Renew Your Passion

Handbook for Delegates

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Apple App Store  Google Play Store
WHAT TO DO WHEN

FRIDAY, May 17

6:30-7:30 am
TexMed Orientation: Tower Lobby, Topaz
New members of the house meet for breakfast to review procedures.

7 am-6 pm
Registration: Tower Lobby, Expo Hall

8 am
House of Delegates convenes: Tower Lobby, Chantilly Ballroom

Immediately Following Opening Session
Reference committees meet in rooms off the Tower Lobby:
- Financial & Organizational Affairs: Topaz Room
- Medical Education & Health Care Quality: Senator’s Lecture Hall
- Science & Public Health: Governor’s Lecture Hall
- Socioeconomics: Sapphire Room

Noon-1 pm
Sponsored by the Texas Beef Council
Free Networking Lunch: Tower Lobby, Expo Hall

12:30-2 pm
Candidate Forum: Tower Lobby, Sapphire Room
Learn about the candidates running for TMA offices. Candidates will answer questions from the audience. This year’s forum also will feature an interactive strategy session featuring TMA’s legislative advocacy leaders. Any member who attends will be entered into a drawing for an Amazon gift card. Must be present to win.

3:30-5 pm
Sponsored by TMLT
Opening General Session: Tower Lobby, Expo Hall
Wendy Sue Swanson, MD, MBE
How Technology is Transforming Health Care and the Physician-Patient Relationship

5-6 pm
Sponsored by TMLT
Welcome Reception: Tower Lobby, Expo Hall

6-7 pm
Sponsored by TMAIT
2019-20 TMA/TMAA Presidents’ Reception:
Tower Lobby, Topaz Room

7-10:30 pm
TMA Foundation’s 26th Annual Gala, Grand Atrium, Grand Ballroom
Ticket required. Your attendance supports a Healthy Now and a Healthy Future and award-winning TMA health improvement and education initiatives like Be Wise — ImmunizeSM and Hard Hats for Little Heads, all supported by TMAF.

SATURDAY, May 18

6 am-1:30 pm
Registration: Tower Lobby, Expo Hall

8:30 am
House of Delegates meets: Tower Lobby, Chantilly Ballroom

12:30-1:30 pm
Sponsored by Texas Prescription Monitoring Program
Free Expo Lunch: Tower Lobby, Expo Hall

1:30-2:30 pm
Closing General Session: Tower Lobby, Expo Hall
Lipi Roy, MD, MPH
The Opioid Crisis: How Did We Get Here and How Do We Get Out?

Caucus Meetings
- Bexar County Medical Society
  Saturday, 6:30 am, West Wing, De La Salle
- Dallas County Medical Society
  Saturday, 6:30 am, West Wing, Coronado D
- Harris County Medical Society
  Saturday, 6:30 am, West Wing, Cortez A
- Lone Star Caucus
  Friday, 6:30 am, West Wing, Metropolitan
  Saturday, 6:30 am, West Wing, Coronado A
- Tarrant County Medical Society
  Saturday, 6:30 am, West Wing, Cortez D
- Travis County Medical Society
  Saturday, 7 am, West Wing, Coronado B
- Medical Student Section
  Saturday, 6:30 am, Tower Mezzanine Level, Manchester

NOTES
- Availability of Reference Committee Reports: We will post final reports on the TMA House of Delegates webpage as early as possible. Printed report packets will be available by 6 am on Saturday in the West Wing, De Soto A.
- Caucuses: Don't forget to pick up your packets!
- 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.
- Wi-Fi: The free wireless network is TexMed and the password is texmed19.
REFERENCE COMMITTEES
May 2019

CHIEF TELLER
Leah Hanselka Jacobson, MD, Bexar County Medical Society

CREDENTIALS
Nefertiti C. DuPont, MD, chair, Montgomery County Medical Society
Ellia Ciammaichella, DO (Resident), Harris County Medical Society
Prabhdeep Kaur Grewal, MD, Bexar County Medical Society
Robert E. Wolf, MD, McLennan County Medical Society

FINANCIAL AND ORGANIZATIONAL AFFAIRS
David T. Lam, MD, chair, Bexar County Medical Society
Lisa Go, MD, Bell County Medical Society
Shannon B. Hancher-Hodges, MD, Harris County Medical Society
Kalarickal J. Oommen, MD, Lubbock County Medical Society
Graves T. Owen, MD, Travis County Medical Society
Pervaiz Rahman, MD, Dallas County Medical Society
Lisa Louise Swanson, MD, Dallas County Medical Society

MEDICAL EDUCATION AND HEALTH CARE QUALITY
Manish Rungta, MD, chair, Harris County Medical Society
Patrick Bettiol (Student), Lubbock County Medical Society
Justin M. Bishop, MD (Resident), Dallas County Medical Society
Esther J. Cheung-Phillips, MD, Travis County Medical Society
Sameer Islam, MD, Lubbock County Medical Society
Arthur Lim, MD, Harris County Medical Society
Linda M. Siy, MD, Tarrant County Medical Society

SCIENCE AND PUBLIC HEALTH
Susan Rossmann, MD, chair, Harris County Medical Society
Emily D. Briggs, MD, Comal County Medical Society
Victor Gonzalez, MD, Dallas County Medical Society
Katharina Hathaway, MD, Travis County Medical Society
David R. Hoyer, Jr., MD, Harris County Medical Society
Brian D. Masel, MD, Galveston County Medical Society
Angela D. Self, MD, Tarrant County Medical Society

SOCIOECONOMICS
Brian T. Boies, MD, chair, Bexar County Medical Society
Christopher Sung Jin Chun, MD, Dallas County Medical Society
Nancy Thorne Foster, MD, Travis County Medical Society
Dara Grieger, MD (Resident), Hidalgo-Starr County Medical Society
Faraz A. Khan, MD, Harris County Medical Society
Angela K. Sturm, MD, Harris County Medical Society
Roxanne Marie Tyroch, MD, El Paso County Medical Society

Reference committee item tracker — see which reference committee agenda items are being discussed in real time on your mobile device at: http://refcom.texmed.org.

Agenda item status updates also will be displayed on a monitor just outside the reference committee hearing rooms.
TEXMED 2019 Texas Caucus Meetings

LEGEND

- Bexar
- Dallas
- Harris
- Lone Star
- Tarrant
- Travis

Caucus Meetings

**Bexar County Medical Society**
Michael A. Battista, MD, Co-Chair
Jayesh B. Shah, MD, Co-Chair
Saturday, 6:30 am, West Wing, De La Salle

**Dallas County Medical Society**
Mark A. Casanova, MD, Co-Chair
Leslie Secrest, MD, Co-Chair
Saturday, 6:30 am, West Wing, Coronado D

**Harris County Medical Society**
Sherif Zaafran, MD, Chair
Bradford Patt, MD, Vice Chair
Saturday, 6:30 am, West Wing, Cortez A

**Lone Star**
Brad Holland, MD, Co-Chair
Jed Grisel, MD, Co-Chair
Lenore DePagter, DO, Vice Chair
Friday, 6:30 am, West Wing, Metropolitan
Saturday, 6:30 am, West Wing, Coronado A

**Tarrant County Medical Society**
Robert J. Rogers, MD, Co-Chair
Gary Floyd, MD, Co-Chair
Saturday, 6:30 am, West Wing, Cortez D

**Travis County Medical Society**
Tony A. Aventa, MD, Chair
Michelle Berger, MD, Vice Chair
Saturday, 6:30 am, West Wing, Coronado B
GOVERNANCE STRUCTURE

Board of Councilors
- Physician Health and Wellness

House of Delegates

Board of Trustees
- Interspecialty Society
- Membership

International Medical Graduate Section
Medical Student Section
Resident and Fellow Section
Young Physician Section
Texas Delegation to AMA

Council on Constitution and Bylaws
Council on Health Care Quality
Council on Health Promotion
Council on Health Service Organizations
Council on Legislation

Council on Medical Education
- Continuing Education
- Physician Distribution and Health Care Access

Council on Practice Management Services

Council on Science and Public Health
- Cancer
- Child and Adolescent Health
- EMS and Trauma
- Infectious Diseases
- Reproductive, Women’s, and Perinatal Health

Council on Socioeconomics
- Medical Home and Primary Care
- Patient-Physician Advocacy
- Rural Health

July 2016
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 Report to House of Delegates

Reference Committee Executive Sessions

Reference Committee Hearings

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

Speaker of House of Delegates

Resolution or Action Report
Flow Chart for Business Items

1. Did a member of the house request that the item be extracted from the consent calendar?
   - **YES**
   - The reference committee recommendation is enacted when consent calendar is adopted.
   - **NO**
   - Proceed to 5.

2. Did the reference committee recommend “adopt”?
   - **YES**
   - The original item of business is before the house, and the reference committee suggests a “yes” vote.
   - **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”?
   - **NO**
   - The original item of business is before the house, and the reference committee suggests a “no” vote.
   - **YES**
   - Original item is before the house as the Main Motion, with the subsidiary motion “refer” as the immediately pending motion – discussion is on “refer.”
   - The reference committee recommends a “yes” vote on referral.

4. Did the reference committee recommend “refer”?
   - **NO**
   - Did the house adopt “refer”?
     - **NO**
     - Original item is disposed of and will be considered by the body to which it was referred.
     - **YES**
     - Original item is before the house without a recommendation from the reference committee.
   - **YES**
   - Original item is before the house as the Main Motion, with the subsidiary motion “refer” as the immediately pending motion – discussion is on “refer.”
   - The reference committee recommends a “yes” vote on referral.

5. Did the reference committee recommend “amend”?
   - Original item is before the house as the Main Motion, with the subsidiary motion “amend” as the immediately pending motion – discussion is on “amend.”
   - **YES**
   - Did the house adopt the amendment?
     - **YES**
     - Original item, as amended, is before the house; reference committee recommends a “yes” vote on the item as amended.
     - **NO**
     - Original item is before the house, without a recommendation from the reference committee.
   - **NO**
   - Did the house adopt the amendment?

6. Did the reference committee recommend “amend by substitution” or “adopt the following in lieu of the original”?
   - **YES**
   - Substitute language is before the house as the Main Motion – discussion is on the proposed substitute.
   - **NO**
   - Did the house adopt the proposed substitute?
     - **YES**
     - Substitute is enacted.
     - **NO**
     - Original item is before the house as the Main Motion – discussion is on the original item.

7. The speaker will explain the situation.

Original item is before the house as the Main Motion, with the subsidiary motion “refer” as the immediately pending motion – discussion is on “refer.”

The reference committee recommends a “yes” vote on referral.
**PROCEDURE FOR BUSINESS ITEMS**

*July 2017*

**If There Is Objection to Consideration**

If a delegate objects to consideration of an item of business by the house *before* it is referred to a reference committee, the correct motion is “object to consideration.” The motion requires a three-fourths supermajority vote of the house for passage. Debate is limited to the merits of the “object to consideration” motion; no debate is permitted on the original item. Passage of this motion kills the item.

**Items Placed on Consent Calendar**

All items considered by the reference committees are automatically placed on a consent calendar with recommended actions. All items are subject to extraction.

**If An Item is Not Extracted**

If an item of business is *not* extracted from the consent calendar, when the consent calendar is adopted, the House of Delegates is agreeing to whatever action the reference committee recommended – whether that be “adopt,” “do not adopt,” “adopt as amended,” “adopt the following substitute in lieu of the resolution(s),” “refer” – or some other action.

**If An Item Is Extracted**

If an item of business is extracted from the consent calendar, it may come before the house in different forms, with different motions pending, depending on the recommendation of the reference committee:

- **“Adopt”** – If the reference committee recommends that the item of business (the original resolution, or the recommendation or recommendations if recommendations in a report are under consideration) “be adopted,” and the item is extracted from the consent calendar, the original item of business is before the house as a main motion. The reference committee is suggesting that members should vote “yes” on the item of business.

- **“Do Not Adopt”** – If the reference committee recommends that the item of business (the original resolution, or the recommendation or recommendations if recommendations in a report are under consideration) “not be adopted,” and the item is extracted from the consent calendar, the original item of business is before the house as a main motion. *The house votes on the original item, not on the reference committee recommendation.* A “yes” vote is in favor of the original item, and a “no” vote is in opposition to the original item. The reference committee is suggesting that members should vote “no” on the item of business.

- **“Refer”** – If the reference committee recommends that the item of business “be referred,” and the item is extracted from the consent calendar, the original item of business is before the house as a main motion, and “refer” is before the house as a subsidiary motion. The house first considers the higher-ranking “immediately pending” motion, which is the motion to “refer,” and the reference committee is suggesting that members should vote “yes” on referral.

  If referral is adopted, the item of business has been disposed of by the house, and the body to which referral is directed (whether a committee, the Board of Trustees, or some other body) will take up the item.

  If referral is defeated, the original item of business is now before the house, and the house may adopt it, defeat it, amend it, or take whatever other actions are proper to dispose of the original item. Since the reference committee recommended
Referral, and referral was defeated, the reference committee now has no recommendation in its report on how to dispose of the original item, although the speaker may ask the reference committee chair to consult with the committee members and indicate the committee’s recommendation, if the committee has one.

“Refer” may be “for study,” or “for decision.”

If an item is referred “for study,” the body to which it is referred will investigate the issue and report to the house its findings and any recommendations.

If an item is referred “for decision,” the body to which it is referred is being given 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. Although not required, the body will report back to the house, explaining its findings and the actions performed.

If an item is referred without designating whether the referral is “for study” or “for action,” the referral is “for study.” The referral also may include a request for a formal handbook report back to the house, or even specify the body that should take up the referred item.

“Approval and Referral” – If an item of business is approved by the house, TMA staff and leadership will automatically see that the appropriate person, committee, officer, staff person, or other individual or group, implements the action of the house. Therefore, adding “and referral” to a motion that the house is planning to adopt is unnecessary, whether suggested by the reference committee or by a member of the house. If the speaker permits this addition, the effect is to assure that if the item is adopted, it will be implemented, but this will occur anyway if the item of business is adopted.

- **“Amend”** (and “adopt as amended”) – If the reference committee recommends that the item of business “be amended,” and/or that it be “adopted as amended,” and the item is extracted from the consent calendar, the original item of business is before the house as a main motion, and “amend” is before the house as a subsidiary motion.

The house first considers the higher-ranking “immediately pending” motion, which is the motion to “amend,” and the reference committee is suggesting that members should vote “yes” on the amendment, and then vote “yes” on the main motion as amended.

If the amendment is defeated, the original item of business is now before the house, and the house may adopt it, defeat it, amend it (in ways other than those recommended by the reference committee), and take whatever other actions are proper to dispose of the original item. Since the reference committee recommended amendment, and amendment was defeated, the reference committee now has no recommendation in its report on how to dispose of the original item, although the speaker may ask the reference committee chair to consult with the committee members and indicate the committee’s recommendation, if the committee has one.

If “amend” is recommended, the full motion, resolution, or recommendation (or existing policy, if a change in existing policy is being proposed) is usually printed in full in the reference committee report, with words proposed for deletion indicated by “strike-through,” and words proposed for insertion or addition indicated by underlining. This presentation assists delegates to visualize the final wording of the item of business, if the proposed amendment(s) are adopted.
“Substitute” – If the reference committee recommends that the item of business “be amended by substitution,” or that “the following be adopted in lieu of the original item,” and the item is extracted from the consent calendar, the proposed substitute is before the house. The reference committee is suggesting that members should vote “yes” on the proposed substitute. If the house wishes, it may amend the proposed substitute before taking final action on it.

If the proposed substitute is adopted, it is TMA’s practice to regard the substitute as having been accepted by the house in place of the original item of business, which is not considered by the house.

If the proposed substitute is defeated, the original item of business now comes before the house as a main motion, and the house may adopt it, defeat it, amend it, and take whatever other actions are proper to dispose of the original item. Since the reference committee recommended adoption of a substitute, and the substitute was defeated, the reference committee now has no recommendation in its report on how to dispose of the original item, although the speaker may ask the reference committee chair to consult with the committee members and indicate the committee’s recommendation, if the committee has one.

“Amendment by substitution” from the floor of the house – If a delegate moves, from the floor, to amend a pending motion by substituting a differently worded motion for it, and the amendment by substitution is adopted, the substitute becomes the main motion, and must be voted on once again as the main motion. Although this may seem like an unnecessary second step, the rationale is that the house has decided which motion it prefers between the original and the proposed substitute, but has not decided whether it actually wishes to adopt either one, until a second (final) vote is taken. This is different from the procedure when the reference committee proposes a substitute; in that situation, if the house does not want to do anything at all, it must vote “no” on both the proposed substitute and the original item.

Secondary amendments – Whenever a primary amendment is the immediately pending motion, the wording in the primary amendment may be changed by secondary amendment(s). Only one primary amendment and one secondary amendment to a motion may be pending at one time. Amendments must be “germane to (have direct bearing on)” the motion they propose to change.
### Basic Rules Governing Motions

**In order of precedence**

#### PRIVILEGED MOTIONS

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<tr>
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<tr>
<td>1.</td>
<td>No</td>
<td>Yes</td>
<td>Yes²</td>
<td>Yes²</td>
<td>Majority</td>
<td>None</td>
<td>Amend, close debate, limit debate</td>
<td>Yes</td>
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<tr>
<td>2.</td>
<td>No</td>
<td>Yes</td>
<td>Yes²</td>
<td>Yes²</td>
<td>Majority</td>
<td>None</td>
<td>Amend, close debate, limit debate</td>
<td>Yes⁶</td>
</tr>
<tr>
<td>3.</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None</td>
<td>None</td>
<td>None</td>
<td>Yes</td>
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#### SUBSIDIARY MOTIONS

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<td>4.</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>2/3</td>
<td>Debatable motions</td>
<td>None</td>
<td>Yes</td>
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<td>5.</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>2/3</td>
<td>Debatable motions</td>
<td>None</td>
<td>Yes</td>
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<td>6.</td>
<td>No</td>
<td>Yes</td>
<td>Yes²</td>
<td>Yes²</td>
<td>Majority</td>
<td>Main motion</td>
<td>Amend, close debate, limit debate</td>
<td>Yes⁶</td>
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<td>7.</td>
<td>No</td>
<td>Yes</td>
<td>Yes²</td>
<td>Yes²</td>
<td>Majority</td>
<td>Main motion</td>
<td>Amend, close debate, limit debate</td>
<td>Yes⁶</td>
</tr>
<tr>
<td>8.</td>
<td>No</td>
<td>Yes</td>
<td>Yes²</td>
<td>Yes²</td>
<td>Majority</td>
<td>Main motion</td>
<td>Amend, close debate, limit debate</td>
<td>Yes⁶</td>
</tr>
<tr>
<td>9.</td>
<td>No</td>
<td>Yes</td>
<td>Yes¹</td>
<td>Yes</td>
<td>Majority</td>
<td>Reworkable motions</td>
<td>Amend, close debate, limit debate</td>
<td>No⁶</td>
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#### MAIN MOTIONS

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<tr>
<td>10. a.</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>Majority</td>
<td>None</td>
<td>Subsidiary</td>
<td>No</td>
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#### Incidental Motions

**No order of precedence**

#### MOTIONS

<table>
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<tbody>
<tr>
<td>Appeal</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
<td>Majority</td>
<td>Ruling of chair</td>
<td>Close debate, limit debate</td>
<td>No</td>
</tr>
<tr>
<td>Suspend the rules</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>2/3</td>
<td>Procedural rules</td>
<td>None</td>
<td>Yes</td>
</tr>
<tr>
<td>Consider informally</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>Majority</td>
<td>Main motion or subject</td>
<td>None</td>
<td>Yes</td>
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#### REQUESTS

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<tbody>
<tr>
<td>Point of order</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None</td>
<td>Procedural error</td>
<td>No</td>
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<tr>
<td>Inquiries</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None</td>
<td>All motions</td>
<td>No</td>
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<tr>
<td>Withdraw a motion</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None</td>
<td>All motions</td>
<td>No</td>
</tr>
<tr>
<td>Division of question</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None</td>
<td>Main motion</td>
<td>No</td>
</tr>
<tr>
<td>Division of assembly</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>None</td>
<td>Indecisive vote</td>
<td>No</td>
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</table>

1. Motions are in order only if no motion higher on the list is pending. Thus if a motion to close debate is pending, a motion to amend would be out of order; but a motion to recess would be in order, since it outranks the pending motion.
2. Restricted.
3. Is not debatable when applied to an undebatable motion.
4. A member may interrupt the proceedings but not a speaker.
5. Withdraw may be applied to all motions.
6. Renewable at the discretion of the presiding officer.
7. A tie or majority vote sustains the ruling of the presiding officer; a majority vote in the negative reverses the ruling.
8. If decided by the assembly, by motion, requires a majority vote to adopt.
<table>
<thead>
<tr>
<th>Purpose</th>
<th>Motion</th>
</tr>
</thead>
</table>
| Present an idea for consideration and action | Main motion  
Resolution  
Consider informally |
| Improve a pending motion | Amend  
Division of question |
| Regulate or cut off debate | Limit or extend debate  
Close debate |
| Delay a decision | Refer to committee  
Postpone to a certain time  
Postpone temporarily  
Recess  
Adjourn |
| Suppress a proposal | Table  
Withdraw a motion |
| Meet an emergency | Question of privilege  
Suspend rules |
| Gain information on a pending motion | Parliamentary inquiry  
Request for information  
Request to ask member a question  
Question of privilege |
| Question the decision of the presiding officer | Point of order  
Appeal from decision of chair |
| Enforce rights and privileges | Division of assembly  
Division of question  
Parliamentary inquiry  
Point of order  
Appeal from decision of chair |
| Consider a question again | Resume consideration  
Reconsider  
Rescind  
Renew a motion  
Amend a previous action  
Ratify |
| Change an action already taken | Reconsider  
Rescind  
Amend a previous action |
| Terminate a meeting | Adjourn  
Recess |

*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 of the board 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.
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Page 2

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Goddy T. Corpuz, MD
Kaparaboyna Ashok Kumar, MD

Resident Fellow Section

Ann C. Hughes Bass, MD, Chair
Arindam Sarkar, MD, Chair Elect
Habeeb Munir Salameh, MD, Immediate Past Chair
Carla C. Khalaf McStay, MD, Secretary
Fatma Youssef Ahmed, MD
Steven Blake Baker, MD
Patrick D. Crowley, DO
Michael G. Dakkak, DO
Dara Grieger, MD
Collin M. Juergens, MD
Jayaprada Kasaraneni, MD
Sujan Teegala S. Reddy, MD

Medical Student Section

Luis E. Seija, Chair
Amanda Arreola, Vice Chair
Sarah Miller, Reporter
Alice Jean, TMA Delegation Co-Chair
Pruthali Kulkarni, TMA Delegation Co-Chair
Donald Egan, AMA Delegation Co-Chair
Ky Viet Quach, AMA Delegation Co-Chair
Faith Mason, AMA Alt. Del, Texas Delegation
William Estes, BOT Special Appointee
Jennifer Nordhauser, Immediate Past-Chair
<table>
<thead>
<tr>
<th>Name</th>
<th>City/State</th>
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<td>Frederick R. Jenkins, Jr., MD</td>
<td>Arlington</td>
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# HOUSE OF DELEGATES COMPOSITION

May 2019

## County society delegates

- County society delegates: 478

## Ex officio-voting positions

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<th>Position</th>
<th>Members</th>
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<tr>
<td>President</td>
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<tr>
<td>President-Elect</td>
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<tr>
<td>Immediate Past President</td>
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<tr>
<td>Secretary/Treasurer</td>
<td>1</td>
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<tr>
<td>Speaker</td>
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<tr>
<td>Vice Speaker</td>
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<td>At-large members of the Board of Trustees</td>
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<tr>
<td>Councilors</td>
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<tr>
<td>Texas Delegation to the AMA</td>
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<tr>
<td>Members of the Council on Legislation</td>
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<tr>
<td>Chairs of all other councils</td>
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<tr>
<td>International Medical Graduate Section delegate</td>
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<tr>
<td>Young Physician Section delegates</td>
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<td>Resident and Fellow Section delegates</td>
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<td>Specialty society delegates</td>
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<td>Past Presidents</td>
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## Ex officio nonvoting positions:

- TEXPAC Chair: 1
- Delegates emeritus of the Texas Delegation to the AMA: 1

## Total voting membership

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<td>Voting Ex officio</td>
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<td>Less those holding multiple voting positions</td>
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*Past presidents who are active or emeritus members have a vote, but are not included in the Total voting membership to determine a quorum.
MEMBERS OF THE HOUSE OF DELEGATES AND VICE COUNCILORS
May 2019

