the state of Texas was required to report all mental health diagnoses and treatment in the past five years without regard to current impairment; and

Whereas, previous Texas medical licensure applications included questions related to mental illness in likely violation of Title II of the Americans with Disabilities Act (ADA), which states it is unlawful to subject individuals with disabilities to greater requirements or burdens than a nondisabled person; and

Whereas, the ADA defines as a disability the diagnosis of major depressive disorder, bipolar disorder, substance abuse disorders, and other mental health conditions; and

Whereas, substantial prevalence of mental illness exists among physicians and medical students, with 11.3% of physicians reporting moderate to severe depression in one study and another study estimating the rate of depression in medical students at 27.2%; 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, 75% of surgeons who had experienced suicidal thoughts within the previous year of being surveyed reported they had not sought help due to concerns that doing so would affect their ability to renew their license; and

Whereas, physicians working in a state where the mental health question(s) violate ADA standards were 20% more likely to be reluctant to seek help than physicians working in states that met ADA standards; and

Whereas, 40% of all surveyed physicians in states that did not meet ADA standards reported reluctance to seek formal medical care for their mental health conditions; and

Whereas, in 2018 the American Medical Association House of Delegates adopted a widely supported Council on Medical Education report calling on medical licensing boards to not ask questions about history of mental illness; therefore be it

RESOLVED, That the Texas Medical Association support as policy that the Texas Medical Board licensure application require disclosure of only current or active mental health conditions; and
RESOLVED, That TMA support policy and judicial decisions in line with the American Medical Association, that physicians not be required to disclose previous treatment for mental health conditions and instead be evaluated solely on performance and current impairment.

Fiscal Note: TBD

Relevant TMA Policy:
None

Relevant AMA Policy:
H-275.970 Licensure Confidentiality
D-275.974 Depression and Physician Licensure
H-275.945 Self-Incriminating Questions on Applications for Licensure and Specialty Boards

References:
8. Dyrbye, L. N. Medical licensure questions and physician reluctance to seek care for mental health conditions.
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 211
2021

Subject: Medical School Compliance With the Americans with Disabilities Act

Introduced by: Medical Student Section

Referred to: Reference Committee on Medical Education and Health Care Quality

Whereas, Disability is included in the definition of diversity put forth by the Association of American Medical Colleges (AAMC) Group on Diversity and Inclusion; and

Whereas, Physician diversity has been shown to improve care in underserved populations; and

Whereas, Studies have indicated patients from various backgrounds feel more comfortable with physicians who share similar backgrounds; and

Whereas, Patients with a disability are more likely to experience ineffective patient-physician communication that detrimentally affects their care; and

Whereas, A disparity in individuals reporting a disability exists among the general American population (20%), medical students (4.6%), and practicing physicians (2%), demonstrating underrepresentation of people with disabilities; and

Whereas, Diversity within medical school student bodies, which AAMC supports, will create a diverse physician workforce in the future; and

Whereas, Many universities have created initiatives to promote inclusion of physicians with disabilities, such as the University of Michigan’s #docswithdisabilities campaign to normalize disability in medicine; and

Whereas, To eliminate discrimination and bias against those with disabilities, medical schools must provide reasonable accommodations, made known to students who are considering applying; and

Whereas, Reasonable accommodation for people with disabilities may include magnifying devices for students with visual disabilities, auxiliary aids for students with communication disabilities, extended test times for students with learning disabilities, or a convertible wheelchair for students with paraplegia to stand at a surgical table; and

Whereas, Improving accommodations for medical students with hearing disabilities has been found to increase patient quality of care by increasing the number of physicians providing culturally and psychologically compatible care to deaf and hard of hearing populations; and

Whereas, In spite of the passage of the Americans with Disabilities Act (ADA) of 1990, many medical schools have made few to no changes in accommodations in line with their legal obligations for people with disabilities; and
Resolution 211 2021
Page 2

Whereas, Research shows that two-thirds of medical schools do not provide information on their websites about accommodations and do not have reasonable accommodations in compliance with the ADA for students with vision, hearing, and mobility disabilities; and

Whereas, AAMC recommended in 2019 that all medical schools provide on their websites information about accommodations and their university’s policies because not providing this information could discourage applicants; and

Whereas, AAMC suggests medical schools also employ a disability services provider, who is an administrator knowledgeable about the accommodations the university and the medical facilities provide; and

Whereas, Our Texas Medical Association and American Medical Association supports the Joint Medical Admission Program, which works to recruit, enroll, and retain qualified applicants from racially diverse backgrounds to increase diversity in health professions, but this does not include students with disabilities; and

Whereas, Our TMA supports a diverse, qualified medical student body for Texas medical schools, and diversity includes those with disabilities; therefore be it

RESOLVED, That our Texas Medical Association encourage medical schools to provide reasonable accommodations for students with disabilities in accordance with the Americans with Disabilities Act and to describe these accommodations on their websites; and be it further

RESOLVED, That TMA support medical schools’ efforts to recruit, enroll, and retain qualified students with disabilities; and be it further

RESOLVED, That TMA encourage medical schools to employ a disability services provider, a staff member who is knowledgeable about accommodations for students at that university and can provide support to students with disabilities; and be it further

RESOLVED, That TMA amend Policy 200.031 Medical School Admissions as follows:

Medical School Admissions: The Texas Medical Association reaffirms its current policy supporting medical schools’ efforts to recruit, enroll, and retain qualified underrepresented minorities and strongly supports a diverse, qualified medical student body for Texas medical schools. In addition, TMA strongly supports the State of Texas partnership with Texas medical schools in efforts to increase the representation of underrepresented minorities including but not limited to Hispanic and African American students, and students with disabilities medical students among those attending Texas medical schools toward the goal of reaching their proportion in the Texas population (Council on Medical Education, p 73, I-96; reaffirmed BOT Rep. 11-I-99; reaffirmed CME Rep. 2-A-09; reaffirmed CME Rep. 1-A-19).

Related TMA Policy:
60.008 Rejection of Discrimination
200.040 Joint Admission Medical Program
200.031 Medical School Admissions
200.007 Medical Student and Resident Abuse
1 Related AMA Policy:
2 Minorities in the Health Professions H-350.978
3 Strategies for Enhancing Diversity in the Physician Workforce H-200.951
Whereas, Burnout is defined as a work-related mental health impairment comprising three dimensions: emotional exhaustion, depersonalization, and reduced personal accomplishment; and

Whereas, During the past 30 years, 182 studies involving 109,628 physicians in 45 countries reported overall burnout at 67%, emotional exhaustion at 72%, depersonalization at 68.1%, and low personal accomplishment at 63.2%; and

Whereas, As of 2018, approximately 300-400 physicians commit suicide each year nationwide, at a rate of 28-40 per 100,000, which is more than double the suicide rate of the general population; and

Whereas, Burnout is detrimental to physicians experiencing it, and can increase medical errors and impact patient satisfaction; and

Whereas, Medical personnel involved in treating and diagnosing patients with COVID-19 should undergo regular screening by multidisciplinary psychiatry teams to evaluate stress, depression, and anxiety; and

Whereas, Screening measures estimated that between 61.9% and 80.5% of physicians experience burnout or other mental health issues, indicating screening may be beneficial in settings with high prevalence of mental illness; and

Whereas, Interventions, such as training on coping mechanisms and communication skills; yoga, and other spiritual programs based on meditation; teamwork; computer programs; and staff appreciation can help reduce burnout among physicians and nurses, such that 50% of interventions positively impacted physicians and 67% positively impacted nurses; and

Whereas, Interventions that emphasize relationships, such as those in a health-care team, and balanced performance measures that recognize positive and negative aspects of a medical career are more likely to promote well-being and improve workplace cultures, reducing burnout among physicians; and

Whereas, The Centers for Disease Control and Prevention recognizes these coping mechanisms for stress: healthy diet, regular exercise, scheduled breaks, proper sleep, conversation with others, drug and alcohol avoidance, acknowledgement of personal limits, and counseling; and

Whereas, Previous studies have shown motivational programs, communication training skills, electronic methods, and/or psychiatric programs can reduce burnout in physicians; and

Whereas, American Medical Association policy supports existing programs to assist physicians in early identification and management of stress, and affirms the importance of physician health and education about physician health and wellness; therefore be it
RESOLVED, That the Texas Medical Association recognize burnout – defined as emotional exhaustion, depersonalization, and reduced sense of personal accomplishment – as a critical issue among healthcare workers and medical students; and be it further

RESOLVED, That TMA support training for medical practitioners to recognize burnout, and help prevent burnout by encouraging healthy coping mechanisms and the use of support services such as physician health and wellness programs; and be it further

RESOLVED, That TMA amend Policy 215.020 Improved Funding for Mental Illness and Substance Use Disorder(s) as follows:

The Texas Medical Association advocates for: (1) improved prevention, identification, and treatment of mental illness, burnout, and substance use disorder(s); (2) 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) no psychiatric hospital beds to be closed based solely on budgetary concerns in Texas (Res. 402-A-10, amended C-SPH Rep. 2 2020).

Related TMA Policy:
100.022 Emergency Psychiatric Services
105.010 Physician Health and Wellness
215.020 Improved Funding for Mental Illness and Substance Use Disorder(s)

Related AMA Policy:
D-310.968 Physician and Medical Student Burnout
D-345.983 Study of Medical Student, Resident, and Physician Suicide
H-295.858 Access to Confidential Health Services for Medical Students and Physicians
H-295.993 Inclusion of Medical Students and Residents in Medical Society Impaired Physician Programs
H-310.907 Resident/Fellow Clinical and Educational Work Hours
H-405.961 Physician Health Programs
H-405.957 Programs on Managing Physician Stress and Burnout

References:
6. Martin MS, Potter BK, Crocker AG, Wells GA, Colman I. Yield and Efficiency of Mental Health Screening: A Comparison of Screening Protocols at Intake to Prison. 


Science and Public Health Reports and Resolutions
AGENDA
REFERENCE COMMITTEE ON SCIENCE AND PUBLIC HEALTH
Saturday, May 8, 2021


5. Committee on Infectious Disease Report 1 – Sunset Policy Review

6. Committee on Reproductive, Women’s, and Perinatal Health Report 1 – Sunset Policy Review


8. Committee on Emergency Services and Trauma Report 1 – Cardiac Arrest as a Reportable Condition

9. Committee on Emergency Services and Trauma Report 2 – Recommendation on Emergency Department Diversion and Saturation Policy


11. Resolution 301 – Access to Direct-acting Antiviral Therapy for Texas Medicaid Beneficiaries Infected With Hepatitis C (Tabled Res 310 2020)

12. Resolution 302 – Advocating for the Improvement of Access to Mental Health Services Among Minority Teens (Tabled Res 311 2021)

13. Resolution 303 – Designating Texas Hospitals as Sensitive Locations (Tabled Res 315 2020)


21. Resolution 311 – Lowering the Legal Age for Minors to Access Contraceptive Services (Tabled Res 328 2020)
22. Resolution 312 – Advocating Against Electronic Nicotine Delivery Systems (ENDS) (Tabled Res 301 2020)
24. Resolution 314 – Promoting Safe and Effective Disposal of Polystyrene Foam Medication Case(s) With or Without Ice Packs
25. Resolution 315 – Possible Upcoming Shortage of Fentanyl and Other Opioid Injections
27. Resolution 317 – Decommissioning Existing and Not Constructing New Wastewater Treatment Plants in or Near Flood Plains and Waterways (Tabled Res 307 2020)
29. Resolution 319 – Support for the Texas-CARES Program (Tabled Res 312 2020)
30. Resolution 320 – Impact of Social Networking Services on the Health of Adolescents
31. Resolution 321 – Restore and Add Funding to Public Health
33. Resolution 323 – Education and Action to Arrest the Effects of Climate Change on Health (Tabled Res 309 2020)
34. Resolution 324 – Required Platelet Products at a Facility in Maternal Levels of Care Designation (Tabled Res 314 2020)

38. Resolution 328 – Outreach and Education in Mixed-Status and Undocumented Communities Regarding Information Gathering and COVID-19 Vaccine Distribution

39. Resolution 329 – In Support of Comprehensive Sexuality Education Reform

40. Resolution 330 – In Support of Reevaluating the Use of Race in Estimated Glomerular Filtration Rate

41. Resolution 331 – Support for Increasing Digital Access

42. Resolution 332 – Opposition to Criminalization of Gender-Affirming Care for Transgender Youth

43. Resolution 333 – Opposition to Sobriety Requirement for Hepatitis C Treatment

44. Resolution 334 – Racism as a Public Health Issue

45. Resolution 335 – Public Health and Health Care Protections While Incarcerated

46. Resolution 336 – Results and Regulation of Freestanding Birthing Centers and at Home Birthing Services (Tabled Res 426 2020)

47. Resolution 337 – Advocating for Evidence-Based Care for Incarcerated Pregnant Women in Texas Correctional Facilities

48. Resolution 338 – Support for Immunization Information System Interjurisdictional Data Exchange

49. Resolution 339 – Support for Texas Department of State Health Services Efforts to Address Racial and Ethnic Disparities in Health

50. Resolution 340 – Supporting the Health of Undocumented Immigrants During the COVID-19 Pandemic and Future Pandemics

51. Resolution 341 – Acknowledging Abortion is a Time-Sensitive Medical Procedure

52. Resolution 342 – Advocating for Increased Transparency at “Crisis Pregnancy Centers”

53. Resolution 343 – Study to Improve Healthcare Access and Care for Persons with Disabilities


55. Resolution 345 – TMA Statement on the Health Impact of Racism

57. Resolution 347 – Increasing Education Regarding the Effects of Bias and Discrimination on Patients Experiencing Homelessness

58. Resolution 348 – School Physicals Should Be Conducted by Physicians or Their Supervised Designee (Tabled Res 409 2020)

59. Resolution 349 – Reducing Intimate Partner Homicide

60. Resolution 350 – Restricting School Immunization Exemptions to Exemptions for Medical Reasons

61. Resolution 351 – Support of a Statewide Contact Tracing App

62. Resolution 352 – Mental Health Education in Schools


64. Resolution 354 – Addressing Race in Medicine

65. Resolution 355 – Support of Medical Student Health and Wellness

66. Resolution 356 – Support Statewide Planning and Communication for a Vaccine Plan During a Pandemic
REPORT OF COUNCIL ON SCIENCE AND PUBLIC HEALTH

C-SPH Report 1 2021

Subject: Sunset Policy Review

Presented by: Wendy M. Chung, MD, Chair

Referred to: Reference Committee on Science and Public Health

House of Delegates policies in the association’s Policy Compendium are reviewed periodically for relevance and appropriateness. Following are policies reviewed by the council with recommendations for retention, amendment, and deletion.

155.001 Laboratory Director Requirements: The Texas Medical Association supports maintaining the existing requirement calling for the position of laboratory director to be filled by a medical doctor for the following reasons: (a) The director of transfusion services and blood banks must deal directly with surgeons, oncologists, hematologists, obstetricians, pediatricians and other medical professionals on clinical issues regarding therapy (i.e., the type, amount and timing of blood transfusions); (b) The director interprets laboratory data for clinicians and advises on the clinical significance of data (i.e., antibodies and coagulation changes); (c) The director must educate medical staff and physicians-in-training in transfusion medicine; (d) The director must do quality assurance not only for the laboratory, but also on utilization and transfusion practices; and (e) The director must relate to operating room practices and the procedures directly related to patient care (i.e., therapeutic apheresis) (Committee on Blood Banking and Blood Transfusion, p 120, A-91; reaffirmed CSE Rep. 5-I-01; reaffirmed CSE Rep. 8-A-11).

260.086 Retire Coal-Fired Power Plants and Replace With Cleaner Energy Sources: The Texas Medical Association urges the Texas Legislature to establish a statewide energy plan formulated and maintained by an energy planning council, whose goals are to maintain the integrity of the electricity grid; ensure reasonable electricity rates; reduce air, water, and other environmental pollution; and manage water usage in power generation (Res. 202-A-11).

260.088 United States-Mexico Border Health Commission: The Texas Medical Association recognizes the many contributions of both the United States-Mexico Border Health Commission and the Border Health Caucus and urges the two TMA-sponsored groups to continue to work together and advance the goals of TMA and organized medicine in Texas and all along the southern border of the United States (Res. 204-A-11).

Recommendation 1: Retain.

The council recommends amending these policies as follows:

260.004 Scalding Hot Water: Recognizing that water at a temperature of 150 degrees can cause third degree burns in two seconds, water at 140 degrees can cause third degree burns in less than five seconds, and that 215 percent of all burns in children are caused by scalding incidents primarily in the home, and that scalds may result in significant morbidity, loss of autonomy, and health care costs for the elderly, the Texas Medical Association recommends that all residential water heaters, including those in older residences, be updated and maintained at
a thermostat setting of no more than 120 degrees Fahrenheit according to International Plumbing Code 2015 (IPC 2015) adopted and amended by the Texas Industrialized Housing and Buildings Program. TMA will continue to incorporate into its existing public and professional education programs information about burns and burn prevention (Res. 27F, p 168, I-90; reaffirmed CM-CAH Rep. 2-A-01; amended CSPH Rep. 3-A-11).

280.003 Science and Education in Public Schools: Considering the goal of improving the public school system through active participation, and Concerned with the anticipated shortage of health care professionals and fewer students taking science and math courses, the Texas Medical Association supports the promotion of science and health education, and endorses involvement by TMA members within the public school system where possible, whether through direct mentorship, outreach efforts, or enrichment programs continuation of outreach efforts to expose students to science and the benefits of a health career. In addition, TMA encourages its members to work with local school systems to establish advanced placement and enrichment programs in Science, Technology, Engineering, and Math (STEM) with special emphasis on encouraging participation of disadvantaged students in these programs.

Recommendation 2: Retain as amended.

The council recommends deletion of the following policies as they are no longer relevant or the policy was consolidated with other similar policy:

55.027 Public School Education: With the goal of improving the public school system through active participation, TMA members are encouraged to become involved with the public school system in their areas to the degree possible, including mentoring students and joining in community/school partnership programs, where available. In addition, TMA encourages its members to work with local school systems to establish advanced placement and enrichment programs in Science, Technology, Engineering, and Math (STEM) with special emphasis on encouraging participation of disadvantaged students in these programs (Council on Medical Education, p 92, A-98; reaffirmed CM-PDHCA Rep. 2-A-08; amended CM-PDHCA Rep. 2-A-18).

95.016 Computer Pharmacy Records Used for Marketing Purposes: As a means of protecting patient privacy, physicians and patients should be allowed to “opt out” of pharmacy plan data acquisition upon written request, except as otherwise required by law for scheduled or narcotic drugs. Any specific consent for data accumulation should have specific time and use restrictions. Data management companies employed by pharmacies and HMO plans should be prohibited from selling access, direct or indirect, to physician-patient lists for the purposes of marketing. (Substitute Res. 29P, p 164, I-97; reaffirmed CSA Rep. 2-I-01; reaffirmed CSPH Rep. 3-A-11).

95.020 Breach of Privacy with Patient Prescription Drug Profiles: Confidential quality assurance/quality initiative prescription drug profiles should not be provided by pharmaceutical companies to their marketing staff or other unauthorized persons for marketing purposes. The Texas Medical Association voted to seek legislative controls to prohibit the use of this patient drug information in the marketing of pharmaceutical companies (Res. 409-I-98; reaffirmed CSA Rep. 2-I-01; reaffirmed CSPH Rep. 3-A-11).
Driving While Using Hand-Held Electronic Communication Devices: The Texas Medical Association firmly stands against the epidemic use of hand-held electronic communication devices while driving (Res. 201-A-11).

Recommendation 3: Delete.

Presented by: Wendy M. Chung, MD, Chair

Referral 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 the Texas Medical Association 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 a drug user or addict; has a prior conviction for domestic assault or is subject to a domestic protective order; is a fugitive or 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 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 the physician has diagnosed as having a disorder or disability as noted in the DPS requirements (see also TMA Board of Councilors Current Opinions, Impaired Drivers).

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 Driver Licensing Office Referral**
- Driving record
- Observed or admitted medical conditions

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
The National Traffic and Safety Administration notes several states have 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:
1. **260.015 Firearms**
2. **260.079 Mandated Patient Information**
3. **260.094 Head Injuries and Sport-Related Concussion**
4. **280.021 Stroke Prevention Awareness**
5. **115.018 Overwhelming Compliance Mandates and Payment Uncertainty**
6. **165.009 Excessive Federal Paperwork Requirements**
7. **245.003 Professional Freedom Erosion**

Related AMA Policy:
8. **H-470.963 Boxing Safety**
9. **H-470.954 Reduction of Sports-Related Injury and Concussion**
10. **H-470.984 Brain Injury in Boxing**
11. **H-145.974 Increasing Toy Gun Safety**
12. **H-145.979 Prevention of Unintentional Shooting Deaths Among Children**
13. **H-145.997 Firearms as a Public Health Problem in the United States - Injuries and Death**
14. **H-145.978 Gun Safety**
15. **H-145.975 Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care**
16. **D-145.995 Gun Violence as a Public Health Crisis**
17. **H-145.996 Firearm Availability**
18. **D-145.997 Physicians and the Public Health Issues of Gun Safety**
19. **H-145.985 Ban on Handguns and Automatic Repeating Weapons**
20. **H-145.989 Safety of Nonpowder (Gas-Loaded/Spring-Loaded) Guns**
21. **H-60.947 Guns in School Settings**
22. **H-215.977 Guns in Hospitals**
23. **H-145.999 Gun Regulation**
24. **H-145.988 AMA Campaign to Reduce Firearm Deaths**
25. **H-145.972 Firearms and High-Risk Individuals**
26. **H-145.999 Waiting Period Before Gun Purchase**

Sources:
1. Texas Administrative Code. Title 37, Public Safety and Corrections. Part 1, Texas Department of Public Safety.  
   Chapter 6, License to Carry Handguns.
2. Texas Administrative Code. Title 37, Public Safety and Corrections. Part 1, Texas Department of Public Safety.  
   Chapter 15, Driver License Rules. Subchapter B, Application Requirements – Original, Renewal, Duplicate, Identification Certificates
4. Texas Department of Public Safety. Texas Medical Evaluation Process for Driver Licensing.
5. Texas Health and Human Services. Texas Department of State Health Services. Resources for Physicians – Medical Advisory Board.
   Section 46.01, Definitions (3) “Firearm.”
8. The State of Texas. Legislative Budget Board. Statewide Services for Traumatic Brain Injuries, Alzheimer’s Disease, and Dementia. 2018.
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 of the 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 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 cost-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 the Texas Medical Association 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
1 115.004 Indemnification of Physicians
2 170.001 Good Samaritan and Charitable Immunity Laws
3 170.002 Charitable Immunity
4
5 **Related AMA Policy:**
6 [Childhood Anaphylactic Reactions D-60.976](#)
7 [Preventing Allergic Reactions in Food Service Establishments D-440.932](#)
8 [Food Allergic Reactions in Schools and Airplanes H-440.884](#)
9 [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>
</tr>
</thead>
<tbody>
<tr>
<td><strong>86th Legislative Session (2019)</strong></td>
<td></td>
</tr>
<tr>
<td>House Bill 4260 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>
</tr>
<tr>
<td>House Bill 1015 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>
</tr>
<tr>
<td>House Bill 1849 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>Senate Bill 869 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>Senate Bill 1827 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>House Bill 2243 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>
<tr>
<td><strong>85th Legislative Session (2017)</strong></td>
<td></td>
</tr>
<tr>
<td>Senate Bill 1367 by Senator Menendez – passed</td>
<td>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.</td>
</tr>
<tr>
<td>Senate Bill 1683 by Senator Lucio – Senate passed but no House hearing</td>
<td>Required a food service establishment to have a poster on food allergen awareness for food service employees</td>
</tr>
<tr>
<td>Senate Bill 579 by Senator Taylor; comp HB 1583 by Representative Cortez – passed</td>
<td>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.</td>
</tr>
</tbody>
</table>
REPORT OF COMMITTEE ON CANCER

CM-C Report 1 2021

Subject: Sunset Policy Review

Presented by: Lynn N. Stewart, 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’s recommendations for retention, amendment, or deletion are as follows:

The committee recommends amending the following policy:

- **Colon Cancer Screening**: The Texas Medical Association supports state and national legislation in Texas to require insurance for coverage of colorectal cancer screening in which patients and physicians should have the option to utilize a variety of tests, such as fecal occult blood test, fecal immunochemical test, stool DNA test, flexible sigmoidoscopy, colonoscopy, double-contrast barium enema, CT colonography (virtual colonoscopy), or other appropriate techniques, in accordance with the most recently established national guidelines in consultation with interested specialty societies and scientific organizations for the ages, family histories, and frequencies referenced in these guidelines (Amended Res. 303-A-01; amended CM-C Rep. 1-A-11).

**Recommendation**: Retain as amended.
REPORT OF COMMITTEE ON INFECTIOUS DISEASES

CM-ID Report 1 2021

Subject: Sunset Policy Review

Presented by: Thomas A. Kaspar, MD, Chair

Referred to: Reference Committee on Science and Public Health

House of Delegates policies in the association’s Policy Compendium are reviewed periodically for relevance and appropriateness. Following are policies reviewed by the council with recommendations for retention, amendment, and deletion.

The Committee on Infectious Diseases recommends amending these policies as follows:

135.018 Pertussis and Cocooning: The Texas Medical Association (1) actively promotes the Centers for Disease Control and Prevention’s CDC’s Advisory Committee on Immunization Practices recommendations on the use of the tetanus-diphtheria-acellular pertussis (Tdap) vaccine, and provide education and assistance to physicians with strategies for implementing pertussis vaccination in various settings, which includes providing tools to promote Tdap for postpartum pregnant women and their families, as well as the use of Tdap in emergency departments; (2) supports increased physician awareness regarding payment for diphtheria-tetanus-pertussis (DTaP) and Tdap vaccine under health insurance plans; (3) works with the Texas Department of State Health Services (DSHS) and local public health agencies to ensure current infectious disease data, guidance on responding to disease outbreaks, and physician-focused materials are disseminated to physicians (TMA can work with stakeholders to encourage information-sharing among public health agencies, hospitals, and health care professionals); (4) works with DSHS on reviewing Texas notifiable condition requirements and recommending enhancements to support improved surveillance of pertussis deaths among infants; and (5) advocates for the allocation of additional DSHS resources for Tdap vaccine that will assist local health departments during outbreaks (CM-CID Rep. 1-A-11).

95.033 Drug Shortages and Physician Communications: The Texas Medical Association will work with the AMA and other appropriate federal agencies to increase federal monitoring of potential drug and medical equipment shortages, and enhance communications with physicians regarding drug shortages and alternative treatments (CM-ID Rep. 2-A-11).

135.02 Fairness in Timely Delivery of Vaccines: The Texas Medical Association advocates for the importance of ensuring vaccine supply to physicians, and supports strengthening the supply chain network and electronic allocation and reporting systems works to ensure fair and timely delivery of vaccines to all available sources that participate in the vaccination of patients (Res. 209-A-11).

135.019 Promotion of Antimicrobial Stewardship: The Texas Medical Association (1) supports physician efforts to develop and promote comprehensive antibiotic stewardship and infection prevention programs in inpatient and outpatient health care facilities, and (2) encourages physicians to participate in education programs and to use current evidence-based resources such as those provided by professional societies and the Centers for Disease Control and Prevention (CDC). Physicians are encouraged to use the available patient education tools to...
inform their patients about antimicrobial therapy, prescribing guidelines, and appropriate use
of antibiotic therapies. This includes, but is not limited to, the proper use and handling of
antibiotics as prescribed by their physician, and the information that antibiotics should not be
shared, and are not needed and that antibiotics are inappropriate for viral infections; and (2)
(3) recommends that the Texas Department of State Health Services (DSHS) and medical
schools inform medical students and residents about antimicrobials and the impact of
antimicrobial resistance on public health, patient outcomes, and health care costs, and that
TMA collaborate with DSHS to promote the use of evidence-based programs for the
continuing education of physicians on the problem of antimicrobial resistance; and (4)
encourages continued scientific research into the impact of antimicrobial stewardship
programs to reduce antibiotic resistance, such as CDC’s Get Smart program. (CM-CID Rep.
3-A-11).

**Recommendation:** Retain as amended.
REPORT OF COMMITTEE ON REPRODUCTIVE, WOMEN’S, AND PERINATAL HEALTH

CM-RWPH Report 1 2021

Subject: Sunset Policy Review

Presented by: Patrick S. Ramsey, MD, Chair

Referred to: Reference Committee on

The Texas Medical Association periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness. The committee reviewed the policies and offers recommendations for the following policies as summarized in this report.

The committee recommends amending these policies as follows:

140.010 Newborn Genetic Screening: The Texas Medical Association supports universal screening in Texas of all core and secondary conditions identified by the U.S. Department of Health and Human Services’ Advisory Committee on Heritable Disorders in Newborns and Children in its Recommended Uniform Screening Panel for newborns. TMA recognizes that a comprehensive newborn screening program should consist of a statewide continuum of services coordinated by the Texas Department of State Health Services, including education, screening, tracking, follow-up, diagnosis, treatment, and management of those conditions identified in the program. To ensure early detection and appropriate follow-up care for all babies born in Texas with genetic diseases or congenital conditions, including critical congenital heart defects, and hearing loss, all delivery care attendants are urged to participate in the state’s newborn screening program and to use the state’s available tracking and reporting systems. (CSA Rep. 3-A-07; amended CM-MPH Rep. 2-A-11).

Other components of the state’s newborn screening program should include an accountable stakeholder group, an independent clinical advisory group, use of a regional specialty services process, and use of evidence-based measures defined as science published in peer-reviewed journals and supported by a consensus of experts. Ongoing and continuous quality evaluation and improvement is critical and must protect patient confidentiality and ethical handling/storage of dried blood spots. Education efforts should include parents/families, state policy makers, clinicians, and hospitals, and medical schools and institutions. (CSA Rep. 3-A-07; amended CM-MPH Rep. 2-A-11).

140.002 Prenatal and, Perinatal, and Postpartum Care: The Texas Medical Association supports a system to meet the needs of low- and high-risk perinatal and prenatal, perinatal, and postpartum care in both the private and public sectors based on the coordinated efforts of private physicians; medical schools; federal, state, and local health agencies; the state perinatal quality collaborative; and other available resources. (Committee on Maternal and Child Health, p 114, A-91; reaffirmed CM-MPH Rep. 3-A-01; reaffirmed CM-MPH Rep. 1-A-11).

Recommendation 1: Retain as amended
REPORT OF COMMITTEE ON CHILD AND ADOLESCENT HEALTH

CM-CAH Report 1
2021

Subject: Sunset Policy Review

Presented by: Kimberly C. Avila Edwards, MD

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 reviewed the policies and offers recommendations as summarized in this report.

The committee recommends retention of the following policies:


Recommendation 1: Retain.

The committee recommends amending these policies as follows:

55.033 Children’s Mental and Behavioral Health: Texas has a relatively young population, with about 28% of Texans under the age of 18. Significant brain development occurs in childhood and adolescence, making it a critical point in an individual’s lifespan during which mental and behavioral health disorders may emerge. TMA recognizes that many mental and behavioral health disorders of childhood and adolescence are the basis of both physical and mental disease throughout an entire lifespan, affecting individuals’ physical, mental, and social health in adulthood. Childhood and adolescence are critical times for brain development; consequently, many mental disorders develop during these periods. As such, the evaluation and treatment of these disorders in childhood and adolescence are critical to the health of Texans at all ages.

Managing mental and behavioral health disorders among children requires multiple strategies.

1) Physician Education. All physicians should have adequate information that enables them to recognize common mental disorders. Primary care physicians should receive the necessary training, support, and educational resources to prevent, properly screen for, diagnose, and treat mental and behavioral health disorders. Educational tools regarding the screening, diagnosis, and current available treatment modalities for mental health disorders including but not limited to attention deficit disorder, autism, substance use disorder,
mild depression, and mild anxiety. TMA can provide resources for physicians on national screening and treatment guidelines, and billing and coding information.

2) 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 American Academy of Pediatrics and United States Preventive Services Task Force (USPSTF) recommendations for screening children and adolescents for mental health and substance use disorders.

All physicians who see and treat children should be able to recognize and either treat or refer children with obvious mental illness health disorders including and substance abuse disorder use disorders.

Because school is the "workplace of the child," primary care physicians should have knowledge of the demands and resources of their local school districts.

3) 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 use;
   b. Medical schools and graduate medical education programs that to recognize the role of primary care physicians in the diagnosis and treatment of mental and behavioral health conditions and provide effective training, support, and research in all aspects of these areas 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. Additional support for the expanded training of mental health professionals and increased support for improved access to mental health services, that will establish increased adequate numbers and quality of mental health professionals throughout the state;
   i. Coordinating with the educational system to ensure a school environment that supports mental health for mentally healthy schools, free of stigma related to mental or behavioral health issues; and


Recommendation 2: Retain as amended
The committee recommends deletion of the following policy:

285.002 **Weight Requirements:** The Texas Medical Association believes that while a healthy weight should be encouraged for all sports participants, schools are urged not to make weight requirements a prerequisite for any sports activity and that all students, regardless of weight, should be allowed to participate on sports teams (Committee on School Health, p 114, I-90; amended CM-CAH Rep. 2-A-01; amended CSPH Rep. 3-A-11).

**Recommendation 3:** Delete.
Subject: Cardiac Arrest as a Reportable Condition

Presented by: Richard Bradley, MD, Chair

Referred to: Reference Committee on Science and Public Health

Out-of-hospital cardiac arrest is a potentially preventable and treatable condition that could see improved survival outcomes with enhanced data collection and sharing. Data reporting and response initiatives are developing at the state and national levels, including the Texas Cardiac Arrest Registry to Enhance Survival (CARES) and the American Heart Association’s (AHA’s) Telecommunicator CPR Taskforce. Texas CARES is a partnership of emergency medical services (EMS) agencies, health care providers, and university researchers committed to improving out-of-hospital cardiac arrest reporting and response. The AHA taskforce engages in research and recommends policy to improve 9-1-1 operator and bystander CPR response to sudden cardiac arrest. Several Texas Medical Association members are involved in these programs. The committee believes the state should collect data on out-of-hospital cardiac arrest events and report the data to an out-of-hospital cardiac arrest registry. The Committee on EMS and Trauma asks that TMA support recognizing sudden cardiac arrest as a reportable condition in Texas.

As of 2020, 28 states and the District of Columbia participate in the national CARES, managed by Emory University. In addition, 45 community sites in 14 additional states collect and submit data voluntarily. CARES captures data for 45% of the U.S. population. Texas participates in CARES through McGovern Medical School at UTHealth; however, the school has no mandate to, and may not financially be able to, continue to support this program. Only a portion of cardiac arrests in Texas are reported, because reporting data to Texas CARES is voluntary. State recognition of out-of-hospital cardiac arrest as a reportable condition would streamline and bolster data collection and reporting and guarantee continuity.

The committee believes that strong data reporting will help identify and implement the proper response to these time-sensitive, sudden, and deadly medical events. Cardiac arrest is a potentially preventable and treatable condition that results in the death of more than 475,000 Americans per year, and more than 350,000 of those cardiac arrests occur outside of the hospital. Cardiac arrest survival is worse in communities of color and among those with lower socioeconomic status, making out-of-hospital cardiac arrest an issue of health equity. Texas already mandates reporting on many other conditions, such as cancer, drowning, controlled substance overdoses, lead poisoning, spinal cord injury, and traumatic brain injury.

A high-quality chain of survival – a timely response plan – has the potential to improve the survival rate of sudden cardiac arrest. Such plans consist of rapid activation of the emergency response system, immediate high-quality CPR, rapid defibrillation, basic and advanced emergency medical services, and advanced life support and post-arrest care. The survival outcomes from out-of-hospital cardiac arrest vary widely across the country, from 3% to 35%. A robust cardiac arrest registry would bolster an evidence-based chain of survival by providing the data necessary to adjust and improve response plans as new interventions are tried and evaluated. Mandatory reporting of cardiac arrests to a state registry also would give physicians and policymakers much richer data on the extent of socioeconomic and racial disparities, and enable the design and evaluation of interventions to reduce them.
A statewide out-of-hospital cardiac arrest registry will allow researchers, public health experts, policymakers, and the public to view the state of out-of-hospital cardiac arrest outcomes and the direct, effective, evidence-based interventions that improve these outcomes. Data from CARES are released in two ways: (1) agencies that contribute can see their own data, and (2) researchers can submit a research request to the CARES board. Scientifically valid requests can access deidentified data.

The Committee on EMS and Trauma proposes the following:

Recommendation 1: That the Texas Medical Association support amending the Texas Health and Safety Code to mandate data collection on all out-of-hospital cardiac arrests in Texas in which emergency medical services personnel (EMS) attempt resuscitation, including management and evaluation by EMS personnel and outcome data from hospitals.

Recommendation 2: That TMA support management of Texas out-of-hospital cardiac arrest data by the Texas Cardiac Arrest Registry to Enhance Survival with funding from the state for the organization’s management services, data collection, and sharing.

Recommendation 3: That TMA supports the appropriate application of data protection and security laws regarding out-of-hospital cardiac arrest patient data collected by the state or a contracted entity.

References
1. TX-CARES.
2. Healthy People 2030. Cardiac Arrest Registry to Enhance Survival (CARES).
REPORT OF THE COMMITTEE ON EMERGENCY MEDICAL SERVICES AND TRAUMA

CM-EMST Report 2 2021

Subject: Recommendation on Emergency Department Diversion and Saturation Policy

Presented by: Richard Bradley, MD, Chair

Referred to: Reference Committee on Science and Public Health

At its 2021 Winter Conference meeting, the committee met with SouthEast Texas Regional Advisory Council (SETRAC) Chief Executive Officer Darrell Pile to discuss SETRAC’s adoption of a new emergency department (ED) “saturation” policy in place of traditional ED diversion policy. All hospitals in SETRAC’s designated region follow saturation policy. It has been in effect regionally since 2013.

SETRAC is one of 22 Regional Advisory Councils (RACs) in the state contracted by the Texas Department of State Health Services (DSHS). RACs are administrative bodies responsible for developing, implementing, and overseeing emergency medical services (EMS) trauma system plans in a designated region. SETRAC covers nine counties, including Harris and Fort Bend. DSHS asks each RAC to develop its own ED diversion policy. SETRAC’s policy was brought to the committee’s attention by Kenneth Mattox, MD, a committee consultant and TMA member involved in SETRAC. The saturation policy was developed by a diverse group of end users, including hospital and EMS leaders.

Traditional emergency department diversion policy allows hospitals to communicate to EMS agencies that they are on “diversion status” when the emergency department is full or the ED staff find the situation to be unusually taxing. Hospitals use this status to avoid emergency patients arriving at an overcrowded ED and experiencing delayed care due to lack of capacity. When activated, diversion status directs EMS to transport patients to another hospital. If all hospitals in a region are on diversion status, or if there is only one hospital for a wide area, which is not uncommon in rural Texas, the ambulance could be directed to drive extraordinary distances that leave the patient without hospital care in time-sensitive emergency medical situations. In Texas, given the large number of rural hospital closures over the past several years, this scenario is not unimaginable.

Ambulance diversion was developed to be a short-term and rare option for hospitals to cope with extraordinary circumstances. However, use of the status has become common in the U.S., with an average of about one incidence of ambulance diversion per minute. A study conducted in Houston found that hospitals were on diversion more than 27% of the time for 23 of 30 months. High-frequency diversion use is a result of consistently high emergency department traffic. Another Houston study found a possible effect of EMS diversion on mortality rates in Texas. Death rates of patients hospitalized on significant diversion days, defined as days when both Level I hospitals were on diversion for more than eight hours, were higher than nonsignificant diversion days (no statistical significance). Percentage of deaths is calculated among all trauma patients, including those transferred. Authors of the study concluded: “1) delays in treatment of trauma patients caused by hospital diversion may increase mortality; 2) diversion is frequently caused by saturation of the ER [emergency room]; and 3) primary care-related ER use of trauma centers contributes to ER saturation.”

Saturation is a description of status rather than an EMS directive. By directing health care professionals to drive to another facility, diversion status could delay care further than if the patient were admitted to an overwhelmed emergency department. SETRAC’s system asks hospitals to use saturation status in place of diversion, communicating the emergency department’s condition and enabling EMS agencies to make
informed decisions. Medical directors participating in SETRAC’s workgroup designing saturation policy provided insight on the information EMS agencies need to determine where to transport a patient, rather than having a licensed hospital issue a proclamation to divert. If EMS believes taking a patient to a nearby saturated facility increases the chance of a positive health outcome or survival compared with driving lengthy distances to seek care, it can choose the closer facility. Saturation status lasts four hours; then the hospital must redefine its status. SETRAC’s system is a mechanism for increased EMS-hospital communication, rather than hospitals telling EMS their current capabilities. In addition to SETRAC, trauma service areas G, H, Q, R, U, and V also use a saturation system.

SETRAC developed the saturation system because stakeholders felt diversion was not working. Direction to divert was not well defined and could be used liberally to slow down the pace of activity. For example, some facilities would place themselves on diversion but still accept transfer patients. Some EMS agencies would bypass the hospital on diversion, and others would not, until they became one of many ambulances waiting to offload patients. SETRAC felt EMS agencies needed better descriptors of hospital capabilities and statuses to make better decisions on which hospital could best serve the patient. For example, if the patient is suspected of having a long-bone fracture, EMS can easily see if orthopedic service is available that day. Hospitals on saturation can describe their circumstances with phrases such as “eight ambulances waiting,” “no ICU beds available,” or “(number) patients holding in ER for a bed.”

Since addressing the overarching issue of emergency department capacity will take longer for physicians, EMS agencies, and hospital stakeholders to address systematically, the committee supports SETRAC’s policy change as a means to test whether this approach improves timeliness of care and patient outcomes in addition to improving communications between ED and EMS systems. After discussing SETRAC’s proposal, the committee recommends that TMA support adoption of SETRAC’s saturation language in lieu of conventional ED diversion policy.

The committee does recommend that further data be collected and efficacy of the policy be shown before supporting policy adoption statewide. SETRAC expects to release a report to hospital system presidents in the near future that evaluates the saturation policy during the COVID-19 crisis and Texas’ recent winter storm emergency, when ED utilization and accessibility challenges were exacerbated. The region currently can report individual facility status changes by day over time or hourly to determine trends in peak times for both hospitals and EDs. SETRAC also collects data to assess the frequency with which individual hospitals reported saturation over a single month. Some were saturated for more than 70% of the month. Hospital system presidents have examined the data to determine if their system could help individual hospitals that are frequently saturated.

Because the Department of State Health Services currently tasks each Regional Advisory Council in Texas with developing its own diversion policy, its rules would need to be amended to coordinate statewide ED diversion policy reform. The committee believes that expressing support for the SETRAC policy will help facilitate DSHS and other RACs in revisiting existing diversion policies.

The Committee on EMS and Trauma proposes the following:

**Recommendation 1:** That the Texas Medical Association support exploring the Southeast Texas Regional Advisory Council’s (RAC’s) use of emergency department saturation status in place of an emergency department diversion policy to describe when hospitals within the region are experiencing high patient volume. Each RAC should test saturation policy and gather data and feedback before TMA recommends statewide adoption. The policy should be adjusted or expanded by each RAC pending periodic reviews of data regarding policy efficacy and patient outcomes within its unique region.
Recommendation 2: Any hospital that adopts a saturation policy in lieu of diversion must consult emergency physicians and other emergency department personnel to ensure the policy is descriptive rather than directive, and that it enables emergency medical services (EMS) medical directors and their staff to make informed decisions for the benefit of patient health and survival outcomes.

Recommendation 3: That TMA request that the Texas Department of State Health Services and the Governor’s EMS and Trauma Advisory Council evaluate data collected by RACs over the course of this policy change and make recommendations accordingly.

References:
1. DSHS. Regional Advisory Councils.
2. DSHS. Metropolitan, nonmetropolitan, frontier county map of Texas.
3. Tribble, SJ. After A Rural Hospital Closes, Delays In Emergency Care Cost Patients Dearly. KHN. Aug. 19, 2019.
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 appoint a TMA 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, and 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; the effect of bed bug infestations on MDUs; and the role of the U.S. Department of Housing and Urban Development in bed bug management.

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, DSHS 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.

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 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. 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
Joint Report 1 2021
Page 4

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 disproportionally 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
• Health impact (CDC): [www.cdc.gov/parasites/bedbugs/health_professionals/index.html](http://www.cdc.gov/parasites/bedbugs/health_professionals/index.html)
• CDC Public Health Law: Environmental Odors and Public Nuisance Law: A Research Anthology
• Integrated pest management: [Collaborative Strategy on Bed Bugs](http://www.cdc.gov/parasites/bedbugs/health_professionals/index.html)
• Environmental Protection Agency: Bed Bugs: Get Them Out and Keep Them Out
• Environmental Protection Agency: Bed Bug Clearinghouse by Audience
• EPA and the University of Washington Evans School of Public Policy and Governance: Tackling Bed Bugs: A Starter Guide for Local Governments,
• Texas A&M AgriLife Extension: Insects in the City
• City and state examples of bed bug management:
  • Chicago
  • Michigan
  • New York City
  • Ohio
  • Seattle
  • Toronto

References:
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
## Appendix B.

**State Bed Bug Laws, November 2016** – *(pulled from National Pest Management Association with added TMA comment)*

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<tr>
<th>State</th>
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| Alabama     | **ALA. ADMIN. CODE § 420-3-11-.12, Construction, Maintenance, and Operation of Hotels - Insect and Rodent Control** | 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. | - Not unique to bedbugs (included as “insects”);  
- Relates specifically to hotels;  
- No reporting requirements;  
- No mention of medical/health concern or physician involvement |
| Arizona     | **ARIZ. REV. STAT. § 9-500.31, Prohibition on adopting landlord tenant bedbug control requirements, city or town** | 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. | - Relates to defining landlord/tenant responsibilities;  
- No reporting requirements;  
- No mention of medical/health concern or physician involvement |
|             | **ARIZ. REV. STAT. § 11-269.11, Prohibition on adopting landlord tenant bedbug control requirements, Board of Supervisors** | 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. | - Relates to defining landlord/tenant responsibilities;  
- No reporting requirements;  
- No mention of medical/health concern or physician involvement |
|             | **ARIZ. REV. STAT. § 33-1319, Bedbug control; landlord and tenant obligations; definitions** | 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. | - Relates to defining landlord/tenant responsibilities;  
- No reporting requirements;  
- No mention of medical/health concern or physician involvement |
|             | **ARIZ. REV. STAT. § 36-601, Public nuisances dangerous to public health**       | 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. | - No reporting requirement;  
- Relates only to public spaces |
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| California| CAL. CODE REGS. Sections 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 Properties                     | 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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<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><strong>MICH. ADMIN. CODE r. 400.57, Family Services Administration Inspection and Licensing - County Infirmaries Care of Residents</strong></td>
<td>Requires county infirmaries to implement procedures to prevent and treat bedbug infestations.</td>
<td>- Relates to county infirmaries</td>
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<tr>
<td>Minnesota</td>
<td><strong>MINN. R. 4625.1700, Lodging Establishments - Insect and Rodent Control</strong></td>
<td>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.</td>
<td>- Relates to lodging establishments; - No reporting requirements; - No mention of medical/health concern or physician involvement</td>
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<td><strong>MINN. R. 4665.2300, Supervised Living Facilities, Insect and Rodent Control</strong></td>
<td>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.</td>
<td>- Relates to all insects; - No reporting requirements; - No mention of medical/health concern or physician involvement</td>
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<td>Nebraska</td>
<td><strong>25 NEB. ADMIN. CODE § Chap.2 - 005.02B(A)(a), Structural Health Related Pest Control</strong></td>
<td>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.</td>
<td>- Relates to all insects; - No reporting requirements;</td>
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<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.</td>
<td><strong>REV. STAT. ANN. § 540:2, Termination of Tenancy</strong></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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<td>N.H.</td>
<td><strong>REV. STAT. ANN. § 540:13-e, Bed Bug Remediation Liability</strong></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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<td>N.H.</td>
<td><strong>REV. STAT. ANN. § 540-A:3, Landlord Prohibited Acts</strong></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>
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<td>New York</td>
<td><strong>N.Y. CITY ADMIN. CODE § 27-2018.1, Notice of bed bug infestation history</strong></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>
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<td>New York</td>
<td><strong>N.Y. EDUC. LAW § 920 (McKinney), Public Schools - Infestation of Bed Bugs</strong></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><strong>OHIO REV. CODE ANN. § 3731.13, Hotels - Bedding, Floors and Carpet Must be Kept Sanitary</strong></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><em>OR. REV. STAT. § 570.880, Confidentiality of Bed Bug Infestation Report</em></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><em>OR. ADMIN. R. 333--030--0070, Campgrounds - Insect and Rodent Control</em></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>
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<tr>
<td>Pennsylvania</td>
<td><em>7 PA. CODE § 82.15, Seasonal Farm Labor Camps - Insect Rodent Control</em></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>
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<td>Rhode Island</td>
<td><em>25-3 R.I. CODE R. § 24:7, Categories for Commercial Applicators</em></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>
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<td>South Dakota</td>
<td><em>S.D. ADMIN. R. 44:02:08:05, Vacation Homes - Vermin Control</em></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>Texas</td>
<td><strong>TEX. HEALTH &amp; SAFETY CODE ANN. § 341.011, Nuisances and General Sanitation</strong></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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| West Virginia| **W.VA. CODE R. § 16-6-16**, Hotels and Restaurants - Bed Bugs                 | In every hotel, any room infected with vermin or bedbugs shall be fumigated, disinfected and renovated until said vermin or bedbugs are exterminated.                                                           | - Relates to hotels and restaurants;  
- No reporting requirements;  
- No mention of medical/health concern or physician involvement                                                                                                         |
| Wisconsin    | **WIS. ADMIN. CODE DEPT. OF HEALTH SERV. § 190.08**, Institution Sanitation - Pest Control | 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. | - Relates to specific housing institutions;  
- Not unique to bedbugs;  
- No reporting requirements;  
- No mention of physician involvement                                                                                                                                       |
Subject: Access to Direct-Acting Antiviral Therapy for Texas Medicaid Beneficiaries Infected With Hepatitis C (Tabled Res 310 2020)

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, Hepatitis C virus (HCV) is a bloodborne 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 2030, 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 adopt the following language as policy:

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:**

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 302 2021

Subject: Advocating for the Improvement of Access to Mental Health Services Among Minority Teens (Tabled Res 311 2021)

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, An estimated 10% to 20% of adolescents worldwide experience mental health conditions, which go 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 Youth Risk Behavior Survey by the Centers for Disease Control and Prevention found significantly higher prevalence 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 who provide care are less likely to be board certified than health care professionals who treat white patients; and

Whereas, School-based mental health centers can address significant barriers that limit access to mental health care by providing services in the setting where students spend much of their time; and

Whereas, A 2018 meta-analysis suggests child psychiatrists and other mental health professionals are wise to recognize the important role school personnel, who are naturally in children’s lives, can play in decreasing mental health problems in youth; and

Whereas, Only 34% of teachers believed they had the skills 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”, and exclusionary discipline rates are significantly higher for students of color and students in special education classrooms; and
Whereas, Research indicates individuals possess explicit biases that individuals with mental illness are helpless and bad but not blameworthy, which conflict with their implicit biases that individuals with mental illness are helpless, bad, and blameworthy; and

Whereas, Everyone harbors implicit biases, and these biases influence every aspect of society; however, people can “unlearn” implicit biases, once the biases are identified; and

Whereas, As mental health disparities are addressed, identifying interventions to achieve the greatest positive mental health outcome among minority teens remains an area for research and evaluation; and

Whereas, Texas Health and Human Services supports the use of the Child and Adolescents Needs and Strength Assessment, one of the few existing assessment tools, as an effective tool to provide metrics on trauma-informed behavioral and mental health needs within the state; and

Whereas, The use of culturally appropriate methodology is most effective to yield conclusive results for cross-cultural research; and

Whereas, Current Texas Medical Association policy advocates for school-based mental health services 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 have access to appropriate mental health screening and treatment services, and that support 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 TMA advocate for culturally informed mental health outreach and services to increase utilization by minority youth in schools, including increasing 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:
55.033 Children's Mental and Behavioral Health
215.023 Identifying Trauma and Mental Health Susceptibilities in Schools
265.018 Evidence-Based Medicine and Practice

Relevant AMA Policy:
D-345.994 Increased Detection of Mental Illness and Encouraging Education
H-60.991 Providing Medical Services through School-Based Health Program
H-345.977 Improving Pediatric Mental Health Screening
References:

Resolution 303
2021

Subject: Designating Texas Hospitals as Sensitive Locations (Tabled Res 315 2020)

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, Undocumented immigrants are concerned they will face legal action, such as deportation, when they visit 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 information except in rare circumstances; and

Whereas, Texas Medical Association policy advocates that children “be able to receive nonemergency and preventive care and supports health care professionals delivering medical care to children regardless of immigration status” (Policy 55.057); and

Whereas, Latina women, regardless of immigration status, are less likely to use health services for 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 at hospitals have reported ICE activities such as interrogations and arrests, despite ICE policy to not operate at hospitals; and

Whereas, American Medical Association policy encourages hospitals to “promote their status as sensitive locations” and opposes the presence of ICE enforcement (Policy D-160.921); and

Whereas, After the 2019 mass shooting in El Paso, authorities reported concern some undocumented immigrants did not seek care for traumatic injuries at hospitals out of fear of deportation; therefore be it

RESOLVED, That the Texas Medical Association oppose U.S. Immigration and Customs Enforcement operations in hospitals; and be it further

RESOLVED, That TMA advocate for state legislation designating 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.
Relevant TMA policy:
55.057 Health Care of Undocumented Children

Relevant AMA policy:
D-160.921 Presence and Enforcement Actions of Immigration and Customs Enforcement (ICE) in Healthcare

References:
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 304
2021

Subject: Updating Texas Medical Association Teenage Sexual Health Guidelines
(Tabled Res 318 2020)

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, The U.S. has one of the highest teen pregnancy rates among developed nations; and
Whereas, Texas has one of the highest teen pregnancy rates in the U.S.; and
Whereas, Rates for many sexually transmitted diseases have risen among younger age groups in Texas; and
Whereas, The percentage of Texas high-school students who have had sexual intercourse is equal 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 the risk of pregnancy and sexually transmitted infections among adolescents; and
Whereas, The American Academy of Family Physicians explicitly opposes abstinence-only sexual education, instead promoting sexual health education that is evidence-based, includes comprehensive and effective community programs, and “recognizes 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, American Medical Association policy opposes “the sole use of abstinence-only education” (Policy H-170.968); therefore be it

RESOLVED, That the Texas Medical Association encourage its members to engage with their local communities and school boards to develop comprehensive sexual education programs for adolescents that teach more than abstinence as an 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:

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 offer recommendations to state and local governmental agencies and other
interested organization based on scientific, medically accurate information on adolescent
sexuality, dispelling medical misinformation.

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 (Council on Public Health, p 106, and Res. 28N, p 172, A-94; reaffirmed CM-CAH Rep. 4-

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:
4. Breuner C, Mattson G, Committee on Adolescence, Committee on Psychosocial Aspects of Child and
e20161348.
Subject: Supporting an Opt-Out Organ, Eye, and Tissue Donation System in Texas
(Tabled Res 319 2020)

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

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 residents 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 daily waiting for a transplant; and

Whereas, Approximately 1,500 Texans are removed annually 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 U.S.; and

Whereas, During the 2017 Texas legislative session, the 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, That TMA adopt new policy to support an opt-out organ, eye, and tissue donation system in Texas; and be it further

RESOLVED, That 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:
5. Goard A. Texas bill aims to make organ donation opt-out, sparking debate. KXAN Austin. April 27, 2017.
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 306  
2021

Subject: Maternal Health and Postpartum Depression Screening (Tabled Res 320 2020)

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, A recent meta-analysis shows 12% of women who give 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 within 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 (odds ratio [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 recommends 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 recognizes that screening can provide clinical benefits, although initiation of treatment or referral to mental health care professionals offers maximum benefit; and

Whereas, American Medical Association policy supports working with stakeholders to encourage 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 about 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 about postpartum depression screenings to primary care physicians who treat perinatal and postpartum women.

Related TMA Policy:
None.
Related AMA Policy:
- D-420.991 Improving Treatment and Diagnosis of Maternal Depression Through Screening and State-Based Care Coordination
- H-420.953 Improving Mental Health Services for Pregnant and Postpartum Mothers

References:
Subject: Saving Energy, Reducing Costs, and Increasing Efficiency in Medical Practices
(Tabled Res 321 2020)

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 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 carbon dioxide
emissions; and

Whereas, Switching to copy paper with at least 30% recycled content and setting the default print option
to double-sided printing for networked printers reduced University of Wisconsin Hospital and Clinics’
paper use by 25% to 30%, lowering monthly costs by $11,000 to $13,000; 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 saves
enough energy to power, heat, and cool nearly 300 average-size homes daily; and

Whereas, The My Green Doctor initiative, used by medical offices, clinics, and outpatient centers in 58
countries and 38 U.S. states, 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 outlines discussion and decision
topics, as well as 50 energy-efficiency action and education steps physicians can consider for their
offices; and

Whereas, The Texas Medical Board adheres to a resource efficiency plan to promote energy savings in
Texas; and

Whereas, Texas Medical Association policy promotes energy conservation measures for homes,
businesses, and public buildings to decrease Texas energy consumption (TMA Policy 260.077); and

Whereas, American Medical Association policy supports physicians in adopting environmental
sustainability programs in their practices (AMA Policy H-135.923); and

Whereas, AMA guidelines work to support and educate physicians in implementing programs that 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 to 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: Mandatory Waiting Period for Firearm Purchases (Tabled Res 324 2020)

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, Firearm violence is a public health issue in the U.S., given that it is responsible for the deaths of 36,000 Americans each year (an average of 100 per day), is one of the top three causes of death among American youth, and costs the U.S. at least $174 billion annually; and

Whereas, 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 (60%) of all suicides in Texas in 2016 were by firearm, and the firearm suicide rate in Texas increased 18% from 2006 to 2016; and

Whereas, More than three-quarter (78%) 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, The 417 mass shootings in 2019, including the deadliest one of the year in El Paso, exceeded the number of days in the year; and

Whereas, Accessibility to firearms increases the risk for completed suicide and for becoming a victim of homicide; and

Whereas, Texas currently has no mandated waiting period for firearm purchases; and

Whereas, Waiting periods require a number of days to pass between when a buyer purchases a firearm and then takes possession of that firearm; and

Whereas, Waiting periods can provide 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, American Medical Association policy advocates a waiting period and encourages legislation that enforces a waiting period for firearm purchasers (AMA Policy H-145.996); and

Whereas, States with mandatory waiting periods – no matter the length – had, on average, 17% fewer homicides and 10% fewer suicides; therefore be it

RESOLVED, That 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:
D-145.995 Gun Violence as a Public Health Crisis
H-145.996 Firearm Availability
H-145.984 Data on Firearm Deaths and Injuries

References:
10. Luca M., Malhotra D, Poliquin C. Handgun waiting periods reduce gun deaths. PNAS. 2017 Nov;114(46), 12162-12165.
Subject: Promoting and Improving Health Literacy (Tabled Res 325 2020)

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 with or an inability to perform simple health-related tasks; and

Whereas, Lower 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 on the topic; therefore be it

RESOLVED, That the Texas Medical Association recognize 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 communication by physicians and other health care professionals, and improve educational approaches to patient visits; and be it further

RESOLVED, That TMA encourage the allocation of public and private funds for research about 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
Early Literacy Programs H-60.914

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.
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 310
2021

Subject: Improving Access to Immediate Postpartum Long-Acting Reversible Contraception for Adolescents (Tabled Res 327 2020)

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, The teenage birth rate in the U.S. remains among the highest in the developed world; and

Whereas, Approximately 19% of sexually active women aged 15 to 19 in the U.S. 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 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 Texas were repeat births compared with only 16% of adolescent pregnancies in the U.S. as a whole; and

Whereas, Of the approximately 574,000 adolescent pregnancies that occur each year in the U.S., 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 (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 a markedly more 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 are the only two states in the nation where adolescent mothers must receive parental consent to request prescriptive birth control, including long-acting reversible contraceptives, from a physician or 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 Healthy Texas Women and the Texas Family Planning Program, including to minors who lose Children’s Health Insurance Coverage 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 policy recognizes the efficacy of long-acting reversible contraceptives immediately postpartum; and

Whereas, Current Texas Medical Association 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 support increased funding for long-acting reversible contraceptives and other prescriptive contraceptives for women who do not qualify for services under Healthy Texas Women and the Texas Family Planning Program and who do not have reliable access to Title X-funded clinics; and be it further

RESOLVED, That our TMA support and advocate for the reduction of the age in Texas 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) 18 to 15, to accommodate the entire age group of adolescents who are at increased risk of teenage pregnancy within the state; and be it further

RESOLVED, That our TMA advocate 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 (e.g., oral contraceptives, shots, and intrauterine devices), and sexual health services (e.g., pap smears and treatment for urinary tract infections) without parental consent.
Related TMA Policy:

- **55.004 Adolescent Sexual Activity**
- **330.015 Physician-Led Initiatives to Address Maternal Mortality and Morbidity**
- **260.075 Preventive Health Care for Texas Women**

Related AMA Policy:

- **Increasing Availability and Coverage for Immediate Postpartum Long-Acting Reversible Contraceptive Placement H-75.984**
- **Coverage of Contraceptives by Insurance H-180.958**
- **Reducing Unintended Pregnancy H-75.987**

References:

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 311
2021

Subject: Lowering the Legal Age for Minors to Access Contraceptive Services
(Tabled Res 328 2020)

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

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 to 17 was 15.1 births per 1,000 girls compared with the U.S. teen birth rate of 8.8 births 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 age 17; and be it further

RESOLVED, That TMA continue to support initiatives, programs, and funding that eliminate barriers to adolescents accessing reproductive health care.
Related TMA Policy:
1. 55.035 Right to Confidential Care
2. 55.004 Adolescent Sexual Activity
3. 55.016 Sexuality Education

Related AMA Policy:
4. Opposition to HHS Regulations on Contraceptive Services for Minors H-75.998
5. Confidential Health Services for Adolescents H-60.965

References:
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 312
2021

Subject: Advocating Against Electronic Nicotine Delivery Systems (ENDS)
(Tabled Res 301 2020)

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, 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
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 313
2021

Subject: Elimination of Human Abuse and Persecution (Tabled Res 302 2020)

Introduced by: Lone Star Caucus

Referred to: Reference Committee on Science and Public Health

Whereas, Cultures of the East and West alike have long recognized 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 personal liability when passing confidential information regarding alleged abuse or persecution of a patient 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 urge physicians 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
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 314

2021

Subject: Promoting Safe and Effective Disposal of Polystyrene Foam Medication Case(s) With or Without Ice Packs

Introduced by: Webb-Zapata-Jim Hogg County Medical Society and Lone Star Caucus

Referred to: Reference Committee on Science and Public Health

Whereas, Drug companies ship temperature-sensitive medications to patients and physicians’ offices in polystyrene foam case(s) with ice packs; and

Whereas, In the past, some of the companies supplied return labels to ship the polystyrene foam case(s) back to the company or point of origin after the medications were removed from the case(s); and

Whereas, Now the practice of returning these polystyrene foam case(s) with the ice packs is not encouraged (and instead often discouraged); and

Whereas, Physicians’ offices and patients are disposing polystyrene foam materials and ice packs into the garbage, which eventually ends up in the landfills; and

Whereas, Polystyrene foam takes a long time to degrade, and the ice packs are labeled “safe, nontoxic, not for human consumption”; therefore be it

RESOLVED, That the Texas Medical Association encourage county medical societies to work with local physicians to disseminate information in their office to their patients and staff about the improper disposal of polystyrene foam case(s) with or without ice packs; and be it further

RESOLVED, That TMA encourage pharmaceutical firms to take full responsibility for the return of polystyrene foam case(s) with or without ice packs and paying for the proper and safe disposal or reuse of these materials; 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:
95.042 Promoting Safe and Effective Disposal of Unused Medications

Related AMA Policy:
H–135.936 Proper Disposal of Unused Prescription and Over-the-Counter (OTC) Drugs
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 315
2021

Subject: Possible Upcoming Shortage of Fentanyl and Other Opioid Injections

Introduced by: Webb-Zapata-Jim Hogg County Medical Society and Lone Star Caucus

Referred to: Reference Committee on Science and Public Health

Whereas, Fentanyl injection is used in multiple procedures for conscious sedation; and

Whereas, Fentanyl injection may be used as an alternative to meperidine injection for conscious sedation in patients who cannot tolerate the latter medication; and

Whereas, If a fentanyl shortage occurs in Texas (e.g., during the COVID-19 pandemic), Texas facilities might hoard the medication (as has happened in the past and is happening currently with other medication shortages); and

Whereas, If a shortage occurs, patients who need to undergo procedures will need to use more expensive sedation medications or cancel the procedures; and

Whereas, With limited health care resources and the increasing Texas population subsequently leading to more procedures, Texas physicians have to find alternative solutions to ensure procedures performed in Texas are affordable to patients; and

Whereas, The Texas Medical Association supports addiction prevention in the current opioid crisis; and

Whereas, In 2019, the Drug Enforcement Administration proposed to reduce the amount of fentanyl manufactured in the U.S. the following year by 31%; and

Whereas, The Food and Drug Administration may have underestimated the legitimate medical needs of injectable opioid medications used for procedures; therefore be it

RESOLVED, That the Texas Medical Association restudy the potential shortage of fentanyl and other injectable opioids, and promote alternative supplies made domestically; and be it further

RESOLVED, That TMA work with stakeholders and policymakers to ensure that the legitimate availability and affordability of fentanyl and other injectable opioids do not fall below the current and future medical need for procedures performed in Texas as well as for disaster preparedness; and be it further

RESOLVED, That TMA advocate physicians using the minimum amount of opioids needed for procedures to make patients comfortable; 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:
95.033 Drug Shortages and Physician Communications

Related AMA Policy:
H-100.956 National Drug Shortages

Reference:
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.
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.