**KEY**

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<th>Code</th>
<th>Description</th>
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**SPECIALTY CODES**

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<tr>
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<td>Jay R. Zdunek, DO, MBA</td>
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<td>Yasser Fahmy Zeid, MD</td>
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### Delegates and Alternates by County Medical Society
**As Of 4/8/2019**

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Cherokee CMS
Delegate: Lucia L. Williams, MD, MPH

Collin-Fannin CMS
Delegate: Brent B. Belvin, MD
Delegate: Carrie E. De Moor, MD
Delegate: Neha V. Dhudshia, MD
Delegate: Marlene Diaz, MD
Delegate: Aimee C. Garza, MD
Delegate: Bryan G. Johnson, MD
Delegate: Sejal S. Mehta, MD
Delegate: Sherine E Boyd Reno, MD
Delegate: Marian D. Steininger, MD
Alternate: Peter Andrew Brokish, MD
Alternate: Timothy Rae Chappell, MD
Alternate: Mei Melvin Hu, MD
Alternate: Radha Gopal iyengar, MD
Alternate: Fareha Abid Kazi, MD
Alternate: Paul Daniel Kivela, MD
Alternate: Alan David Koenigsberg, MD
Alternate: Brent A. Spencer, MD
Alternate: Daniel Joseph Verret, MD

Colorado Basin CMS
Delegate: James Ray Burleson, MD

Comal CMS
Delegate: Randal Keith Jacks, MD
Delegate: Judith Lynn Thompson, MD
Alternate: Claire Marie Coco, MD

Dallam-Hartley-Sherman-Moore CMS
Delegate: Ositadinma Ogugua Opara, DO

Dallas CMS
Delegate: Drew Wilson Alexander, MD
Delegate: Christine Ann Becker, MD
Delegate: Justin M. Bishop, MD
Delegate: Adam C. Carter, MD
Delegate: William Hampton Caudill, MD
Delegate: Vella Victoria Chancellor, MD
Delegate: Samuel J. Chantlis, MD
Delegate: Christopher Sung Jin Chun, MD
Delegate: Wendy M. Chung, MD, MSPH
Delegate: Shashi K. Dharmar, MD
Delegate: John Stockton Early, MD
Delegate: Walter Francis Evans, II, MD
Delegate: Lauren Cortell Fine, MD
Delegate: Robert Lee Fine, MD, FACP, FAAHPM

Denton CMS
Delegate: Julianna M. Fort, MD
Delegate: Raymond L. Fowler, MD
Delegate: Deborah Anne Fuller, MD
Delegate: Angela Fulgham Gardner, MD
Delegate: John Russell Gilmore, MD
Delegate: Victor Gonzalez, MD
Delegate: Robert D. Gross, MD
Delegate: Robert Ware Haley, MD
Delegate: Madeline Weinstein Harford, MD
Delegate: Sarah Lynn Helfand, MD
Delegate: Amy F. Ho, MD
Delegate: Eugene Pitts Hunt, III, MD
Delegate: Zachary S. Jones, MD
Delegate: Seth David Kaplan, MD
Delegate: R Elizabeth Kassanoff, MD
Delegate: Rainer Anil Khetan, MD

Dallas CMS (continued)
Delegate: Roger Sunil Khetan, MD
Delegate: Kevin Wayne Klein, MD
Delegate: Yolanda R. Lawson, MD
Delegate: C. Turner Lewis, III, MD
Delegate: Warren E. Lichiliter, MD
Delegate: Nathan P. Long, MD
Delegate: Dan Ken McCoy, MD
Delegate: David Wayne Mercier, MD
Delegate: Edward Joseph Prejean, III, MD
Delegate: James E. Race, MD
Delegate: Pervaiz Rahman, MD
Delegate: Assad Joe Saad, MD
Delegate: John Stuart Scott, DO
Delegate: Pranavi V. Sreramoju, MD
Delegate: Laurie Jayne Sutor, MD
Delegate: Lisa Louise Swanson, MD
Delegate: John Morrow Truelson, MD
Delegate: Michael Ian Vengrow, MD
Delegate: Joe B. Ventimiglia, MD
Delegate: Jim Walton, DO, MBA
Alternate: Leyka M. Barbosa, MD
Alternate: Matthew G. Brooker, DO
Alternate: M. Brett Cooper, MD
Alternate: Shashi K. Dharmar, MD
Alternate: Christopher J. Farmakis, MD
Alternate: Emily Jean Goulet, MD
Alternate: Preeti Malladi, MD
Alternate: Dawood Nasir, MD
Alternate: Wendy Carmen Parnell, MD
Alternate: Shawnta R. Pittman-Hobbs, MD
Alternate: Adnan Rafique, MD
Alternate: Roy Lynn Rea, MD
Alternate: Grant P. Redrow, MD
Alternate: Tami R. Roberts, MD
Alternate: F. David Schneider, MD
Alternate: Bharath Thankavel, MD
Alternate: Anil Kumar Tibrewal, MD

Delegate: Shikha Kaushik Mane, MD
Delegate: Udaya Bhaskar Padakandla, MD
Delegate: Elizabeth Ruth Seymour, MD
Delegate: Joseph S. Valenti, MD
Delegate: Victor Lee Vines, MD
Alternate: Folahan Kolawole Ayoolla, MD
Alternate: John Gerard Flores, MD
Alternate: Roshni Kandiyil Foster, MD, PhD
Alternate: Hannah G. Moussa, MD
Alternate: Rachel M. Osborn, MD
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Kaufman CMS
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Alternate: Joseph T. Martins, MD
Alternate: Kamran Shahid, MD
Alternate: Evans S. Smith, MD
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Delegates and Alternates by County Medical Society
Page 7

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Delegate: T. David Greer, MD
Delegate: Evan C. Meyer, MD
Delegate: Bruce Lee Palmer, MD

Williamson CMS
Delegate: Allyson K. McDonough, MD
Delegate: Susan M. Pike, MD
Delegate: Candida Dawn Suffridge, MD
Delegate: Grace Patricia Tamesis, MD
Alternate: Ronak D. Ghiya, MD
Alternate: Anupama Reddy, DO
Alternate: Nancy W. Waiganjo, MD

Young CMS
Delegate: Donald A. Behr, MD
Alternate: Hal Davis Huffman, MD
## Voting Ex-Officio Members of the House of Delegates

As of April 9, 2019 (multiple voting positions are listed but member only has ONE vote)

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<td>Bohn D. Allen, MD</td>
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<td>Member</td>
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<td>Michael A. Altman, MD</td>
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<tr>
<td>Linda M. Siy, MD</td>
<td>Tarrant</td>
<td>Council on Legislation</td>
<td>Member</td>
</tr>
<tr>
<td>Richard Wesley Snyder, II, MD</td>
<td>Dallas</td>
<td>TMA Board of Trustees</td>
<td>Member At-Large</td>
</tr>
<tr>
<td>Michael E. Speer, MD</td>
<td>Harris</td>
<td>TMA Past Presidents</td>
<td>Member</td>
</tr>
<tr>
<td>Susan M. Strate, MD</td>
<td>Wichita</td>
<td>TMA Officers</td>
<td>Speaker</td>
</tr>
<tr>
<td>John M. Sullivan, MD</td>
<td>Ellis</td>
<td>Texas' Inter-Specialty Society</td>
<td>Delegate</td>
</tr>
<tr>
<td>Robert Mayo Tenery, Jr., MD</td>
<td>Dallas</td>
<td>TMA Past Presidents</td>
<td>Member</td>
</tr>
<tr>
<td>Jason V. Terk, MD</td>
<td>Tarrant</td>
<td>Council on Legislation</td>
<td>Member</td>
</tr>
<tr>
<td>Lyle Sheldon Thorstenson, MD</td>
<td>Dallas</td>
<td>Texas Delegation to AMA</td>
<td>Texas Delegate</td>
</tr>
<tr>
<td>Elizabeth Torres, MD</td>
<td>Harris</td>
<td>Council on Health Promotion</td>
<td>Chair</td>
</tr>
<tr>
<td>Elizabeth Torres, MD</td>
<td>Harris</td>
<td>Texas Delegation to AMA</td>
<td>Texas Alternate Delegate</td>
</tr>
<tr>
<td>Edward Wilmar Tuthill, MD</td>
<td>Dallas</td>
<td>TMA Board of Councilors</td>
<td>Councilor</td>
</tr>
<tr>
<td>Roxanne Marie Tyroch, MD</td>
<td>El Paso</td>
<td>Council on Legislation</td>
<td>Member</td>
</tr>
<tr>
<td>Roxanne Marie Tyroch, MD</td>
<td>El Paso</td>
<td>Texas Delegation to AMA</td>
<td>Texas Alternate 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>Joseph S. Valenti, MD</td>
<td>Denton</td>
<td>TMA Board of Trustees</td>
<td>Member At-Large</td>
</tr>
<tr>
<td>Ryan D. Van Ramshorst, MD</td>
<td>Bexar</td>
<td>Texas' Inter-Specialty Society</td>
<td>Delegate</td>
</tr>
<tr>
<td>David Vanderpool, MD</td>
<td>Dallas</td>
<td>TMA Past Presidents</td>
<td>Member</td>
</tr>
<tr>
<td>E. Linda Villarreal, MD</td>
<td>Hidalgo-Starr</td>
<td>Texas Delegation to AMA</td>
<td>Texas Delegate</td>
</tr>
<tr>
<td>E. Linda Villarreal, MD</td>
<td>Hidalgo-Starr</td>
<td>TMA Board of Trustees</td>
<td>Member At-Large</td>
</tr>
<tr>
<td>Stanley S. Wang, MD</td>
<td>Travis</td>
<td>Texas' Inter-Specialty Society</td>
<td>Delegate</td>
</tr>
<tr>
<td>Arlo F. Weltge, MD</td>
<td>Harris</td>
<td>Texas Delegation to AMA</td>
<td>Texas Alternate Delegate</td>
</tr>
<tr>
<td>Arlo F. Weltge, MD</td>
<td>Harris</td>
<td>TMA Officers</td>
<td>Vice Speaker</td>
</tr>
<tr>
<td>Sara A. Westgate, MD</td>
<td>Travis</td>
<td>Texas' Inter-Specialty Society</td>
<td>Delegate</td>
</tr>
<tr>
<td>Kristin A. Wong, MD</td>
<td>Travis</td>
<td>Texas' Inter-Specialty Society</td>
<td>Delegate</td>
</tr>
<tr>
<td>Sherif Z. Zaafran, MD</td>
<td>Harris</td>
<td>Texas Delegation to AMA</td>
<td>Texas Alternate Delegate</td>
</tr>
<tr>
<td>Abbas Raza Zaidi</td>
<td>El Paso</td>
<td>Medical Student Section</td>
<td>Delegate</td>
</tr>
<tr>
<td>Yasser Fahmy Zeid, MD</td>
<td>Gregg-Upshur</td>
<td>Council on Legislation</td>
<td>Member</td>
</tr>
</tbody>
</table>
TMA Balloting Procedures

TMA BY LAWS 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.

ELECTRONIC VOTING

The preferred method of balloting used by the TMA House of Delegates (HOD) is an electronic audience response system (ARS). During credentialing on the second day of the Annual Session, each voting member is issued a voting unit. Each wireless, handheld unit has a unique identification code on the back.
Units are scanned during credentialing to allow for retrieval of the units should they not be returned at the close of house business.

Ballots and voting instructions for each election are projected onto two large screens at the front of the house meeting room. Should a ballot require amending, TMA technical staff will dim the screens while the changes are made. The speakers will notify members once it is time for the election to resume.

Using the keypad on the handheld voting unit, a delegate may change his or her vote as many times as necessary during the “active” period of a called vote. The active period is the time between the speaker of the house stating “Vote Now” and “Time.”

Under the supervision of the chief teller, TMA’s Associate Vice-President for Technology and Information Systems uses the ARS system software to capture each vote cast. The votes are then processed through a software application, which ensures their conformance with TMA Bylaws.

The chief teller provides the final election results to the speakers for reporting to the house.

A voting member may request the chief teller to validate his or her vote to ensure the wireless voting system has captured it accurately. This request must be made within one hour following adjournment of the house, after which the voting histories of individual house members are destroyed.

**VOTING BY HAND OR PAPER BALLOT**

If the speaker or vice speaker, or a member of the House of Delegates, requests a vote be tallied by ballot or hand, the chief teller is prepared with alternative vote collection tools. These include blank paper ballots and handheld tally-counter clicker devices.

Paper ballots ARE NOT provided to HOD voting members during credentialing. In the event the speaker or vice speaker requests an election using paper ballots, the chief teller will distribute blank paper ballots to voting members of the house.

The chief teller will call upon the Credentials Committee to assist with the distribution, collection, and counting of the paper ballots.

Delegates will follow the direction of the speaker or vice speaker as to the proper method for casting a valid paper election ballot. Upon the request of the speaker or vice speaker, the chief teller and the Credentials Committee will collect ballots and, with the support of four TMA staff, enter a predetermined location to count ballots.

The method for counting ballots is at the discretion of the chief teller, but it is suggested that ballots be divided into four counting groups, each comprising one delegate and one TMA staff member. One member of each counting group reads the name(s) of the candidate(s) selected on each ballot, and the other member tallies the votes. Once all counting groups have completed their tally, the ballots are passed to a second counting group to verify the votes in the same manner as the first counting group. If the vote totals are the same, the numbers from each counting group are provided to the chief teller for final documentation. If the vote counts do not match, the ballots are given to another counting group until the ballot count is verified.

The chief teller makes the final determination as to the validity of any ballot in question.
The chief teller uses the verified vote counts from each counting group to complete the final voting results document and hand-deliver this document to the speaker or vice speaker. The speaker or vice speaker will announce the results or the need for a subsequent run-off ballot.

TMA staff will keep all paper ballots until one hour following house adjournment, at which time the ballots will be disposed of properly.

**TALLY SHEETS**

For all contested elections, tally sheets will include: (1) the number of individuals voting, (2) the number of valid ballots (ballots cast in conformance with TMA Bylaws section 7.421), (3) the number of invalid ballots, and (4) the number of votes received by each candidate.

**RECORD OF ELECTION RESULTS**

The chief teller uses a tally sheet to record the election results. The results are given to the speakers, who announce the winners in each election. Any house member can view the election results, including candidate vote counts, by visiting the HOD staff table onsite at the house meeting once all elections have concluded, or by contacting their local county medical society executive. Members may also contact HOD staff following the meeting to be provided with a copy of the election results.
### OFFICERS

<table>
<thead>
<tr>
<th>Office</th>
<th>Incumbent</th>
<th>Eligible for Election</th>
<th>Term of Position</th>
<th>Candidates Announced as of April 26</th>
</tr>
</thead>
<tbody>
<tr>
<td>President-Elect</td>
<td>David C. Fleeger</td>
<td>No</td>
<td>2019-20</td>
<td>Diana L. Fite Harris</td>
</tr>
<tr>
<td>Speaker, House of Delegates</td>
<td>Susan M. Strate</td>
<td>Yes</td>
<td>2019-20</td>
<td>Arlo F. Weltge Harris</td>
</tr>
<tr>
<td>Vice Speaker, House of Delegates</td>
<td>Arlo F. Weltge</td>
<td>Yes</td>
<td>2019-20</td>
<td>Bradford W. Holland McLennan</td>
</tr>
<tr>
<td>Two Trustees*</td>
<td>Diana L. Fite</td>
<td>Yes</td>
<td>2019-22</td>
<td>Diana L. Fite Harris</td>
</tr>
<tr>
<td></td>
<td>Sue S. Bornstein</td>
<td>Yes</td>
<td></td>
<td>Sue S. Bornstein</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Dallas</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Cynthia A. Jumper</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Lubbock</td>
</tr>
</tbody>
</table>

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. However, nominations will be accepted on the floor of the house whether or not prior notification of intent to seek election has been received or published.

If you wish to announce your candidacy or a candidate for election or reelection, please notify Marti Francisco, executive coordinator, Office of the EVP, at marti.francisco@texmed.org or (800) 880-1300, ext. 1307.

*Trustee positions are “at large,” not slotted. TMA Bylaws provide that all nominees for trustee will be listed on a single ballot.
COUNCILOR AND VICE COUNCILOR ELECTIONS
May 2019

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 April. 26</th>
</tr>
</thead>
<tbody>
<tr>
<td>District 3</td>
<td>Carlos Rizo-Patron</td>
<td>No</td>
<td>2019-22</td>
<td>Harry E. Hall</td>
</tr>
<tr>
<td>District 4</td>
<td>Vacant</td>
<td></td>
<td>2019-21</td>
<td></td>
</tr>
<tr>
<td>District 5</td>
<td>Donald J. Gordon</td>
<td>Yes</td>
<td>2019-22</td>
<td>Donald J. Gordon</td>
</tr>
<tr>
<td>District 6</td>
<td>Mario R. Anzaldua</td>
<td>Yes</td>
<td>2019-22</td>
<td>Mario R. Anzaldua</td>
</tr>
<tr>
<td>District 12</td>
<td>Roland A. Goertz</td>
<td>Yes</td>
<td>2019-22</td>
<td>Roland A. Goertz</td>
</tr>
<tr>
<td>District 15</td>
<td>Louis J. Kirk III</td>
<td>Yes</td>
<td>2019-22</td>
<td>Louis J. Kirk III</td>
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</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 April. 26</th>
</tr>
</thead>
<tbody>
<tr>
<td>District 3</td>
<td>Harry E. Hall</td>
<td>No</td>
<td>2019-22</td>
<td>Jack E. DuBose</td>
</tr>
<tr>
<td>District 5</td>
<td>K. Ashok Kumar</td>
<td>Yes</td>
<td>2019-22</td>
<td>K. Ashok Kumar</td>
</tr>
<tr>
<td>District 4</td>
<td>Vacant</td>
<td></td>
<td>2019-21</td>
<td></td>
</tr>
<tr>
<td>District 6</td>
<td>Sandra Esquivel</td>
<td>Yes</td>
<td>2019-22</td>
<td>Sandra Esquivel</td>
</tr>
<tr>
<td>District 7</td>
<td>Vacant</td>
<td></td>
<td>2019-20</td>
<td>Jeffrey M. Apple</td>
</tr>
<tr>
<td>District 11</td>
<td>Vacant</td>
<td></td>
<td>2019-21</td>
<td>Brenda M. Vozza</td>
</tr>
<tr>
<td>District 12</td>
<td>Alisa M. Berger</td>
<td>Yes</td>
<td>2019-22</td>
<td>Alisa M. Berger</td>
</tr>
<tr>
<td>District 15</td>
<td>Cindy R. Porter</td>
<td>Yes</td>
<td>2019-22</td>
<td>Cindy R. Porter</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. Should you have a nomination for vice councilor, please notify Ann Arnett, assistant to the Board of Councilors, at ann.arnett@texmed.org or (800) 880-1300, ext. 1340.
# AMA DELEGATION ELECTIONS
## May 2019

## DELEGATES

<table>
<thead>
<tr>
<th>Delegates</th>
<th>Incumbent</th>
<th>Eligible for Reelection</th>
<th>Term (2 Years) Jan. 1-Dec. 31</th>
<th>Candidates Announced as of Feb. 8</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Diana L. Fite</td>
<td>Yes</td>
<td>2020-21</td>
<td>Diana L. Fite</td>
</tr>
<tr>
<td>2</td>
<td>Gary W. Floyd</td>
<td>Yes</td>
<td>2020-21</td>
<td>Gary W. Floyd</td>
</tr>
<tr>
<td>3</td>
<td>John T. Gill</td>
<td>Yes</td>
<td>2020-21</td>
<td>John T. Gill</td>
</tr>
<tr>
<td>5</td>
<td>David N. Henkes</td>
<td>Yes</td>
<td>2020-21</td>
<td>David N. Henkes</td>
</tr>
<tr>
<td>6</td>
<td>Jayesh Shah</td>
<td>Yes</td>
<td>2020-21</td>
<td>Jayesh Shah</td>
</tr>
<tr>
<td>7</td>
<td>Lyle S. Thorstenson</td>
<td>Yes</td>
<td>2020-21</td>
<td>Lyle S. Thorstenson</td>
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</tbody>
</table>

## ALTERNATE DELEGATES

<table>
<thead>
<tr>
<th>Alternate Delegates</th>
<th>Incumbent</th>
<th>Eligible for Reelection</th>
<th>Term (2 Years) Jan. 1-Dec. 31</th>
<th>Candidates Announced as of Feb. 8</th>
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</thead>
<tbody>
<tr>
<td>1-2</td>
<td>Two Vacancies</td>
<td></td>
<td>2020-21</td>
<td>Matthew G. Brooker</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Bryan G. Johnson</td>
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<tr>
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<td></td>
<td>Ezequiel Silva III</td>
</tr>
<tr>
<td>3</td>
<td>John T. Carlo</td>
<td>Yes</td>
<td>2020-21</td>
<td>John T. Carlo</td>
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<tr>
<td>5</td>
<td>John G. Flores</td>
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<td>2020-21</td>
<td>John G. Flores</td>
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<tr>
<td>6</td>
<td>Steven R. Hays</td>
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<td>2020-21</td>
<td>Steven R. Hays</td>
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<tr>
<td>7</td>
<td>Jennifer R. Rushton</td>
<td>Yes</td>
<td>2020-21</td>
<td>Jennifer R. Rushton</td>
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<tr>
<td>8</td>
<td>Sherif Z. Zaafran</td>
<td>Yes</td>
<td>2020-21</td>
<td>Sherif Z. Zaafran</td>
</tr>
<tr>
<td>9</td>
<td>Theresa Phan*</td>
<td>Yes</td>
<td>2019-20</td>
<td>Theresa Phan</td>
</tr>
<tr>
<td>10</td>
<td>Faith C. Mason*</td>
<td>Yes</td>
<td>2019-20</td>
<td>Faith C. Mason</td>
</tr>
</tbody>
</table>

Delegates and alternate delegates serve two-year terms, Jan. 1, 2020-Dec. 31, 2021; except that the terms for alternate delegate Places 9 and 10, which are designated for a resident and medical student, are May 19, 2019-May 18, 2020.

*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: ___________________________________________
ATTACHMENT A

RELATED ENTITIES

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

- TEXAS MEDICAL ASSOCIATION LIBRARY dba TMA KNOWLEDGE CENTER
  - Ervin E. and Gertrude K. Baden Trust (Baden fund)
- TEXAS MEDICAL ASSOCIATION SPECIAL FUNDS FOUNDATION
  - Durham Endowment
  - Durham Student Loan Fund
  - Harriet Cunningham Memorial Graduate Fellowship in Medical Writing
  - Medical Student Loan Fund
  - Harris County Medical Society Alliance Scholarship Fund
  - Overton Annual Lectureship
  - Young Physician Section Rural Student Scholarship Fund
  - TMA Minority Scholarship Program
  - 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

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

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

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

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

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

- THE PHYSICIANS BENEVOLENT FUND

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

- ANNIE LEE THOMPSON LIBRARY TRUST FUND

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

- MAY OWEN IRREVOCABLE TRUST
President-Elect
(Vote for one)

Diana L. Fite, MD

The Harris County Medical Society (HCMS) is honored to endorse the candidacy of Diana L. Fite, MD, for president-elect of the Texas Medical Association.

If one word describes Dr. Fite, it is “dedication.” Dr. Fite has been a member of TMA and HCMS since 1979. She has served on 17 different boards, councils, and committees. In 2014 she was elected to the TMA Board of Trustees, where she has served in a number of capacities.

Nothing shows her dedication to organized medicine more than her participation in the HCMS Delegation to the TMA. She has attended every TMA House of Delegates meeting since 1986, including through the arrival of seven of her eight children. In addition, she has served on the Texas Delegation to the AMA since 2003.

Dr. Fite has dedicated much of her free time advocating for good health care legislation. A consistent TEXPAC Capitol Club member, and now charter Patron member, she has taken multiple days out of her practice to attend First Tuesdays at the Capitol during each legislative session since the program began in 2003, including all First Tuesdays in the past three legislative sessions.

Dr. Fite has demonstrated her excellent leadership qualities by serving as president of the Houston Society of Emergency Medicine, the Texas College of Emergency Physicians, the American Association of Women Emergency Physicians, and the Harris County Medical Society.

Board certified in emergency medicine, she has chaired multiple hospital committees and served on medical executive committees at three different hospitals. Dedicated to giving back to her community, she has received much recognition for her work, including the 2013 James D. Mills Outstanding Contribution to Emergency Medicine Award from the American College of Emergency Physicians, and the 1996 Toby Myers State Leadership Award from the Texas Council on Family Violence.

Dr. Fite’s vast experience in medical issues, gained from her tireless service outside the emergency department, garnered her the trust of her colleagues to elect her as chair of the TMA Board of Trustees in 2018. She possesses a diverse perspective on our issues cultivated from her leadership experience both in
and outside of organized medicine. Her knowledge and experience will contribute much to the decisions that will successfully guide our TMA through the challenges ahead. Finally, her dedication to our profession, our colleagues, and our patients ensure that we can count on her to represent all of us before the board and the public.

**Personal Statement:** “As physicians, we fight for the lives of our patients every day. Now we are in a fight for ours. There are forces that want to fundamentally change the way we practice medicine in ways that aren’t good for us or our patients. Make no mistake, change is coming, and we can either be a catalyst for it or a victim of it. If you will support me for president-elect, I will pledge to fight for this house of medicine and all who join with me within it.”

**PROFILE**

Name: Diana L. Fite, MD  
Specialty: Emergency Medicine  
Medical School (with year graduated): The University of Texas Medical School at Houston, 1978  
Residency Program: The University of Texas Medical School at Houston, obstetrics-gynecology  
Primary Residence: Magnolia, Texas  
Practice Type/Employment Status: Direct patient care-solo, small group, or shared overhead, 100 percent  
Primary Practice/Employment Location: self-employed (independent contractor) in emergency departments in Tomball, and Katy, Texas  
Do you expect to maintain your current employment status and location through your term in office? Yes  
Does your current employment situation(s) require you to work outside of Texas? No  
Including the past five years, list all other organizations from which you have received payment, reimbursement, or financial consideration for consulting, advisory, or leadership responsibilities exceeding $1,000 per year in excess of actual expenses: None  
Have you been convicted of a felony or is your medical license restricted? Please explain. No  
What TMA positions have you held?  
**Current**  
- Board of Trustees, 2014-present; chair 2018-2019; secretary 2014-2015  
- Texas Delegation to the AMA  
**Past**  
- Chair, Educational Scholarship and Loan Committee  
- Member, Council on Socioeconomics  
- Member, Task Force on Balanced Billing 2014-2016  
- Member, Ad Hoc Committee on Managed Care and Insurance  
- Chair, Council on Medical Education  
- Chair, Committee on Physician Distribution and Health Care Access  
- Chair, Blue Ribbon Task Force on Domestic Violence  
- Member, Special Committee on Texas Physician Work Force  
- Chair, Committee on Manpower  
- Chair, Credentials Committee  

**DISCLOSURE OF AFFILIATIONS**  
- American College of Emergency Physicians  
- Texas College of Emergency Physicians  
- Memorial Hermann Tomball Hospital
The Harris County Medical Society (HCMS) is proud to nominate Arlo F. Weltge, MD, for election as speaker of the Texas Medical Association House of Delegates.

During his four years as vice speaker, Dr. Weltge has worked with speaker Susan Strate, MD, on several projects designed to make the House of Delegates operate more efficiently. Together they have worked with the Speakers’ Advisory Council and involved Leadership College representatives to improve house operations, including the design of the House of Delegates website, improved web access to TMA policies, and transition to the new American Institute of Parliamentarians parliamentary authority.

Dr. Weltge is a skilled and experienced parliamentarian and presiding officer who previously served as speaker and vice speaker for the American College of Emergency Physicians from 2007 to 2011.

Dr. Weltge is a board certified emergency physician in full-time clinical practice for more than 35 years. He has been an active member of TMA and the American Medical Association for more than 30 years. He previously chaired the TMA Council on Constitution and Bylaws, the HCMS Delegation to the TMA, and the TEXPAC Candidate Evaluation Committee. Dr. Weltge served as a consultant to the TMA Council on Legislation for more than 10 years and is a frequent participant in First Tuesdays at the Capitol. He has been an active member of the TMA House of Delegates for more than 15 years.

Because of his extensive leadership experience in state and national health care issues, Dr. Weltge received the John A. Rupke Legacy Award in 2014 for his lifelong commitment to the American College of Emergency Physicians. He has served on the American Heart Association’s Emergency Cardiac Care PROAD and ACLS subcommittees and was president of the Texas College of Emergency Physicians in 1994. During the tort reform debates, he served on the Board of Directors of the Texas Alliance for Patient Access (TAPA) (2002-04).

Dr. Weltge also has a wide variety of clinical experience in primary and specialty care, and has gained a perspective of health care challenges in rural, suburban, and urban hospitals. He currently practices emergency medicine in the Memorial Hermann Hospital-Texas Medical Center, a Level I trauma center, and the Harris Health System’s Lyndon Baines Johnson General Hospital in Houston.

**Personal Statement:** “The Texas Medical Association is among the most effective professional organizations in the country due to the connection of the grassroots issues of our members and the patients we serve to the policies and actions of the organization. The success of our organization stems from its truly democratic nature and the fact that we have a process that allows one physician with enough passion, insight, and persuasiveness to guide an idea all the way through to become TMA policy and even, perhaps, state law. It would be a supreme honor to be vested by my colleagues with the opportunity to preside over the process of setting policy for TMA.”
PROFILE
Name: Arlo F. Weltge, MD, MPH, FACEP
Specialty: Emergency Medicine
Medical School and Post Graduate Education (with years):
   The University of Texas Medical School at Houston, MD, 1978;
   Rice University, Jesse Jones Graduate School of Business, The Management Program, 1988;
   University of Texas School of Public Health, Master of Public Health, 1994.
Residency Program: Baylor College of Medicine Affiliate Hospitals
Board Certification(s): American Board of Emergency Medicine and American Board of Preventive Medicine, Occupational Medicine (former)
Primary Residence: Bellaire (Houston), Texas
Practice Type/Employment Status: Academic 100 percent (60 percent clinical)
Primary Employer and Employment Location: UTHealth, The University of Texas at Houston, McGovern School of Medicine, Department of Emergency Medicine, Clinical Professor, Houston, Texas
Do you expect to maintain your current employment status & 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: UTHealth, The University of Texas at Houston McGovern School of Medicine, Clinical Professor
   Houston Community College Program in EMS, Medical Director
   American Medical Response EMS Service, Houston Operations
   Occasional review for medical defense law firms for the Texas Medical Board and medical legal cases; no listing of specific firms, nor am I accepting new reviews.
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
   • TMA Board of Trustees
   • Alternate delegate, Texas Delegation to the AMA
Past
   • Chair and member, Council on Constitution and Bylaws
   • Consultant, Council on Legislation
      Chair, Council on Legislation Ad Hoc Committee on Physician Hospitals
      Member, Council on Legislation Ad Hoc Committee on Retail Medical Clinics
      Member, Council on Legislation End of Life Subcommittee
   • Delegate to the TMA House of Delegates from HCMS
      Chair and member, Reference Committee on Science and Public Health
      Chair and member, Committee on Tellers
   • Officer, TEXPAC Board of Directors and Executive Committee
   • Chair and member, TEXPAC Candidate Evaluation Committee and Membership Committee
   • District chair and vice chair, TEXPAC Board of Directors
DISCLOSURE OF AFFILIATIONS
   • Spouse, Janet Macheledt, MD, owns a limited partnership interest in a medical office building and land
   • Specialty society committee member, Texas Chapter (TCEP) and national American College of Emergency Physicians (ACEP)
   • The University of Texas Medical School at Houston, Department of Emergency Medicine, Clinical Professor of Emergency Medicine
   • Houston Recovery Center LGC (Board), Texas Medical Center Library (Board, representing HCMS)
Vice Speaker
(Vote for one)

Bradford W. Holland, MD

The Lone Star Caucus and the McLennan County Medical Society are proud to endorse the candidacy of Bradford W. Holland, MD, for vice speaker of the Texas Medical Association’s House of Delegates at TexMed 2019.

Dr. Holland’s first TMA meeting was 26 years ago, and he has been fully engaged in organized medicine ever since. He is an inaugural year graduate of TMA’s Leadership College and has held multiple positions within TMA and his county society, including past president of the McLennan County Medical Society and six years of service on the TMA Committee on Professional Liability. Dr. Holland served as chair of the Membership Committee, the Candidate Evaluation Committee, and the Executive Committee of TEXPAC, and ultimately as TEXPAC chair. Currently he is serving on the Council on Legislation, and in 2014 he helped form the Lone Star Caucus, serving as its co-chairman since. Additionally, Dr. Holland is an active member of the Speaker’s Advisory Council.

Outside of 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 also 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 teenage children in junior high and high school.

Personal Statement: “While some state medical societies are questioning the value of their large statewide assemblies and houses of delegates, let me affirm my absolute belief that we need a strong House of Delegates in Texas now more than ever:

‘The House of Delegates is the pinnacle authoritative body of TMA. We elect our Board of Trustees, our president, our representatives to the AMA, and we debate and decide the policies and positions of TMA. No part of TMA could be more important, and I must emphatically state that the changes that are so critically needed in the practice of medicine in order to preserve our profession will come from the TMA House of Delegates.”
Much work lies ahead if we are to right the ship of medicine. Together, we can protect our patients, preserve our profession, and leave a lasting legacy for the generations yet to come. I ask for your support as I seek the office of vice speaker, and I thank you for your commitment to medicine in Texas.”

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, Texas
Practice Type/Employment Status: Direct patient care-solo, small group, or shared overhead, 100 percent
Primary Practice/Employment Location: Waco Ear, Nose, and Throat, Waco, TX
Do you expect to maintain your current employment status and location through your term in office? Yes
Does your current employment situation(s) require you to work outside of Texas? 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, Dept. 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
• Member, Council on Legislation
• Member, Speaker’s Advisory Council
• Caucus Chair and Founder, Lone Star Caucus
Past
• Chair, TEXPAC
• Chair, Small Districts Caucus
• 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
• Baylor University Adjunct Faculty, Department of Communication Sciences and Disorders
TMA Board of Trustees
(Vote for two)

Sue S. Bornstein, MD

The Dallas delegation to the Texas Medical Association is proud to nominate Sue S. Bornstein, MD, for the position of trustee on the TMA Board of Trustees. Dr. Bornstein graduated in 1992 from Texas Tech University Health Sciences Center School of Medicine, which has named her a distinguished alumna. She received the same designation from the University of North Texas Center for Studies in Aging. Dr. Bornstein completed her internal medicine residency at Baylor University Medical Center at Dallas (BUMC) in 1995. Board certified in internal medicine, she was in private practice at BUMC from 1995 to 2005. She was the first woman elected president-elect of the hospital’s medical staff. In January 2019, the Dallas County Medical Society (DCMS) honored Dr. Bornstein’s legacy of leadership with the Charles Max Cole, MD, Leadership Award.

Since 2008, Dr. Bornstein has been executive director of the Texas Medical Home Initiative, a nonprofit physician-led organization dedicated to advancing accessible, continuous, and coordinated person-centered care for all Texans.

As a national leader, she has been named a regent to the American College of Physicians (ACP) after completing a four-year term as governor to the ACP’s Texas Northern Region.

Within TMA, Dr. Bornstein was the initial chair of the Committee on Primary Care and the Medical Home. She has chaired the influential Primary Care Coalition, and served on the Committee on Physician Distribution and the Physician Services Organization Committee. In 2008 and 2013, she served on the Ad Hoc Committee on Advance Practice Nurse Scope of Practice Issues, and continues work on the Select Committee on Medicaid, CHIP, and the Uninsured. Since being elected a TMA trustee, Dr. Bornstein has chaired the Value-Based Payment Workgroup and the Committee on Educational Scholarships and Loans.

At DCMS, Dr. Bornstein helped launch the Women in Medicine committee. She served on the DCMS Board of Directors from 2005-07, including a term as secretary/treasurer. Dr. Bornstein also is an integral part of TMA’s First Tuesdays at the Capitol program, where she meets with legislators about issues important to the medical profession.

Personal Statement: “As a primary care physician, I understand the difficulties faced by physicians on the frontline who work hard to provide their patients with timely, patient-centered, accessible, affordable, and appropriate care. The desire to give our patients the care they deserve cuts across all specialties and unites us as the house of medicine.”
“I believe strongly that physicians should have the opportunity to practice in whatever setting suits them best. If re-elected, I would continue to seek the development of tools and resources to enable physicians to remain in their practice setting of choice.

“TMA best fulfills its vision to improve the health of all Texans when it advocates not only for physicians but also for public health in Texas. We are facing a drastic reduction in funding to our public health infrastructure, and I am committed to making sure that our public health system remains viable. In addition, the safety net for vulnerable Texans is strained. I will work diligently to improve access to health care for all Texans.

“Finally, TMA has been tireless in its advocacy for increasing funding for Graduate Medical Education (GME) in our state. In many visits to the Capitol, I have educated legislators and their staffers on the implications of inadequate funding for GME. As a TMA Trustee, I will continue to highlight this critically important issue for our state.”

PROFILE
Name: Sue S. Bornstein, MD
Specialty: Internal Medicine
Medical School (with year graduated): Texas Tech University Health Sciences Center School of Medicine, 1992
Residency Program: Baylor University Medical Center Dallas, 1995
Board Certifications: Internal Medicine
Primary Residence: Dallas, Texas
Practice Type/Employment Status: Executive Director, nonprofit organization
Primary Practice/Employment Location: Texas Medical Home Initiative, Dallas, Texas
Do you expect to maintain your current employment status and location through your term in office? Yes
Does your current employment situation(s) require you to work outside of Texas? No
If yes, what is the nature of that work and how many days each month do you work outside of Texas?
Including the past five years, list all other organizations from which you have received payment, reimbursement or financial consideration for consulting, advisory or leadership responsibilities exceeding $1,000 per year in excess of actual expenses: None
Have you been convicted of a felony or is your medical license restricted? Please explain. No
What TMA positions have you held?
Current
Chair, Committee on Educational Scholarships and Loans
Chair, Value-Based Payment Workshop
Past
Member, Select Committee on Medicaid, CHIP, and the Uninsured, 2010-2017
Chair, Primary Care Coalition, 2012-2013
Chair, Committee on Primary Care and the Medical Home, 2014-2016
Member, Committee on Physician Distribution, 2013-2014
Member, TMA Interspecialty Society (Texas ACP delegate), 2007-2014; 2016-2017
Mentor, TMA Leadership College, 2012-2014
Delegate, TMA House of Delegates (Texas ACP delegate), 2013-2017
Member, Physician Services Organization Select Committee, 2013
Alternate Delegate, TMA Delegation to the American Medical Association, 2014-2016
Member, Physician Services Organization Steering Committee, 2014-2015
DISCLOSURE OF AFFILIATIONS
• American College of Physicians
• Blue Cross/Blue Shield (D)
• PathAdvantage Associated
• Texas Medical Home Initiative
The Lone Star Caucus and Lubbock County Medical Society are proud to nominate Cynthia A. Jumper, MD, for the Texas Medical Association Board of Trustees member at-large. Dr. Jumper has been an active member of organized medicine for more than 34 years. She is a dedicated leader with extensive knowledge in public health, health care policy, and fiscal resource management.

Since becoming a member of TMA as a student in 1984, Dr. Jumper has participated in committees, councils, foundations, and as alternate delegate to the AMA and TEXPAC. She testified before the legislature representing TMA to ensure that Texas medical students will have adequate clinical sites for their clerkships. Dr. Jumper currently uses her expertise by serving on the AMA Council on Medical Education.

Each of her positions as a faculty member at Texas Tech University Health Sciences Center School of Medicine-Lubbock (TTUHSC-Lubbock) over the last 24 years has taught Dr. Jumper different facets of medicine. As the former chair of Internal Medicine, she learned the business of medicine and conflict management. As the former chief of staff of a large teaching hospital, she learned organized medicine. As vice president of Health Care Policy, she learned policy, advocacy, and business development. Dr. Jumper held each of these positions while still practicing pulmonary/critical care and general medicine at a free clinic. The latter kept her grounded to the reason she stays in health care – patient care and wellness. For her contributions and leadership, in 2010 Dr. Jumper was awarded the distinguished alumnus award at TTUHSC-Lubbock.

Serving as both a community caregiver and a health care educator, Dr. Jumper supervises medical students at local flu clinics and health fairs, participates in global health care electives in Nicaragua, and volunteers as medical staff at the local homeless medical clinic. She is a member of and donor to various civic committees and charities, and is a TMA Foundation donor. Dr. Jumper has received several professional achievement awards including: the 2010 President’s Community Engagement Award, the YWCA Woman of Excellence in Science and Medicine Award, and she is a Woman of Distinction among Girl Scouts of Texas and Oklahoma.
Personal Statement: “TMA gave me my voice, and for that I will always be thankful. If elected to the TMA Board of Trustees, I will be part of the team that provides the foundation for Texas physicians to drive the direction of health care in our state, which often establishes a template for the nation.”

PROFILE
Name: Cynthia A. Jumper, MD, MPH
Specialty: Internal Medicine
Medical School and Post Graduate Education (with years):
  - Texas Tech University Health Sciences Center, MD, 1984-88
  - University of Texas Health Sciences Center Houston, MPH, 1996
Residency Program: Baylor College of Medicine, Internal Medicine, Fellowship PUD/CCM
Board Certification(s): ABIM – Hospice and Palliative Care, Internal Medicine, Critical Care, Pulmonary Medicine
Primary Residence: Lubbock, Texas
Practice Type/Employment Status:
  - Direct Patient Care: large group practice (over 20 members), 30 percent
  - Administrative: government, health plan, or health-related, but no direct patient care, 70 percent
Primary Employer and Employment Location:
  - Texas Tech University Health Sciences Center, Lubbock, Texas
Do you expect to maintain your current employment status and location through your term in office? Yes
Does your current employment situation(s) require you to work outside of Texas? No
Including the past five years, list all other organizations from which you have received payment, reimbursement, or financial consideration for consulting, advisory, or leadership responsibilities exceeding $1,000 per year in excess of actual expenses: None
Have you been convicted of a felony or is your medical license restricted? Please explain. No
What TMA positions have you held?
Current
- Member, Council on Legislation
- Special Counsel, Council on Medical Education
- Mentor, TMA Leadership College
- Alternate delegate, Texas Delegation to the AMA
- Delegate to the Texas Medical Association House of Delegates from LCMS
- TEXPAC Board of Directors
Past
- Member, Council on Socioeconomics
- Member and chair, Reference Committee on Public Health
- Member and chair, Council on Medical Education
- Trustee, TMA Student Loan Program
- Member and chair, Committee on Cancer
- Secretary, Pulmonary Division

DISCLOSURE OF AFFILIATIONS
- Texas Tech University Health Sciences Center
AMA Alternate Delegate
(Vote for two)

Matthew G. Brooker, DO

The Dallas Delegation to the Texas Medical Association is proud to nominate Matthew G. Brooker, DO, to serve as alternate delegate to the American Medical Association House of Delegates.

Dr. Brooker has been a member of TMA since his first year of medical school in 2006. In medical school, he was active in the TMA chapter at the University of North Texas Health Science Center at Fort Worth Texas College of Osteopathic Medicine, and with the Tarrant County Medical Society. In AMA, Dr. Brooker has served in many roles and at many levels during his medical education and professional career. He was chair of Membership and Chapter Development for the AMA Medical Student Section (MSS), and he led the MSS Osteopathic Caucus to become a true caucus, which meets biannually. During residency in Louisiana, Dr. Brooker was a Resident and Fellow Section delegate to AMA for three years. Upon returning to Texas after residency, he continued his service as a Young Physician Section delegate to AMA on behalf of Texas. Dr. Brooker served on the AMA LGBTQ Advisory Committee for four years, serving as vice chair in his last year. More recently, he has been involved with the TMA LGBTQ workgroup for TMA, helping build a voice for LGBTQ patients and physicians.

Dr. Brooker moved to Dallas and joined the Dallas County Medical Society in 2016. With his strong background at AMA and across Texas, we quickly appointed him to the Dallas Delegation to the TMA House of Delegates. We are proud that he has chosen Dallas as his home, and we hope you will join us in voting to elect Dr. Brooker to the Texas Delegation to the AMA.

**Personal Statement:** “I would love to continue to serve my fellow Texas physicians in the role of Alternate Delegate to the AMA. The AMA represents a multitude of different voices from across the nation, and the voice of Texas physicians is a very important voice in the organization. I hope you’ll allow me to lend my voice to the group.”
PROFILE
Name: Matthew G. Brooker, DO
Specialty: Emergency Medicine
Medical School (with year graduated): University of North Texas Health Science Center at Fort Worth
texas College of Osteopathic Medicine, 2010
Residency Program: Louisiana State University - Baton Rouge, 2013
Primary Residence: Dallas, Texas
Practice Type/Employment Status: Direct patient care-solo, small group, or shared overhead, 100 percent.
Primary Practice/Employment Location: True Partners, Amarillo, Texas
Do you expect to maintain your current employment status and location through your term in office? Yes
Does your current employment situation(s) require you to work outside of Texas? No
Including the past five years, list all other organizations from which you have received payment,
reimbursement, or financial consideration for consulting, advisory, or leadership responsibilities
exceeding $1,000 per year in excess of actual expenses: None
Have you been convicted of a felony or is your medical license restricted? Please explain. No
What TMA positions have you held?
Current
• Delegate, Dallas County Delegation to the TMA
• Delegate, Texas Delegation to the AMA, Young Physician Section
• Member, TMA LGBTQ Health Workgroup Council on Science and Public Health
• Donor, TMA Foundation
Past
• Alternate Delegate, TMA Delegation to the AMA
AMA Alternate Delegate
(Vote for two)

Bryan G. Johnson, MD

The Lone Star Caucus and Collin-Fannin County Medical Society proudly nominates Bryan G. Johnson, MD, for alternate delegate on the TMA Delegation to the American Medical Association.

Dr. Johnson has served the Texas Medical Association by participating in several positions of leadership over the past two decades. Currently he is an active member of the Council on Legislation, where he has served since 2014. Dr. Johnson’s service also includes his term as the president of the Collin-Fannin County Medical Society, and he is a board member for TEXPAC. For nearly a decade, he represented his medical society as a member of TMA’s House of Delegates. Last year, Dr. Johnson was appointed to be a representative to the Organized Medical Staff Section of the American Medical Association. This entity functions to empower physicians whether employed or in private practice, to improve patient outcomes and promote positive changes in their practice environments.

Dr. Johnson’s desire to serve his country led him to join the U.S. Army, where he served as a field grade officer. That same passion for community service led him to serve on several local government positions for the City of Frisco, Texas, including commissioner for the Planning and Zoning board and chairman of the Advisory Committee, dedicated to fostering economic development of the Railroad District in Frisco.

For over two decades, Dr. Johnson’s practice in internal medicine in Frisco has thrived. He considers himself an “old school” physician, continuing to treat both hospital and nursing home patients, while serving as a medical director for a hospice company and holding board positions on several health care-focused businesses. Please cast your vote for Dr. Johnson at TexMed 2019 as your next alternate delegate to the American Medical Association.

Personal statement: “My experience in the various aspects of health care has allowed me to develop a very broad understanding of the financial underpinnings of our health care system. This is my greatest organizational strength and what I believe I can contribute to the position of alternate delegate. My experience in the corporate side of the health care system, juxtaposed with the traditional delivery system of care, will empower TMA in strategically navigating organized medicine to ensure physicians retain their right to practice autonomously and maintain physician leadership in the delivery of the highest quality health care in this country.”
PROFILE
Name: Bryan G. Johnson, MD
Specialty: Internal Medicine
Medical School (with year graduated): University of Kansas School of Medicine (1994)
Residency Program: Brooke Army Medical Center, San Antonio (1997)
Board Certifications(s): American Board of Internal Medicine
Primary Residence (City, State): Frisco, Texas
What is your current practice status? Check all that apply and provide percentages: Direct patient care:
solo, small group, or shared overhead, 100 percent
Primary Employer and Employment Location (City, State): Bryan G. Johnson, MD, PA, Frisco, Texas
Do you expect to maintain your current employment status and location through your term in office? Yes
Does your current employment situation(s) require you to work outside of Texas? No
Including the past five years, list all other organizations from which you have received payment,
reimbursement, or financial consideration for consulting, advisory, or leadership responsibilities
exceeding $1,000 per year in excess of actual expenses: None
Have you been convicted of a felony or is your medical license restricted? Please explain. No
What TMA positions have you held?
Current
• Member, TMA Council on Legislation
• TEXPAC
• Delegate, TMA House of Delegates
Past
• Alternate Delegate, TMA House of Delegates
• Member, TMA PSO Task Force
• District vice chair, TEXPAC
AMA Alternate Delegate
(Vote for two)

Ezequiel “Zeke” Silva III, MD

The Bexar County Medical Society (BCMS) proudly nominates Ezequiel “Zeke” Silva III, MD, for TMA alternate delegate to the AMA. Dr. Silva has been a member of the Texas Medical Association for more than 25 years and has been engaged in organized medicine for more than 15 years. He has been a private-practice diagnostic and interventional radiologist since 2002. In addition, he is an adjunct professor of radiology at UT Health San Antonio, a fellow of the American College of Radiology (ACR), the Society of Interventional Radiology (SIR), and the Radiology Business Management Association.