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.
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 317
2021

Subject: Decommissioning Existing and Not Constructing New Wastewater Treatment Plants in or Near Flood Plains and Waterways (Formally Res 307 2020)

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
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 to and be responsible for the necessary resources to effectively eliminate recurrent flooding in Texas.

Related TMA Policy:

None
Subject: Support for the Texas-CARES Program (Formally Res 312 2020)

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); emergency medical services 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 investigate options, identify strategies, and support ongoing efforts to sustain the Texas Cardiac Arrest Registry to Enhance Survival (Texas-CARES) Program 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 to maximize survival after OHCA; and be it further

RESOLVED, That TMA work to ensure 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**
3. **Providing Emergency Services**
4. **D-295.972 Standardized Advanced Cardiac Life Support (ACLS) Training for Medical Students**
5. **H-300.945 Proficiency of Physicians in Basic and Advanced Cardiac Life Support**
6. **H-360.998 Cardiac Resuscitation by Nurses**
7. **D-470.992 Implementation of Automated External Defibrillators in High-School and College Sports Programs**
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 320
2021

Subject: Impact of Social Networking Services on the Health of Adolescents

Introduced by: Harris County Medical Society and the Texas Pediatric Society

Referred to: Reference Committee on Science and Public Health

Whereas, Distinct from use of the broader internet, the use of social networking services (SNS) such as Facebook, Twitter, Instagram, Tik Tok, and Snapchat, among others, which are engineered to maximize engagement and have potential for addiction, can result in a dependence with a severity of symptoms and consequences traditionally associated with substance-related addictions; and

Whereas, Adolescents are particularly vulnerable to unhealthy SNS use, the negative effects of which are incompletely understood but involve psychosocial health, neurocognitive development, weight, and sleep; exposure to inaccurate, inappropriate, or unsafe content and contacts; and compromised privacy and confidentiality; and

Whereas, Adolescents under the age of 18 are not recognized in the law as adults, nor do they have the fully developed capacity of adults to understand the risks and long-term implications of online communication, yet they regularly enter into contractual agreements with operators of websites to send and post information about themselves without the knowledge or consent of their parents; and

Whereas, Many of the protections under the Children’s Online Privacy Protection Act of 1998 such as verifiable parental consent may be beneficial if extended to adolescents, yet they currently apply only to children under age 13; therefore be it

RESOLVED, That the Texas Medical Association affirm that use of social networking services has the potential to negatively impact the physical and mental health of individuals, especially adolescents and those with preexisting psychosocial conditions, and therefore these services should have established, evidence-based, reliable safeguards to protect vulnerable populations from harm; and be it further

RESOLVED, That the Texas Delegation to the American Medical Association introduce a resolution to the AMA House of Delegates to advocate for the study of the biological, psychological, and social effects of social networking services use, and to advocate for legislative or regulatory action, including the expansion of Children’s Online Privacy Protection Act of 1998 protections, to mitigate the potential harm from the use of social networking services to adolescents and other vulnerable populations.

Related TMA Policy:
None

Related AMA Policy:
H-60.915: Emotional and Behavioral Effects of Video Game and Internet Overuse
D-60.974: Emotional and Behavioral Effects of Video Game and Internet Overuse
References:


TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 321
2021

Subject: Restore and Add Funding to Public Health

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Science and Public Health

Whereas, The Texas Department of State Health Services monitors the health of 30 million Texans in 254 counties; and

Whereas, Public health funding has failed to keep pace with Texas’ growth and has been reduced by more than 40 percent (from $26 million in 2013 to $15 million in 2019); and

Whereas, The COVID-19 pandemic has provoked an economic collapse in Texas eclipsing the great recession of 2007-09; therefore be it

RESOLVED, That the Texas Medical Association, which represents 55,000 Texas physicians, work with academic centers, medical schools, and schools of public health to encourage the Texas Legislature to restore and add funding to public health to assist with the current pandemic crisis and prepare for the next.

Related TMA Policy:
260.037 Essential Public Health Services
260.042 Core Public Health Functions

Related AMA Policy:
None
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 322
2021

Subject: Improving Physician Access to Immigrant Detention Facilities (Tabled Res 304 2020)

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, U.S. Immigration and Customs Enforcement (ICE) operates 30 immigration enforcement
detention facilities in Texas, with 12 located along the Texas-Mexico border; and

Whereas, As of 2019, Texas detains the highest number of immigrants in the U.S. with more than 14,000
detained individuals, more than three times Louisiana’s detained population, the second highest at more
than 4,000 individuals; and

Whereas, Human beings are being held for increasingly longer times in these immigrant detention
facilities, with the average length of stay increasing from 22 days in 2016 to 34 days in 2017, and recent
delays in immigration processing from the COVID-19 pandemic are prolonging people’s stay in detention
facilities; 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, In 2019, the Department of Homeland Security Office of the Inspector General reported that
ICE has a documented history of refusing to adequately report data on the daily operations of its facilities,
even though lapses in compliance with detention standards are known to occur, such as failing to meet its
obligation to employ sufficient medical staff to perform basic exams and treatments for all detainees; and

Whereas, Inadequate access to medical care within immigrant detention facilities has been well
documented and found to be a contributing factor in 23 out of 52 deaths in ICE detention facilities
between March 2010 and March 2018; and COVID-19 was the cause of eight out of 21 reported deaths in
2020; 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, Detention facilities lack a centralized authority overseeing the provision of medical care, since
the ICE Health Service Corps manages the health care of only 22 out of 200 immigration detention
facilities, leading to inconsistencies in the provision of medical care, with multiple contracts lacking
specific staffing requirements or 24-hour access to care; and

Whereas, Scope-of-practice violations, including having licensed vocational nurses clinically assess
patients without physician oversight, and medical neglect, including refusing care to individuals with
shortness of breath, are documented occurrences inside detention facilities; and
Whereas, Severe medical neglect occurred in 2020 in an ICE detention facility in Georgia where a physician, practicing as a nonboard-certified gynecologist, performed unnecessary hysterectomies on at least 17 women; and

Whereas, Only one-third of ICE detention centers are located within 25 miles of a hospital with intensive care beds, further emphasizing the need for adequate access to care within facilities to prevent worsening conditions; and

Whereas, U.S. Customs and Border Protection (CBP) allowed Texas physicians to provide medical care within immigrant detention facilities in 2014, but starting in 2018 has denied physicians access to those same facilities to provide medical care; and

Whereas, When community physicians were allowed to provide care in CBP detention facilities in 2014, 20 community physicians were on call every day to evaluate children and adults, improving the physician/provider-to-patient ratio in these detention centers; 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 CBP 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, On July 24, 2019, Congress passed H.R. 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, 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, The American Medical Association in AMA Policy D-350.983 resolves to “advocate for access to health care for individuals in immigration detention”; and 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 physicians and 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.
Relevant TMA Policy:

260.005 Community and Migrant Health Centers

Relevant 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:


TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 323
2021

Subject:   Education and Action to Arrest the Effects of Climate Change on Health
(Tabled Res 309 2021)

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 proved conclusively that the
main cause of the earth’s warming is the emission of carbon dioxide (CO2) and methane (CH4) –
“greenhouse gases” – from burning 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, and 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 allows 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 methods 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 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 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
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 324
2021

Subject: Required Platelet Products at a Facility in Maternal Levels of Care Designation
(Tabled Res 314 2020)

Introduced by: Dallas County Medical Society

Referred to: Reference Committee on Science and Public Health

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 by September 2020 one of four defined standard levels of care to receive Medicaid funding for obstetrical care; and

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

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

Whereas, Many such facilities had never stocked a platelet on site before and have rarely if ever transfused a platelet product; and

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

Whereas, Platelets can be delivered to such facilities if needed for transfusion; and

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

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 puts the entire community supply at risk for those patients who do need them; therefore be it

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.
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 325
2021

Subject: Employee Rights to Lactation Accommodation (Tabled Res 317 2020)

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 employees; 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, Texas Medical Association policy 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 with less than 50 employees; and be it further

RESOLVED, That TMA amend Policy 140.008 as follows:

TMA supports the adoption of legislation and employer programs that allow breast feeding 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.
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).
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 326
2021

Subject: Pediatric Iron Deficiency Anemia Treatment and Diagnosis Guidelines
(Tabled Res 326 2020)

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 the Centers for Disease Control and
Prevention 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, The burdens of unnecessary specialty referrals have exacerbated negative effects on physicians
and patients amidst the ongoing COVID-19 global health crisis; 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 and Practice](#)

**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
2021

Subject: Expanding Access to Regularly-Scheduled Dialysis for All Individuals With ESRD
(Tabled Res 330 2020)

Introduced by: Lone Star Caucus

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 only receive treatment 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 undocumented immigrants receiving regularly scheduled dialysis; and

Whereas, Emergent hemodialysis is a large cost to local health care systems in Texas; for example, emergency dialysis costs $285,000 per patient, annually, in Houston; 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 cost 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 cost savings of $72,000 per person per year; and

Whereas, currently only two programs – Harris Health System’s Riverside Dialysis Center and San Antonio’s University Health System – provide regularly scheduled dialysis to undocumented immigrants; and

Whereas, 10 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 migrants; and
Whereas, Clinicians providing emergent hemodialysis experience professional burnout due to the moral distress of providing substandard care, and the frustration related to the inappropriate use of resources; and

Whereas, *AMA 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 which dialysis is appropriately indicated; and be it further

RESOLVED, That TMA collaborate with relevant stakeholders in identifying and implementing potential solutions to achieving regularly scheduled dialysis as a standard of care for all individuals with ESRD in Texas.

Relevant TMA Policy:
- **55.057 Health Care of Undocumented Children**
- **110.006 Health Plan**

Relevant AMA Policy:
- **H-440.876 Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients**

**Sources:**
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 328
2021

Subject: Outreach and Education in Mixed-Status and Undocumented Communities Regarding Information Gathering and COVID-19 Vaccine Distribution

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, Roughly 1.6 million undocumented immigrants live in Texas, comprising 6% of the total state population in 2016; and

Whereas, Roughly 2.7 million Texans, including 1.2 million children, live with at least one undocumented family member in the same household; and

Whereas, Immigrants have greater risk of exposure to COVID-19, as they are more likely to work in jobs where they are unable to practice social distancing; and

Whereas, Immigrants have greater risk of exposure to COVID-19, as they are more likely to use public transit to travel between locations; and

Whereas, Immigrants are more likely to live in multigenerational households with elderly family members more susceptible to COVID-19; and

Whereas, Nearly 70% of undocumented immigrant workers have jobs that provide essential infrastructure required for the continued functioning of our nation during the pandemic and our economic recovery following the pandemic; and

Whereas, The Centers for Disease Control and Prevention prioritized COVID-19 vaccinations for essential workers by including food and agricultural workers, manufacturing workers, grocery store workers, public transit workers, and child care workers in Phase 1b; and

Whereas, The American Psychiatric Association recognizes that distrust of the U.S. legal system and fear of deportation are significant barriers limiting undocumented immigrants’ use of health care and social services; and

Whereas, Fear of deportation, mistrust of government agencies, and misinformation have prompted resistance to the COVID-19 vaccine among undocumented immigrant communities; and

Whereas, Large swaths of unvaccinated populations can lead to the resurgence of vaccine-preventable diseases, such as measles, mumps, and rubella, as evidenced in Belgium in 2013; and

Whereas, Despite the exclusion of “testing, screening, or treatment of communicable diseases, including COVID-19” within the public charge rule, fear of being denied a visa may still discourage vaccine uptake among mixed-status and undocumented communities; and
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Page 2

Whereas, The U.S. Department of Health and Human Services (HHS) retrospective report on the 2009 H1N1 influenza pandemic acknowledged that communication and education initiatives should have relied on community-based, faith-based, and grassroots organizations to disseminate information, as minority and disadvantaged populations were not successfully reached; and

Whereas, During the 2009 H1N1 pandemic, the Embassy of Mexico in Washington, D.C., partnered with HHS to develop a one-page flyer in Spanish to address the fears of undocumented immigrants, and distributed it to all Mexican consulates in the U.S.; and

Whereas, Community-based interventions, including outreach activities and inclusion of staff familiar with targeted neighborhoods, have been proven to help overcome distrust among hard-to-reach populations and improve vaccine delivery to them; and

Whereas, A tailored intervention that detects and addresses hesitancy is an evidence-informed strategy to address vaccine hesitancy in subgroup populations, such as undocumented immigrants; therefore be it

RESOLVED, That our Texas Medical Association amend policy 260.080 Vaccine Delivery as follows:

Vaccine Delivery: The Texas Medical Association is dedicated to helping ensure all Texans are fully vaccinated. TMA recommends several actions to help remove barriers for physicians and add accountability and transparency to all aspects of vaccine delivery.

1. That TMA work with the Texas Legislature to highlight the critical contribution of Texas physicians in reaching the state’s public health immunization goals by eliminating vaccine-preventable illnesses and also ensuring comprehensive services in the medical home setting. In addition, TMA supports legislation to:

a. Eliminate the business tax on vaccines;
b. Establish a purchase reference for acquisition of each vaccine recommended for children, based on a standard transparent source, such as the Centers for Disease Control and Prevention (CDC) Private Sector Price List;
c. Mandate vaccine payment reporting by insurance companies to determine if they are covering the true costs of these preventive services;
d. Further universal reporting to the state’s immunization registry;
e. Protect and preserve as the primary site of the receipt of immunizations a patient-centered medical home with a primary care physician; and
f. Mandate electronic reporting, by the vaccinating provider, of vaccines administered to children and adults outside their medical home (e.g., in pharmacies or through community-based delivery) to either (i) the public health agency immunization registry, or (ii) the local public health immunization exchange using the appropriate, current national health information standard (e.g., HL7 2.5.1 or C-CDA release 2.1 Common Clinical Data Set).

2. That TMA support increased federal funding of the Section 317 program and state funding to increase physician payments for the administration of immunizations to patients in the Medicaid and Texas Vaccines for Children programs; encourage the Texas Department of State Health Services and CDC to work toward a significant decrease in the administrative burden for physicians participating in the federal Vaccines for Children program so more physicians can provide vaccines under the program at reasonable cost; and support federal and continued state funding to preserve the Adult Safety Net Program for access to vaccines, noting the health care savings and health benefits of this program greatly exceed the immediate cost.
3. That TMA oppose any policies, regulations, or legislation requiring physicians and institutions to collect data regarding a patient's legal residence status and proof of citizenship as a condition of providing vaccines.

4. That TMA work with the Texas Department of State Health Services and other recognized groups to expand and promote resources to assist physician members on how practices can best establish a business and public health case for providing immunizations and determine the tools necessary to negotiate best price (CPH Rep. 1-A-09; amended CSPH Rep. 5-A-19)

; and be it further

RESOLVED, That our TMA create and implement accessible outreach and education programs pertaining to the COVID-19 vaccine that can be distributed via community-based, faith-based, and grassroots organizations in mixed-status and undocumented communities; and be it further

RESOLVED, That our TMA collaborate with community-based, faith-based, and grassroots organizations to create outreach and education programs for undocumented and mixed-status immigrant communities.

Related TMA Policy:

135.010 Immunization Education Efforts for Texas
55.057 Health Care of Undocumented Children

Related AMA Policy:

Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients H-440.876
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
Education and Public Awareness on Vaccine Safety and Efficacy H-440.830

References:


TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 329
2021

Subject: In Support of Comprehensive Sexuality Education Reform

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, In 1995, 81% of adolescent males and 87% of adolescent females reported receiving formal instruction about birth control methods compared with the 55% of adolescent males and 60% of adolescent females in 2011–13; and

Whereas, As of 2019, Texas ranked among the top 10 states in teen birth rate with a teen birth rate of 24%; and

Whereas, Texas is not among the 30 states that require public schools to teach sex education; and

Whereas, According to the Sexuality Information and Education Council of the United States (SIECUS), Texas does not require sex education to be medically accurate with some programs often providing medically inaccurate information about abortion and using textbooks that omit the use of condoms as a method to prevent sexually transmitted infections (STIs); and

Whereas, 25% of school districts in Texas did not teach sex education; and

Whereas, As of 2015–16 only 17% of school districts in Texas taught abstinence-plus sex education that included instruction on contraceptive use and birth control options; and

Whereas, A recent systematic review by the American Academy of Pediatrics demonstrated there is no evidence that abstinence-only programs delay initiation of sexual intercourse; and

Whereas, In 2018, SIECUS reported that 89% of voters believe it is important to teach sexuality education to middle schoolers, and 98% of voters believe it is important to teach sexuality education to high schoolers; and

Whereas, Comprehensive sexuality education is defined as sexuality education composed of human sexuality, intimate relationships, human sexual anatomy, sexual reproduction, sexually transmitted infections, sexual activity, consent, sexual orientation, abstinence, contraception, and reproductive rights and responsibilities; and

Whereas, Comprehensive sexuality education can reduce pregnancy, HIV, and STIs for U.S. children and adolescents; and

Whereas, An examination of the National Survey of Family Growth for teens aged 15–19 revealed that teens who received comprehensive sexuality education were 50% less likely to report a pregnancy than those who received abstinence-only education; and
Whereas, A methodological review of comprehensive sex education aimed at reducing high-risk sexual activity was 57% effective in reducing high-risk sexual behaviors; and

Whereas, Research on comprehensive sex education programs shows these programs help teens delay the onset of sexual activity, reduce the number of sexual partners, and increase condom and contraceptive use; and

Whereas, The American College of Obstetricians and Gynecologists, Society for Adolescent Health and Medicine, American Medical Association, American Public Health Association, National Education Association, and National School Boards Association endorse comprehensive sexuality education for teens that includes abstinence, contraceptive use, human sexuality, and STIs, and they oppose abstinence-only education; and

Whereas, AMA Policy H-170.968 encourages an integrated strategy for making condoms available to students and for providing both factual information and skill-building related to reproductive biology, sexual abstinence, sexual responsibility, contraceptives including condoms, alternatives in birth control, and other issues aimed at prevention of pregnancy and sexual transmission of diseases; and

Whereas, If a school district uses the curriculum developed by the Texas Department of State Health Services, it must teach that homosexuality is an unacceptable lifestyle that, according to Texas Penal Code Section 21.06, can be criminally penalized; and

Whereas, Inclusive sex education programs are those that help youth better understand gender identity and sexual orientation with medically accurate and age-appropriate information; and

Whereas, Sex education programs must be inclusive of LGBTQ+ members for LGBTQ+ youth to have health benefits comparable to their non-LGBTQ+ peers, such as a better understanding of their gender identity, sexual orientation, and need for contraception that in turn supports positive health outcomes, such as teen pregnancy and STI rates comparable to the rates of their non-LGBTQ+ peers; and

Whereas, AMA Policy H-170.968 supports and comprehensively addresses the sexual behavior of all people, inclusive of sexual and gender minorities; and

Whereas, Fewer than 5% of LGBTQ youth had health classes that provided accurate representation of related topics; and

Whereas, Literature from Guttmacher Institute and Columbia University finds that the impact of COVID-19 on adolescents and young adults will have an immediate and long-term negative effect on their sexual and reproductive health needs and behaviors due to their schools not prioritizing sexuality education; therefore be it

RESOLVED, That our Texas Medical Association amend Policy 55.016 Sexuality Education as follows:

55.016 Sexuality Education
Sexuality Education: The Texas Medical Association supports age- and developmentally appropriate, comprehensive sexuality education from kindergarten through college that (a) uses an Effective, evidence-based, medically accurate comprehensive curriculum; (b) should address abstinence-plus practices, avoidance of sexual risk-taking behaviors, various forms of contraception, availability of reproductive health choices, and include responsible decisionmaking, social influences, and peer pressures; and (c) includes factual information and
skill-building related to sexual reproduction anatomy, biology, and other health-related
knowledge that would aid in preventing pregnancy and transmission of sexually transmitted
diseases.

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 and encouraging the inclusion of the
LGBTQ+ community in sexuality education programs that address the sexual behaviors of all

Relevant TMA Policy:
55.016 Sexuality Education

Relevant AMA Policy:
Sexuality Education, Sexual Violence Prevention, Abstinence, and Distribution of Condoms in
Schools H-170.968
Human Sexuality Education H-170.966

References:
1. Abstinence-Only Education Is a Failure. Columbia University Mailman School of Public Health
2. Martin JA, Hamilton BE, Osterman MJK, Driscoll AK. Teen Birth Rate by State. Centers for Disease
5. Waller A. Texas Board Revises Sex Education Standards to Include More Birth Control. The New
6. On Our Side: Public Support for Sex Education. Sexuality Information and Education Council of the
8. Reduced Disparities in Birth Rates Among Teens Aged 15–19 Years - United States, 2006–2007 and
9. Pedlow CT, Carey MP. HIV Sexual Risk-Reduction Interventions for Youth: A Review and
   Methodological Critique of Randomized Controlled Trials. Behavior Modification. 2003;27(2):135-
    2021.
11. American Adolescents’ Sources of Sexual Health Information. Guttmacher Institute. Published Jan. 3,
    Adolescents and Young Adults During the COVID-19 Pandemic. Perspectives on Sexual and
    Reproductive Health.
Subject: In Support of Reevaluating the Use of Race in Estimated Glomerular Filtration Rate

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, “Race” has been poorly defined in medical practice, ranging from use as a population descriptor to a proxy for ancestral background; and

Whereas, Racial categories in the U.S. Census have changed every decade since the 1790s; and

Whereas, Use of race as a surrogate for shared genetic and biological variation is limited by actual genomic variability within racial categories; and

Whereas, Clinical corrections for race were developed on the basis of race being a proxy for biological traits; and

Whereas, The American Medical Association and the American Academy of Family Physicians recognize that race is a social rather than a biological construct; and

Whereas, The premise of the race correction in estimated glomerular filtration rate (eGFR) is based on the assumption that Black individuals have more muscle mass and thus release more creatinine into their blood at baseline; and

Whereas, The two most widely used equations to estimate GFR, the Chronic Kidney Disease Epidemiology Collaboration (CKD-EPI) equation and the Modification of Diet in Renal Disease study equation, yield a higher estimated GFR for Blacks than whites at all levels of creatinine; and

Whereas, AMA Policy H-65.953 and the American Academy of Family Physicians support ending the practice of using race as a proxy for biology or genetics in medical education, research, and clinical practice; and

Whereas, The National Kidney Institute and the American Society of Nephrology created a task force in September 2020 to reevaluate eGFR as a metric based on the premise that race is a social rather than a biological construct; and

Whereas, A variety of major medical centers, including Beth Israel Deaconess Medical Center, Stanford, and the University of Washington, have successfully discontinued the race correction in their eGFR calculation; and

Whereas, A New England Journal of Medicine analysis of 13 clinical corrections for race found that they each systemically directed care away from Black or Latinx patients in areas of existing health disparities; and
Whereas, AMA Policy H-350.974 recognizes that racial and ethnic disparities are a major public health problem in the U.S. and a barrier to effective medical diagnosis and treatment, and states that the elimination of racial and ethnic disparities is of highest priority; and

Whereas, Despite similar rates of chronic kidney disease (CKD) across different major racial and socioeconomic groups, the rate of end-stage renal disease in Black patients is approximately 3.5 times the rate of white patients, and a contributing factor is that Black patients with CKD are more likely than whites to have delayed or no nephrology referral; and

Whereas, If the consideration of race were removed from the CKD-EPI equation, the recommended formula for estimating GFR in adults, one out of four Black patients with CKD would be classified as having a more severe state of CKD and would be eligible for more advanced care; and

Whereas, If race were removed from the CKD-EPI equation, more than 60,000 Black adults in the U.S. with CKD would be able to receive specialty care for kidney disease, and the number of Black adults eligible for kidney transplant would increase by 3%; therefore be it

RESOLVED, That our Texas Medical Association recognize that race is an inaccurate proxy metric to use in estimating glomerular filtration rate (GFR) because race is a social rather than biological construct; and be it further

RESOLVED, That our TMA support and encourage efforts to study and redefine the currently used race correction factor, so that GFR can be estimated with factors other than self-identified race.

Related TMA Policy:
265.018 Evidence-Based Medicine and Practice
265.030 Social Determinants of Health

Related AMA Policy:
Elimination of Race as a Proxy for Ancestry, Genetics, and Biology in Medical Education, Research and Clinical Practice H-65.953
8.5 Disparities in Health Care
Racial and Ethnic Disparities in Health Care H-350.974
Race and Ethnicity as Variables in Medical Research H-460.924
Establishment of State Commission / Task Force to Eliminate Racial and Ethnic Health Care Disparities H-440.869
Strategies for Eliminating Minority Health Care Disparities D-350.996

References:


Texas Medical Association House of Delegates

Resolution 331
2021

Subject: Support for Increasing Digital Access

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, The United Nations has declared universal internet access a basic human right; and

Whereas, Access to the internet, particularly in the era of COVID-19, influences all six social determinants of health domains as defined by the American Medical Association, including access to health care, education, and social support; and

Whereas, More than 2 million Texas households do not have high-speed internet; and

Whereas, Only 69% of rural households have access to high-speed internet, but the U.S. Census Bureau reports that three times as many households in urban areas remain unconnected compared to rural areas; and

Whereas, Roughly half (49%) of U.S. senior citizens reported they did not have home broadband services in 2017; and

Whereas, Half of non-broadband users state they do not subscribe to broadband because the cost is too expensive; and

Whereas, 52 million adults do not know how to use a computer properly even when they have access to one; and

Whereas, The proportion of respondents to the National Telecommunications and Information Administration (NTIA) survey who reported that they did not subscribe to home broadband primarily due to digital literacy issues doubled between 2009 and 2017; and

Whereas, Adults who are not digitally literate are, on average, less educated, older, and more likely to be Black, Hispanic, or foreign born, compared to digitally literate adults, populations which tend to be concentrated in urban centers; and

Whereas, Timely, accurate information pertaining to the COVID-19 pandemic, including stay-at-home orders or vaccine distribution information, is often distributed over the internet; and

Whereas, The ability to self-isolate during the COVID-19 pandemic is tied to individuals’ access to home high-speed internet; and

Whereas, Many hospital systems have switched to using telehealth to deliver care during the COVID-19 pandemic; and
Whereas, Telehealth visits increased by 154% from March 2019 to March 2020 in the United States, illustrating the large increase in the use of telehealth; and

Whereas, Digital literacy gaps have been shown to decrease the efficacy of telehealth interventions; and

Whereas, Existing AMA policy H-65.960 (Health, In All Its Dimensions, Is a Basic Right) acknowledges that optimizing the social determinants of health is an ethical obligation; and

Whereas, Existing AMA policy H-478.980 (Increasing Access to Broadband Internet to Reduce Health Disparities) advocates for the expansion of broadband and wireless connectivity to rural and underserved areas of the U.S.; and

Whereas, Existing TMA policy does not address the digital divide in urban areas or digital literacy barriers to internet access; and

Whereas, Existing TMA policy (275.006 Broadband Internet Access to Rural Texas) advocates for expeditious expansion of broadband connectivity to all rural areas of Texas; therefore be it

RESOLVED, That the Texas Medical Association advocate for increased access to high-speed home broadband internet, particularly to address needs in both elderly and underprivileged communities for the purposes of improving telehealth access and reducing health disparities; and be it further

RESOLVED, That TMA advocate to improve digital literacy, particularly to address needs in both elderly and underprivileged communities for the purposes of improving telehealth access and reducing health disparities.