Dr. Silva’s candidacy is an extension of the value he sees in TMA, and his enthusiasm and willingness to contribute. He is the immediate past president of the Texas Radiological Society (TRS), where his leadership agenda included promoting greater contribution by radiologists to the TMA and AMA. In his roles with the TRS, Dr. Silva has testified before the legislature on balanced billing-related matters and met with the Texas Health and Human Services Commission on Medicaid-related matters. Dr. Silva has been an active participant in the TMA Interspecialty Society Committee, the TMA Council on Socioeconomics and the TMA Advocacy Retreat.

His contributions to the AMA are noteworthy. He has been involved with the Relative Value Scale Update Committee (RUC) for more than a decade, eight as advisor for the ACR, and the last three as a member of the RUC Panel. He has served on the RUC Practice Expense Subcommittee and currently chairs the RUC Research Subcommittee. He is also a member of the RUC Health Care Professionals Advisory Committee. In these roles, he helps the AMA and CMS determine appropriate physician payment across all specialties. He is co-chair of the AMA Digital Medicine Payment Advisory Group, translating his knowledge of payment systems into clinical and policy solutions across the rapidly evolving digital medicine space. This includes telemedicine, digital therapeutics, and augmented intelligence applications.

Dr. Silva serves on the ACR Board of Chancellors as Chairman of the Commission on Economics. Previously, he served as chair of the Society of Interventional Radiology (SIR) Economics Committee, and as editor of the SIR Coding Guide. Each of these roles has required extensive collaboration across the house of medicine on issues of common interest.
Dr. Silva is a leader in San Antonio. He is the director of radiology at the Methodist Texan Hospital and the Methodist Ambulatory Surgery Hospital. He serves on the Methodist Healthcare System’s Committee for Unified Professional Excellence. He previously served as chair of Radiology at Southwest General Hospital and as director of Interventional Radiology at the South Texas Radiology Imaging Centers.

**Personal Statement:** “I have the good fortune of representing radiology at a national and state level. These positions require collaboration with other medical specialties, which makes me realize that I can be more effective as a delegate representing ALL physicians. I have the sincere desire to represent all Texas physicians and help address the challenges we and our patients face.”

**PROFILE**

**Name:** Ezequiel “Zeke” Silva III, MD  
**Specialty:** Diagnostic and Interventional Radiology  
**Medical School (with year graduated):** Baylor College of Medicine, 1996  
**Residency Program:** Baylor College of Medicine, Internship, 1996-1997, Residency, 1997-2001  
  Massachusetts General Hospital, Fellowship, 2001-2002  
**Board Certifications(s):** American Board of Radiology, 2001, lifetime certificate  
**Primary Residence:** San Antonio, Texas  
**Practice Type/Employment Status:** Direct patient care-large group practice (over 20 members), 100 percent  
**Primary Practice/Employment Location:** South Texas Radiology Group, 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?** No  
**Including the past five years, list all other organizations from which you have received payment, reimbursement, or financial consideration for consulting, advisory, or leadership responsibilities exceeding $1,000 per year in excess of actual expenses:** None  
**Have you been convicted of a felony or is your medical license restricted? Please explain.** No  
**What TMA positions have you held?**  
- Interspecialty Society Committee  
- Council on Socioeconomics (Nominated for term starting in 2019)  
- TMA Advocacy Retreat
FROM REFERENCE COMMITTEE ON FINANCIAL AND ORGANIZATIONAL AFFAIRS:


REFERRED TO: Council on Constitution and Bylaws and Office of the EVP

STATUS: The Council on Constitution and Bylaws reviewed the report and the recommendations do not contravene the TMA Bylaws. On Recommendation 1, CCB revised the TMA Balloting Procedures resource document to reflect amendments to TMA Bylaws Chapter 7, Elections, Section 7.42, Balloting, Subsection 7.421, First ballot, and Subsection 7.422, Run-off ballot which were adopted at the 2018 annual session. The TMA Balloting Procedures resource document was posted to the TMA website and will be published in the Handbook for Delegates at each annual session.

Speakers Report 2 – Election of TMA Board of Trustees Members, Filling Vacancies by Special Election (Resolution 101-A-17): That: (1) each at-large and ex-officio member of the TMA Board of Trustees elected prior to TexMed 2018 continue to abide by the term of office and length of tenure provisions specified in the TMA Bylaws at the time the member first was elected to the board, regardless of future amendments to these bylaws provisions; and (2) TMA Policy 295.013, Election Process be amended. Adopted.

REFERRED TO: Council on Constitution and Bylaws and Office of the EVP


Board of Trustees Report 12 – Sunset Review of TMA Standing Committees: That: (1) the following components be continued for three years: Interspecialty Society Committee, Committee on Membership, Committee on Physician Health and Wellness, Committee on Continuing Education, Committee on Physician Distribution and Health Care Access, 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, Committee on Medical Home and Primary Care and the Committee on Rural Health; (2) the charge of the Patient-Physician Advocacy Committee be amended in Section 10.532 of the TMA Bylaws; and (3) the Patient-Physician Advocacy Committee, as amended, be continued for three years. Adopted.

REFERRED TO: Council on Constitution and Bylaws and Office of the EVP

STATUS: Updated TMA Bylaws to reflect amendments adopted by the house.
Board of Trustees Report 14 – TMA 2025: That TMA’s 2025 strategic plan be approved. Adopted.

REFERRED TO: Division of Communication and Division of Membership and Business Development

STATUS: Updated and communicated.


REFERRED TO: Council on Science and Public Health


REFERRED TO: Office of the EVP

STATUS: Texas Delegation Operating Procedures have been updated to reflect the amendments adopted by the house.

Medical Student Section Report 1 – Medical Student Section Operating Procedures Update: That the recommended amendments to the Medical Student Section Operating Procedures be approved. Adopted.

REFERRED TO: Office of the EVP

STATUS: Medical Student Section Operating Procedures have been updated to reflect amendments adopted by the house.

Young Physician Section Report 1 – Young Physician Section Operating Procedures Update: That the TMA Young Physician Section Operating Procedures be amended with necessary updates to clarify the election process and streamline meeting scheduling. Adopted.

REFERRED TO: Office of the EVP

STATUS: Young Physician Section Operating Procedures have been updated to reflect amendments adopted by the house.

Council on Science and Public Health Report 1 – Rejection of Discrimination (Resolution 304-A-17): That the Texas Medical Association does not discriminate, and opposes discrimination, based on race, religion, disability, ethnic origin, national origin, age, sexual orientation, sex, or gender identity; and (2) 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. Adopted as amended.

REFERRED TO: Add to TMA Policy Compendium

STATUS: Added 60.008 Rejection of Discrimination to TMA Policy Compendium.
Resolution 101 – Patient-Centered Medical Record Responsibilities (Webb-Zapata-Jim Hogg County Medical Society): That the Texas Medical Association: (1) encourage appropriate organizations, e.g., disaster preparedness agencies, utility companies, and county health departments, to educate Texans on the importance of having access to or possession of an accurate summary of their medical record whenever and wherever it is needed, and (2) support a legislative proclamation that designates a Texans Medical Record Checkup Day at the beginning of hurricane and tornado season to encourage Texans to have access to or possession of an accurate summary of their medical record should it be needed. Referred with a report back at A-19.

REFERRED TO: Council on Practice Management Services, Ad Hoc Committee on HIT and Division of Public Affairs


Resolution 103 – Internet-Based Notification of Patients When a Physician is Closing or Leaving a Practice (Travis County Medical Society): That the Texas Medical Association formally recommend to the Texas Medical Board amendment of the current provisions of 22 Texas Administrative Code §165.5(b)(2) as follows: “Notification shall be accomplished by: (A) posting a notice on the website of the physician, to be kept available for two years, or publishing notice in the newspaper of greatest general circulation in each county in which the physician practices or practiced; (B) placing a written notice in the physician’s office; or (C) sending an email notice or postal letters to patients seen in the last two years notifying them of discontinuance of practice.” Adopted as amended.

REFERRED TO: Office of the General Counsel and add to TMA Policy Compendium

STATUS: Added 245.022 Notification of Physician Closing or Leaving Practice to TMA Policy Compendium. TMA will work to ensure the development of a more timely and technology-based solution exist for physicians notifying their patients when closing or leaving a practice. TMA sent a letter to TMB requesting it review 22 Texas Admin Code, section 165.5(b)(2), and consider the recommendations found in Resolution 103.

Resolution 104 – Clarification of Guidelines for Online Prescribers in Texas (Travis County Medical Society): That: (1) the Texas Medical Association support national efforts to amend federal law and federal Drug Enforcement Administration regulations to allow for the e-prescribing of a medication, including a controlled substance, needed by a patient with a mental health or behavioral health diagnosis when an appropriate patient-physician relationship has been established through telemedicine and in accordance with state law and accepted standards of care; and (2) our Texas Delegation to the American Medical Association take this, or a similar, resolution to the AMA House of Delegates for consideration. Adopted.

REFERRED TO: Add to TMA Policy Compendium

STATUS: Added 95.044 Online Prescriber Guidelines to TMA Policy Compendium.

Resolution 105 – Revision of Section 165.155 (a) of the Texas Occupations Code, Solicitation of Patients (Bexar County Medical Society): That the Texas Medical Association work to pass legislation that would rewrite Section 165.155 of the Texas Occupations Code, in particular, part (a) of the section, in order to eliminate the great potential for selective regulatory abuse, to eliminate any competitive burdens that are now placed on some groups of physicians, and to eliminate the present situation where physicians are unknowingly breaking the law. Referred for decision.
REFERRER TO: Board of Trustees

STATUS: Since this subject matter is closely tied to medical ethics and implicates current TMA Board of Councilors ethics opinions and TMA Bylaws provisions regarding fee splitting, the board approved a recommendation to refer Resolution 105-A-18 to the TMA Board of Councilors. See BOT Report 10-A-19.

Resolution 106 – Creation of a TMA Ad Hoc Committee on the Power and Influence of the Texas Non-Profit Health Corporation (NPHC)/501A Organization (Bexar County Medical Society): That the Texas Medical Association study and make legislative recommendations on the effects of nonprofit health corporations (NPHCs)/5.01(a) organizations on the patients and physicians of Texas. Adopted as amended with a report back at A-19.

REFERRER TO: Council on Legislation and Office of the General Counsel

STATUS: TMA is pushing legislation (HB 1532 (Meyer)/SB 1985(Hughes)) which would establish a process at Texas Medical Board (TMB) to handle complaints of corporate interference and retaliatory practices.

Resolution 107 – Physician Protections When Reporting Violations of Nonprofit Health Corporations (Harris County Medical Society): That: (1) that the Texas Medical Association: (1) develop legislation that forbids retaliation by a nonprofit health corporation (NPHC) against any person working for the NPHC who files a complaint or reports a suspected violation of state or federal law; (2) develop legislation, or ask the Texas Medical Board (TMB) to adopt more robust rules providing TMB authority to accept, process, and dispose of complaints against a licensed NPHC; and (3) ask the Texas Medical Board to develop a complaint form to facilitate filing complaints against NPHCs. Adopted as amended.

REFERRER TO: Council on Legislation and Office of the General Counsel

STATUS: TMA is pushing legislation (HB 1532 (Meyer)/SB 1985 (Hughes)) which would establish a process at Texas Medical Board (TMB) to handle complaints of corporate interference and retaliatory practices.

Resolution 108 – Inclusion of Medical Students in Good Samaritan Laws and Policies for Disaster Settings (Medical Student Section): That the Texas Medical Association: (1) support medical students volunteering inside of their institutional affiliations during times of disaster and emergency, due to both the need for and the competency of medical students, as demonstrated by previous research and disaster situations; and (2) study the involvement of medical students in natural disaster and emergency situations in order to develop TMA policy regarding medical student roles in disaster situations. Adopted as amended.

REFERRER TO: Council on Medical Education and Office of the General Counsel

STATUS: Council on Medical Education conducted a study in conjunction with the Office of General Counsel and a report containing policy proposals was submitted to the house for consideration. See C-ME Report 5-A-19.

Resolution 109 – Liability Exemptions for Volunteer Medical Health Workers (Harris County Medical Society): That the Texas Medical Association develop legislation that establishes a statewide medical liability exemption for physicians and health care providers who work under the supervision of a physician who respond to a call for medical volunteers from a state or local governmental or medical entity. Adopted as amended.
REferred to: Council on Legislation and Office of the General Counsel

status: HB 1353 (Oliverson)/SB 752 (Huffman) provides additional liability protection for physicians that are volunteering their services to patients in times of disaster.

FROM Reference Committee on Medical Education and Health Care Quality:

Council on Medical Education Report 3 – Aligning Future Graduate Medical Education Capacity With Target Enrollments of New Texas Medical Schools: That TMA adopt new policy Aligning Future Graduate Medical Education Capacity With Target Enrollments of New Texas Medical Schools to read: (1) The Texas Medical Association supports an amendment to state law that would stipulate that public medical schools are required to submit a plan to meet the graduate medical education (GME) needs for the school’s planned target class size. The GME plan is to be submitted to the Texas Higher Education Coordinating Board as part of its application for approval to offer a program leading to an MD or DO degree. If at any time a medical school substantially increases its class size after approval from the Texas Higher Education Coordinating Board to offer a program leading to an MD or DO degree, the Texas Medical Association believes the medical school then should be required to provide an updated GME plan to the board that reflects the subsequent increase in class size. TMA believes the Texas Higher Education Coordinating Board should make a determination as to what constitutes a substantial increase in class size for the purposes of this reporting requirement; (2) 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. 

Adopted as amended.

Referred to: TMA drafted language for SB 1378 (Buckingham, R-Lakeway)/HB 4039 (Turner, D-Grand Prairie) to implement this policy and advocated in support of the passage of this legislation during the 2019 Legislative Session. Added 200.052 Aligning Future Graduate Medical Education Capacity with Target Enrollments of New Texas Medical Schools to TMA Policy Compendium.


Referred to: Add to TMA Policy Compendium, Division of Public Affairs and Department of Medical Education

Status: Added 200.053 Physician Representation on the Texas Higher Education Coordinating Board to TMA Policy Compendium. TMA continues to work with state leadership to advocate for appointment of a physician to the board.

Council on Practice Management Services Report 1 – Reducing Errors in Pharmacy (Resolution 307-A-17): That the Texas Medical Association: (1) support improving quality and patient outcomes through the collection and analysis of e-prescribing mishaps through reporting in a transparent and non-punitive manner; (2) participate in the National Council for Prescription Drug Program (NCPDP) to influence national standards for pharmacies and the e-prescribing process; and (3) provide education specific to e-prescribing best practices so that pharmacies receive accurate prescriptions the first time, reducing callbacks to the physician’s office. Adopted.
Council on Practice Management Services Report 2 – HIT Policy Review and New Cyber Security Policy: That the Texas Medical Association: (1) amend Policies 95.029 and 265.012 to align with TMA’s overall policy goals on the subject of HIT; (2) delete Policies 265.021 and 115.019; (3) extract a portion of Policy 265.012 on health information exchange as new stand-alone policy titled Health Information Technology – Health Information Exchange; and (4) adopt new TMA Policy: Health Information Technology – Cyber Security. Adopted.

Resolution 201 – Incorporating High-Value Care into Undergraduate and Graduate Medical Education in Texas (Medical Student Section): That the Texas Medical Association support the inclusion and integration of topics of health care value in medical education. Adopted as amended.

Resolution 202 – Addressing Gender Bias in Undergraduate Medical Education With Implicit Bias Training (Medical Student Section): That the Texas Medical Association: (1) support the implementation of implicit bias training for all Texas medical school faculty; and (2) advocate for the creation and implementation of formal mentorship programs at medical schools between residents, fellows, or attending physicians and female medical students for specialties in which women are underrepresented. Referred.
Referral: Council on Medical Education

Status: The Council on Medical Education is continuing to study this issue and will report back to the house at the A-20 meeting with a status update.

Resolution 203 – Freedom from Maintenance of Certification (Ori Z. Hampel, MD): That the Texas Medical Association: (1) take the position in its advocacy efforts that all requirements for maintenance of board certification in medical staff bylaws for Texas health-related facilities, institutions, and programs that fall within the differentiation prohibition of Senate Bill 1148 (2017) should be considered null and void effective Jan. 1, 2018; (2) take the position in its advocacy efforts that any requirements for maintenance of board certification in medical staff bylaws for Texas health-related facilities, institutions, and programs that fall within the differentiation prohibition of Senate Bill 1148 (2017) require the vote of the medical staff (or satisfaction of another exception under the law); (3) take the position in its advocacy efforts that any vote for requiring maintenance of board certification in medical staff bylaws for Texas health-related facilities, institutions, and programs that fall within the differentiation prohibition under Senate Bill 1148 taken before the effective date of the bill should be considered null and void effective Jan. 1, 2018; and (4) be actively and immediately engaged in the rule-making process of SB 1148. Adopted as amended.

Referral: Council on Legislation, Council on Health Service Organizations and add to TMA Policy Compendium

Status: Added 175.025 Freedom from Maintenance of Certification to TMA Policy Compendium. TMA has been working with Senator Buckingham on S.B. 1882 (companion bill HB 4258 by Rep. Murphy) in the current legislative session specifically on these issues.

Resolution 205 – Graduate Associate Physician (International Medical Graduate Section): That the Council on Medical Education study the issue of unmatched candidates for U.S. residency programs and to report back in 2019. Adopted as substituted.

Referral: Council on Medical Education


From Reference Committee on Science and Public Health:

Council on Science and Public Health Report 2 – Addressing the Diaper Gap (Resolution 305-A-17): That the Texas Medical Association: (1) encourage physicians to screen for social and economic risk factors in order to support care plans and to direct patients to appropriate local social support resources; (2) provide information to members on community resources related to free and low-cost diapers and other basic material needs; and (3) recognize diapers, especially for adults, are a basic and essential health care necessity that helps to mitigate disease and illness and enables many to remain at home, and support efforts to remove the state sales tax applied to diapers. Adopted.

Referral: Council on Science and Public Health and add to TMA Policy Compendium

Status: Added 260.108 Addressing the Diaper Gap to TMA Policy Compendium. An update was provided to the Council on Science and Public Health on the approved policy. TMA is monitoring the legislation filed on taxation of essential personal products including diapers.
That the Texas Medical Association adopt new policy on Appropriate Supplementation of Vitamin D.
Adopted.

REFERRED TO: Add to TMA Policy Compendium

STATUS: Added 260.109 Vitamin D3 Supplementation to TMA Policy Compendium.

Council on Science and Public Health Report 4 – Implementing a Sugar-Sweetened Beverage Tax in
Texas (Resolution 311-A-17): That the Texas Medical Association: (1) collaborate with the public health
community to promote and support evidence-based interventions that will reduce obesity and its
complications. These evidence-based interventions should include providing information and resources for
physicians to support obesity screening and diagnostic tools for use in the primary care setting, physician
payment for the evaluation and management of patients with obesity, and research on culturally appropriate
education and public awareness to address obesity and its complications; and (2) amend TMA Policy
260.095. Adopted.

REFERRED TO: Add to TMA Policy Compendium

STATUS: Added 260.110 Implementing a Sugar-Sweetened Beverage Tax in Texas to TMA Policy Compendium; amended 260.095 Eligibility of Sugar-Sweetened Beverages for SNAP and Counseling.

Council on Science and Public Health Report 6 – Physician Role in Increasing Vaccination for HPV:
That new TMA policy on Physician Role in Increasing Vaccination for HPV be adopted to read: In an
ongoing effort to reduce the burden of preventable cancers associated with human papillomavirus (HPV) in
Texas, TMA will: (1) Continue to educate physicians, monitor, and support implementation of interventions
to improve the rate of HPV vaccination per Centers for Disease Control and Prevention (CDC) Advisory
Committee on Immunization Practices (ACIP) recommendations using the following evidence-based
strategies: a. educate physicians, families, and patients on the key message that the HPV vaccine prevents
cancer safely in women and men, b. recognize that physicians are leaders within the community and are
critical in improving HPV vaccination rates, c. communicate that strong physician recommendation is the
most important determinant of vaccine acceptance, d. strengthen communication through the utilization of
the principles of successful management of vaccine hesitancy, HPV cancer survivor stories, and
local/regional champions including trained community health workers, e. establish consistency in the
messaging over the HPV vaccine’s importance, effectiveness, and safety among all clinical/practice
physicians and staff, f. utilize effective vaccine delivery strategies, which include reviewing the vaccine
status of all patients at all visits, and using standing orders, simultaneous administration, i.e., “bundling” the
vaccine with other vaccines, and school-based clinics, g. track the progress of vaccine delivery through the
utilization of EMR functions, surveillance/monitoring systems, regular performance reviews, and
maintaining knowledge of the trends in the rates of HPV vaccine coverage and HPV-associated cancer; (2)
Support the continued testing, development, improvement, and dissemination of effective HPV vaccine
intervention research and reviewing and editing policy recommendations accordingly; (3) Continue active
collaborations with the Texas Department of State Health Services to optimize the use of the state
immunization registry with the goal of having it be fully functional, as defined by the CDC, and utilized by
physicians in order to have a reliable method to measure HPV immunization coverage rates in the state.
TMA will encourage development of data sharing agreements among groups that are collecting valid HPV
vaccine coverage rate data until a fully functional immunization registry is implemented; and (4) Continue to
collaborate both internally and externally with health stakeholders to leverage and improve HPV vaccination
rates in Texas. Adopted as amended.
REFERRED TO: Council on Science and Public Health, TMA Division of Communication and add to TMA Policy Compendium

STATUS: Added 50.011 Physician Role in Increasing Vaccination for HPV to TMA Policy Compendium. The Committee on Infectious Diseases continues to be engaged in promoting HPV vaccination including participating in American Cancer Society HPV roundtable and maintaining TMA’s HPV Resource Center.

Council on Science and Public Health Report 7 – Evidence-Based Management of Substance Use Disorders: That the Texas Medical Association (1) approve new policy on the chronic disease of substance use disorders; and (2) delete current TMA Policy 25.008, Alcoholism. Adopted.

REFERRED TO: Add to TMA Policy Compendium

STATUS: Added 95.045 Evidence-Based Management of Substance Use Disorders to TMA Policy Compendium; deleted 25.008 Alcoholism from TMA Policy Compendium. A workgroup of the Task Force on Behavioral Health has been convened to develop a CME on substance use disorders.

Council on Science and Public Health Report 8 – Improving Electronic Health Records, Health Information Exchange, and other Health Information Technology Products to Address Issues of Sex and Gender: That TMA work with the American Medical Association and leaders in the field of lesbian, gay, bisexual, transgender, queer, or questioning (LGBTQ) health such as the World Professional Association for Transgender Health and the Gay and Lesbian Medical Association to develop requirements for electronic health records (EHRs), health information exchanges (HIEs), and other health information technology (HIT) products reflecting best practices that include the ability to support, capture, and provide easy use by physicians of the following information: a. Current gender identity, b. Gender assigned at birth, c. Sexual orientation, d. Name (or names) and pronoun preference, e. Indicated health screenings, f. Appropriate clinical decision support tools, and g. History of gender-affirming surgery or treatment as part of past medical or surgical history, and h. Sex assigned at birth. These products also should incorporate effective privacy attributes, particularly for adolescents, and enable physician use of a longitudinal view of changes in demographics, gender identity, sexual preference, medical and surgical history, and past interventions; (2) that TMA and AMA continue to advocate for the rapid incorporation of best practice requirements into EHRs, HIEs, and other HIT products; (3) that TMA adopt the following policy opposing increased costs to physicians and patients for required updates of EHR and HIT systems: Costs to Update EHR and HIT Systems: The Texas Medical Association believes that neither physicians nor patients should incur additional costs when electronic health records (EHRs) or health information technology (HIT) systems are updated to reflect the latest in regulatory requirements or evidence-based medical care in the area of lesbian, gay, bisexual, transgender, queer, or questioning health; and (4) That TMA adopt the following policy on increasing physician awareness and removing barriers to LGBTQ health care access: Improving LGBTQ Health Care Access: The Texas Medical Association recognizes that lesbian, gay, bisexual, transgender, queer, or questioning (LGBTQ) individuals have unique health care needs and suffer significant barriers in access to care that result in health care disparities. TMA will provide educational opportunities for physicians on LGBTQ health issues to increase physician awareness of the importance of building trust so LGBTQ patients feel comfortable voluntarily providing information on their sexual orientation and gender identity, thus improving their quality of care. TMA also will continue to study how best to reduce barriers to care and increase access to physicians and public health services to improve the health of the LGBTQ population. Adopted as amended.