Related TMA Policy:
275.006 Broadband Internet Access to Rural Texas
290.002 Telemedicine Use to Improve Health Care

Related AMA Policy:
Health, In All Its Dimensions, Is a Basic Right H-65.960
COVID-19 Emergency and Expanded Telemedicine Regulations D-480.963

References:


TEXAS MEDICAL ASSOCIATION HOUSE OF DElegates

Resolution 332
2021

Subject: Opposition to Criminalization of Gender-Affirming Care for Transgender Youth

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, Transgender youth have a greater risk of developing internalizing psychopathologies, suicidality, and substance use disorders compared with cisgender youth due to gender dysphoria, discrimination, and stigma; and

Whereas, Transgender and gender-nonconforming youth report decreased use of health care resources compared with cisgender youth because of barriers to health care access such as anticipated stigma, unmet gender affirmation needs, delayed access to pubertal blockers or hormone replacement therapy, and insurance exclusions; and

Whereas, Transgender youth of color face unique barriers that limit access to medical care such as high rates of homelessness, arrests, and detentions, and exposure to street violence; and

Whereas, Gender-affirming care refers to care that distinguishes between gender identity and sex, validates patients’ gender identity, avoids pathologizing transgender identities, and provides a safe environment for transgender patients; and

Whereas, Transgender youth who receive gender-affirming medical care experience longitudinally improved mental health status, including decreased suicidal ideation, depression, and gender dysphoria; and

Whereas, Access to gender-affirming care has been further restricted during the COVID-19 pandemic, delaying medically necessary and time-sensitive treatments, which can exacerbate adverse mental health outcomes among transgender youth; and

Whereas, Texas Medical Association Policy 55.058 supports evidence-based, gender-affirming therapies for adolescents but does not address or articulate a strategy against efforts to criminalize those who provide evidence-based therapy; and

Whereas, State legislators in Texas, Alabama, Colorado, Florida, Illinois, Kentucky, Missouri, Oklahoma, South Carolina, and South Dakota have introduced legislation that restricts transgender youths’ access to gender-affirming care and restricts physicians from providing gender-affirming care; and

Whereas, In May 2019, six leading medical organizations – the American Academy of Family Physicians, American Academy of Pediatrics, American College of Obstetricians and Gynecologists, American College of Physicians, American Osteopathic Association, and American Psychiatric Association – issued a joint statement opposing “efforts in state legislatures across the United States that inappropriately interfere with the patient-physician relationship, unnecessarily regulate the evidence-based practice of medicine and, in some cases, even criminalize physicians who deliver safe, legal, and necessary medical care”; therefore be it
RESOLVED, That our Texas Medical Association opposes efforts to criminalize evidence-based, gender-affirming care for transgender youth; and be it further

RESOLVED, That our TMA amend Policy 55.058 Sexual Orientation Change Efforts for Minors as follows:

(1) The Texas Medical Association supports treatment and therapies rooted in acceptance and support regarding an individual’s sexual orientation and gender identification and therefore opposes practices aimed at changing an individual’s sexual orientation, including conversion therapy; (2) TMA supports physician efforts to provide medically appropriate therapies affirming gender identity and opposes the criminalization of these practices; (23) TMA supports the prohibition of any person licensed to provide mental health counseling from engaging in sexual orientation change efforts with patients younger than 18 years of age. TMA supports the practice of evidence-based therapies and will aggressively oppose the use of potentially harmful, unproven therapies for children. In addition, the association supports any regulatory changes to prohibit coverage for conversion therapy under the state’s Medicaid program as well as any health insurers in the state; (34) TMA encourages physicians to stay informed on the potential harms associated with sexual orientation change efforts. (CM-CAH & TF Rep. 4-A-17)

Related TMA Policy:
55.004 Adolescent Sexual Activity
55.058 Sexual Orientation Change Efforts in Minors
265.028 Improving LGBTQ Health Care Access
55.016 Sexuality Education
60.008 Rejection of Discrimination
60.009 Gender Identity and Public Facility Use
60.010 Opposing Legislation that Mandates Physician Discrimination

Related AMA Policy:
Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations H-160.991
Plan for Continued Progress Toward Health Equity H-180.944
Reducing Suicide Risk Among Lesbian, Gay, Bisexual, Transgender, and Questioning Youth Through Collaboration with Allied Organizations H-60.927
Preventing Anti-Transgender Violence H-65.957
Access to Basic Human Services for Transgender Individuals H-65.964
Support of Human Rights and Freedom H-65.965
Removing Financial Barriers to Care for Transgender Patients H-185.950
Clarification of Medical Necessity for Treatment of Gender Dysphoria H-185.927
Improving Screening and Treatment Guidelines for Intimate Partner Violence (IPV) Against Lesbian, Gay, Bisexual, Transgender, Queer/Questioning, and Other Individuals (LGBTQ) D-515.980
Patient-Reported Outcomes in Gender Confirmation Surgery H-460.893
Health Disparities Among Gay, Lesbian, Bisexual, Transgender and Queer Families D-65.995
Patient Access to Treatments Prescribed by Their Physicians H-120.988

References:


TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 333
2021

Subject: Opposition to Sobriety Requirement for Hepatitis C Treatment

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, The annual incidence rate of hepatitis C virus (HCV) in the U.S. has tripled in the past decade, and conservative estimates place prevalence at 2.4 million people in the U.S. and 376,000 people in Texas; and

Whereas, Additionally, with current HCV management protocols, a projected 320,000 patients will die, 157,000 will develop hepatocellular carcinoma, and 203,000 will develop decompensated cirrhosis during the next 35 years; and

Whereas, Much of the morbidity and mortality associated with HCV can be prevented with early diagnosis and treatment, as direct acting antiviral (DAA) medications cure more than 95% of those with HCV; and

Whereas, Injection drug use is the largest driving factor for HCV spread, and an estimated 53% of people who inject drugs (PWID) have HCV, relative to 1% of the general U.S. population; and

Whereas, In spite of their greater vulnerability to HCV, PWIDs face greater barriers to accessing treatment, as some Medicaid groups require abstinence from alcohol and substance use for up to six months prior to receiving DAA medications; and

Whereas, One study found that up to 96% of PWID who were diagnosed with HCV would likely be restricted from accessing essential treatment based on unwarranted contraindications, such as drinking, depression, and recent drug injection, compared with only 11% of the non-PWID diagnosed with HCV; and

Whereas, Those with substance use disorder have the same HCV cure rates as their healthy counterparts, and were shown to have high adherence to treatment and low six-month reinfection rates; and

Whereas, The Social Security Act states that requirements by the states for abstinence “should not result in the denial of access to effective, clinically appropriate, and medically necessary treatments using DAA drugs for beneficiaries with chronic HCV infections”; and

Whereas, In Texas, Medicaid fee-for-service requires 90 days of sobriety before even a prior authorization request to receive curative treatment for hepatitis C; and

Whereas, Thirteen of the 15 Medicaid managed care organizations in Texas (Aetna, Amerigroup, Blue Cross and Blue Shield of Texas, Cigna HealthSpring, Christus Health Plan, Community Health First Plans, El Paso First Health, FirstCare STAR Health Plans, Molina Healthcare, Scott & White, Sendero Health Plans, Superior HealthPlan, and UnitedHealthcare) have a 90-day requirement of sobriety to be eligible to receive treatment; and
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Whereas, The National Viral Hepatitis Roundtable and the Center for Health Law and Policy Innovation at Harvard Law School report that state laws requiring abstinence greatly limit those who can receive hepatitis C treatment, and they graded Texas “D+”; and

Whereas, The Centers for Medicare & Medicaid Services, U.S. Department of Veteran Affairs, and leading professional associations of Medicaid providers have stated that sobriety restrictions are an unnecessary restriction to care; and

Whereas, Abstinence policies prior to treatment are in contradiction to the Recommendations for Testing, Managing, and Treating Hepatitis C published jointly by the American Association for the Study of Liver Diseases and the Infectious Diseases Society of America; and

Whereas, Not providing hepatitis C treatment to those with substance use disorder is discriminatory towards patients with a substance abuse disorder and may violate the Americans with Disabilities Act, and the Center for Health Law and Policy Innovation at Harvard Law School has asked the Department of Justice to investigate this matter; and

Whereas, In 2020, 74% of Medicaid programs had stopped enforcing abstinence requirements prior to providing hepatitis C treatment, and Texas is one of the last 13 states that still imposes a sobriety requirement; and

Whereas, By increasing DAA treatment in injection drug users, other countries halved HCV prevalence (51% in 2015 to now 18% as of 2019), which has decreased transmission to younger injection drug users; and

Whereas, Those with HCV are at an increased risk of serious illness from COVID-19, and withholding life-saving treatment for HCV during the COVID-19 pandemic due to sobriety requirements could increase morbidity and mortality; therefore be it

RESOLVED, That our Texas Medical Association oppose the Texas Medicaid 90-day sobriety requirement for hepatitis C virus (HCV) treatment; and be it further

RESOLVED, That TMA support efforts to remove the sobriety requirement as a barrier to HCV treatment; and be it further

RESOLVED, That TMA encourage the awareness and avoidance of barriers relating to access to HCV treatment.

Related TMA Policy:
260.060 Hepatitis C
95.045 Evidence-Based Management of Substance Use Disorders
95.021 National Drug Policy
145.019 Mental Health Equitable Treatment and Parity

Related AMA Policy:
Advocacy for Hepatitis C Virus Education, Prevention, Screening and Treatment H-440.845
Substance Use and Substance Use Disorders H-95.922
Federal Drug Policy in the United States H-95.981
References:


Whereas, Institutional racism is defined as policies, rules, practices, and the like that have become a usual part of the way an organization or society works and that result in and support a continued unfair advantage to some people and unfair or harmful treatment of others based on race; and

Whereas, After controlling for socioeconomic differences, race and ethnicity remain predictors of the quality of health care patients receive; and

Whereas, In a 2018 National Health Interview Survey, 13.8% of Black respondents and 12.3% of Hispanic or Latino respondents reported health in fair or poor condition compared with only 8.3% of white respondents; and

Whereas, Individuals from racial minority groups consistently experience worse health outcomes and lower quality of care; and

Whereas, The American College of Physicians has found that Black/African American people are at risk of being subjected to discrimination and violence against them because of their race, endangering them and even costing them their lives; and

Whereas, A study suggests that medical students and residents hold and may use false beliefs about biological differences between Black and white patients to inform medical judgments; and

Whereas, Hospitals and clinics that previously were designated for racial and ethnic minorities continue to experience significant financial constraints, are often underresourced, and are improperly staffed; and

Whereas, Framing racism as a public health issue can compel organizations and governmental units to begin initiatives to address racism; and

Whereas, Many Texas medical schools and health science centers have initiated antiracism resources for their students; and

Whereas, A hospital faculty development workshop designed to teach about the role of racism in creating disparities in health care reported a significant change in attitude in 72 out of 120 participants with regard to racism and related issues; and

Whereas, The Association of American Colleges has stated that the medical community has used diversity, equity, and inclusion programs to help reduce racial bias and discrimination; and

Whereas, The American Hospital Association acknowledges racism and has provided resources on addressing and mitigating the effects of racism during the COVID-19 pandemic; and
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Whereas, The cities of Austin and San Antonio, and Harris and Dallas counties have acknowledged racism as a public health issue; and

Whereas, The American Pharmacists Association and the American Academy of Family Physicians recognize the impact of racism within the U.S. health care delivery system, which has historically engaged in the systematic segregation and discrimination of patients based on race and ethnicity, the effects of which persist to this day; and

Whereas, American Medical Association Policy H-350.974 acknowledges that racial health disparities pose a major public health problem; and

Whereas, AMA Policy 350.025MSS recognizes that systemic, cultural, interpersonal, and other forms of racism are a threat to public health and continue to cause harm; and

Whereas, Texas Medical Association Policy 50.012 recognizes that racial health disparities in cancer care lead to worse health outcomes in racial minorities and are a public health issue; and therefore it be

RESOLVED, That our Texas Medical Association acknowledge that systemic and structural racism within the health care system has caused and continues to cause health inequity that harms marginalized communities; and be it further

RESOLVED, That TMA recognize racism, in its systemic, cultural, interpersonal, and other forms, poses a threat to public health, the advancement of health equity, and the delivery of appropriate medical care; and be it further

RESOLVED, That TMA support resource development for health care institutions, physician practices, and academic medical centers to recognize, address, and mitigate the effects of racism on patients, physicians, providers, and populations.

Related TMA Policy:
50.012 Addressing Cancer Health Disparities
60.008 Rejection of Discrimination

Related AMA Policy:
Racial and Ethnic Disparities in Health Care H-350.974

References:
Whereas, The Texas Department of Criminal Justice has one of the highest rates of COVID-19 infections and deaths of any state or federal prison system in the country; and

Whereas, COVID-19 deaths in the Texas prison system have remained high throughout the course of the pandemic, while other states with prison systems that had high death counts early in the pandemic adopted measures that reduced deaths over time; and

Whereas, Prisons and jails are breeding grounds for virus transmission among the incarcerated population and the general public due to dense crowding, disparate access to hygiene supplies and personal protective equipment, inability to quarantine and maintain social distance, transfers between facilities and release, and jail staff who often become vectors of disease transmission; and

Whereas, COVID-19 infection in prisons and jails gives rise to more severe illness and mortality because of the high rates of chronic disease among incarcerated populations; and

Whereas, The United Nations Office on Drugs and Crime recognizes that alternatives to imprisonment, reassessing pretrial detention, and commuting sentences all are measures that should be considered to protect people inside and outside the prison; and

Whereas, The U.S. Supreme Court applied the Eighth Amendment to incarcerated people such that they are entitled to a quality of medical care equivalent to that provided for the general public and that a lack thereof constitutes cruel and unusual punishment; and

Whereas, The United Nations Standard Minimum Rules for the Treatment of Prisoners (the Nelson Mandela Rules) dictate that health care in prison should include preventive medicine, which in the context of COVID-19 includes access to educational information, hygiene supplies, testing, and personal protective equipment; and

Whereas, Texas Department of Criminal Justice leadership have undermined measures for mitigating viral spread during the pandemic: Prison employees have been forced to share and reuse personal protective equipment, infected prisoners are often not isolated or quarantined for an adequate length of time, and prisoners have been transferred to new facilities while sick; and

Whereas, Incarcerated individuals are disincentivized from seeking medical care during the pandemic for fear of being placed in solitary confinement or otherwise punished; and

Whereas, Access to health care for other reasons, such as substance abuse treatment, has also diminished due to the pandemic and resultant strains on prison personnel; many prisons have restricted access for nonessential staff, including contracted and external physicians and health care providers; and
Whereas, The COVID-19 vaccine rollout plan for Texas includes no timeline or strategy for the
vaccination of incarcerated and detained individuals, reflecting a violation of the state’s duty to protect
the health of those in its custody; and

Whereas, The Centers for Disease Control and Prevention (CDC) has not approved using incarcerated
people as a strategy to mitigate local community COVID-19 transmission or relieve an overwhelmed
medical system; and

Whereas, CDC defines incarcerated people as a population protected from research, given their
vulnerability to undue influence compared with the general population; and

Whereas, Although incarcerated people enjoy the right to work, they are not in the ethical position to
provide informed consent to work in hazardous conditions; and

Whereas, The American Medical Association has two policies supporting health care for the incarcerated,
H-430.986 and D-430.997, and TMA currently has none; therefore be it

RESOLVED, That our Texas Medical Association recognize incarcerated health is public health by
protecting the health and safety of incarcerated and detained individuals through the following actions
including, but not limited to:

1. Advocating for equivalence of care for those incarcerated and detained;
2. During infectious disease outbreaks, (a) advocating for the urgent provisioning of personal protective
equipment and needed hygiene supplies, and (b) encouraging the adoption of safety measures such as
social distancing, reduced crowding, and decarceration to mitigate disease spread in facilities;
3. Promoting access to nonemergent health services during disease outbreaks;
4. Opposing using incarcerated people to respond to public health emergencies;
5. Recognizing incarcerated and detained individuals as a high-risk group for prioritization of vaccine
access;
6. Encouraging the enactment of safeguards that protect the ability of incarcerated people to access care
without fear of retaliation;
7. Supporting strengthening the Eighth Amendment rights of incarcerated people to access adequate
medical care;
8. Supporting legislation requiring U.S. Occupational Safety and Health Administration protections in
incarcerated workplaces;
9. Encouraging the Texas state Medicaid agency to accept and process Medicaid applications from
eligible juveniles and adults who are incarcerated to improve access to care, particularly during a
pandemic;
10. Advocate for adequate payment to physicians and health care providers, including primary care,
mental health, and addiction treatment professionals, to encourage improved access to comprehensive
physical and behavioral health care services to juveniles and adults throughout the incarceration
process from intake to reentry into the community;
11. Supporting partnerships and information-sharing among correctional systems, community health
systems, and state insurance programs to provide access to a continuum of health care services for
juveniles and adults in the correctional system; and
12. Supporting (a) linkage of those incarcerated to community clinics upon release to accelerate access to
comprehensive health care, including mental health and substance abuse disorder services, and
improve health outcomes among this vulnerable patient population, as well as adequate funding; and
(b) the collaboration of correctional health workers and community physicians and health care
providers for those transitioning from a correctional institution to the community.
Related TMA Policy:
1. 260.042 Core Public Health Functions
2. 260.103 Disaster Preparedness Planning and Response
3. 260.037 Essential Public Health Services
4. 105.009 Informed Consent

Related AMA Policy:
1. 7.1.2 Informed Consent in Research
2. Health Care While Incarcerated H-430.986
3. Support for Health Care Services to Incarcerated Persons D-430.997

References:
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 336
2021

Subject: Results and Regulation of Freestanding Birthing Centers and at Home Birthing Services
(Formally Res 426 2020)

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Science and Public Health

 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 these 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, Texas Medical Association has policy about reducing maternal mortality; 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
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 337
2021

Subject: Advocating for Evidence-Based Care for Incarcerated Pregnant Women in Texas Correctional Facilities

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, Approximately 4,000 pregnant women pass through Texas county jails each year, and Texas state prisons admit an average of 241 pregnant inmates every year; and

Whereas, In 1976 in Estelle v. Gamble, the U.S. Supreme Court established that correctional facilities have an obligation to provide access to health care in prison settings under an interpretation of the Eighth Amendment; and

Whereas, A significant number of pregnant inmates will require at least one prenatal visit during their period of incarceration based on the average length of stay for pregnant inmates and the current American College of Obstetricians and Gynecologists (ACOG) and American Academy of Pediatrics (AAP) Guidelines for Perinatal Care; and

Whereas, Section 501.0666 of Texas Government Code regarding inmate welfare states that pregnant inmates shall be provided sufficient food and dietary supplements, including prenatal vitamins, as ordered by an appropriate medical professional; and

Whereas, According to the Texas minimum jail standards in Texas Administration Code (TAC) Section 273.2, each correctional facility must follow a written plan approved by the Texas Commission on Jail Standards, that “provide[s] procedures for obstetrical and gynecological care, mental, nutritional requirements, special housing and appropriate work assignment, and the documented use of restraints during labor, delivery, and recovery for pregnant inmates”; and

Whereas, According to TAC Section 273.2(15), each facility under its written plan also must train staff to identify when a pregnant inmate is in labor and provide access to appropriate care; and

Whereas, According to the Texas Commission on Jail Standards 2016 House Bill 1140 report on the care of pregnant women in Texas county jails, approximately 27% of sheriffs representing each county jail report having no specific policy regarding frequency of prenatal visits with a specified type of physician or provider; and

Whereas, Regarding initial and routine visits to the physician or provider, sheriffs report conducting or monitoring blood testing (16%), blood pressure on initial visit (14%), fetal heart tones (18%), urinalysis (18%), abdominal palpations (18%), fetal movement (16%), weight measurement (17%), and symphysis fundus height (15%); and

Whereas, Also regarding prenatal procedures and tests, 17% of sheriffs report having no jail policy regarding the frequency of blood testing, and 18% report having no specific jail policy on the frequency
of monitoring blood pressure, fetal heart tones, urinalysis, abdominal palpations, fetal movement, weight, or symphysis fundus height; and

Whereas, In regard to substance abuse management, sheriffs report having routinely available chemical dependency treatment (24%), detox protocol (45%), detox support (36%), and methadone access (11%); and

Whereas, Regarding nutritional standards, 150 county jails report an average daily caloric intake of 2,780, ranging from 1,800 to 6,800 calories, with some counties reporting caloric need is determined by trimester or by a physician on an individualized basis, demonstrating a lack of uniformity across facilities; and

Whereas, Regarding supplemental nutrition, sheriffs report they routinely provide a supplemental snack (70%), prenatal vitamins and fresh fruits/vegetables (81%), nutritional beverages such as Ensure (29%), and fresh water (89%); and

Whereas, Texas does not require jails to follow specific guidelines on the provision of appropriate nutrition to pregnant inmates and what constitutes ‘appropriate nutrition’; and

Whereas, Texas fails to report all pregnant inmates’ pregnancies and outcomes; and

Whereas, The detrimental perinatal outcomes of inadequate prenatal care include up to a seven-fold increased risk for preterm delivery, increased risk for stillbirth, low birth weight, admission to the neonatal intensive care unit, short interpregnancy interval, and decreased odds of initiating breastfeeding or having an infant immunized; and

Whereas, Other states such as Pennsylvania, North Carolina, and Oklahoma have explicit standards of care for incarcerated pregnant mothers, such as specific lab tests, frequency of prenatal visits with an obstetrician, and screening for high-risk pregnancies; and

Whereas, In Policy 265.018, the Texas Medical Association, “strongly supports the standardization of a national set of evidence-based measures that are clinically meaningful and lead to improvement while improving both patient outcome and patient satisfaction”; and

Whereas, ACOG states care provided to pregnant inmates should follow the ACOG and AAP Guidelines for Perinatal Care and mechanisms to ensure implementation of these guidelines must be secured; therefore be it

RESOLVED, That our Texas Medical Association recognize the lack of uniform prenatal care provided to incarcerated pregnant women in Texas correctional facilities; and be it

RESOLVED, That TMA encourage the Texas Commission on Jail Standards and Texas Department of Criminal Justice to comply with evidence-based guidelines from national physician organizations regarding the care and management of incarcerated pregnant women in Texas correctional facilities; and be it

RESOLVED, That TMA encourage the Texas Commission on Jail Standards and Texas Department of Criminal Justice to report all pregnant inmates’ pregnancies and outcomes.
Related TMA Policy:
265.018 Evidence-Based Medicine and Practice

Related AMA Policy:
Standards of Care for Inmates of Correctional Facilities H-430.997
Health Care While Incarcerated H-430.986

References:
Subject: Support for Immunization Information System Interjurisdictional Data Exchange

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, Immunization information systems (IISs), or immunization registries, are computerized, confidential databases that record immunization doses administered by participating physicians and providers in a given jurisdiction; and

Whereas, IISs provide consolidated patient immunization histories across multiple physicians/providers and generate immunization reminders for patients and physicians/providers; and

Whereas, IISs provide aggregate data on vaccinations, allowing assessment of coverage levels and guiding public health action to reduce vaccine-preventable disease; and

Whereas, Individual states and regions currently maintain 64 IISs within the U.S., including Texas’ immunization registry, ImmTrac2; and

Whereas, Each IIS is subject to local, state, and federal laws and regulations for protection of health information, posing barriers to interjurisdictional data sharing; and

Whereas, Thirty-four of the 64 IISs have signed memorandums of understanding allowing interjurisdictional data exchange across IISs; and

Whereas, ImmTrac2 has not signed such a memorandum of understanding; and

Whereas, Texas does not permit interjurisdictional sharing of personal immunization data from ImmTrac2, instead allowing only aggregate, statistical data to be shared; and

Whereas, On average, people in the U.S. move more than 11 times in their lifetime, potentially leading to incomplete immunization records due to limited interjurisdictional immunization data exchange; and

Whereas, Incomplete immunization records lead to overvaccination and missed opportunities for vaccination, and pose challenges during multijurisdictional outbreaks when public health officials, physicians, and health care providers need to ascertain immunization status; and

Whereas, The National Vaccine Advisory Committee and the American Immunization Registry Association support and prioritize the improvement of IIS-to-IIS data exchange across jurisdictions; and

Whereas, American Medical Association Policy H-440.899 encourages states to develop comprehensive, lifespan immunization registries interfaced with other state registries; and

Whereas, The ongoing COVID-19 pandemic and immunization efforts have highlighted the need for interjurisdictional data on immunizations to ensure individuals receive appropriate, timely follow-up
doses of existing multidose vaccines even if individuals leave their state or region between doses; and therefore be it

RESOLVED, That our Texas Medical Association support sharing Texas immunization registry (ImmTrac2) data interjurisdictionally with other state and regional immunization information systems to help ensure accurate and complete patient immunization records while maintaining patient privacy.

Related TMA Policy:
135.011 Immunization Registry for Texas
135.025 Improving the ImmTrac Registry by Reverting Back to an Opt-Out System
135.017 ImmTrac
135.021 Immunization Records
135.008 Immunizations Administering

Related AMA Policy:
Immunization Registries H-440.899
Establishment of a Network of State Immunization Registries D-440.961
Distribution and Administration of Vaccines H-440.877

References:
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 339
2021

Subject: Support for Texas Department of State Health Services Efforts to Address Racial and Ethnic Disparities in Health

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, Texas’s 29 million residents are 40% Hispanic or Latino, 13% Black, 5% Asian, and 41% white non-Hispanic or -Latino, according to U.S. Census Bureau population estimates for 2019; and

Whereas, In a 2018 National Health Interview Survey, 13.8% of Black respondents and 12.3% of Hispanic or Latino respondents reported health in fair or poor conditions compared with only 8.3% of white respondents; and

Whereas, Statewide racial and ethnic disparities in health exist, with a 2017 Texas Department of State Health Services study indicating the African American population makes up 11.8% of the Texas population but 39.8% of the obese Texas population, while the white population makes up 41.9% of the Texas population and only 30.1% of the obese Texas population; and

Whereas, The ongoing COVID-19 pandemic has exacerbated statewide racial and ethnic disparities in health, with Hispanic Texans accounting for 49% of known COVID-19 fatalities in July despite making up only 40% of the state population, and Black Texans accounting for 14% of the fatalities despite only making up 12% of the state population; and

Whereas, The Texas Office of Minority Health Statistics and Engagement studied and worked to solve racial inequities across Texas’s health agencies prior to its defunding in the 2017 legislative session; and

Whereas, Advocates and state lawmakers have stated that had the Office of Minority Health Statistics and Engagement not been dismantled, Texas would have been in a better position to identify and take action on disparities in racial and ethnic health earlier in the COVID-19 pandemic and vaccine rollout; and

Whereas, The Office of Minority Health Statistics and Engagement fell within the oversight of the Texas Health and Human Services Commission, of which the Texas Department of State Health Services is a part; and

Whereas, The Texas Department of State Health Services initially struggled to collect and provide comprehensive information on race and ethnicity in early COVID-19 cases, limiting early information on COVID-19-related racial and ethnic disparities in health; and

Whereas, The Texas Department of State Health Services’ statewide COVID-19 vaccine rollout designates fewer vaccine distribution sites in majority Hispanic and Black areas in Harris, Dallas, and Travis counties, limiting vaccine accessibility for minority populations in major Texas counties; and
Whereas, American Medical Association Policy H-350.974 recognizes racial and ethnic health disparities as a major public health problem and prioritizes the elimination of racial and ethnic disparities in health care; and therefore be it

RESOLVED, That our Texas Medical Association support the Texas Department of State Health Services prioritizing continued efforts to address racial and ethnic disparities in health.

Related TMA Policy:
- 60.008 Rejection of Discrimination
- 50.012 Addressing Cancer Health Disparities
- 265.030 Social Determinants of Health

Related AMA Policy:
- Racial and Ethnic Disparities in Health Care H-350.974

References:
Whereas, In 2016, Texas had an estimated 1.6 million undocumented immigrants, who comprised 33% of the immigrant population and 6% of the total population; and

Whereas, A 2020 study found that in Texas, approximately 32% of undocumented immigrants live below the poverty line and 64% are uninsured, limiting access to medical treatment; and

Whereas, Longstanding federal policies such as the five-year waiting period all immigrants, including undocumented immigrants, must follow to qualify for federally funded public benefits has impeded attempts to reduce the impact of COVID-19 on immigrant populations, specifically those who are undocumented; and

Whereas, Undocumented immigrants are more likely to be uninsured due to restrictions from participating in Medicare, Medicaid, the Children’s Health Insurance Program (CHIP), and the Affordable Care Act (ACA) marketplaces; and

Whereas, Undocumented immigrants often live in multigenerational housing, which increases their risk for COVID-19 exposures; and

Whereas, Undocumented workers are at a disproportionately higher risk of contracting COVID-19 as they often hold essential, frontline jobs that put them at significant risk; and

Whereas, Undocumented immigrants often have low-to-moderate incomes with no regular medical care, making them more likely to delay seeking medical care for COVID-19; and

Whereas, Testing provided by the optional state Medicaid program in the Families First Act restricts COVID-19 testing to immigrants who are already eligible for Medicaid, which does not include undocumented immigrants; and

Whereas, While many fears have been quelled by the U.S. Citizenship and Immigration Services’ (USCIS) announcement that COVID-19 related testing, treatment, or preventive care will not count against aliens in the public charge analysis, financial barriers to care of undocumented individuals and fear of deportation are still prevalent; and

Whereas, Undocumented immigrants are often excluded from public assistance programs and have been excluded from stimulus payments and other benefits provided by COVID-19 relief bills; and

Whereas, The Coronavirus Aid, Relief, and Economic Security Act (CARES Act) only covers COVID-19 testing for uninsured individuals, not their treatment costs; and
Whereas, The CARES Act extended funding for Community Health Centers and created reimbursement opportunities for health care providers facing lost revenue as a result of COVID-19, but providers are not required to take part and patients often have difficulty discerning which providers are currently participating; and

Whereas, In Texas, approximately 50% of undocumented immigrants lack English proficiency and are therefore less likely to receive and understand public health messages, warnings, and updates provided by the Centers for Disease Control and Prevention or state officials; and

Whereas, The Health Resources and Services Administration (HRSA) COVID-19 Uninsured Program only reimburses the cost of care for patients with a primary diagnosis of COVID-19 and does not cover the cost of follow-up care or care for secondary symptoms brought on by the virus; and

Whereas, If providers fail to submit a bill for a patient’s COVID-19 related treatment or testing to the HRSA COVID-19 Uninsured Program, the patient may be fully responsible for the bill; and

Whereas, According to Pew Research Center, more than 68% of American adults believe the country has a responsibility to expand health care access to combat COVID-19 and provide care to affected undocumented immigrants; and

Whereas, New Jersey and California provide free COVID-19 treatment to all individuals, regardless of insurance or immigration status; and

Whereas, Recent administrations stated all persons in the U.S., regardless of status, should have access to free COVID-19 services including testing, vaccinations as they become available, and hospitalization; and

Whereas, It has been estimated that approximately 50-80% of the population needs to be vaccinated to reach the herd immunity threshold for COVID-19, so excluding undocumented immigrants from vaccination distribution plans would undermine herd immunity, preventing the U.S. from recovering from the COVID-19 pandemic; and

Whereas, Expanding statewide COVID-19 coverage and reimbursements for undocumented children is supported by Texas Medical Association policy 55.057;28 and

Whereas, Providing COVID-19 testing, treatment, relevant follow-up appointments, vaccinations, and hospitalizations free of charge to undocumented immigrants in Texas is supported by TMA policy 110.006; therefore be it

RESOLVED, That the Texas Medical Association advocate for assistance for the reduction of language barriers by medical centers, community centers, free clinics, and physicians in the communication of COVID-19 and any future pandemic-associated information, testing, treatment, and vaccinations; and be it further

RESOLVED, That TMA support physician participation in any current and future pandemic-related government assistance programs such as the Health Resources and Services Administration (HRSA) COVID-19 Uninsured Program; and be it further

RESOLVED, That TMA support the distribution of life-saving vaccinations to all individuals in the community, including undocumented immigrants, during a pandemic in order to swiftly achieve herd immunity; and be it further
RESOLVED, That TMA support the allocation of additional funding for health care coverage of undocumented immigrants during any national pandemic.

**Related TMA Policy:**
- 55.057 Health Care of Undocumented Children
- 145.013 Private Healthcare System, Impact of Uninsured
- 110.006 Health Plan
- 260.103 Disaster Preparedness Planning and Response

**Related AMA Policy:**
- Health Care Payment for Undocumented Persons D-440.985
- Federal Funding for Safety Net Care for Undocumented Aliens H-160.956
- Medical Needs of Unaccompanied, Undocumented Immigrant Children D-65.992
- Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients H-440.876
- Patient and Physician Rights Regarding Immigration Status H-315.966
- Financial Impact of Immigration on American Health System D-160.988

**References:**


Resolution 341
2021

Subject: Acknowledging Abortion Is a Time-Sensitive Medical Procedure

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, In May 2020, the U.S. surgeon general called for hospitals to consider stopping elective procedures during the COVID-19 outbreak to ensure adequate hospital space and resources for COVID-19 patients, leading many states to issue varied forms of restrictions on elective procedures; and

Whereas, Often a surgical procedure is designated as “elective” to distinguish between emergent and nonemergent cases though medically necessary procedures can fall under both forms of care; and

Whereas, Studies have shown that any delay in access to an “elective surgery” that is medically necessary can have a variety of harmful effects including, but not limited to, higher morbidity and mortality, reduced quality of life, reduced activity and mobility, and increased costs for the health system; and

Whereas, Multiple times during the ongoing COVID-19 pandemic, Texas Gov. Greg Abbott implemented bans on elective medical procedures and called for procedures that were not “immediately, medically necessary” to be barred temporarily; and

Whereas, In his July 9, 2020, executive order, Governor Abbott extended the suspension of nonemergent surgeries to more than 100 counties and asked that hospitals within certain trauma service areas “postpone surgeries and procedures that are not medically necessary to diagnose or correct a serious medical condition, or to preserve the life of a patient” and also stated that the suspension does not apply to “any surgery or procedure that, if performed in accordance with the commonly accepted standard of clinical practice, would not deplete any hospital capacity needed to cope with the COVID-19 disaster”; and

Whereas, A March 22, 2020, executive order by Governor Abbott postponing all surgeries and procedures “not immediately necessary” resulted in confusion regarding the status of abortions as to whether they were considered elective procedures, which launched a legal battle within the state; and

Whereas, The confusion regarding how the call for a suspension of elective procedures applied to abortion resulted in decreased access to abortion services as some clinics shut down while awaiting a legal verdict on the matter; and

Whereas, The temporary restriction on access to abortion care created a gap in access to this care for many Texas women; one Journal of the American Medical Association study found the number of abortions in Texas declined by 38% during the executive order’s duration, while concurrently the number of out-of-state abortions increased by six-fold; and

Whereas, After Governor Abbott’s first executive order expired in May 2020, there was a 61% increase in second-trimester abortions in Texas; and
Whereas, The increase in second-trimester abortions likely reflects delays in care among those who
waited for an appointment and facilities’ limited capacity to meet backlogged patient need as a result of
the ban on elective procedures; and

Whereas, The American College of Obstetricians and Gynecologists released a joint statement in March
2020 stating that “[a]bortion is an essential component of comprehensive health care. It is also a time-
sensitive service for which a delay of several weeks, or in some cases days, may increase the risks or
potentially make it completely inaccessible. The consequences of being unable to obtain an abortion
profundely impact a person’s life, health, and well-being,” and the American Medical Association, the
World Health Organization, and the United Nations Population Fund issued similar statements of support;
and

Whereas, There is a long history of discourse around the use of “elective” to describe abortion services
for women even though delaying access to abortion prevents women from obtaining a previability
abortion, which can increase the risk of medical complications by necessitating a surgical procedure later
in the pregnancy course; and

Whereas, Texas Medical Association Policy 10.002 emphasizes early access and referral for abortion
services, if indicated, and is generally supportive of abortion access; therefore be it

RESOLVED, That the Texas Medical Association amend TMA Policy 10.002 as follows:

Abortion, 10.002
The Texas Medical Association recognizes abortion as a legal and time-sensitive medical
procedure, and the performance of abortion must be based upon early and accurate diagnosis of
pregnancy; informed and nonjudgmental counseling; prompt referral to skillful and understanding
personnel working in a good facility; reasonable cost; and professional follow up. (Remarks of
Speaker, p 12, A-85; reaffirmed: Council on Public Health, p 105, I-89; Res. 28WW, p 218-D, A-
92; Res. 28I, p 168, A-94; and Council on Health Facilities, p 64, A-97; reaffirmed CPH Rep. 2-

; and be it further

RESOLVED, That our TMA advocate against restrictions that limit access to any time-sensitive or
medically necessary procedures for Texans.