REFERRED TO: (1) and (2) to Council on Practice Management Services and Ad Hoc Committee on HIT; (3) and (4) Add to TMA Policy Compendium
STATUS: (1) and (2) See C-PMS Report 2-A-19 (3) Added 265.027 Costs to Update Health Information Technology Products to Address Issues of Sex and Gender (4) Added 265.028 Improving LGBTQ Health Care Access to TMA Policy Compendium. A continuing medical education program on LGBTQ health will be presented at TexMed 2019.

Committee on Child and Adolescent Health Report 2 – Referred 2017 Resolutions Relating to Concussions and Head Injuries: That the Texas Medical Association: (1) amend and retain policy 260.094; (2) create a network in which TMA members could provide and receive consultations on concussions with one another, and possibly link physicians with specialists in sports medicine, as the best way to share information on concussion protocol, current knowledge on how to manage patients, and information for patients; and (3) start an education and awareness campaign directed toward athletes to ensure education and timely information is shared directly with students. Adopted.

REFERRED TO: (1) Add to TMA Policy Compendium; (2) Committee on Child and Adolescent Health; (3) Council on Health Promotion

STATUS: (1) Amended 260.094 Head Injuries and Sport-Related Concussions (SRC) in TMA Policy Compendium. (2) The Committee on Child and Adolescent Health established a workgroup to explore feasibility of establishing a network for consultation, as well as alternatives to provide information and practice resources to members. (3) The Council on Health Promotion discussed the topic and directed staff to develop an educational campaign for student athletes. The plan for that campaign is under review.

Committee on Reproductive, Women’s, and Perinatal Health Report 1 – Evaluation and Management of Stillbirth: That the Texas Medical Association: (1) promote physician awareness of the comprehensive process for evaluation and management of stillbirth including current clinical management guidelines developed by the American College of Obstetricians and Gynecologists; (2) work with the relevant state health and human service agencies, public and private insurance organizations, and health care associations to explore opportunities to incorporate fetal death data into quality improvement initiatives addressing maternal and infant health and explore the costs and benefits associated with the evaluation and management of stillbirths; and (3) delete policy 140.009 Perinatal Autopsies Following Stillbirth. Adopted.

REFERRED TO: (1) and (2) to Committee on Reproductive, Women’s and Perinatal Health; (3) Delete from TMA Policy Compendium

STATUS: (1) and (2) The Committee on Reproductive, Women’s, and Perinatal Health established a workgroup to develop written continuing medical education materials to promote best practices in the evaluation and management of stillbirth. A second workgroup met with representatives from state agencies, health plans, and associations and determined that there are no current opportunities to develop quality improvement initiatives at this time. (3) Deleted 140.009 Perinatal Autopsies Following Stillbirth from TMA Policy Compendium.

Resolution 301 – Synthetic Cannabis Educational Resources for Providers (Medical Student Section): That the Texas Medical Association: (1) advocate for research on the prevalence, effects, and implications of synthetic cannabinoid use; and (2) encourage the development and circulation of evidence-based educational materials on synthetic cannabinoids for physicians to share with patients. Adopted as amended.
Resolution 302 – Appropriate Physician Oversight of EMS Medical Practices (Travis County Medical Society): That the Texas Medical Association recommend Texas emergency medical services (EMS) systems adopt these physician oversight ratios to support safe oversight of EMS medical practices: one full-time equivalent (FTE) physician per 500 basic life-support providers; one FTE physician per 300 intermediate life-support providers; one FTE physician per 100 advanced life support-providers, and; two FTE nonphysician support personnel for each physician to ensure appropriate support for management of the EMS medical practice. Referred.

Resolution 303 – “Bathroom” Bills (Harris County Medical Society): That the Texas Medical Association oppose any efforts to prevent a transgender person from accessing basic human services and public facilities in line with one’s gender identity, including, but not limited to, the use of restrooms. Adopted.

Resolution 306 – Addressing HB3859 – A Misstep in the Protection of Foster Care Children (Medical Student Section): That the Texas Medical Association: (1) support legislation and other efforts to improve access to health care resources for children in the foster care system; (2) support legislation that protects the rights of foster care children to receive evidence-based care; and (3) oppose any legislation that allows for discrimination against adolescent patients seeking contraception. Referred.

Resolution 307 – Restrictions of Provisions of HB 2561 to Schedule II Drugs (Bexar County Medical Society): That the Texas Medical Association work to limit enforcement of HB 2561 to only the prescribing of drugs found in Schedule II of the Texas Controlled Substances Act. Adopted.
STATUS: HB 3284 (Sheffield) proposes to alter the mandated PMP check to only Schedule II drugs in four classes – opioids, benzodiazepines, barbiturates, and carisoprodol. SB 2316 (Hinojosa) pushes the mandate off from September 1, 2019 to March 1, 2020 to allow the process of electronic integration to further develop. It retains the current requirements of drugs to be checked and does not limit it to Schedule II.

Resolution 308 – Texas Prescription Drug Monitoring Program Data Integration Into Electronic Health Record Technology (Medical Student Section): That the Texas Medical Association advocate for integration of real-time prescription drug monitoring program data into Texas electronic health record systems and electronic prescribing systems should be at no cost to the physician. Adopted as amended.

REFERRED TO: Council on Legislation

STATUS: About $6 million in funding in both House and Senate supplemental budgets is earmarked for the Board of Pharmacy to begin the process of electronic integration between the PMP and EMR systems. This funding allows the Board of Pharmacy to purchase the licenses from the vendor, Appriss Health, for all prescribers and pharmacists. That is probably the most expensive part of doing a one off integration deal. There may be charges from the EMR vendor but we are working with their industry groups to minimize the additional charges.

Resolution 311 – Encouraging Unstructured Playtime in School (Medical Student Section): That the Texas Medical Association: (1) encourage daily physical activity for children as a means to prevent childhood obesity and promote physical and mental health; (2) recognize the importance of unstructured playtime in addition to the current physical education requirements to encourage physical, cognitive, and emotional development; and (3) support the development of a recess policy to encourage each school district to have unstructured playtime in addition to physical education at each elementary school campus. Adopted.

REFERRED TO: Add to TMA Policy Compendium

STATUS: Added 55.060 Encouraging Unstructured Playtime in School to TMA Policy Compendium.

Resolution 312 – Identification Bracelets for Patients With Hearing Loss (Tarrant County Medical Society): That the Texas Medical Association adopt as policy a recommendation for medical care settings, especially hospitals and emergency departments, to provide identification bracelets on patients with hearing loss indicating their hearing status. Referred.

REFERRED TO: Council on Health Service Organizations


Resolution 313 – Raising the Minimum Purchase Age for All Guns to 21 (Ryan Van Ramshorst, MD, Texas Pediatric Society): That the Texas Medical Association support federal and state bills that raise the purchase age for all guns to be in line with the current minimum age for handguns, which is 21 years. Referred for study with a report back.

REFERRED TO: Council on Science and Public Health and Council on Legislation

Resolution 314 – Extreme Risk Protection Orders and Gun Violence (Ryan Van Ramshorst, MD, Texas Pediatric Society): That the Texas Medical Association advocate for legislation permitting extreme risk protection orders in Texas. **Referred.**

**REFERRED TO:** Council on Legislation and Council on Science and Public Health

**STATUS:** See C-SPH Report 1-A-19.

**FROM REFERENCE COMMITTEE ON SOCIOECONOMICS:**

President’s Report 1 - Physician-Led Initiatives to Address Maternal Mortality and Morbidity: That the Texas Medical Association: (1) Pursue legislation authorizing the Texas Health and Human Services Commission to: (a) submit a federal Medicaid 1115 demonstration waiver requesting approval to design and implement a tailored health benefits program for eligible uninsured women of childbearing age that provides 12 months’ continuous coverage for preventive, primary, and specialty care coverage, including behavioral health services, to women before, during and after pregnancy; (b) ensure adolescents aging out of the Children’s Health Insurance Program (CHIP) are seamlessly enrolled into Healthy Texas Women; (c) ensure women losing CHIP-Perinatal are seamlessly connected to the Family Planning Program to avoid gaps in preventive health care; and (d) implement initiatives that improve early-entry prenatal care, including a statewide campaign on the importance of prenatal care during the first trimester, expediting Medicaid eligibility and enrollment for pregnant women, promoting use of telemedicine for routine prenatal care, and reforming the Medicaid transportation program to ensure pregnant women with young children can travel with their children to obtain preventive services; (2) Develop a continuing medical education program for physicians that covers: information on publicly funded support services for women with substance use disorders (SUDs); guidelines for the prescribing of opioids and pain management; efforts to better connect SUD treatment physicians and providers with women’s health physicians and providers to ensure women undergoing treatment for these disorders are able to obtain preventive health care services; and diagnosis and treatment of behavioral health issues such as anxiety and depression; (3) Develop legislation to allocate sufficient state resources to resolve red tape and payment barriers preventing widespread adoption of long-acting reversible contraceptives (LARCs), including ensuring the state pays physicians, hospitals, and clinics their full LARC acquisition costs so women can obtain a LARC according to clinical best practice; ensure availability of LARCs immediately following delivery to women enrolled in the Children’s Health Insurance Program (CHIP)-Perinatal; and remove roadblocks preventing teens from simultaneously enrolling in CHIP and Healthy Texas Women to obtain contraceptive services with parental consent; (4) Develop a continuing medical education program, in partnership with the American College of Obstetricians and Gynecologists District XI (Texas Chapter), Texas Association of Obstetricians and Gynecologists, and Texas Academy of Family Physicians, designed to increase patients’ and physicians’ awareness of long-acting reversible contraceptives as the most effective form of contraception; (5) Develop continuing medical education programs on quality-based initiatives with standardized protocols and best practices to improve prenatal, labor and delivery and postpartum health outcomes; and implementation of hospital-based quality improvement initiatives that reduce maternal mortality and morbidity, based on best practice and standardized protocols; (6) Introduce legislation to improve the quality of health data records for women of reproductive age to support patient health, the quality of maternal death records, and the exchange of health information for women of reproductive age. The legislation should encompass: (a) support of comprehensive efforts to improve the state’s surveillance of maternal mortality and ensuring Texas’ maternal death records have accurate information on the factors associated with maternal deaths; (b) mandates to the Texas Department of State Health Services to develop training and educational materials for physicians and other medical certifiers to accurately report maternal deaths; and (c) mandates to electronic health record systems to improve the interoperability of health records, including resolution of barriers that are preventing the exchange of health information critical to providing quality maternal and postpartum care; (7) Develop a public campaign to increase awareness of the importance of early and timely maternal health care and
promote existing community based efforts; and (8) That the Texas Medical Association adopt as formal policy the goals of eliminating maternal mortality in Texas. **Adopted as amended.**

**REFERRED TO:**

(1) Council on Legislation and Council on Socioeconomics; (2) and (4) Council on Science and Public Health; (3) and (6) Council on Legislation; (5) Council on Science and Public Health and Council on Healthcare Quality; (7) Council on Health Promotion; (8) Add to TMA Policy Compendium

**STATUS:**

(2) (4) and (5) The Committee on Reproductive, Women’s, and Perinatal Health developed online continuing medical education on Long Acting Reversible Contraceptives available on TMA website and will conduct a CME and practicum at TexMed 2019. The Quality track at TexMed 2019 will include a presentation on the Texas AIM bundles and will be recorded for the development of an enduring CME. A workgroup of the Task Force on Behavioral Health has been convened to develop a CME on management of maternal substance use disorders. (7) Staff has issued several news releases and published several blog posts on the issue. A formal campaign is awaiting the outcome of the maternal health legislative package in the 2019 Texas Legislature. The issue is on the agenda for the May 2019 meeting of the Council on Health Promotion. (8) Added 330.015 Physician-Led Initiatives to Address Maternal Mortality and Morbidity to TMA Policy Compendium. (1) (3) and (6) Numerous pieces of legislation have been filed dealing with women’s health initiatives, the Healthy Texas Women’s program, maternal mortality, and many of the other issues outlined in the report. TMA is working to cut red tape and improve the prior authorization processes in Medicaid that will benefit Texas patients and physicians. TMA is also working with house and senate budget conferees on providing additional financial resources to improve services in the program and delivering additional treatment options for women. Finally, TMA is working with HHSC to address red tape issues regarding long-acting reversible contraceptives and other regulatory issues that make it difficult for women to get appropriate access to services. Both the work on the legislative and budget fronts should result in significant improvements to women’s health services in Texas.

**Council on Health Service Organizations Report 2 – Medical Staff Rights and Responsibilities Bill of Rights:** That TMA adopt new policy on medical staff rights and responsibilities. **Adopted.**

**REFERRED TO:**

Add to TMA Policy Compendium

**STATUS:**

Added 130.026 Medical Staff Rights and Responsibilities Bill of Rights to TMA Policy Compendium.

**Council on Health Service Organizations Report 3 – Due Process Rights in Physician Contracts with Hospitals:** That: (1) the Texas Medical Association advocate for the Centers for Medicare & Medicaid Services’ strengthening of the due process rights of physicians by revising Medicare’s Conditions of Participation for hospitals to guarantee that physicians be entitled to fair hearings by peers before any termination or restriction of medical staff privileges and that those due process rights cannot be denied through a third-party contract; and (2) TMA Policy 185.020 Principles for Employment Contracts be amended. **Adopted.**
REFERRED TO: (1) Council on Health Service Organizations and Council on Socioeconomics; (2) Add to TMA Policy Compendium

STATUS: (1) Letter sent to Seema Verma, Administrator of the Centers for Medicare and Medicaid Services seeking additional specificity on due process requirements under the Medicare of Conditions of Participation for Hospitals. (2) Amended 185.020 Principles for Employment Contracts in TMA Policy Compendium.


REFERRED TO: Add to TMA Policy Compendium

STATUS: (1) Amended 235.034 Authorizations Initiated by Third-Party Payers, Benefit Managers, and Utilization Review Entities; (2) Added 235.038 Standardized Electronic Prior Authorization Transactions to TMA Policy Compendium.

Council on Socioeconomics Report 6 – Medicaid Work Requirements: That: the Texas Medical Association oppose: (1) any federal Medicaid waiver seeking to impose mandatory work requirements, but instead collaborate with lawmakers, the Texas Health and Human Services Commission, and the Centers for Medicare & Medicaid Services to support constructive measures to help Medicaid enrolled and eligible patients overcome barriers that prevent them from working or engaging in other meaningful community activities; (2) efforts to impose lifetime limits on adult Medicaid enrollees; and (3) any policy or regulation that punitively limits access to affordable health care for Medicaid-eligible patients. Adopted.

REFERRED TO: Add to TMA Policy Compendium

STATUS: Added 190.037 Medicaid Work Requirements to TMA Policy Compendium.

Resolution 401 – Physicians Allowed to Delegate Ability to Enter EHR Data (McLennan County Medical Society): That the Texas Medical Association: (1) supports the ability of the physician to delegate the collection and entry into the medical record any component of the medical history that they deem appropriate, provided that the physician reviews the information with the patient and takes responsibility for the full medical record being created and used to support billing; and (2) will ask the Centers for Medicare & Medicaid Services (CMS) to communicate this policy to other Medicare administrative contractors. Adopted as amended.

REFERRED TO: (1) Add to TMA Policy Compendium; (2) Council on Socioeconomics and Council on Practice Management Services

STATUS: (1) Added 30.038 Physicians Allowed to Delegate Ability to Enter EHR Data to TMA Policy Compendium; (2) TMA will continue to include this issue as a topic of discussion during regular meetings with CMS and Novitas.
Resolution 402 – Opposition to Medicaid Work Requirements (Ryan Van Ramshorst, MD, Texas Pediatric Society): That the Texas Medical Association apply all appropriate resources to oppose Medicaid work requirements to ensure that vulnerable, low-income adults with children and other covered populations continue to receive necessary medical services and that Texas does not increase uncompensated care for physicians. Adopted.

REFERRED TO: Add to TMA Policy Compendium

STATUS: Added 190.037 Medicaid Work Requirements to TMA Policy Compendium

Resolution 403 – Under-Reporting of Optometric Diabetic Eye Examinations to Treating Physicians (Harris County Medical Society): That the Texas Medical Association work with the Texas Optometry Board to develop guidelines around conditions that need to be reported to the patient’s physician. Adopted as amended.

REFERRED TO: Interspecialty Society Committee

STATUS: The Interspecialty Society Committee will discuss this resolution at their TexMed 2019 meeting.

Resolution 404 – Opposition of Pain Score as a Contributor to Hospital Financial Incentives (Medical Student Section): That the Texas Medical Association oppose the allocation of financial incentives for high patient satisfaction scores that weigh patient-rated treatment of pain against other factors involved in patient care. Adopted.

REFERRED TO: Add to TMA Policy Compendium

STATUS: Added 235.039 Opposition to Pain Score as a Contributor to Hospital Financial Incentives to TMA Policy Compendium.

Resolution 405 – Compensation to Physicians for Authorizations and Preauthorizations (Ori Z. Hampel, MD): That insurance and managed care companies (“payers”) compensate physicians for the time that physicians and their staff spend on authorization and preauthorization procedures. Such compensation shall be paid in full by payers to physicians without deductible, coinsurance, or copayment billable to patients; thus, patients will not bear the burden for such processes imposed by payers. The fee schedule shall be based on the compensation due physicians for patient evaluation and management according to the Current Procedural Terminology (CPT) coding system. For physicians contracted with payers, the payers shall compensate the physician at the contracted fee schedule. For out-of-network physicians, the payers shall compensate physicians at 60 percent of billed charges. The physician and/or physician staff shall track the time spent per patient per day performing tasks related to authorization and preauthorization, and round the time spent per task up to the nearest five-minute increment. The physician shall bill the payer in accordance with the CPT coding system based on the time spent. If necessary, multiple codes shall be used and payable to account for the time spent. Billable minutes for authorization and preauthorization include, but are not limited to, time spent filling out forms, making telephone calls (including time spent negotiating phone trees and hold time), documenting in the patient’s medical record, communicating with the patient, printing, copying, and faxing. Texas laws pertaining to payment timeliness by third-party payers shall apply to payers for such billing as well. Referred for decision.

REFERRED TO: Board of Trustees; Medical Economics and Payment Advocacy

Resolution 406 – Supporting Reclassification of Complex Rehabilitation Technology (Resident and Fellow Section): That: (1) TMA support the Centers for Medicare & Medicaid Services reclassifying complex rehabilitation technology equipment into its own distinct payment category under the Medicare program to improve access to individuals with substantially disabling and chronic conditions; and (2) the Texas Delegation to the American Medical Association take a similar resolution to the AMA. **Adopted as amended.**

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

**STATUS:** (1) Added 270.007 Supporting Reclassification of Complex Rehabilitation Technology to TMA Policy Compendium. (2) The Texas Delegation introduced Resolution 117-A-18 at the June 2018 AMA House of Delegation annual meeting. It was referred to the AMA Council on Medical Service for a report back to the AMA HOD 2019 annual meeting.

Resolution 407 – Medical Necessity Decisions Are the Practice of Medicine (Harris County Medical Society): That the Texas Medical Association work to: (1) align the Texas Occupation Code, Texas Insurance Code, and Texas Administrative Code with clear verbiage that medical necessity decisions are the practice of medicine and can only be performed by a physician with an active license in the state of Texas; and (2) align the Texas Occupations Code, Texas Insurance Code, and Texas Administrative Code with clear verbiage requiring that those making peer-to-peer medical necessity decisions be in the same or similar specialty as the treating physician seeking authorization. **Adopted.**

**REFERRED TO:** Council on Legislation and Office of the General Counsel

**STATUS:** HB 2387 (G. Bonnen)/SB 1187 (Buckingham) require that medical decisions and reviews by Texas licensed health plans are performed by a physician licensed in the state in the same or similar specialty.

Resolution 408 – Protecting the Prudent Layperson Standard (Carrie de Moor, MD, Collin-Fannin County Medical Society, Nueces County Medical Society, and Heidi Knowles, MD, Texas College of Emergency Physicians): That the Texas Medical Association: (1) adopt the following principles related to out-of-network emergency care: Patients who seek emergency care should be protected under the “prudent layperson” standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered. Patients must not be financially penalized for receiving emergency care from an out-of-network physician or provider. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to physician specialties. Texas Department of Insurance should enforce such standards through active regulation of health insurance company plans. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments, and other out-of-pocket costs that enrollees may incur. Medical necessity review of emergency services must be performed by a board-certified emergency medicine physician licensed in Texas and not affiliated with an insurer, a municipal cooperative health benefit plan, health management organization, or the physician or provider or facility in question; and (2) actively oppose any health plan or other payer policy that dissuades patients from seeking needed emergency care in situations where they believe their health is at risk. **Adopted as amended.**

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

**STATUS:** Added 100.030 Protecting the Prudent Layperson Standard to TMA Policy Compendium.
TEXAS MEDICAL ASSOCIATION
2019 HOUSE OF DELEGATES ANNUAL SESSION

OPENING SESSION
Friday, May 17, 8 am, Hilton Anatole
(The speakers may take items out of order.)