Related TMA Policy:
55.004 Adolescent Sexual Activity
260.075 Preventive Health Care for Texas Women
260.103 Disaster Preparedness Planning and Response
260.037 Essential Public Health Services
260.105 Statewide Crisis Standards-of-Care

Related AMA Policy:
Abortion H-5.995
Support for Access to Preventive and Reproductive Health Services H-425.969
11.1.4 Financial Barriers to Health Care Access
References:

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 342
2021

Subject: Advocating for Increased Transparency at Crisis Pregnancy Centers

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, More than 40% of Texas women live in Texas counties that do not have clinics which provide services for medical termination of pregnancy; and

Whereas, Current Texas Medical Association policy 260.037 “Essential Public Health Service” supports linking Texans to health care when it is otherwise unavailable; and

Whereas, Crisis pregnancy centers (CPCs) are marketed as medical centers specialized to help women obtain information and access procedures for family planning and pregnancy termination; and

Whereas, It is estimated that more than 2 million women nationwide seek services at CPCs annually, and, while many believe that CPCs improve access to family planning resources, CPCs provide incorrect and incomplete medical information, and actively discourage women from accessing the full range of pregnancy health care resources available; and

Whereas, The American Medical Association (AMA) has deemed CPCs unethical due to their practice of misrepresenting and misinterpreting medical evidence, and the lack of patient-centered care and licensed medical professionals available at CPCs; and

Whereas, CPCs have been found to spread inaccurate information about abortion, including claims that suggest abortion leads to an increased risk of breast cancer and may cause emotional or psychological distress and infertility; and

Whereas, CPCs may take advantage of the lack of public knowledge on recent restrictions on abortion and use manipulative tactics to extend their visitors’ pregnancies to the point where abortion is difficult, if not impossible, to access in Texas; and

Whereas, CPC volunteers may convince visitors to delay or postpone their appointments, give fake due dates, or overstate the possibility of miscarriage to convince them to not have an abortion; and

Whereas, CPCs target abortion-minded women by employing online tactics so that their clinics are shown in search results when women look up abortion clinics; and

Whereas, A 2016 study in the Journal of Pediatric and Adolescent Gynecology found inaccurate and misleading information on CPC websites and advised that state governments forego listing CPCs in state directories; and

Whereas, The Texas Health and Human Services Commission (HHSC) list of “Agencies Offering Free Obstetric Sonograms” exclusively lists CPCs, rather than licensed health care providers, lending legitimacy to the flawed information that CPCs distribute; and
Whereas, CPCs, such as those listed by HHSC, are often religiously affiliated and make prayer or proselytization a key part of their services, even though many receive federal and state funding and are thus prohibited from including religion as part of their service provision; and

Whereas, The practice of listing CPCs on the HHSC website is in direct opposition to TMA policy 10.003 “Patient Autonomy and Accuracy of Information in Informed Consent for Abortion”, a policy which urges HHSC to distribute evidence-based information to women inquiring about abortion; and

Whereas, TMA policy 260.075 “Preventive Health Care for Texas Women” states that TMA will serve as a partner to the state in ensuring transparent operation of the states' women's health and family planning programs; therefore be it

RESOLVED, That TMA advocate for increased transparency at crisis pregnancy centers.

Related TMA Policy:
- 10.002 Abortion
- 10.003 Patient Autonomy and Accuracy of Information in Informed Consent for Abortion
- 260.037 Essential Public Health Services
- 260.075: Preventive Health Care for Texas Women

Related AMA Policy:
- Abortion H-5.995

References:
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 343
2021

Subject: Study to Improve Healthcare Access and Care for Persons with Disabilities

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, 22.2% of adults in the United States reported a disability as of 2013; and

Whereas, The American with Disabilities Act defines a disability as a mental or physical impairment that has an effect on the individual’s ability to carry out major life activities; and

Whereas, Those with disabilities are four times more likely to report poorer health compared with their nondisabled counterparts, and this number is increased in minorities with disabilities; and

Whereas, Individuals with a disability also are less likely to receive health care screenings compared with their nondisabled counterparts; and

Whereas, COVID-19 has increased barriers to health care faced by people with disabilities; examples are patients with intellectual/developmental disabilities being left alone in a hospital due to visitor bans and those who are deaf or hard of hearing being denied effective communication; and

Whereas, A report generated on the Association of American Medical Colleges Curriculum Inventory, 2015-16, demonstrated that many medical schools did not explicitly address disabilities in their curriculum; and

Whereas, Previous studies indicated that the current medical education system does not adequately train students to provide care for people with disabilities; and

Whereas, The U.S. surgeon general released a Call to Action to Improve the Health and Wellness of Persons With Disabilities and identified that a failure of medical education programs to teach about disability was a root cause for decreased health status and resources to maintain wellness; and

Whereas, Studies show that physicians and students in medical and health professions harbor negative attitudes about and show discomfort with treating people with disabilities; and

Whereas, A study of the effects of educating medical students about patients with disabilities showed the education positively impacted the students’ opinions and increased their overall knowledge; and

Whereas, The World Health Organization stated that one of the largest barriers to care for those with disabilities is the lack of training on the topic among health care professionals; and

Whereas, The Texas Medical Association has no policy supporting education of physicians about patients with disabilities and no committees to review laws, regulations, and activities that affect the disabled community; and
Whereas, TMA has a variety of committees aimed at promoting and protecting the rights of specific groups such as the committees on Reproductive, Women’s and Perinatal Health; Child and Adolescent Health; and Patient-Physician Advocacy, but none focused on advocacy for Texas’ enormous population of people with disabilities; therefore be it

RESOLVED, That our Texas Medical Association study and recommend actions to address the following issues related to patients with disabilities: (1) identification of problems that lead to poor health outcomes in people with disabilities; (2) how to improve health outcomes for patients with disabilities; (3) ways to increase health care screenings among patients with disabilities; (4) how to improve training in medical schools and residency programs related to caring for patients with disabilities; and (5) how TMA can best educate to its members about caring for patients with disabilities, including reviewing laws, regulations, and activities that impact the disability community; and be it further

RESOLVED, That the results of this study be reported back to the TMA House of Delegates at TexMed 2022.

Related TMA Policy:
60.008 Rejection of Discrimination
200.040 Joint Admission Medical Program
200.031 Medical School Admissions

Related AMA Policy:
Establishment and Function of Sections G-615.001
Minorities in the Health Professions H-350.978

References:
1. Approaches to Training Healthcare Providers on Working with Patients with Disabilities. Association of University Centers on Disabilities; Alliance for Disability in Health Care Education.


Whereas, The World Health Organization listed vaccine hesitancy as a top 10 threat to global health in 2019; and

Whereas, There has been an increase in individuals who do not believe in vaccinations (anti-vaxxers) and vaccine hesitancy across the United States; and

Whereas, In 2019, there were 1,282 cases of measles confirmed across 31 states, which is the largest number of cases reported since 1922; and

Whereas, Texas is ranked 48th on WalletHub's 2020 list of state vaccination rates, and Texas is ranked number one in hotspots for vaccine exemption by the Texas Medical Association; and

Whereas, Harris, Tarrant, Collin, and Travis County rank among the top 15 metropolitan areas in the nation with the highest number of kindergartners who are not vaccinated due to nonmedical reasons; and

Whereas, Texas has experienced a 20-fold increase in K-12 students (an increase of 2,314 to approximately 45,000 students) receiving exemptions from vaccinations and an increase from 0.45% to 1.35% in conscientious exemptions for vaccinations from 2003 to 2016; and

Whereas, It is well known that parents who are against vaccinations often make a choice for their child's health that puts the child in danger; and

Whereas, Research has shown that the anti-vaccination movement is driven by misinformation by media, conspiratorial thinking, and mistrust of government; and

Whereas, Media misinformation has historically resulted in decreased administration of essential vaccines, such as the pertussis vaccination decrease from 81% in 1974 to 31% in 1980 in the United Kingdom, which resulted in a pertussis outbreak; and

Whereas, Research indicates that, albeit the refutation of misleading or false studies, childhood vaccination rates remain decreased following the spread of misinformation; and

Whereas, Statistical analysis of YouTube videos discussing and related to vaccination find that 32% of videos opposed vaccination and that these videos had more views and higher ratings than videos that depicted vaccinations positively; and

Whereas, All states acknowledge the autonomous role older children should have in their health decisions and minors are permitted to consent for their own health care in certain cases such as marriage, emancipation, family planning, and STD treatment; and
Whereas, A mature minor has been defined by the American Medical Association in policy 440.926 as “certain older minors who have the capacity to give informed consent to do so for care that is within the mainstream of medical practice, not high risk, and provided in a non-negligent manner”; and

Whereas, Nine states (California, Delaware, Minnesota, New York, Alaska, Idaho, Alabama, Oregon, South Carolina) and the District of Columbia have legislation providing “mature minors” as young as 11-years-old the ability to independently consent to certain vaccinations without parental consent; and

Whereas, The District of Columbia worked closely with their medical society and recently passed a bill that “permits a minor of any age to consent to receive a vaccine where the vaccination is recommended by the U.S. Advisory Committee on Immunization Practices. It also establishes that if a minor is able to comprehend the need for, the nature of, and any significant risks inherent in the medical care then informed consent is established”; and

Whereas, North Carolina’s law states “Any minor who has reached the age of sixteen years may consent to any health services from a person authorized by law to render the particular health service for himself and the consent of no other person shall be necessary”; and

Whereas, The New England Journal of Medicine supports the enactment of state laws expanding access to vaccines by broadening the rights of minors (aged 12 to 14) to consent to vaccinations; and

Whereas, The Vaccine Information Sheets, required to be given to patients prior to consenting for a vaccination, are written at a tenth grade reading level, and would therefore require revision if minors were permitted to be vaccinated; and

Whereas, A majority of adolescent health professionals surveyed reported they would support minors having the ability to consent for their own vaccines; and

Whereas, Esteemed philosopher John Stuart Mill has established that interfering with autonomy and individual liberties for the purpose of preventing harm to others is justified through the Harm Principle; and

Whereas, The Texas Medical Association supports that all parents, even minors who are parents, can consent for their own vaccinations; and

Whereas, TMA is committed to improving vaccination rates statewide through the Vaccines Defend What Matters program; and

Whereas, The AMA committed to supporting state legislatures in developing policy that will allow mature minors to give consent for vaccinations and supports the ability of physicians to determine if a minor can consent; therefore be it

RESOLVED, That the Texas Medical Association support a physician’s right, if deemed appropriate by the state, to provide vaccinations to mature minors who provide consent; and be it further

RESOLVED, That TMA will encourage physicians to have age-appropriate materials for vaccine information and documentation methods for minors considering obtaining a vaccination; and be it further

RESOLVED, That TMA encourage our legislature to support model legislation expanding access to vaccines by broadening the rights of mature minors who comprehend the need for, nature of, and any
risks inherent to a vaccination to be able to give informed consent to receive a vaccination recommended by the U.S. Advisory Committee on Immunization Practices.

Related TMA Policy:
135.012 Immunization Rates in Texas
50.011 Physician Role in Increasing Vaccination for HPV
260.072 Conscientious Objection to Immunizations
135.022 Adolescent Parent Immunizations

Related AMA Policy:
Model Legislation for "Mature Minor" Consent to Vaccinations D-440.926
Education and Public Awareness on Vaccine Safety and Efficacy H-440.830
National Immunization Program H-440.992
2.2.1 Pediatric Decision Making

References:


TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 345  
2021

Subject: TMA Statement on the Health Impact of Racism

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Science and Public Health

Whereas, African Americans experience the highest rates of mortality from heart disease, cancer, cerebrovascular disease, pregnancy-related conditions, and HIV/AIDS among all U.S. racial or ethnic groups; and

Whereas, These disparate outcomes persist even when controlling for education level, socioeconomic status, and comorbidities; and

Whereas, The COVID-19 pandemic has highlighted that racial inequities prevail even in novel disease entities, with non-Hispanic Black people experiencing 30% greater mortality compared with non-Hispanic white people; and

Whereas, The social determinants of health, defined simply as the environmental and structural impacts of where one is born, educated, lives, and works, have significant impact on health and well-being; and

Whereas, A history of structural or institutional racism, defined as differential access to the goods, services, and opportunities of society based on race, has resulted in shortened life expectancies and 10 times lower household net worth for non-Hispanic Black people in comparison with non-Hispanic white people; and

Whereas, Estimates of economic burdens based on these disparities in Texas are excess health care spending of $2.7 billion per year, the cost of lost productivity of $5 billion per year, and the cost of premature deaths of $22.6 billion; and

Whereas, Multiple organizations including the American Medical Association, the American Academy of Family Physicians, and the American College of Obstetricians and Gynecologists have published official statements on racism; and

Whereas, According to the Oath of Hippocrates, to which we are all sworn, “I will remember that I remain a member of society, with special obligations to ALL my fellow human beings”; therefore be it RESOLVED, That the Texas Medical Association develop an Official Statement on Racism; and be it further

RESOLVED, That comprehensive policy be developed to support the statement and ensure that anti-racism and health equity strategies are prioritized for inclusion in organizational, educational, and advocacy activities; and be it further

RESOLVED, That TMA support identifying racism as a public health emergency.
Related TMA Policy:

1. 50.012 Addressing Cancer Health Disparities
2. 60.008 Rejection of Discrimination
3. 185.012 Physician Recruitment
4. 115.015 Accountable Care Organizations
5. 115.021 Principles for Community-Based Accountable Care Organizations
6. 200.022 Medical Education Admissions
7. 260.029 Preventive Medicine
8. 265.030 Social Determinants of Health
10. 330.013 Maternal Mortality Review

Related AMA Policy Statement:

In June 2020, the AMA Board of Trustees acknowledged the health consequences of violent police interactions and denounced racism as an urgent threat to public health, pledging action to confront systemic racism, racial injustice and police brutality.

The new policy approved by the AMA, representing physicians and medical students from every state and medical specialty, opposes all forms of racism as a threat to public health and calls on AMA to take prescribed steps to combat racism, including: (1) acknowledging the harm caused by racism and unconscious bias within medical research and health care; (2) identifying tactics to counter racism and mitigate its health effects; (3) encouraging medical education curricula to promote a greater understanding of the topic; (4) supporting external policy development and funding for researching racism’s health risks and damages; and (5) working to prevent influences of racism and bias in health technology innovation.

“The AMA recognizes that racism negatively impacts and exacerbates health inequities among historically marginalized communities. Without systemic and structural-level change, health inequities will continue to exist, and the overall health of the nation will suffer,” said AMA Board Member Willarda V. Edwards, M.D., M.B.A. “As physicians and leaders in medicine, we are committed to optimal health for all, and are working to ensure all people and communities reach their full health potential. Declaring racism as an urgent public health threat is a step in the right direction toward advancing equity in medicine and public health, while creating pathways for truth, healing, and reconciliation.”

Though previous AMA policies and principles have emphasized the need to eliminate health disparities and called on physicians to prevent violence of all kinds, the new policy explicitly acknowledges racism’s role in perpetuating health inequities and inciting harm against historically marginalized communities and society as a whole.

Specifically, the new policy recognizes racism in its systemic, cultural, interpersonal, and other forms as a serious threat to public health, to the advancement of health equity, and a barrier to appropriate medical care. It makes clear that a proactive approach to prevent, or identify and eliminate, racism is crucial—particularly considering that studies show historically marginalized populations in the U.S. have shorter lifespans, greater physical and mental illness burden, earlier onset and aggressive progression of disease, higher maternal and infant mortality, and less access to health care.

The policy describes the various forms of racism as follows:

- **Systemic racism:** structural and legalized system that results in differential access to goods and services, including health care services.
• **Cultural racism:** negative and harmful racial stereotypes portrayed in culturally shared media and experiences.

• **Interpersonal racism:** implicit and explicit racial prejudice, including explicitly expressed racist beliefs and implicitly held racist attitudes and actions based upon or resulting from these prejudices.

In addition, the new policy requests AMA to identify a set of best practices for health care institutions, physician practices, and academic medical centers to address and mitigate the effects of racism on patients, providers, international medical graduates, and populations. It also guides the AMA’s position on developing and implementing [medical education programs](#) that generate a deeper understanding of the causes, influences and effects of all forms of racism—and how to prevent and improve the health effects of racism.

Further, the policy asks that AMA support the creation of external policy to combat racism and its effects and encourage federal agencies and other organizations to expand research funding into the [epidemiology of risks and damages related to racism](#). Additionally, the policy asserts that the AMA will work to prevent, and protect against the influences of racism and bias in [innovative health technologies](#).

The AMA has been leading an aggressive effort to embed equity in thoughts, actions, and processes so as not to perpetuate inequities and instead help people live healthier lives. In 2018, the AMA [adopted policy](#) to define health equity and outline a strategic framework toward achieving optimal health for all. To help navigate these challenges, in 2019 the AMA hired its first [chief health equity officer](#) to establish the AMA’s Center for Health Equity to elevate and sustain efforts to address systemic level changes that can improve health.

Fully understanding that there is tremendous work still to be done to ensure that everyone has the opportunity, conditions, resources, and power to achieve optimal health, the AMA is committed to collaborating with stakeholders to confront the issue of racism within our society. The AMA continues to urge other leading health organizations to also take up the mantle of intolerance for racism as it pushes upstream to dismantle racism across all of health care — driving the future of medicine toward anti-racism.

**References:**

**AAFP Statement on Racism**

The American Academy of Family Physicians (AAFP) recognizes that racism is a system that categorizes people based on race, color, ethnicity and culture to differentially allocate societal goods and resources in a way that unfairly disadvantages some, while without merit, rewards others. As a system, racism has been institutionalized in a way that permits the establishment of patterns, procedures, practices and policies within organizations that consistently penalizes and exploits people because of their race, color, culture or ethnic origin. The system of racism affects the attitudes, beliefs and behaviors of one individual towards another (personally-mediated) as well as how individuals perceive themselves (internalized).

The AAFP also recognizes the impact of racism within the U.S. health care delivery system, which has historically engaged in the systematic segregation and discrimination of patients based on race and ethnicity, the effects of which persist to this day. Hospitals and clinics, which were once designated for racial and ethnic minorities, continue to experience significant financial constraints and are often under-resourced and improperly staffed. These issues result in inequities in access to and quality of health care and are major contributors to racial and ethnic health disparities. While segregation and discrimination based on race and ethnicity is no longer legal today, some organizations continue to discriminate based on insurance status, which also disproportionately impacts non-white populations.
The AAFP opposes all forms of institutional racism and supports family physicians to actively work to dismantle racist and discriminatory practices and policies in their organizations and communities. The AAFP recommends that all health care systems, hospitals, clinics and institutions adopt anti-racist policies that advocate for individual conduct, practices and policies that promote inclusiveness, interdependence, acknowledgment and respect for racial and ethnic differences. The AAFP also recommends that organizations take an active approach to dismantling racism by conducting a comprehensive critical examination of policies and procedures, empowering the development of diverse formal and informal leadership at all levels and developing a plan that increases accountability, demonstrates transparency and reorganizes power. (July 2019 BOD) (2019 COD)

ACOG Statement on Racial Bias
Policy & Position Statements
Statements of Policy

There is a growing body of literature that validates the public health impact of racial bias, implicit and explicit, on the lives and health of people of color. As women’s health care physicians, obstetrician-gynecologists (ob-gyns) must work to clearly understand the impact of racial bias and how it manifests in our lives and in the lives of our patients.

Racial bias is an issue that affects our patients, either directly by subjecting them or their families to inequitable treatment, or indirectly by creating a stressful and unhealthy environment. It is critical that physicians are aware of this reality for patients of color regardless of the patient’s financial position.

Many professions, including medicine, are beset by implicit and explicit racial bias. Medicine, including the field of obstetrics and gynecology, has engaged in practices that were very harmful to women of color. These practices include performing experimental gynecologic surgery on enslaved women in the mid-1800s and the testing of high-dose hormonal contraceptives on Puerto Rican women and other women of color in the 1950s. More recently, from 2005 to 2013, numerous incarcerated women in California, who are disproportionately women of color, were sterilized without lawful consent.

In less obvious ways, implicit bias may affect the way ob-gyns counsel patients about treatment options such as contraception, vaginal birth after cesarean, and the management of fibroids. Implicit biases are subconscious assumptions we all make about the world around us. They are formed from our life experiences – who we are, how and where we grew up, who our friends and family are – and all of these experiences influence how we view and interpret the world. Implicit bias has been documented to affect the patient-physician relationship as well as treatment decisions and outcomes. It is our duty to acknowledge that implicit bias affects how we take care of women and to consciously ensure that we treat all patients equitably.

The racial and ethnic disparities in women’s health (including higher rates of preterm birth, maternal mortality, and breast, cervical, and endometrial cancer deaths among Black women1) cannot be reversed without addressing racial bias, both implicit and explicit. We recognize that structural and institutional racism contribute to and exacerbate these biases, which further marginalize women of color in the health care system. Without acknowledging the historical context from which these disparities grew, and examining these disparities through a lens that takes into account race, gender, and class, an equitable health care system that serves all women cannot be realized.

The history and daily experiences of our patients of color may negatively affect their perceptions of the health care system. This may be manifested as mistrust of health care providers, avoidance of care, and not following medical advice. As ob-gyns, we must stand up against policies that disadvantage women and show our patients that we will not tolerate discrimination based on race, color, national origin, disability, age, religion, marital status, sexual orientation, perceived gender, or any other basis.
Further, the American College of Obstetricians and Gynecologists is committed to addressing racial bias and discrimination and their impact on our patients. Below are examples of how women’s health care physicians can work to confront these issues:

- Be aware of one’s own biases when caring for patients
- Perform research on how biases, implicit and explicit, and discrimination are associated with health outcomes in women
- Conduct research with improved outcomes for women of color as a primary objective
- Integrate issues of racial injustice, including recognition of provider bias, into our teaching of students, residents, fellows, and practitioners
- Engage with activists and advocates within communities of color to foster communication about addressing health disparities
- Examine and address the ways health care systems perpetuate inequity in communities of color
- Encourage racial and ethnic diversity at all levels of our profession, from medical school to residency to practice to leadership positions at the American College of Obstetricians and Gynecologists
- Create an Alliance for Innovation on Maternal Health (AIM) disparity bundle for obstetrics

Racial bias is an issue that affects our patients and our colleagues. We must commit to working together to address this issue and create an equitable health care system that serves all women. Our patients deserve no less.

References

Approved by the Executive Board, February 2017

Additional Resources:


Williams, DR, Jackson PB Social Sources of Racial Disparities in Health. Health Affairs 2005 Mar-Apr;24(2):325-34.

DuBois Review: Social Services Research on Race: Vol 8(1) Special Issue on Racial Inequality and Health (The whole document but specifically “Conceptualizing Racial Disparities in Health: Advancement of a Socio-Psychobiological Approach”).

TEXAS MEDICAL ASSOCIATION HOUSE OF DElegates

Resolution 346
2021

Subject: Educating Physicians on the Rights of Immigrant Patients (Tabled Res 107 2020)

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, Most immigrants live in just 20 metropolitan areas in the United States, and health care professionals in safety-net settings in these areas likely will encounter patients who are deeply impacted by immigration policies in manners that affect their access to care; and

Whereas, An undocumented immigrant is defined as someone who crossed a United States border without authorization or who is not living within the terms of an entry visa or other authorization; and

Whereas, The immigration enforcement priorities of the Trump administration and the U.S. Department of Justice have had a negative impact on health care access for documented and undocumented immigrants, as well as for U.S. citizens in mixed-status families, by inciting fear that interaction with the health care system will result in detention or deportation; and

Whereas, More specifically, the federal public charge regulation that went into effect Feb. 24, 2020, only amplifies the fears of immigrants when interacting with the health care system because it allows federal officials to take into account when determining application status whether an applicant for permanent residency used health-related programs, such as Medicaid or the Supplemental Nutrition Assistance Program; and

Whereas, Immigrants face several unique barriers to accessing health care, including adequately conveying their symptoms and medical history, which can be alleviated by training physicians and medical providers to recognize cultural and language barriers; and

Whereas, Physicians and health care 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 an active warrant for a specific individual covers that information; and

Whereas, Hospitals and other health care facilities are considered “sensitive locations” where immigration enforcement agencies are to avoid action without prior approval or a warrant; and

Whereas, Educating physicians on the rights of immigrants pursuing health care can help improve the quality of care delivered to members of this population and reduce their reluctance to seek care; therefore be it

RESOLVED, That our Texas Medical Association advocate for the adoption of policies by health care facilities that protect the rights of immigrants when seeking care, such as those that designate private areas of the clinic and discourage the routine collection of patient immigration status information; and be it further
RESOLVED, That our TMA launch an educational campaign advising 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.

Fiscal Note: TBD

Relevant TMA Policy:
55.057 Health Care of Undocumented Children

Relevant AMA Policy:
H-315.966 Patient and Physician Rights Regarding Immigration Status
D-160.921 Presence and Enforcement Actions of Immigration and Customs Enforcement (ICE) in Healthcare
H-350.957 Addressing Immigrant Health Disparities
D-440.927 Opposition to Regulations That Penalize Immigrants for Accessing Health Care Services
H-440.876 Opposition to Criminalization of Medical Care Provided to Undocumented Immigrant Patients
H-290.983 Support of Health Care to Legal Immigrants

References:
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 347
2021

Subject: Increasing Education Regarding the Effects of Bias and Discrimination on Patients Experiencing Homelessness

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, Based on the Community Point-in-Time count reported to the U.S. Department of Housing and Urban Development in January 2019, 25,848 individuals were experiencing homelessness in Texas; and

Whereas, The COVID-19 pandemic’s detrimental effects on the economy have led to a rise in unemployment in Texas from 3.5% in February 2020 to 8.3% in September 2020, leading to an increase in risk of eviction and homelessness for many Texans; and

Whereas, Homelessness is a driver of poor health outcomes and is associated with a shorter life expectancy by 12 years, higher morbidity, and higher rates of emergency department visits and hospitalizations; and

Whereas, Many homeless individuals are also at high risk for having comorbid physical or mental health conditions, or substance use disorders; and

Whereas, In addition to the stigma faced by individuals with mental health conditions or substance use disorders, homeless people frequently report feeling unwelcome in encounters with physicians and staff, and these negative experiences are detrimental to their trust in the health care system and desire to seek future health services; and

Whereas, Social triage, stigmatization, a nonsystem for health care for the homeless, disrespect, feeling invisible to physicians and health care providers, and delayed medical care secondary to lacking essential resources are common themes described by individuals facing homelessness; and

Whereas, Studies have shown these feelings of discrimination are related to suboptimal treatment plans, such as overprescription for mental health disorders, inadequate pain management, or outright denial of care; and

Whereas, The Health Stigma and Discrimination Framework supports a multicomponent intervention including supporting individuals facing stigma, educating community members on harmful preconceptions, increasing policy-oriented advocacy, and training relevant professionals on appropriate harm-reducing strategies of care as various interventions to decrease stigma; and

Whereas, Effective stigma-reduction strategies can be implemented from the individual to the organizational level through new training programs, patient-centered policy change, education, and advocacy; and

Whereas, Providing educational interventions, increasing meaningful contact with the stigmatized population, increasing peer services, advocating for this population, and effecting legislative and policy
change have proven effective in other interventions, such as those aimed to reduce stigma against
individuals with mental health illnesses; and

Whereas, The American College of Obstetricians and Gynecologists recognizes a physician’s role in
improving health outcomes of homeless patients by screening for patients who may be homeless or at risk
of being homeless, educating patients about community resources, providing equitable medical care, and
offering preventive care; and

Whereas, A shorter hospital length of stay and the identification of payer sources for homeless patients
(such as Medicaid) have been identified as benefits of routinely screening for homelessness as a social
determinant of health in the emergency department; and

Whereas, The American Medical Association supports screening for social determinants of health and is
collaborating with UnitedHealthcare to create 23 new ICD-10 codes related to social determinants to
ensure individual needs are met; and

Whereas, Failure to identify and address social determinants of health and to promote evidence-based
efforts to address the root cause of homelessness, such as housing-first initiatives, leads to inefficient
spending and perpetuates economic burden; and

Whereas, The U.S. Interagency Council on Homelessness’ latest national research agenda recognizes the
need for more research focused on improving health, well-being, and stability of homeless individuals;
therefore be it

RESOLVED, That our Texas Medical Association recognize individuals facing homelessness suffer
significant barriers in accessing health care that result in health care disparities; and be it further

RESOLVED, That our TMA encourage the use of multicomponent stigma-reduction interventions,
including but not limited to increased education and advocacy to reduce the harmful effects of
discrimination and promote health equity for patients experiencing homelessness; and be it further

RESOLVED, That our TMA support the use of standardized social determinants of health screenings to
address the issue of housing status such that patients experiencing homelessness can receive care tailored
to their specific situations; and be it further

RESOLVED, That our TMA encourage further research on how barriers to care negatively impact
outcomes of patients experiencing homelessness.

Relevant TMA Policy:
None.

Relevant AMA Policy:
The Mentally Ill Homeless H-160.978
Eradicating Homelessness H-160.903
Increased Access to Identification Cards for the Homeless Population H-160.894
Expanding Access to Screening Tools for Social Determinants of Health/Social Determinants of Health in
Payment Models H-160.896
References:

Resolution 348
2021

Subject: School Physicals Should Be Conducted by Physicians or Their Supervised Designee
(Tabled Res 409 2020)

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.
Resolution 349
2021

Subject: Reducing Intimate Partner Homicide

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, Gun violence is widely acknowledged as a major public health issue, and the Texas Medical Association recognizes prevention of gun violence as a priority that requires the development of evidence-based strategies (TMA Policy 260.015); and

Whereas, Two-thirds of Texans killed by an intimate partner in 2019 were killed by a firearm; and

Whereas, Since the onset of COVID-19, domestic violence calls in the U.S. to police and shelters have increased by an estimated 6% to 12%, and Google searches for help with domestic violence have spiked by 75%; and

Whereas, Under federal law, possession of firearms is a crime for individuals convicted of misdemeanor domestic violence offenses; however, notable gaps in the law allow for individual state-based interpretations; and

Whereas, Under Texas Penal Code Ann. §§22.01 and 46.04(b), Texas prohibits firearm possession by domestic violence misdemeanants for no longer than five years following release from confinement or community supervision, and

Whereas, In Texas and other states that have low weapon regulation and high firearm prevalence, rates of intimate partner homicide (IPH) from firearms are greatest; and

Whereas, Firearms account for more than half of all female IPHs, and access to firearms is considered the greatest risk factor for IPH, increasing the likelihood by approximately 11 times; and

Whereas, Laws that use high-risk individuals (e.g., those convicted of intimate partner violence) as a criterion for gun removal reflect an approach that seeks to remove a lethal weapon before it becomes part of the abuse; and

Whereas, American Medical Association Policy H-145.972 considers high-risk domestic violence perpetrators to be individuals with domestic violence restraining orders or misdemeanor convictions of domestic violence crimes or stalking, supports the prohibition of this subgroup from possessing or purchasing firearms, and calls on states to adopt protocols or processes for the required removal of firearms by prohibited individuals; and

Whereas, Based on a study investigating temporal trends among 45 U.S. states, restricting access to firearms in individuals with a history of violent misdemeanors reduced IPH rates by 23%; and

Whereas, State laws that prohibit access to firearms for those with intimate partner violence-related restraining orders reduced IPH rates by 9.7%; and
Whereas, State laws that require relinquishment of firearms by those who are high risk for committing intimate partner violence, such as those with domestic violence misdemeanors and domestic violence restraining orders, reduced rates of IPH by 14%; and

Whereas, Stricter firearm policies aimed at reducing IPH are widely supported among Texans; 79% of Texans surveyed supported requiring all convicted domestic abusers to turn in their guns, and 77% supported requiring all convicted stalkers to turn in their guns; therefore be it

RESOLVED, That the Texas Medical Association support Texas law being consistent with federal law in declaring possession of a firearm unlawful for an individual convicted of intimate partner violence; and it be further

RESOLVED, That TMA support efforts to establish guidelines for removal of firearms from those at high risk for committing intimate partner violence, such as people with domestic violence misdemeanors and those convicted of stalking.