1. Call to Order
   Susan M. Strate, MD, Speaker
   Arlo F. Weltge, MD, Vice Speaker

2. Invocation
   Phil H. Berry, MD, TMA Past President

3. Report of Reference Committee on Credentials
   Nefertiti C. Dupont, MD, Chair, Reference Committee on Credentials

4. Approval of May 18-19, 2018 Minutes
   Michelle A. Berger, MD, Secretary/Treasurer

5. Nominating Speeches
   President-Elect
   Trustees
   AMA Alternate Delegates

6. Distinguished Service Award (8:30 am)
   Introduced by John T. Carlo, MD

7. Address of Texas Medical Association Alliance President
   Mrs. Sunshine Moore, TMAA President

8. Address of Texas Medical Association President
   Douglas W. Curran, MD, TMA President

9. Section Awards
   Luis E. Seija, Chair, Medical Student Section

10. Recognition of TMA Past Presidents

11. Recognition of Outgoing Council and Committee Chairs

12. Acceptance of Handbook Items as Business of the House (see Order of Business)

13. Consideration of Late Reports and Resolutions

14. Announcements

15. Recess for Reference Committee Hearings
1. Call to Order
   Susan M. Strate, MD, Speaker
   Arlo F. Weltge, MD, Vice Speaker

2. Report of Reference Committee on Credentials
   Nefertiti C. Dupont, MD, Chair, Reference Committee on Credentials

3. Board of Trustees, Annual Association Finances Report
   Diana Fite, MD, Chair, Board of Trustees

4. Council on Legislation Update
   Jason Terk, MD, Chair, Council on Legislation

5. Section Awards
   Justin Bishop, MD, RFS Board of Trustees Member, Resident Fellow Section
   Sejal S. Mehta, MD, Chair, International Medical Graduates Section
   Gates Colbert, MD, Chair-Elect, Young Physician Section

6. Announcements

7. Moment of Silence for Deceased Physicians

8. Video Taped Presentation of TMA-Established Organizations
   Texas Medical Liability Trust
   Texas Medical Association Foundation
   TEXPAC

9. Initial Extractions from Reference Committee Reports

10. Elections (9:30 am)

11. Installation of TMA and TMAA Presidents (10:45 am)

12. Call for Reference Committee Reports

13. Adjourn
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES
ORDER OF BUSINESS
2019 ANNUAL SESSION
May 17-18, 2019

Reference Committee Key:
Financial and Organizational Affairs = FOA
Medical Education and Health Care Quality = MEHCQ
Science and Public Health = SPH
Socioeconomics = SOCIO

REPORTS:

1. Report of President
   1. Nominations for Board of Governors, Texas Medical Liability Trust
   2. Improving the Quality Payment Program and Preserving Patient Access

2. Report of Speakers
   1. Wireless Handheld Voting/Election System

3. Reports of Board of Trustees
   1. TMA Leadership College
   2. Disclosure of Affiliations
   3. TMAIT, TMFHQI, and TMLT
   4. Pending Lawsuits Involving Texas Medical Association and Audit Trail
   5. Investments
   6. Audit of 2017 Financial Statements and 2018-19 Operating Budgets
   7. 2018-19 Board Officers and Committees
   8. Medical Student and Resident Physician Loan Funds
   9. Minority Scholarship Program
   10. Revision of Section 165.155(a) of the Texas Occupations Code, Res. 105-A-18
   11. TMA Education Center
   12. Celebration of Louis J. Goodman, PhD
   13. Compensation to Physicians for Authorizations and Preauthorizations, Res. 405-A-18
   14. Inactive County Medical Societies
   15. Sunset Policy Review

4. Report of Executive Vice President
   1. 2018-19 Update

5. Report of Interspecialty Society Committee
   1. Informational Update

6. Report of Committee on Membership
   1. Membership Development
   2. Women in Medicine Section

7. Reports of Board of Councilors
   1. Distinguished Service Award – Don R. Read, MD
   2. Opinions of the Board of Councilors
   3. County Medical Societies Constitution and Bylaws and Name Change
   4. Emeritus Nominations
   5. Honorary Nominations

REferred TO:

FOA
MEHCQ
Informational

8. Reports of Committee on Physician Health and Wellness
   1. Policy Review and Amendment to Committee Charge  FOA
   2. Sunset Policy Review  FOA

9. Reports of Texas Delegation to the AMA
   1. AMA House of Delegates Meetings in 2018  Informational
   2. AMA Membership, Representation, and Delegation Leadership  Informational
   3. Texas Delegation Operating Procedure Changes  FOA

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

11. Report of Medical Student Section
    1. Medical Student Section Operating Procedures Update  Informational

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

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

14. Reports of Council on Constitution and Bylaws
    1. Inactive Specialty Societies  FOA

15. Reports of Council on Health Care Quality
    1. Council on Health Care Quality Update  Informational


17. Reports of Council on Health Service Organizations
    1. Supportive Palliative Care Policy  MEHCQ
    2. Identification Bracelets for Patients With Hearing Loss, Resolution 312-A-18  MEHCQ
    3. Sunset Policy Review  MEHCQ


19. Reports of Council on Medical Education
    1. Sunset Policy Review  MEHCQ
    2. Support of Expanded Eligibility for Inpatient Medicaid GME Funding to Teaching Hospitals  MEHCQ
    3. Fixing the Inequity in Medicare GME Funding for Texas Teaching Hospitals Compared to Other States  MEHCQ
    4. Study of Projected Need for More Medical Schools in Texas  MEHCQ
    5. Medical Students in Natural Disaster/Emergency Situations and Related Liability Coverage, Resolution 108-A-18  MEHCQ

20. Reports of Committee on Continuing Education
    1. TMA CME Program Update  Informational
    2. Sunset Policy Review  MEHCQ
21. Reports of Committee on Physician Distribution and Health Care Access
   1. Improving Access to Care in Medically Underserved Areas through Project ECHO and the Child Psychiatry Access Project Model

22. Reports of Council on Practice Management Services
   1. Patient-Centered Medical Responsibilities, Resolution 101-A-18
   2. Improving Health Technology Products to Address the Issues of Sex and Gender
   3. Establish a Standing Committee on Health Information Technology

23. Reports of Council on Science and Public Health
   2. Support of Evidence-Based Medicine, Resolution 107-A-17
   3. Raising the Minimum Purchase Age for Guns, Resolution 313-A-18
   4. Early Childhood Adversity and Health
   5. Sunset Policy Review
   6. Task Force on Behavioral Health

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

25. Reports of Committee on Child and Adolescent Health
   2. Sunset Policy Review

26. Report of Committee on Emergency Medical Services and Trauma
   1. EMS and Trauma Activities Update
   3. Sunset Policy Review

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

28. Report of Committee on Reproductive, Women’s, and Perinatal Health (no report)

29. Reports of Council on Socioeconomics
   1. Health Plan Claim Auditing Programs
   2. Sunset Policy Review
   3. Gender Disparities in Physician Compensation
   4. Establishing the Standing Committee on Medicaid, CHIP, and the Uninsured

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

31. Reports of Patient-Physician Advocacy Committee
   1. Patient-Physician Advocacy Update
   2. Sunset Policy Review

32. Report of Committee on Rural Health
   1. Expand Availability of Broadband Internet Access to Rural Texas
2. Rural Health Activities Update Informational

33. Report of TEXPAC (no report)

34. Report of Texas Medical Association Insurance Trust
   1. Texas Medical Association Insurance Trust 2018 Annual Report Informational

35. Report of Texas Medical Association Foundation
   1. TMF Health Quality Institute Annual Report Informational

36. Report of Texas Medical Association Alliance
   1. TMA Alliance Activities and Accomplishments Informational

37. Report of TMF Health Quality Institute
   1. TMF Health Quality Institute Annual Report Informational

RESOLUTIONS:

101. Saturday-Sunday Meeting Schedule for the Texas Medical Association FOA
102. Written Testimony at TMA Reference Committees FOA
103. Gratitude for Continuing Medical Education Courses FOA
104. Alternate Delegates May Address the House of Delegates FOA
105. Pharmacies Practicing Medicine FOA
106. Establish a Coalition of Medical Societies to Protect Competition and Sustainability in the Health Insurance Marketplace FOA
107. Physician Dispensing of Prescriptions FOA
108. Initial Assessment and Treatment Recommendation by Specialists FOA
109. Licensure Status on TMA Membership Applications FOA
110. Blue Cross and Blue Shield of Texas Charitable Requirements as a Not-for-Profit Corporation FOA
111. Opposing Legislation that Mandates Physician Discrimination FOA
112. Equal Pay for Equal Work FOA
201. Alternative Maintenance of Certification (MOC) Pathways to Comply with Antitrust Rulings MEHCQ
202. Clarification of Physician Protection From Maintenance of Certification (MOC) in Facility Bylaws MEHCQ
203. Restrictions to Requirements of Maintenance of Certification MEHCQ
205. Eliminating Professional and Colloquial Use of the Term “Mental Retardation” by Physicians in a Clinical Setting MEHCQ
206. Considerations for Care of Individuals with Autism Spectrum Disorder (ASD) MEHCQ
207. Increasing Access to Service Learning Opportunities in Undergraduate Medical Education MEHCQ
208. Integration and Maintenance of Wellness Initiatives in Texas Undergraduate and Graduate Medical Education MEHCQ
209. Promoting Health Insurance and Health Policy Education Prior to Residency MEHCQ
210. Recommendation for Hemorrhage Control Training of Healthcare Professionals MEHCQ
211. The Integration of LGBTQ Health Topics into Medical Education MEHCQ
212. Improve Physician-Hospital Relations MEHCQ
213. Complying with Value-Based Care Quality Measures for Medication Adherence MEHCQ
301. Distribution and Display of Human Trafficking Aid Information in Public Places SPH
302. Statement on Personhood Measures SPH
303. Improving Medical Clearance Policies for Traumatic Brain Injury Patients SPH
304. Requirement for Food Allergy Posters and Employee Training in Food Establishments SPH
305. Allow the Possession and Administration of an Epinephrine Autoinjector in Certain Entities SPH
306. Opposition to Limiting the Physician’s Role in the End-of-Life Process SPH
307. Regulatory Recommendations for Bed Bugs
308. Regulation of Electric Scooters
309. Factoring Adolescent Sleep Patterns into Middle and High School Start Times
310. Amending TMA Policy 315.031, Restricting the Sale of Electronic Cigarettes to Minors
311. Identifying Trauma and Mental Health Susceptibilities in Schools
312. Opposition to Increasing Work Requirements for the Supplemental Nutrition Assistance Program (SNAP)
313. Physicians Counseling Patients About the Risks of Direct-to-Consumer Genetic Testing
314. Support of Mandatory Paid Parental Leave
315. Notification of Generic Drug Manufacturing Changes
316. Determinants of Health

401. Participation in Government Programs when Receiving Payment for Uncompensated Care
402. Prescription Monitoring Program Integration Into Electronic Medical Records
403. Prior Authorization Approval
404. Medicare Part B Coverage of Vaccines
405. Lower Drug Costs
407. Compensation to Physicians for Activities Other Than Direct Patient Care
408. Managing Patient-Physician Relations Within Medicare Advantage Plans
409. Update Practice Expense Component of Relative Value Units
410. Laboratory Benefit Managers
411. Data Migration Responsibilities of Electronic Health Record Vendors in Client Contract Termination
412. Medical Necessity Tax Exemption for Feminine Hygiene Products
413. The Benefits of Importation of International Pharmaceutical Medications
414. Studying Financial Barriers of Rural Hospitals
415. Improving Buprenorphine Access for Opioid Substance Use Disorder Treatment
416. Revising the Texas Department of Insurance Division of Workers’ Compensation Designated Doctor Training and Education Process
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES
2019 Annual Session
INFORMATIONAL REPORTS

Reports of Board of Trustees
1. TMA Leadership College
2. Disclosure of Affiliations
3. TMAIT, TMFHQI, and TMLT
4. Pending Lawsuits Involving Texas Medical Association and Audit Trail
5. Investments
6. Audit of 2017 Financial Statements and 2018-19 Operating Budgets
7. 2018-19 Board Officers and Committees
8. Medical Student and Resident Physician Loan Funds
9. Minority Scholarship Program
10. Revision of Section 165.155(a) of the Texas Occupations Code, Res. 105-A-18
11. TMA Education Center
12. Celebration of Louis J. Goodman PhD
13. Compensation to Physicians for Authorizations and Preauthorizations, Res. 405-A-18

Report of Executive Vice President
1. 2018-19 Update

Report of Speakers
1. Wireless Handheld Voting/Election System

Report of Committee on Membership
1. Membership Development

Reports of Board of Councilors
1. Distinguished Service Award — Don R. Read, MD
2. Opinions of the Board of Councilors
3. County Medical Societies Constitution and Bylaws and Name Change

Reports of Texas Delegation to the AMA
1. AMA House of Delegates Meetings in 2018
2. AMA Membership, Representation, and Delegation Leadership

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

Report of Council on Health Care Quality
1. Council on Heath Care Quality Update

Report of Committee on Continuing Education
1. TMA CME Program Update

Report of Committee on Physician Distribution and Health Care Access
1. Annual Physician Workforce Update

Report of Committee on Emergency Medical Services and Trauma
1. EMS and Trauma Activities Update

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

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

Report of Interspecialty Society Committee
1. Informational Update

Report of Medical Student Section
1. Medical Student Section Update

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

Report of Texas Medical Association Insurance Trust
  1. Texas Medical Association Insurance Trust 2018 Annual Report

Report of Texas Medical Association Foundation
  1. TMA Foundation 2018 Annual Report

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

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

Report of Committee on Rural Health
  2. Rural Health Activities Update
In 2004, TMA purchased and began using Reply System’s Interactive Voter Response System (IVRS) that greatly improved the speed and accuracy of the TMA House of Delegates (HOD) voting and elections process. During the 2018 Annual Session, TMA’s IVRS failed to capture all delegate responses during the election process. The TMA IVRS was designed to receive votes from handheld devices on specific radio frequencies. Unfortunately, one of the frequencies used was impacted by a signal from another unknown communications device at the facility that did not occur during testing. Since the older technology required assigning a voting radio frequency to each handheld voting device in advance of the meeting, it was impossible to retrieve the devices and change the frequency in a timely manner. Voting proceeded by paper ballots at the direction of the TMA speaker and vice speaker. Prior to 2018, TMA’s IVRS had been used successfully for HOD voting since 2004.

In an effort to research current approaches used by other associations, TMA reached out to the American Medical Association (AMA), Florida Medical Association (FMA), and American College of Emergency Physicians (ACEP). Each used a unique form of house voting and were evaluated for use by TMA. Self-hosted and vendor-hosted solutions, looking for the best combination of cost and functionality, were also researched.

Beyond the specific systems and methods used by the AMA, FMA, and ACEP, TMA looked at leading solution providers of handheld electronic voting systems and third-party onsite voting consultants. Systems using Wi-Fi based technology, or browser-based solutions, were not evaluated due to inconsistencies in internet service at hotel and convention center locations historically used by TMA for TexMed meetings. In addition, it was determined that solutions that utilized individually owned personal devices, mobile phone, tablets, and laptops, were not feasible due to the large variety of potential devices, potential for poor mobile device internet service, and the number of staff available to support those devices onsite.

Three leading vendors of voting and election systems were fully researched. Each solution uses similar handheld voting devices using radio frequency (RF) technology for transmitting votes. The difference with these systems from the legacy TMA system is that RF frequencies are not set on each device. Each handheld voting unit uses a range of frequencies to find the voting base receiver, eliminating the problem caused during the 2018 Annual Session.

Vendors in the search included Meridia, Padgett, and Reply Systems. The first two vendors provided proposals for a purchased solution that would be operated by TMA. Reply Systems did not respond with a proposal. Each system utilizes wireless handheld voting devices and multiple voting receivers to accomplish both elections and Yes/No voting. Each software system seamlessly integrates with PowerPoint and can be incorporated into the TMA HOD order of business. Both system proposals were based upon 500 voting units and multiple receivers. Both software systems supplied with the devices were evaluated for the effectiveness of supporting current TMA house elections and voting procedures.

To fully evaluate alternatives using wireless handheld voting devices, the option of outsourcing elections to a third party for both equipment and onsite voting execution also were investigated. The leading
solution provider in this space is LumiGlobal. The primary two advantages of outsourcing are that the
voting devices are maintained and supplied by LumiGlobal, resulting in the most recent voting device
technology used each year, and their onsite support staff handle association voting and elections for a
number of organizations throughout the year and are capable of handling any set of unique procedures or
policies.

Primarily due to the annual cost associated with the LumiGlobal solution, it was determined that a
purchased solution was preferred to an outsourced approach. TMA could theoretically update the
technology of a purchased solution every third year and still result in a lower cost of operation than the
outsourced approach.

In December 2018, the TMA Board of Trustees approved the purchase of a Handheld Wireless
Voting/Election System for TMA. This new system will be utilized at the 2019 Annual Session.
Subject: TMA Leadership College

Presented by: Diana L. Fite, 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 ninth year, boasts 160 alumni. Additionally, 130 graduates are currently serving in TMA leadership via councils, committees, and sections with others representing their county and specialty societies. These physicians serve as thought leaders who can close the divide among clinicians and health care policymakers, and serve as trusted leaders in their communities.

Participants must be active TMA physician members under the age of 40 or in the first eight years of practice. There is no tuition charge for scholars, but scholars are responsible for their own travel expenses.

Now Accepting Applications for 2020

Applications for the 2019-20 program are due by June 7, 2019. Visit www.texmed.org/Leadership for more information and to download the application. For questions, contact Melanie Harrison at melanie.harrison@texmed.org, or call (800) 880-1300, ext. 1443.

Congratulations the Class of 2019!

Twenty-four scholars will graduate during a luncheon ceremony held at TexMed 2019 on Saturday, May 18.

Class of 2019 Curriculum

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

Self-Study: Scholar Project

Scholars select from a comprehensive menu of project suggestions or create a project of their own that complements lessons/topics discussed.

<table>
<thead>
<tr>
<th>Scholar</th>
<th>Specialty</th>
<th>Sponsored By</th>
</tr>
</thead>
<tbody>
<tr>
<td>Eman Attaya, MD</td>
<td>R</td>
<td>Lubbock County Medical Society</td>
</tr>
<tr>
<td>Emily Briggs, MD</td>
<td>FM</td>
<td>Texas Academy of Family Physicians</td>
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<tr>
<td>Brett Cooper, MD</td>
<td>PD</td>
<td>Texas Medical Association</td>
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<tr>
<td>Renee Flores, MD</td>
<td>IMG</td>
<td>Harris County Medical Society and Texas Chapter of the American College of Physicians</td>
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<td>Nishant Jalandhara, MD</td>
<td>IM</td>
<td>Tarrant County Medical Society</td>
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<td>Zachary Jones, MD</td>
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<td>Christie Lincoln, MD</td>
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<td>Felicity Mack, MD</td>
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<td>Brian Masel, MD</td>
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<td>Jason McKnight, MD</td>
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<td>Ankur Mehta, DO</td>
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<td>1</td>
<td>Wendy Parnell, MD</td>
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<td>Tina Philip, DO</td>
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<td>James Saucedo, MD</td>
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<td>Alisha Young, MD</td>
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<td>John Zaki, MD</td>
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<td>Acsa Zavala, MD</td>
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</table>
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 website, 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 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.
<table>
<thead>
<tr>
<th>Name</th>
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<tr>
<td>AllCare Physicians Group Board of Directors</td>
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Texas Department of Licensure and Regulations
   G. Ray Callas, MD

Texas Health Services Authority
   David C. Fleeger, MD

Texas Institute of Health Care Quality and Efficiency
   Susan M. Strate, MD

Texas Medical Association PracticeEdge, LLC
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Texas Medical Association Specialty Services, LLC
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Texas Medical Foundation Health Quality Institute
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Texas Medical Home Initiative
   Sue S. Bornstein, MD

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   G. Ray Callas, MD (D)
   Joseph S. Valenti

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   G. Ray Callas, MD (C and D)

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Texoma Independent Physicians
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TIMEO2 Healing Concepts, LLP
   Jayesh B. Shah, MD

University of Texas Medical School at Houston
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   Douglas W. Curran, MD (D)

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Bailey Square Surgery Center
Northwest Surgery Center

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Blue Cross Blue Shield (D)
Memorial Medical Clinic

Arlo F. Weltge, MD
American College of Emergency Physicians
American Medical Response
Houston Community College
University of Texas Medical School at Houston
Subject: Texas Medical Association Insurance Trust, TMF Health Quality Institute, and Texas Medical Liability Trust

Presented by: Diana L. Fite, MD, Chair

Texas Medical Association Insurance Trust (TMAIT) Board of Trustees
The TMA Board of Trustees has responsibility to appoint four members of the TMAIT Board of Trustees. In accordance with TMAIT’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 board also fills the position reserved for a member of the Young Physician Section. In addition, the board offers nominations for the remaining three positions, which are elected by policyholders through the proxy mechanism.

In May 2018, the Board of Trustees recommended Richard J. Noel, MD, to serve a second three-year term; Kevin P. Magee, MD, to serve a three-year term; Charles E. Cowles Jr., MD, to serve a three-year term; Jack L. Cortese, MD, to serve a final three-year term; and Russell J. Juno III, MD, to serve a final three-year term. Dr. Noel and Dr. Magee were appointed by the TMA Board of Trustees; Dr. Cowles, Dr. Cortese, and Dr. Juno were elected at the TMAIT annual meeting in September.

TMF Health Quality Institute (TMFHQI) Board of Trustees
The TMF Health Quality Institute Board of Trustees is composed of nine physicians who are doctors of medicine, three doctors of osteopathy, two Medicare beneficiary representatives, and four nonphysicians, for a total of 18 elected members. The immediate past president serves ex officio with vote.

Nominations for places 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. TMFHQI’s nominating committee then meets to choose one or more nominees for each place to be filled. The report of the nominating committee is sent to the entire TMFHQI membership along with a proxy card. The election, by those attending and by proxy, is held during the institute’s annual meeting in July.

In 2019, no physician terms are expiring.

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

Texas Medical Liability Trust (TMLT) Board of Governors
The Texas Medical Liability Trust Board of Governors makes nominations to the TMLT board and the TMA president submits them to the TMA House of Delegates. Policyholder nominations also are reported to the house for information. Beginning with elections in 2007, places on the TMLT board are slotted.

In 2019, no physician terms were expiring.
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
   (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.

   Vestibular-ocular-reflex (VOR) testing is a diagnostic test, used solely to diagnose a problem of the brain or inner ear, and treatment often involves the use of medications that can only be prescribed by a physician. Symptoms that would prompt VOR testing are dizziness, imbalance, and vertigo, which are very common conditions that cause patients to seek medical attention. It is imperative that a correct diagnosis be made rapidly because these symptoms can 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. Vestibular-ocular-nystagmus testing does not fall within the statutory scope of practice of chiropractic. The board’s adopted rule exceeds the practice of chiropractic as defined by law, and impermissibly attempts to permit chiropractors to practice medicine without a license issued by the Texas Medical Board.

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

TMA again submitted its strong objections in a comment letter on July 19, 2010. TBCE held a
rule hearing pertaining to the rule on Aug. 6, 2010. At that rule hearing, Sara Austin MD,
neurologist, 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 Dr. Richard Kemper for deposition, and both did an excellent job testifying.

The parties filed cross motions for summary judgment and the court held a hearing on the
motions on Dec. 5, 2011. The court’s order essentially granted TMA all relief it sought in the
lawsuit and on March 15, 2012, TBCE filed its Notice of Appeal, and filed its Appellant’s Brief
denied oral arguments and set the case for submission on briefs on Oct. 2, 2012.

On Nov. 21, 2012, the Court of Appeals issued its opinion reversing the trial court’s ruling, which
had granted TMA’s Motion for Summary Judgment. The appellate court also remanded the case
back to the trial court to determine what VON testing is. According to the appellate court,
questions of fact exist 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 feels 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 Dec. 8, 2014, the Third Court of Appeals court affirmed denial of the Plea, and on Feb. 23, 2015, the Third Court of Appeals overruled TBCE’s Motion for Panel Rehearing and/or En Banc Rehearing. After petitioning for review with the Supreme Court of Texas, the petition was denied.

On June 16, 2016, TBCE filed a Motion for Partial Summary Judgment relating to the diagnosis issue, which the court denied. Accordingly, the case proceeded to trial 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 Legislature included only the musculoskeletal system and spine in the definition of chiropractic, TMA argued, the VONT 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 and fact and conclusions of law. These were drafted by TMA’s outside counsel, David Bragg, and signed by Judge Hurley. TBCE requested additional findings of fact and conclusions of law. On Dec. 6, 2016, TMA filed its response to TBCE’s request for additional findings of fact and conclusions of law and made its own request for the same. On Dec. 7, 2016, Judge Hurley signed supplemental findings of fact and conclusions of law.

In 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 VONT provision is invalid because TMA did not demonstrate that VONT was intended to be used exclusively to diagnose disease of the brain, ear, or eye, whereas TBCE contends they offered uncontradicted evidence that VONT 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 Nov. 21, 2018, the Third Court of Appeals issued a Memorandum Opinion (Justice C. Bourland) affirming the trial court’s judgment in part and reversing in part:

1. The Third Court overruled TBCE’s first point on appeal. The fact that nerves are affected by disorders in or treatment of the musculosketal system does not mean that the nervous system or the nerves themselves fall within the scope of chiropratic. Statutorily limited to evaluation of the “biomechanical condition of the spine and musculoskeletal system” citing 201.002(b).

2. The Third Court noted that although VONT may be a useful tool to chiropractors, the evidence establishes that VONT 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 Sept. 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 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 argues that VONT 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. On Jan. 10, 2019, the Court denied TCBE’s Motion for En Banc Reconsideration.

B. LITIGATION AS DEFENDANT

No pending litigation at this time.

C. AMICUS CURIAE BRIEFS

1. Benge v. Williams
   (Regarding whether a primary surgeon must tell a patient not only that a resident will be assisting in a surgery, but also exactly what that resident's education, training, and experience is in the surgery in question and exactly what parts of the surgery the resident is going to perform.)
In this case, Jim P. Benge, MD, and Kelsey-Seybold were sued when a patient, Lauren Williams, suffered a perforated bowel after a laparoscopically assisted vaginal hysterectomy. Ms. Williams did not sue the resident involved or the residency program.

Dr. Benge met with Ms. Williams a week before the surgery to obtain her informed consent. He had her sign a form consenting to the surgery and informing her of the risks, which specifically included the possibility of damage to the bowel (the injury that led to the filing of this lawsuit). The consent form also stated that Dr. Benge could use “such associates, technical assistants or other healthcare providers as he may deem necessary” for the surgery. Such language would have similarly allowed the use of a scrub tech or nurse. The form also stated that Dr. Benge could “require other physicians, including residents, to perform important tasks based upon their skill-set, in the case of residents, under the supervision of the responsible physician.” The form went on to state that “[r]esidents are doctors who have finished medical school but are getting more training.”

A third-year Methodist Hospital OB-GYN resident, Lauren Giacobbe, assisted the Kelsey-Seybold physician with the surgery. While the resident had extensive experience in laparoscopic surgery and hysterectomies, this was her first laparoscopically assisted vaginal hysterectomy. Both Dr. Benge and Dr. Giacobbe performed parts of the procedure. Though neither Dr. Benge nor Dr. Giacobbe saw damage occur, Ms. William’s bowel was perforated during, or as a result of, the surgery. Ms. Williams then developed sepsis, underwent a tracheotomy, was put on a mechanical ventilator, and remained in a chemically induced coma for 3 weeks. Once discharged, she required home health assistance for an extended recovery period and was unable to work. Finally, Ms. Williams had several subsequent surgeries to replace colostomy.

The plaintiff’s lawyer based his claim primarily on the fact that while the plaintiff consented to having residents involved in her treatment, she was not specifically told that this was the first time that Dr. Giacobbe had assisted on this specific procedure. The plaintiff’s lawyer claimed that the plaintiff would have never consented to a resident with that experience level assisting with the surgery. At trial, Dr. Benge requested that the jury be “instructed that in deciding whether [Dr. Benge] was negligent, you cannot consider what [Dr. Benge] told, or did not tell, [Williams] about [Dr. Giacobbe’s] being involved with the surgery. The trial court overruled Dr. Benge’s objection and refused to give the jury the requested instruction.

The jury awarded the plaintiff $1.9 million.

TMA joined with the Texas Alliance for Patient Access and the Texas Osteopathic Medical Association in filing an amicus brief on Sept. 13, 2013, in this case in support of Dr. Benge’s position, arguing that:

(1) The Texas Legislature set up a statutory scheme contained in Chapter 74 regarding informed consent claims.

(2) The legislature decided as a policy matter that most surgical procedures would have a particular and exclusive list of risks as delineated by the Texas Medical Disclosure Panel and that no other disclosures would be required in order to enjoy the benefits of the presumed informed consent.

(3) The experience levels of surgeons and residents are not on List “A” for laparoscopically assisted vaginal hysterectomy procedures, so Dr. Benge was under no duty to disclose that information.

(4) If this jury’s verdict is upheld, it would have a significant impact on resident education as it would be impractical, if not impossible, to tell each patient in advance about which residents
would be involved; what their education, training, and experience was with regard to that type of surgery; and exactly what they would be doing during the surgery.

(5) This could be a slippery slope: The next cause of action could be against primary surgeons for failing to tell patients about the limits of their own experience and training in a particular type of surgery.

The Court of Appeals for the First District of Texas in Houston issued its opinion on Nov. 18, 2014. The court found that there was no common law duty to disclose the relative experience of the surgeon assisting. The court found that the resident-disclosure theory did not concern a risk for hazard inherent to her hysterectomy surgery and that no such duty existed. The court found that the assertion of medical negligence that characterizes the failure to disclose this information as a breach of duty was an invalid theory and should not have been submitted. As the court could not determine whether the jury found in favor of the plaintiff on this theory as opposed to some other valid theory, the court concluded that it was required to order a new trial.

On Jan. 30, 2015, Ms. Williams filed a motion for rehearing and En Banc consideration with the Court of Appeals. On Feb. 26, 2015, the First Court of Appeals requested a response to the motion for rehearing. A response was filed on April 1, 2015.

On Sept. 22, 2015, the Houston First Court of Appeals denied the motion for rehearing en banc filed by the plaintiff in the case. The vote was 5-4 against en banc rehearing, and the panel voted to stay with the panel’s original decision to send the case back down to the trial court for a new trial.

On motion for rehearing en banc, Justices Radack, Jennings, Bland, Massengale, and Brown voted not to have an en banc rehearing, and Justices Bland, Keyes, Higley, and Lloyd voted in favor of an en banc rehearing. Justice Brown wrote a supplemental opinion in response to the motion for rehearing en banc. Justices Jennings, Keyes, and Lloyd all wrote dissenting opinions for the denial of the rehearing en banc.


On March 3, 2017, TMA joined with the Texas Alliance for Patient Access and the Texas Osteopathic Medical Association in filing an amicus brief with the Supreme Court of Texas.

On March 10, 2017, the Supreme Court of Texas granted both Petitions for Review. Oral arguments were made on Jan. 11, 2018. On May 25, 2018, the Texas Supreme Court (Chief Justice N. Hecht) handed down its decision, adopting the position supported by TMA. Plaintiff’s argument that informed consent should have been acquired regarding who was assisting in the surgery was not a proper claim under Texas law. The Court concluded that Ms. Williams’ characterization of the evidence of Dr. Benge’s nondisclosure was not a claim of lack of informed consent for which he could be liable. Indeed, Ms. Williams specifically disclaimed such basis for liability at trial.
Moreover, the Court further found no distinction between a claim of nondisclosure and lack of informed consent. Because the jury could have found that Dr. Benge was negligent in failing to disclose Dr. Giacobbe’s involvement in the surgery and her lack of experience, the jury should have been instructed not to consider the lack of disclosure in determining negligence when that claim was not asserted. As a result of the court’s holding, the case was remanded back to the trial court for a new trial.

2. **Gomez v. Memorial Hermann**

(Regarding whether the Supreme Court of Texas should grant the petition for writ of mandamus in this case.)

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 plain language of the statute provides an exception to the confidentiality and privilege associated with peer review when a judge makes a preliminary finding that a proceeding or record of a medical peer review committee is relevant to an anticompetitive, not antitrust, action.

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

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

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

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

Interestingly, the court went on to discuss how confidentiality would work if a committee was both a “medical committee” and a “medical peer review committee”:

“records and proceedings of a dual medical committee and medical peer review committee do not enjoy any greater confidentiality under 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, 2017 through March 27, 2017. The jury deliberated for 2 days and delivered its verdict on March 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.

TMA submitted its amicus brief to the First Court of Appeals on Oct. 23, 2018. In the brief, TMA noted practical concerns on healthcare 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 Oct. 30, 2018.


   (Regarding the performance of acupuncture by chiropractors.)

This case was brought in a Travis County district court by the Texas Association of Acupuncture and Oriental Medicine (TAAOM) against the Texas Board of Chiropractic Examiners and its executive director (in her official capacity). The plaintiff challenged the validity of rules adopted by TBCE authorizing chiropractors to perform acupuncture. The trial court granted the defendants’ motion for summary judgment and denied a request for summary judgment made by the plaintiff acupuncture and oriental medicine association. The plaintiff appealed the denial to the Third Court of Appeals in Austin. TMA on Dec. 1, 2015, submitted an amicus brief to the appellate court, wherein TMA argued that TBCE went too far in allowing chiropractors to perform acupuncture. TMA asked for a reversal of the trial court’s judgment, as doing so would invalidate the relevant rules of the chiropractic board.

In the amicus brief, TMA argued that the chiropractic board’s rules on acupuncture exceed what state law allows under the Chiropractic Act. TMA also pointed out the Chiropractic Act doesn’t authorize any procedures on the nervous system nor does it authorize chiropractors to perform acupuncture. TMA’s brief said that the Chiropractic Act “addresses biomechanical conditions of the musculoskeletal system, not acupuncture.”

The appeal hearing took place on Dec. 2, 2015. At the hearing, the chiropractic board’s counsel contended that because the Chiropractic Act prohibits only the performance of incisive procedures, chiropractors should be able to perform acupuncture within the scope of their practice act. There was some discussion of whether biomechanics encompassed the use of acupuncture, with one justice saying, “Acupuncture is about nerves; that’s different from biomechanics.”

The Third Court of Appeals delivered its opinion on Aug 18, 2016. The court held that the lower court erred in granting summary judgment in favor of the TBCE on the validity of the TBCE’s rules regarding requirements for practicing acupuncture by chiropractors. The appellate court also opined that the trial court did not err in granting summary judgment in favor of the TBCE on the definition of “incision,” or in the use of needles in nonsurgical/nonincisive procedures, and remanded the case to the trial court. Finally, the appellate court requested that the Legislature solve the long-standing dilemma of how the scope of chiropractic correlates with the scope of practice in other health professionals’ licensing statutes.

On Feb. 17, 2017, the motion for rehearing was granted, in part, the previous opinion was withdrawn, and a new opinion was issued. The new opinion reverses the portion of the trial court’s judgment dismissing TAAOM’s challenge to TBCE’s rule expressly authorizing acupuncture and remands the case for further proceedings.

According to a Dec. 14, 2017 “Parties’ Status Update” of the case on remand, the Board voted “to continue negotiations with the Association as a precedent to rule-making but, rather than proceeding under Chapter 2008 of the Texas Government Code, to conduct informal conferences or use other appropriate methods as preparation for rulemaking concerning the subject matter of this lawsuit. . . . Progress has been made but the Board is still in the process of gathering stakeholder input. It is projected that the entire rulemaking process—including stakeholder meetings—could take a year or longer. As such, this case should remain abated so that the parties can complete the rulemaking process that could lead to the termination of this litigation.” As of March 2018, stakeholder workgroup meetings are continuing.

In July 2018, the TBCE proposed amended rules in the Texas Register. While the status of the parties in litigation remains unchanged, TAAOM has indicated that the proposed rules do not reflect any agreement of the parties. TMA provided comments on these proposed rules (see item D. 1 below). The parties are also exploring agreed legislation this session to resolve the litigation.

4. D.A. and M.A., Individually and as Next Friends of A.A., a Minor v. Texas Health Presbyterian Hospital of Denton, Marc Wilson, MD and Alliance OB/GYN Specialists, PLLC d/b/a OB/GYN Specialists, PLLC

(Regarding whether Texas Civil Practice and Remedies Code §74.153 applies to emergency medical care provided in an obstetrical unit without the patient first having been evaluated in a hospital emergency department.)

This is a health care liability claim arising out of the delivery of M.A. and D.A.’s son, A.A. (Plaintiffs), and the care provided by Marc A. Wilson, MD, Texas Health Presbyterian Hospital Denton, and Alliance OB/GYN Specialists, PLLC (Defendants). The delivery was complicated by a shoulder dystocia. Plaintiffs allege that Dr. Wilson was negligent in failing to stop all maternal pushing efforts once the shoulder dystocia was recognized, in failing to place Mrs. Akers in a correct McRoberts position, and in placing excessive lateral traction on the head and neck of the baby. Plaintiffs also allege that the care constituted “willful and wanton” negligence and gross negligence.

Dr. Wilson and the PLLC (alleged to be vicariously liable for Dr. Wilson’s conduct) argue that the standard applicable to Plaintiffs’ claims is the “willful and wanton” negligence standard contained in §74.153 of the Texas Civil Practice and Remedies Code.

§74.153 (emphasis added) reads:

In a suit involving a health care liability claim against a physician or health care provider for injury to or death of a patient arising out of the provision of emergency medical care in a hospital emergency department or obstetrical unit or in a surgical suite immediately following the evaluation or treatment of a patient in a hospital emergency department, the claimant bringing the suit may prove that the treatment or lack of treatment by the physician or health care provider departed from accepted standards of medical care or health care only if the claimant shows by a preponderance of the evidence that the physician or health care provider, with willful and wanton negligence, deviated from the
degree of care and skill that is reasonably expected of an ordinarily prudent physician or
health care provider in the same or similar circumstances.

Dr. Wilson and the PLLC filed a motion for summary judgment addressing the application of
§74.153 to Plaintiffs’ burden. Plaintiffs disputed that §74.153 applies because they claim the
statute is only triggered if the claim arises out of emergency medical care provided in an
obstetrical unit following the evaluation or treatment of the patient in a hospital emergency
department and that M.A. did not present or receive any care in the emergency department prior
to the delivery in the obstetrical unit of the hospital.

Defendants argue that Plaintiffs erroneously interpreted the plain language of §74.153.
Defendants’ claim the plain language should be interpreted such that evaluation or treatment of
the patient in hospital emergency department is not a prerequisite to application of the statute to a
claim arising out of emergency medical care in an obstetrical unit. Defendants claim that
prerequisite only applies if the claim arises out of emergency medical care in a surgical suite.

The trial court agreed with Defendants and concluded that §74.153 applies even though M.A. was
not evaluated or treated in the emergency department prior to the emergency medical care which
is the subject of this claim. The trial court granted the Defendants’ motion, and signed an order
permitting a permissive interlocutory appeal to answer the following question:

Does the emergency medicine statute, section 74.153 of the Texas Civil Practice and Remedies
Code, apply to a suit involving a health care liability claim against a physician or health care
provider for injury to or death of a patient arising out of the provision of emergency medical care
in an obstetrical unit without the patient first having been evaluated in a hospital emergency
department?

On June 2, 2016, the Second Court of Appeals in Ft. Worth agreed to consider the question.

On Aug. 30, 2016, TAPA, TMA, THA and others filed an amicus curiae brief in the case in of
support Defendants’ position that §74.153 applies to claims arising out of the provision of
emergency medical care provided in an obstetrical unit without the patient first having been
evaluated or treated in a hospital emergency department.

The case was submitted without oral argument on Oct. 11, 2016.

On Feb. 16, 2017, the Second Court of Appeals issued its Opinion, stating that “(w)e hold that
section 74.153, which provides a willful and wanton standard for liability, does not apply to
emergency medical care provided in an obstetrical unit when the patient was not evaluated or
treated in a hospital emergency department immediately prior to receiving the emergency medical
care.”

On May 2, 2017, a Petition for Review was filed by the defendants. On May 9, 2017, the
Supreme Court of Texas requested a response to the Petition for Review. On July 10, 2017, a
Response to the Petition for Review was filed. A Reply to the Response to the Petition for
Review was filed on Aug. 24, 2017. On Sept. 22, 2017 the Court requested briefs on the merits
from all parties. A Brief on the Merits was filed Nov. 22, 2017. A Response Brief was due Jan.
11, 2018 and a Reply Brief was due Jan. 26, 2018. Respondents (Plaintiffs in the lower court)
filed their Brief on the Merits on Jan. 11, 2018. Petitioners (Defendants in the lower court) filed
On Oct. 2, 2018, TMA, TAPA, and the other signatories filed an amicus brief before the Texas Supreme Court. The Court heard oral argument on Oct. 9, 2018, and on Dec. 21, 2018, the Court issued a Memorandum Opinion (J. Boyd). In the brief, TMA noted that the phrase “immediately following” only modifies “surgical suite.” That would mean the higher standard of proof applies to healthcare practitioners who treat patients in any of three places: the ED; the obstetrical unit; or a surgical suite if the patient was previously evaluated or treated in the ED.

The Supreme Court, after careful analysis and construction of the statute, agreed with the argument of Dr. Wilson and TMA in a Dec. 21, 2018 decision. It said the higher “willful and wanton” standard applies when a case “arise[s] out of the provision of emergency medical care in a hospital obstetrical unit, regardless of whether that care is provided immediately following an evaluation or treatment in the hospital’s emergency department.” The Court called that interpretation “the only reasonable construction of the statute’s language” and affirmed dismissal of the case.

5. **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 of 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. After the district court issues a new order, the case is likely to be appealed back to the Fifth Circuit again.

6. **Craig Perkins and Kimberly Perkins v. Stephen Skapek, MD et al.**
(Regarding whether a physician employed by a Texas governmental entity but having staff privileges and performing employee duties at another facility is still entitled to immunity for actions that occurred at the other facility.)

In this case, the Perkins family is suing physicians and the Children’s Medical Center of Dallas (CMCD) as representatives of their deceased 16-year old son who had sought care at CMCD for a brain tumor associated with primary CNS lymphoma. The plaintiffs allege that though the surgery was successful, the follow-up treatment failed to meet the standard of care on the basis that physicians employed experimental protocols designed to treat patients with severe systemic disease, which they claim their son did not have. The plaintiffs allege that other physicians failed to recognize and remove their son from this improper protocol. Finally, they allege that another physician failed to keep their son on medication for his lungs for the proper amount of time and failed to scan the son’s chest prior to discharge.

The issue, though, is that the defendant-physicians were employees of UT Southwestern at Dallas (“UTSW”)—a governmental entity—and as such, would ordinarily be afforded governmental immunity under the Texas Tort Claims Act. As a result of the 2003 tort reforms pushed through by TMA, the Act entitles a Texas governmental entity physician employee to be dismissed from a lawsuit if the employer could have been sued in the employee’s place.

The plaintiffs allege that the physicians were only ostensibly UTSW employees, but when they were treating patients at CMCD, they were acting within the course and scope of their CMCD staff privileges, not their employment at UTSW.

The physician defendants motioned the court to be dismissed under the Texas Tort Claims Act, and then asked for summary judgment on the same grounds. The court dismissed the physicians’ motions, and the physicians appealed. The appellate court ruled in the physicians’ favor, holding that they were indeed employees of UTSW and thus entitled to immunity. The plaintiffs have appealed to the Supreme Court.

On Feb. 14, 2018, TMA and TAPA filed an amicus brief in the case.
The Texas Supreme Court refused to grant the petition for review on April 6, 2018, leaving the favorable court of appeals decision in place.

7. **Gunn v McCoy**

(Regarding medical causation and expert testimony.)

TMA, AMA and TAPA submitted an amicus curiae brief in Gunn v. McCoy with the Texas Supreme Court on Feb. 5, 2018. The case deals with a husband’s lawsuit against physicians, physician groups (Obstetrical and Gynecological Associates, P.A. and Obstetrical and Gynecological Associates, PLLC, together OGA), and a hospital relating to the defendants’ management and treatment of his wife’s disseminated intravascular coagulation (DIC).

When she was 37 weeks pregnant, Shannon McCoy, who had been under the prenatal care of Debra Gunn, MD, an obstetrician and gynecologist, presented at the hospital with severe abdominal pain and lack of fetal movement. Under the supervision of the on-call obstetrician and later Dr. Gunn, Shannon received blood products, including fresh frozen plasma (“FFP”). She delivered a stillborn baby, received additional blood products, not including FFP, and was transferred to the ICU. Shannon continued to lose blood. In the ICU, Shannon developed tachycardia, and her uterus stopped contracting. Shannon underwent a hysterectomy. Just before the surgery, her heart stopped pumping blood and she went into cardiac arrest. CPR was performed. Shannon suffered brain damage and seizures, was transferred to a neurological ICU, and underwent months of therapy. Since Sept. 14, 2004, Shannon has required around-the-clock care as a quadriplegic. Subsequent to the trial, Shannon McCoy passed away.

Plaintiff Andre McCoy’s theory of the causation of the brain injury is that Dr. Gunn failed to adequately treat the DIC by failing to order additional FFP to replace Shannon’s clotting factors and slow her bleeding, and by failing to infuse enough units of blood.

Dr. Gunn and OGA claim that the plaintiff’s expert and the appellate court did not adequately consider the amount of blood and blood products that they did provide the patient, and that the medical record clearly supports that. They alternatively theorize that DIC caused small blood clots in Shannon’s vascular system and that some of those small clots lodged in blood vessels in Shannon’s brain, causing the injury. This theory was supported by testimony by two expert witnesses, a hematologist and a neurologist.

Andre McCoy, Shannon’s husband, sued Dr. Gunn, other physicians, OGA, and the hospital associated with his wife’s care alleging that their negligence in mismanaging his wife’s DIC caused the brain injury. All physicians aside from Dr. Gunn either settled or were dropped out of the lawsuit.

The jury returned an 11-to-1 verdict in favor of McCoy as to Dr. Gunn’s negligence and awarded damages of over $10 million, including approximately $700,000 in past medical expenses and over $7 million in future medical expenses.

On Feb. 5, 2018, TMA and TAPA filed a brief in support of Dr. Gunn and OGA. Oral argument in the case was heard on Feb. 8, 2018.

In June 2018, the Texas Supreme Court affirmed the appellate court’s decision, which affirmed the jury verdict against Dr. Gunn and the other defendants. The court held that the differing causation theories represented a battle of the experts that was properly resolved by the jury.
8. **In re City of Dickinson**

(Regarding preservation of the attorney-client privilege in the context of a designated party expert witness.)

On Sept. 6, 2018, TMA, jointly with the Texas Alliance for Patient Access, submitted an amicus brief in a case carrying implications for medical professional liability lawsuits. The city of Dickinson (the City) sued Texas Windstorm Insurance Association (Texas Windstorm) after a dispute regarding the amount Texas Windstorm owed the City under a policy for property damage caused by high winds during Hurricane Ike. In conjunction with some of its pleadings, Texas Windstorm included an affidavit of its corporate representative, who was also offering opinion evidence as a non-retained expert.

The City sought to compel production of communication between this expert and Texas Windstorm’s attorney relating to the preparation of that affidavit. The City based its argument on certain rules of civil procedure that entitle parties to all documents provided to, reviewed by, or prepared by or for an expert in anticipation of the expert’s testimony. After several hearings, the trial court eventually granted the City’s motion, ordering Texas Windstorm to produce items provided to, reviewed by, or prepared by or for the expert in anticipation of his testimony as an expert, including all e-mails and drafts he exchanged with Texas Windstorm’s counsel.

Texas Windstorm did not produce the documents, and instead filed a petition for writ of mandamus in the court of appeals, arguing that the documents should be protected by the attorney-client communication privilege. The court of appeals granted Texas Windstorm’s petition, holding that the trial court abused its discretion and that Texas Windstorm should not have been required to produce the email exchanges and drafts of the expert affidavit between Texas Windstorm’s counsel and the expert.

The City of Dickinson appealed to the Texas Supreme Court, alleging that the rules of civil procedure entitle parties to all documents provided to, reviewed by, or prepared by or for an expert in anticipation of the expert’s testimony, regardless of whether those documents are attorney-client communication.

The court requested briefing on the issue and set the case for oral argument on Sept. 12, 2018. The TAPPA and TMA brief supports the appellate court’s holding which preserves the protection of candid conversation between legal counsel and defendant experts. Accordingly, TMA argued that the Texas Supreme Court should not grant the petition for a writ of mandamus.

On Feb. 25, 2019, the Texas Supreme Court issued an opinion agreeing with TMA’s position. The Court agreed with the appellate decision (overruling the trial court) and affirmed the holding that a client’s decision to offer expert testimony does not waive the attorney-client privilege.


(Regarding the evidentiary standard for expert testimony in describing the standard of care)

On Oct. 22, 2018, TMA filed an amicus brief with the Texas Supreme Court in support of an appellate court ruling that reversed a trial court judgment of nearly $2 million against a Cypress neurosurgeon. In the underlying suit, Tracy Windrum sued Cypress neurosurgeon Victor Kareh, MD, after her husband, Lancer Windrum, died in May 2010 of complications of hydrocephalus from aqueductal stenosis, a block in the aqueduct of his brain through which cerebrospinal fluid flowed.
On Feb. 3, 2010, Lancer experienced slurred speech, disorientation, and other issues, which required an ambulance to take him to North Cypress Medical Center. Dr. Carrie Blades, the attending emergency room physician, ordered that Lance undergo a CT scan of his head. The CT scan report noted that the ventricles in Lance’s brain were “dilated out of proportion,” indicating hydrocephalus. Dr. Blades ordered an MRI, which was reviewed by Dr. Christina Payan, a neuroradiologist – Dr. Payan noted that the MRI also indicated dilation and that the cerebral aqueduct was narrowed. Lance reported that he had contracted encephalitis when he was six years old and also reported three similar “episodes” over the past several months but that he went back to his “baseline” within a matter of hours.

Dr. Gill then referred Lancer to Dr. Victor Kareh, a neurosurgeon, to determine whether Lance had increased intracranial pressure which might require surgery to alleviate. The next morning on Feb. 4, 2010, Lancer did not have any symptoms he presented the previous evening. All of Lance’s cranial nerves exhibited normal functioning and Lance did not have any double vision or swelling of the optic nerve. Dr. Kareh informed Lance that if he had increased intracranial pressure, he might need to have a shunt placed. Dr. Kareh monitored the intracranial pressure over a 24-hour period, which indicated that there was no increased pressure at the time the monitor was placed. Lancer’s intracranial pressure spiked to higher than normal levels on a few occasions but would quickly return to normal on each occasion and he did not experience any periods of sustained intracranial pressure. Dr. Kareh determined that although Lancer had hydrocephalus, he did not have increased intracranial pressure and no shunt was placed. Lancer eventually took a second MRI scan in April. Dr. Gill did not discuss the MRI results with Lance but Lance did undergo an EEG on April 29, 2010 at Dr. Gill’s direction, which came up with normal results. No one informed Dr. Kareh of Lancer’s symptoms or the results of the April MRI scan. On May 2, 2010, Lancer passed away in his sleep after complaining of similar symptoms the day before (sluggishness, slurred speech, etc.). It was determined that Lancer died from complications of blockage of a cerebral aqueduct.

The family of Lancer Windrum (collectively the “Windrums”) filed suit against Dr. Gill, as well as North Cypress Medical Center, North Cypress Medical Center Operating Company, and Dr. Victor Kareh (a neurosurgeon). All defendants settled with Windrum except Dr. Kareh. The case was tried to a jury in Harris County over 10 days. At trial, the Windrums presented a medical expert, Rob G. Parrish, MD, a board-certified neuro-surgeon and neurosurgery instructor at Methodist Hospital in Houston. Dr. Parrish opined that, when Dr. Kareh saw Lancer on Feb. 4, 2010, the applicable standard of care required Dr. Kareh to install a shunt, or a permanent drain, in Lance’s brain to prevent a fatal build-up of cerebrospinal fluid and intracranial pressure. Dr. Parrish also opined on causation issues related to Mr. Windrum’s death. Dr. Parrish also testified that “but for” Dr. Kareh’s negligence, Mr. Windrum would not have died 3 months after being evaluated. Ms. Windrum claimed that her husband’s fatal spike in intracranial pressure would not have happened if Dr. Kareh had installed a shunt or performed a ventriculostomy.