Related TMA Policy:
260.015 Firearms

Related AMA Policy:
Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care H-145.975
Firearms as a Public Health Problem in the United States - Injuries and Death H-145.997
Firearms and High-Risk Individuals H-145.972
Firearm Availability H-145.996
Firearm Related Injury and Death: Adopt a Call to Action H-145.973
Gun Regulation H-145.999
Family and Intimate Partner Violence H-515.965

References:


TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 350
2021

Subject:   Restricting School Immunization Exemptions to Exemptions for Medical Reasons

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, Texas kindergarten vaccination coverage rates have decreased in the past decade from 99.3% in the 2011-12 school year to 96.9% in the 2018-19 school year; and

Whereas, While TMA opposes conscientious objections to immunizations (TMA Policy 260.072), unvaccinated children in Texas during the 2019-20 school year were 20 times more likely to be unvaccinated as a result of a conscientious exemption than of a medical exemption; and

Whereas, A 2020 study found that Texas ranked 48th in the U.S. in overall vaccination rates and 49th in child and teenage vaccinations; and

Whereas, States that provide exemptions for religious beliefs and other nonmedical reasons harbor increased rates of vaccine-preventable diseases compared with those that do not; and

Whereas, Parents in Texas can obtain vaccine exemptions for their children for reasons of conscience simply by requesting an affidavit and submitting the notarized affidavit; and

Whereas, Although data still demonstrate high rates of vaccine coverage overall in the U.S., spatial clustering of American citizens seeking nonmedical exemptions leads to decreased herd immunity and has resulted in disease outbreaks; and

Whereas, Throughout the U.S. in 2019 alone, there were 1,282 individual confirmed cases of measles in 31 separate states, the largest outbreak since 1922; and

Whereas, California passed a bill in 2016 abolishing nonmedical exemptions from required vaccinations after a measles outbreak, leading to a 3.3% increase in statewide measles-mumps-rubella vaccinations; and

Whereas, In 2016, Mississippi achieved the highest vaccination rate in the U.S. by eliminating nonmedical exemptions and reinforcing the idea that nonmedical exemptions would violate the 14th amendment by rendering exempt children a hazard to other students; and

Whereas, Mississippi and West Virginia, which do not allow nonmedical immunization exemptions, did not report a measles outbreak in 2019, and Mississippi has not had a measles outbreak since 1992; and

Whereas, Misinformation spread via social media has increased vaccine hesitancy and belief in refuted side effects, contributing to an increase in requests for nonmedical exemptions from vaccines; and

Whereas, American Medical Association Policy H-440.970 does not support nonmedical exemptions for immunizations because they risk endangering vulnerable populations, and supports legislation that does not allow nonmedical exemptions for immunizations; and therefore be it
RESOLVED, That our Texas Medical Association advocate for the removal through legislation of nonmedical exemptions from required school vaccinations.

Related TMA Policy:
135.012 Immunization Rates in Texas
260.072 Conscientious Objection to Immunizations

Related AMA Policy:
Education and Public Awareness on Vaccine Safety and Efficacy H-440.830
Nonmedical Exemptions from Immunizations H-440.970
Childhood Immunizations H-60.969
Meningococcal Vaccination for School Children H-60.923
Achieving National Adolescent Immunization Goals H-440.901
HPV Vaccine and Cervical Cancer Prevention Worldwide H-440.872

References:
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 351
2021

Subject: Support of a Statewide Contact Tracing App
Introduced by: Medical Student Section
Referred to: Reference Committee on Science and Public Health

Whereas, The Center for Disease Detection describes contact tracing as the process of tracking individuals who have been exposed to an infected person; and

Whereas, The use of contact tracing during the COVID-19 pandemic has been proven effective in decreasing the spread of the virus; and

Whereas, The success of the contact tracing strategy depends largely on the rapid detection of cases and isolation of contacts to prevent overwhelming the medical system; and

Whereas, The Texas Department of State and Health Services (DSHS) has a contact tracing workforce made up of recently hired personnel and continues to face challenges including lack of staffing and training; and

Whereas, In April 2020, the U.S. had employed only 0.5% of the estimated number of needed contact tracers, and Texas does not meet the estimated need for contact tracers; and

Whereas, Contact tracing apps can address the shortage of contact tracers, reduce overall costs, increase the speed of contact tracing, and complement traditional contact-tracing methods; and

Whereas, App-based contact tracing alone was superior to human-oriented contact tracing at reducing the spread of COVID-19 (6% to 17% decrease vs. 2% to 5% decrease), even with app usage as low as 20%; and

Whereas, The current low adoption rate of contact tracing apps across the U.S. can largely be attributed to a lack of advertising and digital privacy concerns; and

Whereas, Apple and Google have co-created an application programming interface (API) that uses wireless signals to anonymously detect when two phones are in close proximity thus ensuring privacy; and

Whereas, A contact tracing app using the Apple/Google API does not track GPS location and instead uses a decentralized database and decentralized privacy-preserving proximity tracing (DP-3T)-based technology to keep users anonymous; and

Whereas, The states currently using the Apple/Google API in their contact tracing apps allow the user to turn off exposure notification at any time to protect user autonomy; and

Whereas, The Apple/Google API technology aligns with the preferred Centers for Disease Control and Prevention preliminary criteria for digital contact tracing tools; and
Whereas, As of January 2021, Texas remains one of 32 states without a contact tracing app available for
download, and the remaining 18 states including California, New York, Colorado, and Alabama all have
created a contact tracing app using the Apple/Google API; and
Whereas, It is the responsibility of each state’s health department to decide whether or not to create a
statewide contact tracing app; and
Whereas, Both American Medical Association policies H-20.915 and H-440.931, and Texas Medical
Association Policy 15.001 support state adoption of contact tracing and notification programs for sexually
transmitted diseases such as HIV and syphilis; therefore be it
RESOLVED, That our Texas Medical Association support the development of a statewide contact tracing
app made by the Texas Department of State Health Service (DSHS) in accordance with Centers for
Disease Control and Prevention preliminary criteria for digital contact tracing in addition to conventional
tracing methods; and be it further
RESOLVED, That our TMA support efforts to promote and make widely known the use of a contact
tracing app made by DSHS; and be it further
RESOLVED, That our TMA support the efforts to educate the general public that a contact tracing app
made by DSHS ensures patient safety and privacy to encourage public buy-in.

Related TMA Policy:
118.003 Health Information Technology
15.001 HIV and Syphilis Contact Tracing

Related AMA Policy:
H-20.915 HIV/AIDS Reporting, Confidentiality, and Notification
H-440.931 Update on Tuberculosis

References:
1. Keeling MJ, Hollingsworth TD, Read JM. Efficacy of contact tracing for the containment of the 2019
doi:10.1136/jech-2020-214051.
2. Root J. As COVID Cases exploded, workers on Texas’ $295 million contact tracing deal did little to
3. Gonzalez V. Contact tracing – it’s still happening, but don’t expect to hear from someone. The
4. Playoff E. As coronavirus cases surged, Texas’ contact tracing workforce shrunk. The Texas Tribune.
5. Sinha P, Paterson AE. Contact tracing: Can ‘Big tech’ come to the rescue, and if so, at what cost?.
6. Simmons-Duffin S. States Nearly Doubled Plans For Contact Tracers Since NPR Surveyed Them 10
7. Almagor, J., Picascia, S. Exploring the effectiveness of a COVID-19 contact tracing app using an


Subject: Mental Health Education in Schools

Introduced by: Kerr-Bandera Medical Society

Referred to: Reference Committee on Science and Public Health

Whereas, suicide is the second leading cause of death in young people aged 10-24 in the U.S; and

Whereas, suicide is the second leading cause of death for young people aged 10-24 in Texas, and similarly, 19% of all Texas high school students seriously considered suicide during the past year and 10% made a suicide attempt during the past year; and

Whereas, the onset of more serious and chronic mental illnesses typically occurs in childhood and adolescence, during a time when students spend most of their time in a classroom; and

Whereas, as of 2009, Texas no longer mandates that a health class be required for high school graduation; therefore be it

RESOLVED, That the Texas Medical Association urge state legislators to make mental health education and awareness part of mandated school curriculum in Texas from elementary through high school.

Related TMA Policy:
55.019 Comprehensive School Health Education

Related AMA Policy:
D-345.994 Increasing Detection of Mental Illness and Encouraging Education

References:
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 353
2021

Subject: Recognizing the Effect of Climate Change on Public Health (Tabled Res 323 2020)

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

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 Sciences, 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, and 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 one degree Celsius 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 degrees Fahrenheit
between 1986 and 2016, and temperatures are projected to rise another one to six degrees Fahrenheit by
2100; therefore be it

RESOLVED, That the Texas Medical Association concur with the scientific consensus that 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 children, the elderly, and people of low socioeconomic status.

Related TMA Policy:
265.018 Evidence-Based Medicine and Practice

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.
   federal efforts to reduce fiscal exposure, GAO-17-720. 2017.
5. Butler CD. Climate change, health and existential risks to civilization: A comprehensive review
   Needs on the Human Health Effects of Climate Change. Environmental Health Perspectives/National
   Institute of Environmental Health Sciences. April 22, 2010.
   the elderly: A systematic review and meta-analysis of epidemiological evidence. EBioMedicine.
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9. Wehner MF, et al. Attributable human-induced changes in the likelihood and magnitude of the
   observed extreme precipitation during Hurricane Harvey. Geophysical Research Letters. 2017
   Dec;44(24).
    10.1175/JCLI-D-12-00270.1.
    Anthropocene. 2019 Mar;25.
    Fourth National Climate Assessment, Volume I (Wuebbles DJ, Fahey DW, Hibbard KA, Dokken DJ,
    Stewart BC, Maycock TK [eds.]). U.S. Global Change Research Program, Washington, DC, USA,
Whereas, The history of medicine involves injustices against racial minorities by the medical community such as the unconsented use of HeLa cells, racial segregation in the Red Cross blood donor program, and the performance of gynecological operations without anesthesia by J. Marion Sims on Black enslaved people he purchased; and

Whereas, The Tuskegee syphilis study denied syphilis treatment to a group of Black men from 1932 to 1972, leading to significantly lower utilization of medical services by older Black men who lived near study subjects in the immediate years after study conditions were revealed; and

Whereas, 59% of Latina women and 23% of Latino men were at greater risk of forced sterilization in California between 1920 and 1945 under U.S. sterilization laws written to prevent reproduction of “unfit” individuals; and

Whereas, Systemic racism has been integrated into the current health care system, such as the inclusion of race in the calculation of estimated glomerular filtration rates, which results in underestimating chronic kidney disease in Black patients; the underrepresentation of pathologies on dark skin in medical textbooks; an almost tripling of the frequency of occult hypoxia undetected by pulse oximetry in Black patients compared with white patients; and conglomeration of Asian ethnic subgroups, which prevents proper evaluation of health risks per population; and

Whereas, Undocumented immigrants have less access to health care because of policies preventing qualification for the Affordable Care Act, Medicaid, or Medicare; and

Whereas, Increased anti-immigration rhetoric negatively impacts the health of undocumented immigrants, who may avoid seeking health care out of fear of discrimination, detention, and/or deportation; and

Whereas, The national cutoff for obesity of body mass index (BMI) $\geq 30$ kg/m$^2$ is an inaccurate representation for Asians, who demonstrated that lower BMI values ($\sim 23$) tend to have a higher risk of diabetes and hypertension compared with other race/ethnic groups; and

Whereas, Black people, American Indians and Alaska Natives, and Native Hawaiians/Pacific Islanders receive worse care than white people in 40% of quality measures set by the Agency for Healthcare Research and Quality; and

Whereas, Foreign-born Latinx people comprise 48% of the Latinx population in the U.S., with 20% reporting to have experienced discrimination on the basis of ethnic, cultural, and language differences; and

Whereas, Black people, East Asians, and South Asians perceiving discrimination in a health care setting rate their health status as poor and are less likely to use health services; and
Whereas, The Indian Health Service provides care to 2.2 million Native Americans across the country and has been underfunded, limiting health services offered to Native Americans; and

Whereas, 23% of Native Americans reported facing discrimination in clinical encounters, and 15% avoided seeking care for themselves and family members because of anticipated discrimination; and

Whereas, Native Americans have an increased rate of mortality from preventable illnesses such as chronic liver disease and cirrhosis, diabetes, and chronic lower respiratory diseases and face a life expectancy of 20 years less than the national average in some states; and

Whereas, Disparities are seen in COVID-19 cases among minorities, such as non-Hispanic American Indian and Alaska Natives comprising 1.3% of COVID-19 cases despite comprising only 0.7% of the U.S. population; and

Whereas, Only 1,686 out of 29,675 people detained in U.S. Immigration and Customs Enforcement detention centers had been tested for COVID-19 by May 11, 2020, despite the spread of COVID-19 among detainees; and

Whereas, Physicians are not trained in competent cultural humility and history and continue to risk increased incidents of perpetuating inequitable care due to implicit bias; and

Whereas, Physicians’ implicit biases prevent adequate care and amount to worse health outcomes such as Black children receiving fewer antibiotics than their white counterparts, a lower rating for pain assessments in Black patients, and low cancer screening rates in Asian Americans despite cancer being a leading cause of death in this racial group; and

Whereas, The Texas Medical Board does not require physicians to have further education on past and present bias linked to race; and

Whereas, Racial and ethnic representation in clinicians has proven to mitigate inequitable health outcomes for underrepresented racial and ethnic minority communities; and

Whereas, There is a statistically significant change in implicit bias and behavior based on the medical school experiences of a student within a formal curriculum that addresses targeted care for minorities and cultural competency and an informal curriculum that contains interracial contact, behavior of faculty, and the overall cultural climate; and

Whereas, Current training about racism and implicit bias in medical education allows students and clinicians to learn about their effects on health disparities, leading to reduced racism in patient care; and

Whereas, The American Medical Association released a statement on Jan. 6, 2021, in support of “the Biden administration’s comprehensive efforts to dismantle systemic racism and advance equity for all, particularly for historically marginalized communities who have long been underserved and overlooked in our country”; therefore be it

RESOLVED, That our Texas Medical Association support the development of curriculum in Texas medical schools that addresses the history of race in medicine and its present-day effects for minority groups including but not limited to Black, Latinx, Indigenous (American Indians and Alaska Natives, native Hawaiians/Pacific Islanders), and Asian populations; and be it further
RESOLVED, That TMA encourage all members to participate in a continuing medical education program that addresses the history of race in medicine and its present-day effects for minority groups including but not limited to Black, Latinx, Indigenous (American Indians and Alaska Natives, native Hawaiians/Pacific Islanders), and Asian populations; and be it further

RESOLVED, That TMA create a Committee for Minority Health and Issues to address health disparities among minorities in Texas.

Fiscal Note: $2,500/year

Relevant TMA Policy:
185.009 Promotion of Medicine and Health Careers to Underrepresented Minorities
200.020 Medical Education Curriculum
200.049 Advocacy Education in Medical School Curriculum

Relevant AMA Policy:
Reducing Discrimination in the Practice of Medicine and Health Care Education D-350.984

References:


Subject: Support of Medical Student Health and Wellness

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, Research indicates 27% of medical students experience depression, and 11% experience suicidal ideation at some point in their training; and

Whereas, Studies demonstrate that medical students suffer from psychological stress at significantly higher rates than their age-matched peers in the general population; and

Whereas, Approximately half of all medical students are estimated to experience burnout at some point during their medical school training; and

Whereas, Medical students are less likely to seek mental health support than the general population because of concerns about stigmatization, lack of time, and the fear of a lack of confidentiality; and

Whereas, Prolonged burnout can hinder the training of medical students, which can lead to harmful life-threatening consequences for students and their future patients; and

Whereas, Discussion regarding burnout has previously focused on physicians and residents, often excluding the effects of burnout on the medical student population; and

Whereas, Separate investigations conducted at the John A. Burns School of Medicine at the University of Hawai‘i at Mānoa and the School of Clinical Medicine, University of Cambridge showed the promotion of individualized counseling services successfully reduced suicidal ideation and emotional distress in medical students; and

Whereas, American Medical Association Policy H-345.973 supports “availability of timely, confidential, accessible, and affordable medical and mental health services for medical students,” TMA currently lacks similar policy; and

Whereas, Texas Medical Association Policy 105.010 supports the health and wellness of physicians, and has no similar policy regarding medical students; therefore be it

RESOLVED, That Texas Medical Association encourage the development of evidence-based methods to detect, treat, and prevent mental health issues in medical students; and be it further

RESOLVED, That TMA promote awareness of the prevalence of mental illness among medical students and therapeutic resources available to treat these illnesses; and be it further

RESOLVED, That TMA encourage Texas medical schools to recognize common barriers that deter medical students from seeking counseling services; and be it further
RESOLVED, That TMA encourage the development of peer support group sessions within medical schools to promote open discussion of mental health and build support among students.

**Related TMA Policy:**
- 100.022 Emergency Psychiatric Services
- 105.010 Physician Health and Wellness
- 145.019 Mental Health Equitable Treatment and Parity
- 215.019 Public Mental Health Care Funding
- 260.037 Essential Public Health Services

**Related AMA Policy:**
- D-405.990 Educating Physicians About Physician Health Programs and Advocating for Standards
- H-405.961 Physician Health Programs
- H-345.970 Improving Mental Health Services for Undergraduate and Graduate Students
- H-345.973 Medical and Mental Health Services for Medical Students and Resident and Fellow Physicians
- H-405.959 Physicians and Physicians-in-Training as Examples for Their Patients to Promote Wellness and Healthy Lifestyles

**References:**
2. AMA Principles of Medical Ethics: I, II, IV


Subject: Support Statewide Planning and Communication for a Vaccine Plan During a Pandemic

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, An emergency vaccination plan was created by the Center of Disease and Detection and the Advisory Committee on Immunization Practices (ACIPs) in 2020 due to the COVID-19 pandemic and implemented in Texas; and

Whereas, Texas’s attempt to implement the ACIP’s COVID-19 vaccine distribution plan was disorganized and confusing, secondary to poor communication from state officials, technical errors, and logistical delays; and

Whereas, Specifically, throughout the vaccine rollout there have been significant gaps in communication between providers, residents, and Texas state officials regarding COVID-19 vaccine availability and eligibility; and

Whereas, A major technical error occurred when the Texas Division of Emergency Management and the Texas Department of State Health Services displayed different maps of vaccine distribution; and

Whereas, The system used to track vaccinations, ImmTrac2, experienced significant lag in uploading data causing confusion in vaccine availability; and

Whereas, Vaccine hesitancy was listed by the World Health Organization as a top 10 threat to global health in 2019 and misinformation provided throughout the COVID-19 vaccination rollout could further increase this hesitancy in Texas residents; and

Whereas, Vaccine hesitancy and mistrust of the COVID-19 vaccination by the public is exhibited in a November 2020 survey where 39% of Americans reported they do not plan on getting the COVID-19 vaccine; and

Whereas, During this current vaccine rollout there was significant variability in states’ plans for COVID-19 vaccine distribution, with only 23 states having strategies to target minorities and only 18 states having strategies to combat vaccine misinformation, Texas not being one of these; and

Whereas, Texas was one of the first states to break from the CDC’s recommended vaccination plan; and

Whereas, Texas moved towards vaccinating the state’s elderly population, the third highest amongst all states, and the digital race to sign up was a struggle for many seniors; and

Whereas, There are more than 4 million people in phase 1B in Texas alone, and all these individuals cannot receive vaccinations at once, therefore lawmakers have suggested creating subgroups in the future to prevent overwhelming the system and confusing residents, exemplifying Texas’s need for a plan unique to its population; and
Whereas, Texas’s unique population also includes a large amount of small, rural hospitals with less than 975 employees, and many of these small rural hospitals were excluded from the first rollout of COVID-19 vaccines although they employed frontline health care workers battling COVID-19; and

Whereas, TMA already supports in 135.015 the efficient distribution system for delivering vaccines during a shortage in cooperation with the Texas Department of State Health Services, local health departments, and county medical societies; and

Whereas, A strong and reliable vaccine rollout plan, as well as a public education campaign with clear user-friendly information, is necessary to combat mistrust around the COVID-19 vaccine, ensure vaccines are not wasted, and be prepared for future pandemic vaccines; therefore be it

RESOLVED, That TMA support modifying the state’s current emergency vaccination plan to better meet Texas’s population needs, with specific attention given to Texas’s large population, Texas’s elderly population, minority population, and rural populations, and allow for improved communication to citizens in the event of an emergency vaccination rollout; and be it further

RESOLVED, That TMA study ways to improve and simplify vaccine rollout in the future to combat vaccine hesitancy; and be it further

RESOLVED, That TMA support the use of user-friendly, easily accessible resources for information about new vaccines and vaccine roll-out plans in the state of Texas, to decrease vaccine hesitancy and aid in distribution.

Relevant TMA Policy:
135.005 National Vaccine Plan
135.015 Vaccine and Antimicrobials Distribution During a Shortage

Relevant AMA Policy:
Secure National Vaccine Policy H-440.882
Distribution and Administration of Vaccines H-440.877
Influenza Vaccine Availability and Distribution H-440.851
Protecting Patients and the Public Through Physician, Health Care Worker, and Caregiver Immunization H-440.831
Assuring Access to ACIP/AAFP/AAP-Recommended Vaccines H-440.875

References:


Socioeconomics Reports and Resolutions
AGENDA
REFERENCE COMMITTEE ON SOCIOECONOMICS
Saturday, May 8, 2021

3. Patient-Physician Advocacy Committee Report 3 – Legislative Changes Regarding Vacating Orders
4. Board of Trustees Report 18 – Compensation to Physicians for Activities Other Than Direct Patient Care (Tabled BOT Report 13 2020)
5. Committee on Medical Home and Primary Care Report 1 – Sunset Policy Review
6. Committee on Rural Health Report 1 – Sunset Policy Review
7. Resolution 401 – Caps on Insulin Copayments with Insurance (Tabled Res 413 2020)
9. Resolution 403 – Insurance Promotion of Preventive Care Services via Incentive-Based Program (Tabled Res 417 2020)
11. Resolution 405 – Ensuring Medical Practice Viability Through Reallocation of Insurance Savings During the COVID-19 Pandemic
14. Resolution 408 – Need for and Funding of Level I and Level II Trauma Centers (Tabled Res 402 2020)
15. Resolution 409 – Taxes on Medical Billing Services (Tabled Res 403 2020)
17. Resolution 411 – Physicians to Retain Payment During Credentialing (Tabled Res 405 2020)
18. Resolution 412 – Maintaining the Integrity of Physicians Orders in an Electronic Environment
19. Resolution 413 – Compensation to Physicians for Activities Other Than Direct Patient Care (Tabled Res 407 2020)

20. Resolution 414 – Contracted Health Plans Must Apply the Same Level of Benefits Concerning Patient Responsibility (Tabled Res 408 2020)

21. Resolution 415 – Paper Medical Record Chart Preparedness for Electronic Health Record Interruptions


23. Resolution 417 – Verbal Physicians Orders

24. Resolution 418 – Electronic Prescribing of Controlled Substances (EPCS) Unfunded Mandate and Pharma Financial Settlements

25. Resolution 419 – Advocating for Increased Capacity of Local State Mental Health Facilities and Coordination of Behavioral Health Services (Tabled Res 313 2020)

26. Resolution 420 – Step-Edit Therapy Contributes to Denial of Care and Has Not Demonstrated Improved Patient Outcomes or Overall Cost Savings (Tabled Res 412 2020)

27. Resolution 421 – Augmented Intelligence (AI) in Health Care (Tabled Res 201 2020)

28. Resolution 422 – Adjustments to Hospice Dementia Enrollment Criteria (Tabled Res 427 2020)


30. Resolution 424 – Encourage the Establishment of an Express Lane Eligibility (ELE) Program in Texas


32. Resolution 426 – Support for Rural Labor and Delivery Departments


34. Resolution 428 – Insurance Coverage Transparency (Tabled Resolution 401 2020)

35. Resolution 429 – Adoption of Principles of Physician Value-Based Decisionmaking in Medical Practice and Professionalism (Tabled Resolution 424 2020)

36. Resolution 430 – Paid Parental Leave (Tabled Resolution 418 2020)
REPORT OF COUNCIL ON SOCIOECONOMICS

C-SE Report 2 2021

Subject: Sunset Policy Review

Presented by: Rodney Young, MD, Chair

Referred to: Reference Committee on Socioeconomics

House of Delegates policies in the association’s Policy Compendium are reviewed periodically for relevance and appropriateness. Following are policies reviewed by the council with recommendations for retention, amendment, and deletion.

The Council on Socioeconomics recommends retention of the following policies:

30.001 CRNA Direct Reimbursement: To maintain quality anesthesia care, the Texas Medical Association believes that certified registered nurse anesthetists should be under the medical direction of an anesthesiologist or other appropriate physician direction (CSE p 159, A-90; reaffirmed CSE Rep. 5-I-01; reaffirmed CSE Rep. 8-A-11).

115.014 Out-of-Network Referral Requirements: The Texas Medical Association opposes health insurance company policies or procedures that discourage or interfere with medically necessary referrals for medical care out of network by imposing requirements for physicians to obtain patient signatures, sign documents disclosing ownership interests, make telephone calls, or obtain notification numbers (CSE Rep. 4-A-11).

115.016 “A Modest Proposal” to Save our Health Care System: The Texas Medical Association through its membership and leadership position in medicine, strives to change the cost curve by stopping the enlarging bureaucracies and the unfunded mandates, and by asking the federal government to consider the imposed cost on physicians when making clinical recommendations and changes to providing health care (Res. 404-A-11).

130.001 Hospital Contracts: The Texas Medical Association voted to seek legislation to prohibit hospitals from extracting payments from physicians for patient referrals or for the right to serve patients in hospitals for utilizing space, supplies, equipment, utilities, hospital employees, and obtaining billing information (Res. 27CC, p 206, A-90; reaffirmed CSE Rep. 5-I-01; amended CSE Rep. 8-A-11).

145.015 Mandatory Referral and Precertification of Chronic Renal Failure Treatment: The Texas Medical Association seeks agreement of Texas HMO and insurance providers to accept and require only CMS form 2728 as the precertification and referral for dialysis or any subsequent change in renal replacement therapy as per federal guidelines (CSE Rep. 2-A-01; amended CSE Rep. 8-A-11).

190.002 Medicaid Medications: The Texas Medical Association encourages Texas Medicaid to revise its medications policy so that beneficiaries of the program may receive all necessary medications (YPS, p 156, I-90; reaffirmed CSE Rep. 5-I-01; reaffirmed CSE Rep. 8-A-11).

190.003 Medicaid Payments to Increase Participation: The Texas Medical Association supports increasing Medicaid payments to physicians to Medicare parity or better to ensure greater participation by physicians in the program (Committee on Maternal and Child Health, p 113, I-90; reaffirmed CSE Rep. 5-I-01; amended CSE Rep. 8-A-11).
195.009 Medicare Hospital Incentive Payments: Federal law prohibits incentive payments by a hospital which are designed to induce physicians to admit Medicare patients to the hospital. The Texas Medical Association agrees that physicians may not lawfully or ethically accept such payments (Council on Health Facilities, p 72, A-91; reaffirmed CSE Rep. 5-I-01; reaffirmed CSE Rep. 8-A-11).


235.033 Coordination of Benefits: The Texas Medical Association will work with payers to (1) encourage expedited payment policies and streamline the coordination of benefit process by requiring that employers provide employee attestations directly to the health plans in a timely manner and also provide an option for insured members to provide this information directly to the health plan via a form or other electronic means and that all claims be immediately processed and paid by a health plan regardless of the lack of coordination benefit attestation information on file from the employer and/or insured members; and (2) streamline the proof of full-time student status by requiring that employers provide proof of full-time student status directly to the health plans in a timely manner and also provide an option for insured members to provide this information directly to the health plan via electronic means. Further, TMA should work with payers to encourage that all claims be immediately processed and paid by the health plan regardless of the lack of proof of full-time student status information on file from the employer and/or insured member (CSE Rep. 2-A-11).

240.001 Geographic Practice Cost Indices (GPCIs): The Texas Medical Association supports the collection and evaluation of the most current valid and reliable data and its use in calculating accurate geographic practice cost indices and in determining geographic payment areas. Variation between geographic payment areas should be minimized and equitable access to medical care services should not be diminished by geographic practice cost indices that are unreasonably low in rural areas (Supplemental CSE p 162, A-90; reaffirmed CSE Rep. 5-I-01; amended CSE Rep. 8-A-11).

Recommendation 1: Retain.

The Council on Socioeconomics recommends amending of the following policies:

100.003 Patient Transfers: The Texas Medical Association believes that to ensure continuity of care, physician-to-physician communication should occur prior to actual transfer of patients from one hospital facility to another. It should be clear that the receiving institution has available the anticipated services and space, and that the receiving physician and institution will accept the patient.

The physician requesting transfer should make direct contact with the receiving physician; this task should not be delegated to nurses, other hospital personnel or the family of the patient.

The physician-to-physician communication should include planning for and implementation of pretransfer and intratransfer medical care of the transferee.

All transfers should be to facilities appropriate to the needs of the patient, and socioeconomic considerations should be secondary.
If the patient or those responsible for the patient requests transfer which seems medically inappropriate, the medical risks involved must be carefully explained to the patient or those responsible for the patient. The physician should provide the explanation, and if the patient or family insists on transfer, the decision should be documented in writing and signed by the patient or those responsible, as well as by the physician.

All necessary and pertinent medical information and instructions to transfer personnel and other records should accompany the patient.

Proper medical care should be provided before and during transfer, including monitoring and charting the status of the patient.

Nonemergency (elective) patient transfers are beyond the scope of this guideline, and such transfers should follow traditional referral patterns and practices (PPA Committee, p 133-134, A-91; reaffirmed CSE Rep. 5-I-01; reaffirmed CSE Rep. 8-A-11).

115.001 Indigent Care: The Texas Medical Association approved the final report of its Task Force on Indigent Health Care which recommended the following:

1. TMA should work to improve the availability and affordability of comprehensive private health insurance and adopt measures to make health insurance more available and affordable;
2. TMA should work to preserve existing indigent health programs in the short term and work on improving streamlining and simplifying Medicaid eligibility for Medicaid and the Children’s Health Insurance Program in the long run;
3. TMA should continue to advocate that the state pursue all available federal funding to extend comprehensive health care coverage to low-income Texans;
4. TMA should continue to pursue improved reimbursement Medicaid physician payment, and every effort should be made to reduce the administrative complexities of the Medicaid program, including and TMA efforts in this area, such as continuation of monthly-regular liaison meetings with the leadership of the state Medicaid agency and Medicaid managed care organizations carrier and Medicaid director, should continue;
5. TMA should support adequate funding for public mental behavioral health services and recommend that the Texas Medicaid program provide full benefits for treatment of mental illnesses as allowed by federal guidelines;
6. TMA should continue to support legislation and regulation which promote and encourage opportunities for physicians to practice in medically underserved areas of the state; and
7. Physicians should be reminded of their responsibility to provide care to all Texans. Further, physicians should be encouraged to pass these values on to new physicians during their education and training (Amended CSE, p 138-144, I-90; amended CSE Rep. 5-I-01; amended CSE Rep. 8-A-11).

115.015 Accountable Care Organizations and Value-Based Care Models: Accountable Care Organizations will develop into complex organizations tailored to meet the health care needs of a local community. The Texas Medical Association supports accountable care organizations (ACOs) and other value-based care models as a tool in the delivery of medical care if the following safeguards and elements are present:

Physician Outreach and Education. Texas physicians must be informed receive guidance, tools, and education about value-based care models accountable care organizations. Toolkits that provide the information necessary for physicians to make informed decisions about establishing, affiliating, or joining, or participating in an ACOs or other value-based payment
(VBP) arrangement must be developed and disseminated. Educational materials should address governance and participation issues, payment distribution methods, models, as well as economic and quality measures, data collection, financing, and patient care management strategies, including evolving expectations for ACO/VBP initiatives to address social determinants of health (including strategies to meet them) should be undertaken. Various methods of outreach should be utilized including webinars, podcasts, seminars, and publications.

ACO Governance.

Physician Led. ACOs must be physician-led and encourage an environment of collaboration and professionalism among physicians and other health care team members. This ensures that health care delivered under these ACO models is patient-centric and that a physician’s medical decisions are not based on commercial interests but rather on professional medical judgment that puts patients’ interests first. Primary care and subspecialty Physicians must be actively engaged in the organization’s design, implementation, monitoring, and evaluation.

Physicians Retain Independent Medical Judgment Within an ACO. Medical decisions should be made by physicians. ACOs must be operationally structured and governed by an appropriate number of physicians (rather than lay entities) and place patients’ interests first. Physicians are the medical professionals best qualified by training, education, and experience to provide diagnosis and treatment of patients. Clinical decisions must be made by the physician or physician-controlled entity in an environment where they are free to exercise independent medical judgment free from commercial influence.

(1) Policies and Procedures. ACOs must not have any policies and procedures that serve to impede a physician’s primary ethical obligation to the well-being and safety of his or her patients. Any time period for an appeal of an alleged breach of conduct must be heard in a clinically appropriate time frame.

(2) Whistleblowing Protections. Physicians should be afforded the right to whistleblow to ACO leadership and/or to the appropriate regulatory authority if the ACO acts in any way contrary to the patient’s best interests. No retaliation should be permitted by the ACO or associated hospital/parent entity for such whistleblowing. For an ACO to truly be patient-centric, physicians must be free to advocate for their patients. The physician’s ethical obligations to the patient must supersede the physician’s employment or contractual obligations to the ACO or an associated hospital.

(3) Medical Record Ownership. To aid in continuity of care and to ensure the highest quality of treatment, there should be joint ownership of the medical records by the ACO and the participating physician. In the alternative, ACOs should provide participating physicians (including upon their departure from the ACO) with a right of access to the medical record in the same form in which the medical record is typically maintained.

Physician Board of Directors. The ACO should be governed by a physician board of directors that is elected by the ACO professionals. The governing board is ultimately responsible for the care and well-being of patients. The ACO must adopt a conflicts of interest policy and conflicts of interest disclosure policy to ensure that the board of directors appropriately
represents the interests of the ACO. Any physician-entity (e.g., independent physician association (IPA), medical group, and so on) that contracts with, or is otherwise part of, the ACO should be physician-controlled and governed by an elected board of directors.

Hospital-participating ACOs. Where a hospital is part of an ACO:
1. The governing board of the ACO, whose majority shall represent physicians participating in the ACO, which is comprised of physicians, should be separate and independent from the hospital governing board; and
2. Physician privileges and credentialling at the hospitals should not be conditioned on the physician’s exclusive participation in the hospital’s ACO or value-based care contracts, nor should the physician’s privileges at the hospital automatically cease upon the termination of the physician’s agreement with the ACO.

Physician Leadership Licensure/Practice. The ACO’s physician leaders, including the medical directors, should be licensed to practice medicine in Texas the state in which the ACO operates and in the active practice of medicine. To ensure local accountability and oversight, any medical director(s) must report to the physician governing board that is who will be actively engaged in the development and oversight of the ACO’s medical policy, utilization review, quality improvement, and performance measurement.

ACO State Regulation. Existing state laws offer appropriate means for organization of ACOs without the need for further ACO-specific legislation in Texas. Depending upon an ACO’s structure and scope of activities, various state agencies should have oversight authority over an ACO organized and/or operating in Texas. For example, the Texas Medical Board should appropriately regulate the practice of medicine (i.e., clinical aspects) associated with an ACO. If an ACO takes on insurance risk (e.g., capitation), the Texas Department of Insurance (TDI) should appropriately regulate that function. TDI has the background and expertise to deal with the financial and risk-bearing aspects of ACO operations. ACOs should maintain appropriate and adequate reserves and risk-based capital requirements in the same manner as licensed health insurance carriers.

Physician Participation. Physician participation in an ACO generally should be voluntary unless they are a member of a preexisting physician group that elects to participate. Physicians should not be required to join an ACO as a condition of contracting with Medicare, Medicaid, or a private payer or being admitted to a hospital medical staff.

Patient Participation. Patient participation in an ACO must be voluntary. Patients must be free to choose whether or not to enroll participate in an ACO or value-based payment model.

Marketplace Limiting Agreements. As the purpose of an ACO is to promote community-based care, an ACOs and value-based payment models must not impose marketplace limiting agreements (e.g., covenants not to compete and exclusivity provisions) upon physicians or physician practices. Further, they ACO must not interfere with the internal management of physician practices regarding covenants not to compete.

Due Process. Physician participants in an ACO should have due process (consisting of, at a minimum, the right to notice, a hearing, and an appeal to the physician board of directors) to challenge:

The physician’s (or his her group) involuntary termination from participation in an ACO;
The physician’s satisfaction of clinical, utilization, or financial performance standards (with an opportunity to explain and/or cure any alleged departures from performance standards);  
The physician’s eligibility to receive savings or distributions from the ACO;  
The amount of the distribution of savings and/or revenue received by the physician from the ACO (i.e., the appropriate distribution of savings and revenue of an ACO);  
The patients assigned attributed to the physician’s care under by the ACO payer;  
The measurements used to determine the quality of care/efficiency of care provided to patients under the ACO; and  
The ACO’s assessment of the quality of care provided to patients by the physician under the ACO.

Economic and Quality Measures. Rather than payers selecting measures, practicing physicians currently in clinical practice must be actively involved in the development of economic and quality measures used by ACOs for performance measurement in value-based care contracts. Such measures and methodologies must be transparent, valid, and agreed to by the ACO’s governing board or the contracted physician group, approved by the physician governing board. The economic and quality performance standards must meet the TMA principles for reporting, including the use of nationally accepted, physician specialty-validated clinical measures; the inclusion of a sufficient number of patients to produce statistically valid quality information; appropriate attribution methodology; risk adjustment; reflection of geographic costs; and the right for physicians to appeal inaccurate quality/efficiency reports and have them corrected. There also must be timely notification and feedback provided to physicians regarding the economic and quality measures and results. Physicians should be provided all economic and quality measures prior to the evaluation period. ACOs should periodically conduct assessments of patients’ satisfaction with the timeliness and availability of care.

Flexibility in Patient Referral and Antitrust Laws. The federal and state antikickback and self-referral laws and the federal Civil Monetary Penalties (CMP) statute (which prohibits payments by hospitals to physicians to reduce or limit care) should be sufficiently flexible (with bright-line exemptions) to allow physicians to collaborate with hospitals in forming ACOs without being employed by the hospitals or ACOs or in legal jeopardy. This is particularly important for physicians in small- and medium-size practices who may want to remain independent but otherwise integrate and collaborate with other physicians (i.e., so-called virtual integration) for purposes of participating in the ACO. The Patient Protection and Affordable Care Act explicitly authorizes the secretary to waive requirements under the Civil Monetary Penalties statute, the Antikickback statute, and the Ethics in Patient Referrals (Stark) law for Medicare ACOs. The secretary should establish a full range of waivers and safe harbors that will enable independent physicians to use existing or new organizational structures to participate as Medicare ACOs. In addition, the secretary should work with the Federal Trade Commission to provide explicit exceptions to the antitrust laws for ACO participants in Medicare, Medicaid, other state-based programs, and commercial markets. Physicians cannot completely transform their practices only for the Medicare patients, and antitrust enforcement could prevent them from creating clinical integration structures involving their privately insured patients. These waivers and safe harbors should be allowed where appropriate to exist beyond the end of the initial agreement between the ACO and Centers for Medicare & Medicaid Services (CMS) so that any new organizational structures that are created to participate in the program do not suddenly become illegal simply because the shared savings program does not continue.
CMS Provision of ACO Resources. Additional resources should be provided up front to encourage ACO development. CMS’s Center for Medicare and Medicaid Innovation (CMI, the Innovation Center) should provide grants to physicians in order to finance up-front costs of creating an ACO. ACO incentives must be aligned with the physician or physician group’s risks (e.g., start-up costs, systems investments, culture changes, and financial uncertainty). Developing this capacity for physicians practicing in rural communities and solo-small group practices requires time and resources, and the outcome is unknown. Providing additional resources for the up-front costs will encourage the development of ACOs since the “shared savings” model only provides for, particularly given that potential savings at the back-end, which may discourage the creation of ACOs by (particularly among independent physicians and practicing in rural underserved communities).

ACO Spending or Efficiency Benchmarks in Medicare Shared Savings Program, Medicaid, and Commercial ACOs. The ACO Spending benchmarks for all value-based care arrangements should be adjusted for differences in geographic practice costs and risk adjusted for individual patient risk factors.

1. The ACO spending benchmark, which will be based on historical spending patterns by the ACO and/or in the ACO’s service area and negotiated between Medicare and the ACO, must be risk adjusted to incentivize ensure physicians who treat sicker patients with higher clinical and/or socioeconomic risk factors, including patients residing in low-wealth communities, who are uninsured and/or who have higher disease burden, will be able to successfully participate. Studies show that patients with these factors are more likely to experience barriers to care and are more costly and difficult to treat to participate in ACOs and incentivize ACOs to accept and treat sicker patients, such as the chronically ill.

2. Federal, state, and commercial payers should adopt the use of standardized risk-adjustment mechanisms across different types of ACOs will to minimize the administrative complexity and costs of physicians participating in an ACO and make it easier to analyze ACO performance across multiple populations.

3. Prior to assignment to an - The ACO benchmark should be ACOs should conduct patient risk assessments adjusted to identify for the any socioeconomic and/or health status factors that may contribute to a patient’s poorer health outcomes of the patients that are assigned to each ACO, such as income/poverty level, previous insurance status prior to Medicare enrollment, race and ethnicity, and health status chronic health conditions. Data from the assessment should be used to develop tailored patient care coordination plans and to arrange referrals to appropriate social services to address non-medical factors that may impact patient health. Studies show that patients with these factors have experienced barriers to care and are more costly and difficult to treat once they reach Medicare eligibility.

4. The ACO benchmark must be adjusted for differences in geographic practice costs, such as physician office expenses related to rent, wages paid to office staff and nurses, hospital operating factors (i.e., hospital wage index) and physician health information technology (HIT) costs.

5. The ACO benchmark should include a reasonable spending growth rate based on the growth in physician and hospital practice expenses as well as the patient socioeconomic and health status factors.
(6) There shall be a determination that access to care is not compromised in fragile medical environments (e.g., inner city and rural settings).

Medicare Shared Savings Procedural Due Process. An ACO must be afforded procedural due process with respect to the secretary’s discretion to terminate an agreement with an ACO for failure to meet the quality performance standard.

Medicaid ACO Spending Benchmark. Any ACO spending benchmarks established under the Medicaid program should be adjusted for differences in geographic practice costs and risk adjusted for individual patient risk factors.

The ACO spending benchmarks must be risk adjusted to incentivize physicians with sicker patients to participate in ACOs and incentivize ACOs to accept and treat sicker patients, such as the chronically ill. The use of standardized mechanisms across different types of ACOs will minimize the administrative complexity and costs of physicians participating in an ACO and make it easier to analyze ACO performance across multiple populations.

The ACO benchmark should be risk adjusted for the socioeconomic and health status of the patients that are assigned to each ACO, such as income/poverty level, insurance status prior to Medicaid enrollment, race, and ethnicity, and health status. Studies show that patients with these factors have experienced barriers to care and are more costly and difficult to treat once they reach Medicaid eligibility.

The ACO benchmark must be adjusted for differences in geographic practice costs, such as physician office expenses related to rent, wages paid to office staff and nurses, hospital operating factors (i.e., hospital wage-index) and physician HIT costs.

The ACO benchmark should include a reasonable spending growth rate based on the growth in physician and hospital practice expenses as well as the patient socioeconomic and health status factors.

Medicaid ACOs and Value-Based Payment Arrangements.

If Medicaid tests the ACO concept, the Texas Medicaid state should seek ongoing input from practicing physicians and providers on the pilot’s design regarding the state’s value-based payment and quality roadmap, including the pilot’s quality and financial benchmarks, the mechanisms for collecting and reporting data, and how data will be shared with ACO physician participants, patients, and the public. Any ACO pilot tested in the Medicaid system must be of sufficient length to ensure valid and reliable evaluation of the pilot’s impact on health outcomes and spending, including ensuring any required performance measures for Medicaid managed care organizations and network physicians be relevant, practical, and meaningful.

Texas Medicaid should collaborate with practicing physicians, providers, and Medicaid managed care organizations to develop a menu of standardized value-based payment options that promote innovation, while also minimizing complexity stemming from the proliferation of similar but divergent models.

There shall be a determination that access to care is not compromised in fragile medical environments (e.g., inner city, rural settings).
State ACO Pilot Initiatives [e.g., Employee Retirement System (ERS)/Teachers Retirement System (TRS)] Spending Benchmarks. Any ACO spending benchmarks established under a direct contract with a state-funded insurance program and an ACO pilot initiative should be adjusted for differences in geographic practice costs and risk adjusted for individual patient risk factors.

The ACO spending benchmarks must be risk adjusted to incentivize physicians with sicker patients to participate in ACOs and incentivize ACOs to accept and treat sicker patients, such as the chronically ill. Texas Medicaid, ERS, and other state-administered health systems whose contacted health plans contract with ACOs should require the use of standardized risk-adjustment mechanisms across different types of ACOs will to minimize the administrative complexity and costs of physicians participating in an ACO and make it easier to analyze ACO performance across multiple populations.

The ACO benchmark should be risk adjusted for the socioeconomic and health status of the patients that are covered by the ERS/TRS ACO, such as income/poverty level, insurance status prior to ERS/TRS enrollment or ACO assignment, race and ethnicity, and health status. Studies show that patients without health coverage have experienced barriers to care and are more costly and difficult to treat once they do have coverage due to pent up demand.

The ACO benchmark must be adjusted for differences in geographic practice costs, such as physician office expenses related to rent, wages paid to office staff and nurses, hospital operating factors (i.e., hospital wage index) and physician HIT costs.

The ACO benchmark should include a reasonable spending growth rate based on the growth in physician and hospital practice expenses as well as the patient socioeconomic and health status factors.

If ERS tests a direct contract option with a statewide or regional ACO concept, the state should seek input from practicing physicians and providers on the pilot’s design, including the pilot’s quality and financial benchmarks, the mechanisms for collecting and reporting data, and how data will be shared with ACO physician participants, patients, and the public. Any ACO pilot tested in the ERS system must be of sufficient length to ensure valid and reliable evaluation of the pilot’s impact on health outcomes and spending.

There shall be a determination that access to care is not compromised in fragile medical environments (e.g., inner city, rural settings).

Financial Incentives. Public and private payers who partner with ACOs must invest sufficient resources to monitor and evaluate the ACO’s compliance with financial and quality benchmarks, including mechanisms to ensure the entity is not withholding medically necessary care to achieve financial gain.

ACOs should have the flexibility to use a variety of payment methods alone or simultaneously, including fee-for-service, care management fees, shared savings, partial capitation, or global capitation.
ACOs must have the flexibility to develop a mix of financial and other incentives designed to foster safe, high quality and cost-effective patient care. However, to ensure that incentives are fair and reasonable, and not intended to promote the inappropriate denial of medically necessary care or unfair restraint of trade, the ACO’s local physician governing board shall develop and oversee the incentive structure. Further, the ACO shall publicly disclose the types of incentives to avoid appearance of impropriety.

As ACOs organizations gain expertise in patient care management under value-based care models, they may realize and become more cost-effective, there will be a diminishing rate of achievable savings over time. Financial incentives must be designed to recognize that successful ACOs will eventually achieve efficiencies that will not offer ever increasing savings. To impose penalties where there is little or no opportunity to increase savings may create an improper incentives that may adversely affect patient care. To that end, and to ensure an ACO maintains a patient-centered focus, value-based contracts must include a broad set of performance-based measures and benchmarks that recognize and reward incremental and enduring quality improvement. ACOs that perform at or below a national or state spending benchmark should continue to be rewarded for maintaining cost-effective, high quality care.

There shall be a determination that access to care must not be compromised in fragile medical environments (e.g., inner city, rural settings).

Transparency. ACOs should be required to annually disclose administrative expenditures as well as the organization’s aggregate payments to physicians and providers (to permit comparison of payments to physicians versus facilities).

HIT. Health information technology, including use of interoperable electronic medical records, is a desirable feature of an ACO, but should not be a required element (CSE Rep. 6-A-11).

180.002 Managed Care Incentive Withholds: The Texas Medical Association voted to monitor insurer HMO and PPO compliance with Section 1301.068, Texas Insurance Code regarding prohibition of “incentive withholds” and their associated accounting practices. In addition, if carrier practices are determined to be in violation of state laws, TMA agreed to pursue appropriate legal, administrative, or other action to rectify any unlawful practices (Amended Res. 28W, p 169, A-91; reaffirmed CSE Rep. 5-I-01; amended CSE Rep. 8-A-11).

190.020 Sterilization Services: Medicaid policy law and regulations concerning informed consent for sterilization should be amended to remove the time and age restrictions on informed consent to eliminate barriers that prevent any legally competent pregnant woman to from choosing sterilization services while also continuing to ensure women remain in control of their reproductive decision-making (Amended Res. 405-A-01; reaffirmed CSE Rep. 8-A-11).

190.030 Simplified and Streamlined Physician Medicaid Enrollment and Credentialing in Medicaid HMOs: The Texas Medical Association continues to support efforts to establish a single, streamlined, and integrated its efforts to streamline Medicaid HMO paperwork, process for physicians to enroll in Medicaid and to initiate Medicaid HMO credentialing.

195.002 Medicare HMO Disclosure of Limitations on Choice of Physicians: The Texas Medical Association favors a requirement for full disclosure in a timely, simple and clear fashion to all
Medicare recipients as to who will be delivering their medical care in any Medicare HMO (Res. 27AA, p 204, A-90; reaffirmed CSE Rep. 5-I-01; reaffirmed CSE Rep. 8-A-11).

195.004 **Disproportionate Share Fund:** The Texas Medical Association voted to request the American Medical Association to pursue regulatory and statutory means of establishing a disproportionate share fund for physicians in order to assure access to and quality of care (Res. 28CC, p 175, A-91; reaffirmed CSE Rep. 5-I-01; reaffirmed CSE Rep. 8-A-11).

195.006 **Medicare Program Cutbacks:** The Texas Medical Association believes that U.S. representatives and senators from Texas should be educated on the need to formulate an overall plan with input from organized medicine so that any cuts to Medicare will have minimum impact on the quality of health care delivery. TMA also believes the American Medical Association should adopt a similar measure so that any changes in reimbursement payment will not affect the quality of health care delivery and will be a cooperative agreement between governmental agencies and organized medicine. TMA also urges AMA to oppose any further cuts in Medicare expenditures in the coming years as detrimental to beneficiaries' access to quality medical care. Finally, TMA agreed to seek AMA concurrence in support of the continued payment by the Medicare program for all appropriate services to support quality care (Res. 28K, p 157, and Res. 28Y, p 171, A-91; reaffirmed CSE Rep. 5-I-01; amended CSE Rep. 8-A-11).

235.001 **Fee for Service:** While also supporting voluntary participation in value-based payment arrangements, The Texas Medical Association reaffirms its support of the indemnity approach to fee-for-service physician payment (Supplemental CSE, p 161, A-90; reaffirmed CSE Rep. 5-I-01; reaffirmed CSE Rep. 8-A-11).

235.002 **Individual Responsibility for Health Care and Funding:** The Texas Medical Association reaffirms the importance of individual responsibility for health care and health care funding where possible and societal responsibility where funding is unavailable. In addition, TMA encourages liaison with a variety of stakeholders and dialogue with other sectors of society, including members of the health professions, allied health, personnel, researchers, pharmacists, pharmaceutical manufacturers, health insurers, business and industry, liability insurers, and patients, to effect to secure private sector sources of funding for promised health care in addition to direct federal, state, and local government assistance (YPS, p 155, I-90; reaffirmed CSE Rep. 5-I-01; amended CSE Rep. 8-A-11).

235.003 **Reimbursement Payment Based on Years in Practice:** The Texas Medical Association strongly opposes discrimination in reimbursement payment practices based on age, gender, or years in practice (YPS, p 155, I-90; reaffirmed CSE Rep. 5-I-01; reaffirmed CSE Rep. 8-A-11).

235.004 **Third-Party Payer Physician Payment Reductions:** In addressing the arbitrary increase in reductions to payments made to physicians by HMOs and PPOs through manipulation of CPT codes and modifiers, the Texas Medical Association will continue to voted to expand its current activities in investigation of these reductions by HMOs, PPOs and other third party payors (Res. 27H, p 170, I-90; reaffirmed CSE Rep. 5-I-01; reaffirmed CSE Rep. 8-A-11).
Bundled Payment Proposals: The Texas Medical Association opposes mandatory payment models all proposals where payment for an entire episode of care, including physician services, are bundled together and paid to a single provider, who then reimburses other providers (Amended Council on Health Facilities, p 72, A-91; reaffirmed CSE Rep. 5-I-01; reaffirmed CSE Rep. 8-A-11).

Surgical Assistants: The Texas Medical Association will continue to monitor and examine the arbitrary limitation placed on the use of surgical assistants in its investigation of insurance practices. Should abusive practices be identified, TMA will work with appropriate payors and governmental agencies to correct such inequities (Res. 28V, p 168, A-91; reaffirmed CSE Rep. 5-I-01; reaffirmed CSE Rep. 8-A-11).

Reimbursement Payment for Uncompensated Services to the Uninsured or Underinsured: The Texas Medical Association supports legislative relief, such as tax code modifications, financial compensation, and liability relief, for physicians who provide uncompensated services to uninsured or underinsured patients in compliance with governmental mandates (Res. 210-I-01; reaffirmed CSE Rep. 8-A-11).

Medicare Reimbursement Payment for Emergencies: The Texas Medical Association supports reversal of Medicare’s policy of reimbursing for emergency visits only if patients are seen in an emergency room setting (Res. 27C, p 165, I-90; reaffirmed CSE Rep. 5-I-01; reaffirmed CSE Rep. 8-A-11).

Insurance Coverage for New Medical Procedures: The Texas Medical Association will continue to initiate discussions with private insurers to assure that the approval of coverage for new safe and cost-effective medical procedures is prompt conducted. (Res. 27I, p 171, I-90; reaffirmed CSE Rep. 5-I-01; reaffirmed CSE Rep. 8-A-11).

Recommendation 2: Retain as amended.

The Council on Socioeconomics recommends deleting the following policies:

Tax-Deferred Health Benefits Mandate on Over-the-Counter Medication: The Texas Medical Association will work with the AMA to propose legislation to reverse the Patient Protection and Affordable Care Act mandate that patients who participate in certain tax-deferred health benefits (flexible spending accounts, health savings accounts, health reimbursement accounts, and so forth) must get a prescription for over-the-counter medications to be eligible for reimbursement (Res. 405-A-11).

Medicaid Allowance for Preterm Labor: The Texas Medical Association supports Medicaid patients being allowed hospitalization for preterm labor and any other significant antepartum complications that could result in preterm delivery and subsequent neonatal morbidity and mortality (Committee on Maternal and Child Health, p 114, A-91; reaffirmed CSE Rep. 5-I-01; reaffirmed CSE Rep. 8-A-11).

Reimbursement of Preventive Health Care: The Texas Medical Association emphasizes reimbursement of preventive health care in the Medicaid program and urges officials to reduce paper documentation. TMA also emphasizes education of practitioners to improve utilization.
review, rather than the punitive approach presently in operation (Committee on Access to Health Care, p 86, A-91; reaffirmed CSE Rep. 5-I-01; reaffirmed CSE Rep. 8-A-11).

95.001 Prescription Triplicate Forms: The Texas Medical Association opposes state and federal legislation calling for use of triplicate prescription forms for Schedule II through Schedule V drugs (Substitute Res. 27P, p 178, I-90; reaffirmed CSE Rep. 5-I-01; reaffirmed CSE Rep. 8-A-11).

Recommendation 3: Delete.
REPORT OF THE COUNCIL ON SOCIOECONOMICS

C-SE Report 3 2021

Subject: Opposition to New Federal Public Charge Definition

Presented by: Rodney Young, MD, Chair, Council on Socioeconomics

Referred to: Reference Committee on Socioeconomics

Background

In August 2019, the U.S. Department of Homeland Security adopted 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 Program (SNAP) services, public 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. Previously the rules did not take into account health care services, recognizing health care coverage as 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 to quell fear among immigrants that if they or their children, the vast majority of whom are U.S.-born citizens, were 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 where they lived.

At the direction of both the Council on Socioeconomics and the Council on Legislation, the Select Committee on Medicaid, CHIP, and Uninsured reviewed the rules and their potential implications for health care coverage. The committee unanimously recommended that TMA strongly oppose the rules, which TMA did. While the association has historically not taken a position on federal immigration issues, the rules undoubtedly will 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 for the Health of Texans and the 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 U.S., 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 them 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. Pregnant immigrants who are provided coverage are more likely to obtain early prenatal care, a key factor in addressing Texas’ alarmingly 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 affected. However, the indirect impact of the 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 cards. Misunderstanding and confusion about the rules have 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 less 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 with research the Urban Institute conducted 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 rules also will invariably harm the state’s public health by contributing to the spread of communicable diseases. Though the rules explicitly exclude 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 rules, the agency itself acknowledged the many negative consequences the rules will have on people and communities, including increases in emergency department use, prevalence of communicable diseases, and 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. They 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
After multiple lawsuits by state attorneys general and advocacy organizations and several injunctions, the U.S. Supreme Court ultimately allowed the rules to proceed. They took effect Feb. 24, 2020.

Nearly a year later, on Feb. 2, 2021, the Biden Administration issued an executive order instructing the secretary of state, attorney general, secretary of homeland security, and heads of other relevant agencies to review all agency actions related to the implementation of the public charge rules. It is widely expected the rules will be rescinded. Nevertheless, given the rules’ harm and the potential for a future administration to reinstate same or similar rules, the council believes TMA should make its opposition to them official TMA policy.

Recommendation: That the Texas Medical Association (1) adopt new policy opposing revisions to the federal definition of public charge that penalize legal immigrants or their children for using local, state, or national health, nutrition, and housing services, including Medicaid and the Children’s Health Insurance Program; (2) continue to advocate that the new federal rules be rescinded to protect the health of all Texans; and (3) develop resources to help physicians accurately and concisely convey to their patients what federal rules relating to public charge do and do not say.
REPORT OF PATIENT-PHYSICIAN ADVOCACY COMMITTEE

CM-PPA Report 3 2021

Subject: Legislative Changes Regarding Vacating Orders

Presented by: Shannon Hancher-Hodges, MD, Chair

Referred to: Reference Committee on Socioeconomics

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, the 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. The 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, the SOAH judge determines there was no violation of law or regulation, and the TMB adopts the judge’s findings, the TMB does not void the initial suspension or restriction, and it stays as a permanent mark on the physician’s record.

When the 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 the SOAH judge determines there has been no violation, and the TMB affirms SOAH’s findings of fact and conclusions of law that there was no violation by dismissing all allegations against the physician, the 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 the TMB has an obligation to alert relevant parties when it imposes a temporary suspension or restriction, the TMB believes it has no equivalent duty to inform those parties other than the NPDB that the temporary suspension or restriction was “superseded” (voided). The 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 the 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, the 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 the 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, all parties shall be notified that the temporary restriction or suspension is void, any related report to the National Practitioner Data Bank shall be voided, and the case dismissed, unless and until the TMB appeals the case to district court and that court reverses the administrative law judge’s findings of facts and conclusion of law.
REPORT OF BOARD OF TRUSTEES

BOT Report 18 2021

Subject: Compensation to Physicians for Activities Other Than Direct Patient Care (Tabled BOT Report 13 2020)

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.
REPORT OF COMMITTEE ON MEDICAL HOME AND PRIMARY CARE

Subject: Sunset Policy Review

Presented by: Jeffrey Bullard, 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 Committee on Medical Home and Primary Care recommends retention of the following policies:

260.005 Community and Migrant Health Centers: The Texas Medical Association reaffirms the importance of funding for comprehensive primary care, access and public health partnership through community and migrant health center programs (YPS, p 139-140, A-91; amended CPH Rep. 4-A-01; reaffirmed CSPH Rep. 3-A-11).
REPORT OF COMMITTEE ON RURAL HEALTH

Subject: Sunset Policy Review

Presented by: Lucia L. Williams, 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 Committee on Rural Health recommends retention of the following policies:

55.003 School Career Programs in Rural Areas: The Texas Medical Association voted to ask members in rural areas to volunteer to speak at high school career programs to provide information and encourage student interest in health careers, and to encourage county medical societies in rural areas to sponsor medical students who are willing to speak to high school students in rural areas and reimburse them for travel expenses (Committee on Rural Health, p 149, I-90; reaffirmed CSE Rep. 5-I-01; reaffirmed CSE Rep. 8-A-11).
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 401
2021

Subject: Caps on Insulin Copayments With Insurance (Tabled Res 413 2020)

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, the 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, TMA has an existing policy that all patients must have access to medically indicated prescription drugs necessary to treat their illnesses; and

Whereas, 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 TMA 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 402
2021

Subject: Postpartum Maternal Healthcare Coverage Under Children’s Insurance
(Tabled Res 414 2020)

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 during 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 screening provides a significant opportunity to identify factors that can affect maternal health, such as breastfeeding practices, family planning, and depression; and

Whereas, Untreated postpartum depression interferes with the mother’s ability to care for her newborn 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 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 mothers receive at least three visits from time of delivery to six weeks postpartum, where each visit includes psychosocial support to help 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 in 25 state Medicaid programs; and

Whereas, 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 in 2018; 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 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:
Extending Medicaid Coverage for One Year Postpartum D-290.974
Improving Mental Health Services for Pregnant and Postpartum Mothers H-420.953

References:
Subject: Insurance Promotion of Preventive Care Services via Incentive-Based Programs
(Tabled Res 417 2020)

Introduced by: Medical Student Section

Referred to: Reference Committee on Socioeconomics

Whereas, Approximately 45% of 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 high-priority, clinical preventive services; and

Whereas, Small cash incentives to patients have shown to improve primary care visits, and, as a result, improve screening for preventable health conditions; and

Whereas, 79% of commercially available health insurance plans offered members incentives for receiving specific clinical preventive services; and

Whereas, 49% of commercial health insurance plans found incentives useful for uptake of preventive health care services; and

Whereas, Texas created the Wellness Incentives and Navigation project funded by the Medicare Incentives for Prevention of Chronic Disease (MIPCD) program, which from 2011 to 2015 monetarily incentivized use of health promotion programs to prevent diseases such as diabetes, heart disease, and hyperlipidemia; and

Whereas, 76% of MIPCD program beneficiaries nationwide reported participation encouraged lifestyle changes such as setting goals and working toward improving their health; therefore be it

RESOLVED, That the Texas Medical Association advocate for health insurance companies to adopt cash-based incentive programs similar to 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 increase usage of preventive care services.

Related TMA Policy:
145.027 Transparency of Preventive Care Services
260.029 Preventive Medicine
References:


2. McCarthy M. Up to 40% of premature deaths in the US are preventable, says CDC. *BMJ* 2014; 348:g3122.


TExAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 404
2021

Subject: Training Requirements Imposed by Insurance Companies Preventing Patients’ Access to Quality Medical Care (Tabled Res 420 2020)

Introduced by: Lone Star Caucus

Referred to: Reference Committee on Socioeconomics

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 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 TMA 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 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 be it further

RESOLVED, That 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.

Related TMA Policy:
None.

Related AMA Policy:
None.
Subject: Ensuring Medical Practice Viability Through Reallocation of Insurance Savings During the COVID-19 Pandemic

Introduced by: Hidalgo-Starr County Medical Society and Lone Star Caucus

Referred to: Reference Committee on Socioeconomics

Whereas, The impact of COVID-19 has been evident in primary care physician and specialist offices throughout the state; and

Whereas, Government shutdowns and mandates have decreased the patient volume seen in physicians’ offices as well as the volume of elective procedures (including inpatient and outpatient surgeries); and

Whereas, In areas with a large proportion of Medicaid patients, the volume of patients needed to maintain practice viability could be as much as three times more than that in other areas; and

Whereas, Daily patient volume has remained low throughout the pandemic; and

Whereas, Currently uncompensated physician workload in this pandemic has increased because patient panel responsibility has remained unchanged; and

Whereas, Federal, state, and commercial payers function primarily as fee-for-service; and

Whereas, Uniformly decreased patient visits (services) across the state leads to increased savings (revenue) for federal, state, and commercial payers; therefore be it

RESOLVED, That the Texas Medical Association advocate for full transparency regarding Medicaid expenditures relative to allocated funds, as well as expenditures relative to gross income for all commercial payers during the pandemic; and be it further

RESOLVED, That TMA urge adoption of legislation that would mandate a review of the difference between the current physician financial deficit created by the COVID-19 pandemic and subsequent profits the insurance companies have reaped due to the government shutdowns and mandates; and be it further

RESOLVED, That a fair and equitable formula be implemented to divide and allocate the savings directly resulting from decreased patient encounters among patients/employers who paid their premiums, physicians who have been impacted directly by government mandates and shutdowns, and the insurance companies; 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:
145.007 Competitive Insurance Models
145.028 Unequal Insurance Contract Reimbursement for Solo Practitioners
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<th>120.003 Health System Reform Managed Care</th>
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<td>180.026 Health Insurance Plans</td>
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<td>235.001 Fee for Service</td>
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**Related AMA Policy:**

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<th>H-180.975 Insurance Industry Antitrust Exemption</th>
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<td>7</td>
<td>D-130.966 Domestic Disaster Relief Funding</td>
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Subject: Medicaid-Medicare Parity Needed for Patient Access Exacerbated by COVID-19

Introduced by: Hidalgo-Starr CMS and Lone Star Caucus

Resolved, That the Texas Medical Association advocate to increase Texas Medicaid reimbursement rates to physicians at least equal to Medicare rates, as the COVID-19 pandemic has made operating a physician practice financially impossible for many practices with a large Medicaid population.

Related TMA Policy:
190.003 Medicaid Payments to Increase Participation
190.007 Medicaid Funding
190.035 Floor for Medicaid Payments

Related AMA Policy:
H-290.965 Affordable Care Act Medicaid Expansion
H-290.982 Transforming Medicaid and Long-Term Care and Improving Access to Care for the Uninsured
H-330.932 Cuts in Medicare and Medicaid Reimbursement
## References:

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TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 407
2021

Subject: Ensuring That Telehealth Coverage Does Not Discourage Use of Local Physicians

Introduced by: Lone Star Caucus

Referred to: Reference Committee on Socioeconomics

Whereas, Telehealth services play an important role in ensuring the health of Texans and can sometimes be preferable to an in-person visit, especially in the event of a pandemic; and

Whereas, Organized medicine has been advocating over the past year for telehealth coverage by all payers; and

Whereas, Commercial payers have a history of enacting policies that are beneficial to them financially in the short term at the expense of the long-term health of patients and their access to medical care; and

Whereas, There is the potential for some payers to respond to heightened interest in telehealth services by offering telehealth coverage but setting cost-sharing in such a way that patients are encouraged to obtain care from nonlocal physicians or midlevel providers instead of locally based ones; and

Whereas, Incentivizing individuals to schedule multiple telehealth visits for the same problem instead of seeing a local physician for an in-person visit and undergoing a more complete physical exam that could aid in diagnosis and treatment potentially puts patients in medical jeopardy; and

Whereas, Access to care in rural areas and small cities could become limited as a consequence of reducing patient volume to the point that local physicians are unable to cover fixed expenses and are therefore forced to relocate to larger cities; therefore be it

RESOLVED, That the Texas Medical Association recognize that a benefit of having local physicians and their team of local health care providers provide telemedicine services is that they have the ability to ask the patient to switch to an in-person visit if circumstances warrant this approach; and be it further

RESOLVED, That TMA advocate for legislation that requires insurance carriers not to establish cost-sharing policies that encourage patients to use nonlocal physicians and providers instead of local physicians; 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:
290.006 Telemedicine Reimbursement

Related AMA Policy:
D-480.965 Reimbursement for Telehealth
D-480.970 Access and Equity in Telemedicine Payments
D-480.969 Insurance Coverage Parity for Telemedicine Service
1. D-480.968 Telemedicine Encounters by Third Party Vendors
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES
Resolution 408
2021

Subject: Need for and Funding of Level I and Level II Trauma Centers (Tabled Res 402 2020)

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 the 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 Driver Responsibility Program and other funding; and
Whereas, The 86th Texas Legislature enacted a law to repeal the Driver Responsibility Program and reduced 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 needed to support communities throughout Texas and to provide funding to make Level I and Level II trauma centers viable 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
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
Resolution 410
2021

Subject: Individual Physicians Be Paid While Awaiting Credentialing Approval
(Tabled Res 404 2021)

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 formal 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.
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 411
2021

Subject: Physicians to Retain Payment During Credentialing (Tabled Res 405 2020)

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Socioeconomics

Whereas, In addition to signing a contract, physicians must be credentialed 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 for 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 (House Bill 1594, encoded in 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 in Sec. 1452.106, Effect of Failure to Meet Credentialing Requirements, 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”; 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 cover” 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 “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.”

Related TMA Policy:
None.
1 Related AMA Policy:
2 None.
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 412
2021

Subject: Maintaining the Integrity of Physicians Orders in an Electronic Environment

Introduced by: Webb-Zapata-Jim Hogg County Medical Society and Lone Star Caucus

Referred to: Reference Committee on Socioeconomics

Whereas, Physicians place orders after careful medical decisionmaking; and

Whereas, Modification or discontinuation of physician orders by nonphysicians without physician approval may be considered as practicing medicine; and

Whereas, Electronic orders by physicians are sometimes modified or discontinued without knowledge or approval of physicians (e.g., time of discontinuation of Foley catheter) because of policies not approved by the medical staff and/or the physicians responsible for the initial orders; and

Whereas, The authors of electronic health record orders when changes are made by computer algorithms and under whose authority the changes are made can be unclear; therefore be it

RESOLVED, That the Texas Medical Association support legislation stating that altering physician orders without the approval of the order’s original author or the covering physician is practicing medicine and is prohibited except in an emergency (i.e., a patient safety situation).

Related TMA Policy:
30.013 Physician Standing Orders
30.039 Pharmacists Practicing Medicine
130.006 Hospital Medical Staff Bylaws

Related AMA Policy:
H-225.996 Computer-Based Hospital and Order System
D-235.994 Medical Staff Autonomy and Self-Governance
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 413
2021

Subject: Compensation to Physicians for Activities Other Than Direct Patient Care
(Tabled Res 407 2020)

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Socioeconomics

Whereas, Physicians traditionally 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 payment, including 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; and

Whereas, Noncare services have (1) greatly increased expenses for physicians; (2) endangered the ability of physician practices to survive economically; and (3) caused the demise of independent physician practices; and

Whereas, The purpose of such noncare services is to delay and deny care, allowing payers to increase their profits by saving and investing money that otherwise would pay for patient care; and

Whereas, Payers eventually authorize the majority of authorization and preauthorization requests; and

Whereas, Such noncare services harm patients by delaying diagnosis and treatment, causing pain, suffering, morbidity, and mortality; and time spent by physicians and their staff to perform noncare services decreases their availability to provide direct patient care, thus exacerbating physician shortages; and

Whereas, Other professionals, such as attorneys and 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 endanger the viability of the private practice of medicine; and

Whereas, Payers continue to disregard existing TMA policy, physicians currently are not compensated for such noncare services to the benefit of payers, and to the detriment of patients and physicians; and the dire need for relief from payers’ demands and requirements for physicians to provide noncare services necessitates strengthening existing TMA policy; therefore it be
RESOLVED, That the Texas Medical Association adopt a Funding for Physician Noncare Services policy as follows:

The Texas Medical Association advocates for payers – insurance companies and managed care companies, including companies managing governmental insurance plans – to 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 as gathering, compiling, and submitting medical records and data.

TMA also recommends such compensation be promptly paid in full by payers to physicians at a level commensurate with their education, training, and expertise, and at a rate comparable to that of the most highly trained professionals.

Physicians shall bill the payers for time spent by them and their staff to perform noncare services including, but 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, payers shall pay the physician promptly, with significant interest penalties assessed for payment delays. Because noncare services benefit payers, compensation 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 414
2021

Subject: Contracted Health Plans Must Apply the Same Level of Benefits Concerning Patient Responsibility (Tabled Res 408 2020)

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 adopt as 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
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 415
2021

Subject: Paper Medical Record Chart Preparedness for Electronic Health Record Interruptions

Introduced by: Webb-Zapata-Jim Hogg County Medical Society and Lone Star Caucus

Referred to: Reference Committee on Socioeconomics

Whereas, An increasing number of ransomware and other cyber attacks have been made against health care facilities, including physician practices; and

Whereas, Often as a result of these attacks, electronic health record access is limited or nonexistent; and

Whereas, When patients’ electronic medical records are not available for review and use, paper records are used as a last resort; and

Whereas, Many clinicians have no training on the use of paper medical records or have used paper records only for a brief time in their career and may not remember how to use them in an emergency; and

Whereas, Many clinicians and employees are required to go through annual training in HIPAA and other topics but are not required to refresh their knowledge of using paper records; and

Whereas, This unfamiliarity with the paper record not only compromises patient safety, potentially even leading to death, but also creates medicolegal issues such as notes and orders that are not sequential or understandable; therefore be it

RESOLVED, That the Texas Medical Association encourage all users of electronic health records (EHRs) in all health care environments to have an easily accessible paper medical record option available at the time of EHR interruptions, such as those from cyber attacks; and be it further

RESOLVED, That TMA encourage all health care entities to conduct training at least annually on the use of these emergency paper medical records; 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.
Subject: Physician Societies to Create a Self-Funded, Balanced, and Nonpartisan Center for the Study of Health Care Reform (Tabled Res 421 2020)

Introduced by: Harris County Medical Society

Whereas, Evidence suggests growing support among legislators and the general public for expansive health care reform, and national legislation to create a universal Medicare or single-payer system could be proposed soon; and

Whereas, Without 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 often is massive, opaque, and unproven; and without the benefit of pilot studies or existing models, such legislation is unpredictable and riddled with unintended consequences; and

Whereas, Despite support for significant change to the health care system, the implications for patient choice, physician autonomy, and the “rationing of care” often are poorly understood; and

Whereas, Some proposed reforms conflict with Texas Medical Association and American Medical Association policy, specifically that health care reform be evidence-based, responsible, sustainable, and incremental, and preserve patient and physician choice (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 to collect, study, and distribute information about potential effects of proposed health care reform; and

Whereas, The start-up investment by medical societies to create the proposed entity can be structured as a loan for future repayment; and the initial phase could include personnel and resources to create a website, solicit additional 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; and that this entity maintain and promote an online platform to provide for balanced critique about 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.

Fiscal Note: $1.5-$2.5 million/year

Related TMA Policy: 60.004 Freedom of Choice
1 110.003 Private Individualized Medical Care
2 110.009 Health Care Coverage
3 120.001 Health Care Reform
4 120.002 Health System Reform Cost Control
5 120.003 Health System Reform Managed Care
6 120.010 Principles for Evaluating Health System Reform
7 145.005 Single Payer Systems
8 145.007 Competitive Insurance Models
9 145.009 Individual Responsibility for Health Care
10 145.012 Health Insurance Individual Ownership
11 145.013 Private Healthcare System, Impact of Uninsured
12 190.032 Medicaid Coverage and Reform
13
14 Related AMA Policy:
15 H-165.838 Health System Reform Legislation
16 H-165.844 Educating the American People About Health System Reform
17 H-165.888 Evaluating Health System Reform Proposals
18 H-165.904 Universal Health Coverage
19 D-165.935 Protecting Patient Access to Health Insurance Coverage, Physicians, and Quality Health Care
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 417
2021

Subject: Verbal Physicians Orders

Introduced by: Webb-Zapata-Jim Hogg County Medical Society and Lone Star Caucus

Referred to: Reference Committee on Socioeconomics

Whereas, Hospital administrators at some health care facilities have implemented a ban on physician verbal orders to force usage of computerized order entry; and

Whereas, This action can potentially disrupt critical clinician workflows and compromise patient safety; and

Whereas, The art of understanding and implementing verbal orders requires continual practice and can be forgotten; and

Whereas, During disasters (e.g., electricity outages) or computer inaccessibility (e.g., stuck in traffic), physicians may need to give urgent orders verbally to appropriately care for the patient; and

Whereas, The Centers for Medicare & Medicaid Services recently unveiled rules aimed at easing clinician burden that state orders for x-rays may be transmitted by telephone rather than written and signed; therefore be it

RESOLVED, That the Texas Medical Association advocate for legislation or Texas Medical Board rules that require medical staff approval for any limitations on the types of physician orders that are permissible; and be it further

RESOLVED, That TMA advocate for inclusion of “how to give, receive, and document verbal orders” in the training material for clinical staff in health care facilities prior to their matriculation, as well as inclusion of the same material and procedures and their subsequent modifications in the staff’s continuing education.

Related TMA Policy:
None.

Related AMA Policy:
D-160.987 48-Hour Signature Rule
D-225.988 Elimination of 48-Hour Signature Rule for Verbal Orders

References:
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 418
2021

Subject: Electronic Prescribing of Controlled Substances (EPCS) Unfunded Mandate and Pharma Financial Settlements

Introduced by: Harris County Medical Society and the Texas Pain Society (co-sponsors)

Referred to: Reference Committee on Socioeconomics

Whereas, A national opioid crisis has been deemed to exist and mandates are a government-led cure for the crisis; and

Whereas, The federal and Texas governments have mandated electronic prescribing of controlled substances (EPCS) laws in response to the national opioid crisis, which has created direct unreimbursable cost to physicians from electronic health record (EHR) companies; and

Whereas, EHR companies are for-profit supportive industries, that already provide electronic prescription services for Schedule IV non controlled medications as part of their standard service fees; and

Whereas, Physicians have not had a pay raise in 22 years and have no way to pass on financial unfunded mandates; and

Whereas, The U.S. Department of Justice received an $8.3 billion Purdue Pharma opioid settlement, as well as other such settlements; therefore be it

RESOLVED, That the Texas Medical Association work with the American Medical Association to initiate a request to the federal government to use the dollars from the Purdue Pharma settlement, and other such settlements, to help pay for the electronic prescribing of controlled substances financial unfunded mandate; and be it further

RESOLVED, That the Texas Delegation to the American Medical Association take a resolution to the AMA House of Delegates to lobby the federal government to require certified electronic health record companies to provide electronic prescribing of controlled substances as standard basic service; and be it further

RESOLVED, That the Texas Delegation to the AMA take a resolution to the AMA House of Delegates to initiate movement on the request; and be it further

RESOLVED, That TMA review the electronic prescribing of controlled substances laws in other states to inquire on their implementation of this law to see if their law(s) have implicated dollars to cover this cost and better waiver language.

Related TMA Policy:
235.026 Medical Care and Fair Compensation
115.016 A Modest Proposal to Save our Health Care System
115.018 Overwhelming Compliance Mandates and Payment Uncertainty
118.001 Health Information Technology
265.027 Costs to Update Health Information Technology Products to Address Issues of Sex and Gender

Related AMA Policy:

H-270.962 Unfunded Mandates.
D-120.956 Electronic Prescribing and Conflicting Federal Guidelines
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 419
2021

Subject: Advocating for Increased Capacity of Local State Mental Health Facilities and Coordination of Behavioral Health Services (Tabled Res 313 2020)

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 inpatient psychiatric care; and

Whereas, In 2020, Texas ranked third highest among the states in prevalence of mental illness, yet 51st in access to mental health care, according to a report by Mental Health America; and

Whereas, The Parkland Health & Hospital System and 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 inpatient and outpatient status as well as wrap-around services; and

Whereas, Availability of psychiatric inpatient treatment centers specializing in youth and adolescents is even worse than adult bed availability, with only about half the state hospitals accepting patients under age 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 inpatient 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:
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:
4. Texas Department of State Health Services. *State Hospitals.*
5. Mental Health America. *State of Mental Health in America Ranking States.*
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 420
2021

Subject: Step-Edit Therapy Contributes to Denial of Care and Has Not Demonstrated Improved Patient Outcomes or Overall Cost Savings (Tabled Res 412 2020)

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 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
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 421
2021

Subject:  Augmented Intelligence (AI) in Health Care (Tabled Res 201 2020)

Introduced by:  Bexar County Medical Society

Referred to:  Reference Committee on Socioeconomics

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.

Fiscal Note:  $15,000

Related TMA Policy:
None

Related AMA Policy:
Augmented Intelligence in Health Care H-480.940
Augmented Intelligence in Medical Education H-295.857
Subject: Adjustments to Hospice Dementia Enrollment Criteria (Tabled Res 427 2020)

Introduced by: Dallas County Medical Society

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
Subject: Insurance Coverage for Fertility Preservation Procedures for Cancer Patients Undergoing Gonadotoxic Therapy

Introduced by: Dallas County Medical Society

Referred to: Reference Committee on Socioeconomics

Whereas, In 2006, the American Society of Clinical Oncology (ASCO) published a clinical practice guideline on fertility preservation for adults and children with cancer encouraging physicians to address fertility preservation with patients undergoing gonadotoxic therapy; and

Whereas, ASCO updated its guidelines in October 2012 after a systematic review of the new literature and determined that the recommendations remained the same, with the exception of adding oocyte cryopreservation as a standard practice (in the previous guideline, oocyte cryopreservation was still considered experimental); and

Whereas, In August 2018 the Ethics Committee of the American Society for Reproductive Medicine (ASRM) published an opinion that clinicians should inform patients receiving potentially gonadotoxic therapies about options for fertility preservation and future reproduction prior to the initiation of such treatment; and

Whereas, In December 2019, the ASRM Practice Committee published recommendations for fertility preservation in patients undergoing gonadotoxic therapy or gonadectomy, stating that patients facing treatments likely to impair reproductive function deserve prompt counseling regarding their options for fertility preservation and rapid referral to an appropriate program; and

Whereas, Based on the current body of published literature regarding ovarian tissue cryopreservation, this procedure should be considered an established medical procedure with limited effectiveness that should be offered to carefully selected patients; and

Whereas, Established methods of fertility preservation include embryo cryopreservation for men and women, sperm cryopreservation in men, and oocyte cryopreservation in women; and

Whereas, Improvements in treating cancer have enabled many younger persons with cancer to survive, and five-year survival rates with testicular cancer, hematologic malignancies, breast cancer, and other cancers that strike young people may be 90% or greater; however, treatment of these cancers is often detrimental to both male and female reproductive function; and

Whereas, Multiple organizations have published guidelines endorsing fertility preservation procedures prior to receiving gonadotoxic therapy including the American Society of Clinical Oncology, the American Society for Reproductive Medicine, the American College of Obstetricians and Gynecologists, the National Comprehensive Cancer Network, and Livestrong and the Cancer Legal Resource Center; and

Whereas, The American Medical Association encourages third-party payers to make available insurance benefits for the diagnosis and treatment of recognized male and female infertility; and
Whereas, AMA supports payment for fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician; therefore be it

RESOLVED, That the Texas Medical Association advocate for payment of fertility preservation therapy services by all payers when iatrogenic infertility may be caused directly or indirectly by necessary medical treatments as determined by a licensed physician.

Relevant TMA Policy:
None.

Relevant AMA Policy:
Disclosure of Risk to Fertility with Gonadotoxic Treatment H-425.967
Infertility and Fertility Preservation Insurance Coverage H-185.990
Recognition of Infertility as a Disease H-420.952

Reference:
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 424  
2021

Subject: Encourage the Establishment of an Express Lane Eligibility (ELE) Program in Texas

Introduced by: Medical Student Section

Referred to: Reference Committee on Socioeconomics

Whereas, The Children’s Health Insurance Program Reauthorization Act of 2009 introduced express lane eligibility (ELE) to enable the enrollment of eligible children in Medicaid and the Children’s Health Insurance Program (CHIP); and

Whereas, ELE permits states to use income, household size, or other eligibility information previously collected from an Express Lane Agency (ELA) to facilitate enrollment in health coverage; and

Whereas, ELAs include the Supplemental Nutrition Assistance Program, Temporary Assistance for Needy Families, Head Start, National School Lunch Program, and Women, Infants, and Children; and

Whereas, A state also may use income tax data to identify children in families that qualify for CHIP without requiring the family to resubmit income information to verify eligibility; and

Whereas, ELE enables a state to create a Medicaid/CHIP renewal process that does not require action by the family, simplifying renewal processes and enabling continuous coverage for children, which has important implications for their care; and

Whereas, Even brief gaps in children’s coverage are associated with reduced access to care and increased rates of unmet needs and forgone care; and

Whereas, When family income changes, ELE can ease transitions between Medicaid and CHIP because both are ELA agencies; and

Whereas, CHIP and Medicaid use different income methodologies in a state; however, when one program terminates a child’s eligibility based on family income findings, ELE enables coverage in the qualified program without further income analysis; and

Whereas, According to 2019 U.S. Census data, the share of Texans without health insurance – 18.4% – was twice the national average of 9.2%; and

Whereas, The number of Texans without health insurance has risen during the COVID-19 pandemic, which has resulted in economic turmoil and massive job losses; and

Whereas, The Journal of the American Medicine Association (JAMA) highlighted Louisiana, which implemented ELE and automatically enrolled 20,000 people in Medicaid in 2019, costing the state less than an outreach campaign that enrolled only 329 children; and

Whereas, Texas Medical Association Policy 55.055 advocates to increase the number of children enrolled in available health insurance programs; therefore be it
RESOLVED, That our Texas Medical Association encourage the establishment of an express lane eligibility (ELE) program in Texas that permits the use of income, household size, or other eligibility information previously collected from an Express Lane Agency (ELA), as described by the Centers for Medicare & Medicaid Services, to facilitate enrollment in Medicaid and the Children’s Health Insurance Program (CHIP).

References:


Relevant TMA Policy:

55.055 Increase enrollment of children into health insurance plans

190.028 Medicaid and CHIP Applications

Relevant AMA Policy:

Expanding Enrollment for the State Children’s Health Insurance Program (SCHIP) H-290.971
Subject: Making COVID-19 Emergency Telehealth Policies Permanent

Introduced by: Medical Student Section

Referred to: Reference Committee on Socioeconomics

Whereas, The Centers for Disease Control and Prevention (CDC) reports an exponential increase in the use of telemedicine by healthcare providers as a result of the COVID-19 pandemic; and

Whereas, Telemedicine provides a convenient, low-cost means for health care providers to connect with patients and has been used during the pandemic to promote social distancing, and limit hospital visits and supplies to the most urgent cases; and

Whereas, Even before the pandemic, telemedicine had been shown to increase patient access to care by reducing transportation and geographic barriers, and decreasing overall mortality and length of stay in hospitals; and

Whereas, Projected physician workforce shortages compound the need for Texas to provide rural patients with access to primary and specialty care, and Texas Medical Association Policy 185.019 supports the use of telemedicine as a method to improve outreach in underserved communities; and

Whereas, The CDC reports the increase in telemedicine usage could be a result of pandemic-related telehealth policy changes; and

Whereas, Texas Gov. Greg Abbott signed emergency order 28 TAC §35.1 in March 2020, which requires that “health benefit plans provide coverage for covered services or procedures delivered by telemedicine on the same basis and to the same extent that the plan provides coverage for the same service or procedure in an in-person setting;” and

Whereas, The U.S. Centers for Medicare & Medicaid Services (CMS) also broadened access to telehealth services in March 2020 under the 1135 waiver authority and the Coronavirus Preparedness and Response Supplemental Appropriations Act for the COVID-19 public health emergency (PHE) declaration; and

Whereas, The key changes to telemedicine under the COVID-19 PHE declaration include (1) payment parity, meaning telehealth visits are paid at the same rate as in-person visits; (2) payment for Medicare telehealth services in any healthcare facility or patients’ homes; (3) elimination of the requirement requiring a prior relationship between the physician and patient; and (4) allowance for providers to serve out-of-state patients; and

Whereas, The changes to telehealth under the COVID-19 PHE declaration are not permanent and must be renewed every 90 days; and

Whereas, The CMS is proposing making certain telehealth services permanent, such as home visits for the evaluation and management of a patient, and for patients with certain cognitive impairments; and
Whereas, TMA Policy 290.006 supports providing equitable reimbursement for clinical services delivered via telecommunications technology; and

Whereas, In January, TMA began advocating to make permanent the temporary regulatory changes, such as payment parity; therefore be it

RESOLVED, That the Texas Medical Association support policy for payment parity, as initiated by the COVID-19 PHE declaration and 28 TAC §35.1 enacted by Governor Abbott, for the same covered service provided to an enrolled patient by a contracted physician via telemedicine; and be it further

RESOLVED, That TMA support research on the use of telemedicine services in rural settings in response to 28 TAC §35.1 to determine its effect on increasing access to health care services across the state.

Related TMA Policy:
185.019 Rural Physician Workforce Policy
290.002 Telemedicine Use to Improve Health Care
290.003 Telemedicine Use As Supportive Mechanism in Delivery of Care
290.005 Telemedicine
290.006 Telemedicine Reimbursement
290.007 Telemedicine and Confidentiality
290.008 Telemedicine Use in Protecting the Health and Welfare of Citizens
290.009 Guidelines for Electronic Communications with Patients

Related AMA Policy:
H-480.946 Coverage of and Payment for Telemedicine
Subject: Support for Rural Labor and Delivery Departments

Introduced by: Medical Student Section

Referred to: Reference Committee on Socioeconomics

Whereas, Texas has the eighth highest maternal mortality rate in the U.S., with 34.5 deaths per 100,000 births; and

Whereas, High maternal mortality rates often occur because hospitals are unprepared for childbirth or maternal emergencies during childbirth, indicating a need to invest additional resources into labor and delivery departments; and

Whereas, A 2019 study discovered maternal morbidity and mortality rates are 9% higher for rural residents compared with urban residents, when controlled for other variables such as sociodemographic factors and clinical conditions; and

Whereas, Inadequate Medicaid reimbursement has caused a disproportionate increase in the closure of rural labor and delivery departments because they account for significant income loss for rural hospitals; and

Whereas, Rural settings have a higher percentage of Medicaid-eligible patients, whose intrapartum care was reimbursed by the Disproportionate Share Hospital (DSH) provision until it was phased out under the Affordable Care Act’s Medicaid expansion plan; and

Whereas, Texas has not expanded Medicaid, putting even greater financial strain on rural hospitals because of funding gaps resulting from inadequate Medicaid reimbursement; and

Whereas, Smaller hospitals with a limited obstetric workforce experience increased financial strain because of the lack of federal funding and new state regulations for neonatal and maternal care for small hospitals that offer labor and delivery services; and

Whereas, Women in rural counties without labor and delivery departments face increased travel for standard intrapartum care, which contributes to an increased risk of maternal mortality and morbidity, as well as infant mortality; and

Whereas, Lack of access to labor and delivery departments leads to an increase in infant mortality, reduced birth weight, perinatal mortality, neonatal mortality, and an increase in Neonatal Intensive Care Unit (NICU) care; and

Whereas, Infants requiring NICU stays and infants born weighing 119 grams or less cost the state roughly 200 times more in medical expenditures than a healthy, full-term baby; and

Whereas, Texas has experienced the highest rate of rural hospital closures in the U.S., and the COVID-19 pandemic poses further challenges for struggling small, rural hospitals; and
Whereas, TMA Policy 290.010 supports improving access to care in rural and medically underserved areas by promoting Project ECHO and the Child Psychiatry Access Network, but fails to explicitly support access to and funding for labor and delivery departments and intrapartum care, leaving this population overlooked by the general public and policy-makers; and

Whereas, The consequences of the COVID-19 pandemic remain to be seen, and the disruption in health care and intentional choices in response to the pandemic are expected to indirectly result in an increase in maternal and child death; and

Whereas, The Texas Department of Agriculture (TDA) continues to allocate funds from the HHS (Health and Human Services) Provider Relief Fund to provide bridge funding for rural facilities to help ease financial implications of the COVID-19 pandemic; and

Whereas, HHS Provider Relief Fund allocations by TDA target COVID-19 relief and do not address existing burdens on already financially strained rural labor and delivery departments, partly because of the lack of awareness about challenges experienced by rural pregnant women; therefore be it

RESOLVED, That the Texas Medical Association support legislation and advocate for increased funding for rural labor and delivery departments under financial strain to allow for improved access to intrapartum care; and be it further

RESOLVED, That TMA promote awareness to the general public, policy-makers, and physicians about the challenges rural women face when seeking obstetric care that result from decreased access to local labor and delivery departments.

Related TMA Policy:
290.010 Improving Access to Care in Rural and Medically Underserved Areas
330.015 Physician-Led Initiatives to Address Maternal Mortality and Morbidity

Related AMA Policy:
H-465.990 Closing of Small Rural Hospitals
H-465.994 Improving Rural Health
H-465.997 Access to and Quality of Rural Health Care

References:


Subject: Limiting Out-of-Network Ground Ambulance Costs

Introduced by: Medical Student Section

Referred to: Reference Committee on Socioeconomics

Whereas, 71% of ground ambulance transports for patients with large, national insurance plans resulted, in average, with a surprise medical bill of $450; and

Whereas, In Texas, more than 85% of ground ambulance services are billed as out of network; and

Whereas, Nationally, costs associated with ground ambulance usage account for most out-of-network bills; and

Whereas, As of 2021, the federal government does not limit ambulance charges for patients with private insurance; therefore, the cost of an ambulance ride can vary widely by location; and

Whereas, The global ambulance services market has grown significantly during the COVID-19 pandemic, particularly because of emergency transports for COVID-19 patients; and

Whereas, The global ambulance services market is expected to hit $34.8 billion in 2027 with a growth rate of 1.2%, compared to the pre-pandemic projected growth rate of 1.1% from 2019-26; and

Whereas, The Texas Constitution does not allow cities to negotiate lower rates, and most Texas cities follow local ordinances to set rates for their emergency medical services ambulance fees; and

Whereas, Congress passed the bipartisan No Surprises Act Dec. 27, 2020, as part of the omnibus spending bill that protects patients from surprise medical billing; and

Whereas, The No Surprises Act includes patient protections from surprise medical billing for air ambulances, but purposely excludes ground ambulances because of the complexity of local and state regulations, and lack of transparency of ambulance costs; and

Whereas, The No Surprises Act established a commission to study ground ambulance billing; and

Whereas, While the American Medical Association objected to the No Surprises Act for reasons unrelated to ambulances, the AMA states patients must not be penalized financially for receiving unexpected care from out-of-network providers; and

Whereas, Texas Senate Bill 1264 protects consumers who have state-regulated health plans from surprise medical bills in certain situations and bans balance billing for emergency care; and

Whereas, Texas Senate Bill 1264 excluded air and ground ambulances; and
Whereas, The Texas Department of Insurance has urged state lawmakers to “amend the state’s protections against medical balance bills when the consumer doesn’t have choice of providers to include ambulance services;” therefore be it

RESOLVED, That the Texas Medical Association support increased data collection and price transparency of ground ambulance providers and services; and be it further

RESOLVED, That TMA support policies and initiatives to reduce surprise, out-of-network billing related to ground ambulance services.

Related TMA Policy:

110.007 Cost Containment

Related AMA Policy:

D-130.962 Air Ambulance Regulations and Payments
H-240.978 Medicare’s Ambulance Service Regulations
H-285.904 Out-of-Network Care

References:


TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 428
2021

Subject: Insurance Coverage Transparency (Tabled Res 401 2020)
Introduced by: Lone Star Caucus
Referred to: Reference Committee on Socioeconomics

Whereas, Medical offices and facilities want to provide accurate estimates of cost-sharing liability to patients prior to office visits, procedures, and tests; and

Whereas, Medical offices and facilities often are unable to provide such estimates because each commercial health insurance plan has its own rules regarding patient responsibility for deductibles, copays, or coinsurance; and

Whereas, When medical offices and facilities call the insurance carrier or check online to verify coverage, they frequently receive 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 also can delay medical care if the insurance carrier overestimates the patient’s liability, making the patient reluctant to proceed with recommended tests or procedures; and

Whereas, Commercial insurance carriers have the technology to input the diagnosis and CPT codes to immediately determine the patient’s liability, they rarely provide this information to medical offices and facilities; therefore be it

RESOLVED, That the Texas Medical Association advocate for legislation that requires 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 and CPT codes via phone or the internet; and be it further

RESOLVED, That TMA advocate for legislation that requires commercial insurance carriers, during insurance eligibility verification, to provide information regarding factors that may result in denial of the claim, e.g., the insurance carrier is waiting for the primary policyholder to verify whether he or she has other health insurance coverage; and be it further

RESOLVED, That TMA advocate for legislation that requires commercial insurance carriers to respond to telephone inquiries about the patient’s cost-sharing liability by providing accurate information verbally and via fax confirmation; and be it further

RESOLVED, That TMA advocate for legislation that penalizes commercial insurance carriers, via fines and the publication of each carrier’s number of noncompliance complaints, when 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-185.938 Health Insurance Exchange and 90-Day Grace Period
- H-185.981 Third Party Responsibility for Payment
Subject: Adoption of Principles of Physician Value-Based Decisionmaking in Medical Practice and Professionalism (Tabled Resolution 424 2020)

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

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 Social, Technological, Economical, Environmental and Political (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 Physicians 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, the 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 of 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 decisionmaking:

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 decisionmaking, 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 decisionmaking. 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 decisionmaking 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 decisionmaking.

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.

And be it further

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:


TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 430
2021

Subject: Paid Parental Leave (Tabled Res 418 2020)

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.