A Harris County district court found Dr. Kareh was negligent and ultimately awarded Ms. Windrum and her children $1.875 million (after applying statutory caps and settlement credits) The Houston Court of Appeals reversed and decided that Dr. Parrish “presented no evidence concerning the standard of care and Dr. Kareh’s breach of the standard of care” so his testimony was “conclusory and, therefore, legally and factually insufficient to support the jury’s verdict.” It also found that Dr. Kareh’s decision not to recommend placement of a shunt in February 2010 was “too remote from Lance’s death on May 2, 2010 to be proximate cause of Lance’s death.”

Dr. Kareh appealed the judgment to the First Court of Appeals in Houston. On appeal, Dr. Kareh raised several issues including a challenge against Dr. Parrish’s testimony on legal insufficiency grounds, contending his testimony was conclusory and thus constituted “no evidence” for the
required standard of care or causation. The Court of Appeals reversed the trial court’s judgment and rendered a take nothing verdict in favor of Dr. Kareh. On a motion for rehearing and request for en banc consideration, the court upheld the Court of Appeals unanimous decision and a majority of the court denied the en banc consideration. Three judges dissented to the denial of en banc consideration, including Justice Brown who contends there are two areas of possible misinterpretation of the majority opinion regarding the standard for an expert’s negligence opinion that is based on experience and/or supporting literature.

The Windrums then appealed to the Texas Supreme Court which has accepted the Petition for Review. The parties submitted full briefing and the Court held oral argument on Oct. 10, 2018. On Nov. 7, 2018, TMA filed its amicus brief in support of Dr. Windrum. On Jan. 25, 2019, the Texas Supreme Court issued its opinion reversing the appellate court decision and remanding the case to the appellate court. The Court concluded the evidence was legally sufficient to uphold the verdict but instructed the appellate court failed to apply the proper standard of review by assessing the “factual sufficiency” of the evidence.

Specifically, Supreme Court concluded that although Dr. Parrish’s testimony concerning the standard of care Dr. Kareh owed to Mr. Windrum and whether Dr. Kareh’s breach of that standard of care caused Mr. Windrum’s death “was hardly supported by medical literature,” it was not conclusory. The Court concluded that a jury could reasonably find Dr. Parrish’s opinion persuasive over other opinions, and that an appellate court cannot substitute its own judgment for the jury’s. Further, the Court concluded that any breach by Dr. Kareh of the standard of care would not be too remote for a reasonable jury to find proximate cause. However, as noted above, the Court remanded the case to the appellate court to conduct a “factual sufficiency” standard of review to the evidence, which is a heavy hurdle. The standard requires the appellate court to detail the evidence relevant to the issue in consideration and clearly state why the jury’s finding is factually insufficient or is so against the great weight and preponderance of the evidence as to be “manifestly unjust,” ” shock the conscience, “or clearly demonstrates bias.

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

On Feb. 26, 2019, TMA filed an amicus brief the Texas Supreme Court in support of Dr. Aleman and urging reversal of a trial court order affirming the Texas Medical Board’s (the “Board”) assessment of an administrative penalty in the amount of $3,000.00 for Dr. Aleman’s alleged violation of the Texas Medical Practice Act (“MPA”).

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

1. failure to submit the electronic signature was not “unprofessional conduct” as intended under the MPA;

2. the alleged violation of Section 193.005(h) of the Health and Safety Code is not related to the practice of medicine for the purpose of the Board’s enforcement jurisdiction but just an unrelated administrative violation;

3. the sanctions the Board imposed were excessive and arbitrary, and were assessed in retaliation for Dr. Aleman not accepting an agreed order relating to the alleged violation; and

4. SOAH lacked jurisdiction over the formal complaint due to the Board’s failure to comply with a certain statutory notice requirement.

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

TMA filed the amicus brief on Feb. 26, 2019, focusing on whether the Board abused its disciplinary powers by imposing sanctions higher than the lower-end sanctions applicable to first-time violators and in excess of the standard sanctions mandated by the Board’s own rules. Specifically, the Board’s rules, 22 Tex. Admin. Code section 190.14, state:

The standard sanctions outlined in paragraph (9) of this section provide a range from “Low Sanction” to “High Sanction” based upon any aggravating or mitigating factors that are found to apply in a particular case. The board may impose more restrictive sanctions when there are multiple violations…or…any aggravating…factors…. The minimum sanctions…are applicable to first time violators…The following standard sanctions shall apply to violations of the Act.

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

<table>
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<tr>
<th>Sanctions</th>
<th>Low</th>
<th>High</th>
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<tr>
<td>Failure to Electronically sign a death certificate under Health and Safety Code Chapter 193</td>
<td>Remedial Plan: 4 hours of ethics/risk management; $500 administration fee</td>
<td>Agreed Order: 8 hours of risk management; 4-8 hours of medical ethics; $2,000 administrative penalty; take the JP exam</td>
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Instead of issuing a low-end sanction, which is “applicable” to first-time violators, the TMB issued the following sanctions: (1) a $3,000.00 administrative penalty; (2) take and pass the Medical Jurisprudence Exam; (3) complete sixteen hours of continuing education (with at least eight hours each in the areas of ethics and risk management); and (4) distribute copies of the Board’s final Order to health care entities where Dr. Aleman has privileges. Notably, this is higher than the maximum sanctions identified for this type of alleged violation—there were no aggravating factors identified in the Board’s Final Order or SOAH’s findings of fact and conclusions of law. During oral argument, TMB argued that the low-end sanction was only
applicable to informal settlement discussions; however, this is not what the plain language of section 190.14 states. The case is currently pending before the Supreme Court.

11. Evelyn Kelly, Individually and on Behalf of the Estate of David Christopher Dunn, v. Houston Methodist Hospital
(Regarding necessity and constitutionality of the Texas Advance Directives Act)

On Oct. 12, 2015, Aditya Uppalapati, M.D., admitted David Christopher Dunn to Houston Methodist with diagnoses of, among other things: end-stage liver disease; the presence of a malignant pancreatic neoplasm with suspected metastasis to the liver; complications of gastric outlet obstruction secondary to his pancreatic mass; hepatic encephalopathy; acute renal failure; sepsis; acute respiratory failure; multi-organ failure; and gastrointestinal bleed.

Shortly after Mr. Dunn’s admission, Dr. Uppalapati advised Dunn’s family that his condition was irreversible and progressively terminal. Mr. Dunn’s treating physicians concluded that he was suffering from the treatment necessary to sustain his life, and with no expectation for improvement, life-sustaining treatment was medically inappropriate for him. As a result, Mr. Dunn’s attending physicians, patient care team recommended to his divorced parents that aggressive treatment measures be withdrawn, and that only palliative or comfort care be provided. The parents disagreed on the recommendation and plan and since Mr. Dunn did not have an advance directive in place, was not married, and had no children, his parents became his surrogate decision makers.

On Oct. 28, 2015, the matter was referred to the Houston Methodist Biomedical Ethics Committee (ethics committee) for consultation, in accordance with the procedures specified by Texas Health and Safety Code §166.046. Over the next days, hospital representatives exhausted efforts to transfer Mr. Dunn to another facility. Testimony demonstrated that 66 separate facilities were contacted by Houston Methodist representatives requesting transfer. Potential transfer facilities were provided with the patient’s demographic information and recent clinical information so a transfer determination could be made. All 66 facilities declined the transfer.

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

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

On Dec. 23, 2015, Mr. Dunn succumbed to his terminal illnesses and passed away. It is undisputed that from the day of his admission until the time of his death Houston Methodist provided continuous life-sustaining treatment to Mr. Dunn. In fact, following his death, Mr. Dunn’s mother wrote, “we would like to express our deepest gratitude to the nurses who have cared for Chris and for Methodist Hospital for continuing life sustaining treatment of Chris until his natural death.”

On Jan 8, 2016, the court lifted the stay and allowed substitution of the parties as Mr. Dunn had passed (allowing Ms. Kelly, Mr. Dunn’s mother, to substitute as the plaintiff). The suit continued and alleged that the statute failed to provide adequate constitutional protections for her son in the process that culminated in the determination by the hospital ethics committee that life-sustaining treatment was medically inappropriate. Specifically, the plaintiff alleges that §166.046 violates procedural due process by: (1) failing to provide the patient or the patient’s decision-maker an opportunity to be heard; (2) failing to provide a reasonable opportunity to prepare for a hearing; (3) failing to provide reasonable notice of the reasons why removal of life-sustaining treatment is to occur; and (4) failure to utilize an impartial tribunal to make the decision to withdraw life-sustaining treatment. The plaintiff also argues that §166.046 violates substantive due process in that it deprives an individual of rights protected under the U.S. Constitution. Among these rights, according to the plaintiff, is the right of the individual to make their own life-related medical decisions.

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

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

D. COMMENTS TO ADMINISTRATIVE AGENCIES

1. Texas Board of Chiropractic Examiners Proposed Rules Concerning the Practice of Acupuncture (1 Tex. Admin. Code § 78.14)

The Texas Board of Chiropractic Examiners proposed rules reaffirming its position that licensed chiropractors may use acupuncture in their chiropractic practices, notwithstanding ongoing litigation on the very issue (see item C.3 above). The proposed rules also make such changes as
no longer requiring a national standardized certification exam in acupuncture in order to perform acupuncture and allowing chiropractors authorized to practice acupuncture to refer to themselves as being “Board Certified in Acupuncture as an adjunctive modality by the Texas Board of Chiropractic Examiners.”

TMA comments in response to the proposed rules took a similar position as its amicus brief in the ongoing litigation. That is, TMA strongly opposed the rules on the basis that the legislature has not authorized chiropractors to use acupuncture. The legislature has prescribed the scope of chiropractic, and it neither includes acupuncture nor treatment of the nervous system or nerves.

The Chiropractic Board adopted the proposed rules to be effective Dec. 5, 2018. The Chiropractic Board disagreed with TMA’s position on all grounds.


The Texas Health and Human Services Commission proposed rules to “clarify the grounds on which HHSC may establish and adjust fees, rates, and charges for Medicaid services.” The propose rule changes actually would remove parts of the rule, TMA would argue, that provide clarity and transparency for the methods behind HHSC’s rate-setting processes.

TMA and other entities including the Texas Pediatric Society, Texas Academy of Family Physicians, American Congress of Obstetricians and Gynecologists - District XI (Texas), and the Texas Association of Obstetricians and Gynecologists, offered comments in response to the proposed rule changes. TMA and the other entities urged HHSC to maintain in rule the guidance that the rules then offered. For instance, TMA urged that the rules direct HHSC to make specific consideration for economic factors that affect physicians and other providers when setting or adjusting Medicaid rates. TMA further commented that HHSC offer a clearer and more comprehensive notice to the public when it proposes to establish or adjust rates.

HHSC adopted the proposed rules to be effective Dec. 26, 2018. HHSC chose to not make any changes to the rules as proposed.

3. Texas Health and Human Services Commission Proposed Rules Concerning Peer Services

The Health and Human Services Commission proposed rules in September 2018 regarding peer services. The rules were in order to implement House Bill 1486, which requires HHSC to include peer support services provided by certified peer specialists in the scope of services under the state Medicaid plan. HHSC had previously solicited comment on a draft version of these rules, in response to which TMA provided comment. See D.19.

TMA commented to encourage HHSC to include this benefit for Medicaid recipients who are at least 18, rather than imposing a 21-year-old limitation in the draft rules. TMA also commented to ensure that a peer specialist’s services were clearly defined in order to ensure patient safety. While peer specialists provide indispensable support for recipients, TMA noted, it is still important for both the peer specialist and the recipient to understand the limitations of those services and to know when the recipient should seek medical assistance from a physician or another professional with more advanced training. TMA finally commented to say that training curricula should include information on legal obligations regarding services provided under occupational licenses.
HHSC adopted these rules in December 2018, making only minimal changes to the rules from the proposed version.


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

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

As of March 2019, HHSC has not taken final action on the proposed rules.


In September 2018, the Texas Medical Disclosure Panel proposed amendments to two forms—the medical and surgical procedures form and the hysterectomy form. The proposed amendments were purportedly in order to make the document more reader-friendly and more readily understandable.

TMA responded with comments in strong opposition to the changes to the medical and surgical procedures form. TMA asserted that those proposed amendments “contain substantive modifications to the form: (1) without any explanation that justifies the need or intent of those modifications and (2) with insufficient consideration of the potential impact of those changes on healthcare liability costs.” TMA expressed concern that there would be serious potential unintended consequences were the proposed changes to be made effective.

The TMDP responded in December 2018 by stating that it would take TMA’s comments under consideration and would republish an amended form for comment in early 2019. TMDP republished these forms in the Feb. 22, 2019 Texas Registrar. TMA is preparing comments.


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

The Texas Medical Association, Texas Orthopaedic Association, Texas Pediatric Society, Texas Society of Anesthesiologists, Texas Association of Obstetricians and Gynecologists, Texas Society of Pathologists, Texas Ophthalmological Association, Texas Radiological Society,
Texas Ambulatory Surgery Center Society responded with joint comments in strong opposition to the proposed changes. TMA’s comments encouraged TDI to maintain the minimum 90-day notice requirement for a variety of reasons, including that the rule is necessary to implement state statute and that it has been a longstanding part of TDI regulations.

As of March 2019, TDI has not taken formal action on the proposed rules.

7. Texas Board of Nursing Proposed Rules on Conformity with the Advanced Practice Registered Nurse Consensus Model

The Texas Board of Nursing proposed rules in October 2018 that would amend the Board’s rules relating to education and licensing requirements for advanced practice registered nurses. The Board stated that the amendments were intended to promote consistency with the Advanced Practice Registered Nurse Consensus Model and national nursing licensing standards.

In comments sent to the Board in response to the proposal, TMA strongly opposed the proposed rules on the basis that the proposed changes would mark a departure from state law. TMA expressed that the Board should be concerned with maintaining consistency with state law rather than the APRN Consensus Model, which advocates for APRNs to undertake roles and tasks that state law does not authorize. The Consensus Model and the Board’s proposed rules mention, for example, an APRN’s authority to diagnose, while state law expressly states that professional nursing does not include acts of medical diagnosis. TMA’s comments encouraged the Board to withdraw the proposed rules.

As of January 2019, the Board has not taken formal action on the proposed rules.

8. Texas Board of Pharmacy Proposed Rules Relating to the Prescription Monitoring Program

The Texas State Board of Pharmacy proposed rule amendments relating to the Prescription Monitoring Program (PMP). The proposed rules implemented changes to the PMP in accordance with legislation passed in 2017.

TMA opposed parts of the proposed rules that would allow the Pharmacy Board to regulate physicians and enforce its rules against physicians. TMA pointed out that the Pharmacy Board was authorized by the legislature to administer, but not enforce, key provisions of the law that require physicians to check the PMP in certain circumstances. TMA further offered support for rules that clarified that using electronic medical records integrated with the PMP satisfies the requirement to check the PMP.

In light of TMA’s comments, the Pharmacy Board in November 2018 revised the proposed rules to remove provisions authorizing the Board’s regulation of physicians.


In September 2018, the Texas Department of Licensing and Regulation proposed rule changes relating to the department’s regulation of lay midwives. Among other things, the proposed rules altered definitions relating to a midwife’s collaboration and consultation with other health care professionals and amended requirements relating to the transfer of care of a patient from a midwife to a physician or another professional.
TMA in conjunction with District XI of the American Congress of Obstetricians and Gynecologists and the Texas Association of Obstetricians and Gynecologists responded with comments in opposition to certain parts of the proposed rule amendments. TMA’s comments encouraged the rules be further amended to clarify the meaning of certain terms, to be internally consistent, and to require transfer or referral to Texas-licensed physicians (as opposed to a physician licensed in any state). TMA further encouraged TDLR to incorporate references to the Global Practice Standards for Midwifery, to require transfer to physicians under certain circumstances, and to require midwives to do more to record their care for patients and to transfer those records when a physician assumes responsibility for the patient.

As of March 2019, the Department has not taken formal action on the proposed rules.


The Texas Board of Nursing proposed rules in September 2018 to implement Senate Bill 1107 (2017), relating to telemedicine medical services. The proposed rules relate to the provision of telemedicine medical services and telehealth services by nurses.

TMA commented to encourage the Board to add needed clarity to the proposed rules. The proposed rules did not, for instance, specify that in order to issue a prescription in conjunction with a telemedicine medical service, an advanced practice registered nurse must first have prescriptive authority under a proper agreement with a physician. TMA encouraged the Board to add this clarification, as well as to add clarification that in order to provide telemedicine medical services, a nurse must be acting under physician delegation and supervision.

As of November 16, 2018, the Board adopted its final rules without making any changes substantive changes.

11. Texas Department of Insurance-Division of Workers’ Compensation Proposed Rules Relating to Designated Doctors

In May 2018, the Texas Department of Insurance-Division of Workers’ Compensation proposed rules relating to the Designated Doctor Program. The proposed rules sought to identify potential solutions for increasing physician participation in the Designated Doctor program so that injured employees with the most serious injuries will have access to physicians with the highest level of training.

TMA supported some parts of the proposed changes that addressed areas that cause some physician participations frustration with the program. TMA also expressed concern that some parts of the proposed rule changes could be misconstrued with respect to other non-physician health care providers who participate in the program. TMA finally encouraged DWC to make changes with respect to board certification requirements, stating that DWC should be mindful of recently enacted legislation that prohibits differentiating among physicians on the basis of maintenance of board certification.

In October 2018, the DWC adopted the proposed rules without making any substantive changes.

In December 2018, the Texas Medical Board proposed rules relating to its regulation of certified medical radiological technicians and noncertified technicians. The proposed changes made more significant changes to the regulation of noncertified technicians (NCTs).

TMA commented in response to these proposed rules, and its comments focused on regulations relating to NCTs. TMA explained that a physician’s use of NCTs is an effective way to meeting high clinical demands while managing costs of providing services to patients, and thus encouraged the TMB to simply its regulation of and training requirements applicable to NCTs. This included eliminating the requirement in the proposed rules for NCTs to pass the jurisprudence exam, and ensuring that the application and approval procedures are easy, transparent, and efficient.

As of March 2019, the Board has not taken formal action on the proposed rules.

13. **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 the TMB to clarify on TMB’s website and complaint form that the Board has cease and desist authority to enforce unauthorized practice of medicine.

As of February 2019, the TMB has not responded to TMA’s comments.


In November 2018, the Health and Human Services Commission proposed rules changes relating to supplemental payments to eligible teaching hospitals owned and operated by non-state governmental entities. HHSC further solicited comment regarding expanding funding to hospitals owned by non-governmental entities.

TMA commented to express support of adequate funding for graduate medical education (GME) and expanding the state’s GME capacity. TMA expressed the need to increase the state’s physician workforce concomitant with population growth through the training of residents in the state and the need for an adequate number of GME positions to ensure the increasing number of Texas medical school graduates have a reasonable opportunity to remain in the state for training. TMA thus supported HHSC’s expanded supplemental payments and further expressed support for possible expansion of payment to non-governmental hospitals.

As of Jan. 25 2019, HHSC finalized its proposed rules and expanded funding to non-state government-owned and operated teaching hospitals. No update has been made regarding hospitals owned by non-governmental entities. TMA staff will monitor.

In November 2018, the Texas Department of Insurance-Division of Workers’ Compensation (DWC) proposed rule amendments in response to recently enacted legislation relating to special provisions for administrative penalties.

TMA commented that this rule change could impact physicians. TMA encouraged DWC to ensure that the rule changes were in line with the intent of the enacted legislation, including that compliance with a sanction should not be imposed until after an order becomes final and unappealable, and that the rule changes were internally consistent so the rule clearly stated obligations for compliance.

As of Jan. 11, 2019, DWC finalized these proposed rules. DWC incorporated TMA’s recommended changes.


The Health and Human Services Commission in December 2018 proposed rule changes that would serve to inform stakeholders and Laboratory Services Section (LSS) customers that future changes to the public fee schedule would be posted on the LSS website. In response to these proposed changes, TMA submitted comments in support of the intent to increase transparency of fee changes. TMA further recommended that the department provide automatic email notification of changes to the fee schedule through an email subscription management system. TMA recommended that automatic notices should be of final and adopted changes as well as the proposed changes. TMA asserted that these changes would more properly effectuate the department’s goals.

As of March 2019, the commission has not finalized these proposed rule changes.

17. **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 meeting 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.

As of February 2019, HHSC has not responded to TMA’s letter.

In January 2019, the Texas State Board of Pharmacy proposed rules that authorized pharmacists to provide “medication therapy management (MTM) services” in certain pharmacies. TMA commented to express strong opposition to the proposed rules because the rules were not clearly articulated and would result in pharmacists providing medication-related services outside the scope of their practice as defined by state law.

TMA pointed out that there was no statutory basis for a pharmacist’s provision of MTM services and so the extent to which a pharmacist could be authorized to do so under state law was not clear. It was not clear particularly because the proposed rules articulated a scope of MTM services that was very broad.

TMA pointed out that under Medicare, there were much more clearly defined boundaries for MTM services, and Medicare policies also heavily stressed the collaborative nature of MTM services between a physician and a pharmacist. TMA noted that the Board of Pharmacy’s rules should more heavily emphasize this collaborative relationship and ensure that a patient’s physician was involved in any MTM services provided.

TMA encouraged the Board of Pharmacy to wait for authorizing legislation before moving forward with proposed rules, but also provided possible amendments to the proposed rule to ensure that MTM services were provided within a pharmacist’s scope of practice and also were provided on a collaborative basis with a patient’s physician.

As of February 2019, the Board of Pharmacy has withdrawn these proposed rules.


In January 2019, the Texas Medical Board proposed rules relating to a physician’s delegation of authority. In the first set of changes, the 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 the 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 the 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 the 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, the TMB has not finalized these proposed rules. Prior to the submission of TMA’s comments, the TMB did notify TMA that it would be holding a stakeholders meeting on the second set of rules relating to delegation of radiological procedures, but the timing for that meeting has yet to be determined.

20. Texas Department of Insurance Proposed Rules Relating to Utilization Review

In January 2019, the Texas Department of Insurance proposed rules concerning notice of determinations made in utilization review and written procedures for appeals of adverse determinations by utilization review agents. Specifically, the rules would require expedited appeals for denials of prescription drugs or intravenous infusions for which an enrollee is receiving benefits under the health insurance policy, and adverse determinations of a step therapy protocol exception request under Insurance Code §1369.0546.

TMA commented to express strong support for the changing, noting that the rule changes would be in line with recently enacted legislation. TMA stated that the proposed amendment would aid the regulated community and enrollees in understanding statutory requirements for expedited appeals, thereby increasing the value of important consumer protections in law.

As of March 2019, TDI has not finalized the proposed rule changes.


In April 2018, the Health and Human Services Commission 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 March 2019, HHSC has not officially proposed these rules. TMA staff will continue to monitor the progress of these rules.

22. Texas Office of Inspector General Solicitation for Feedback on the IG’s Determination of Administrative Actions or Sanctions

In May 2018, the Texas Office of the Inspector General 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). 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.

TMA staff is monitoring any further development of what may be amendments to these rules.


In June 2018, the Health and Human Services Commission released and solicited comments on draft rule regarding peer services. The draft rules were in order to implement House Bill 1486, which requires HHSC to include peer support services provided by certified peer specialists in the scope of services under the state Medicaid plan.

TMA commented to encourage HHSC to include this benefit for Medicaid recipients who are at least 18, rather than imposing a 21-year-old limitation in the draft rules. TMA also commented to ensure that a peer specialist’s services were clearly defined in order to ensure patient safety. While peer specialists provide indispensable support for recipients, TMA noted, it is still important for both the peer specialist and the recipient to understand the limitations of those services and to know when the recipient should seek medical assistance from a physician or another professional with more advanced training.

HHSC has proposed and adopted rules concerning peer services. See D.27.


The Texas Board of Nursing proposed rules in June 2018 in response to Senate Bill 507, which amended the state’s out-of-network health benefit claims mediation process. The proposed rules would implement changes made by that legislation in order to apply to the board’s licensees.

TMA provided comment in order ensure that the rules properly and accurately followed the underlying legislation in order to avoid confusion among licensing boards whose licensees would be subject to the legislation. This included encouraging the board to make it clear that its rules did not apply to any licensee regulated by another state agency.

In August 2018, the board finalized its proposed rules. The board did accept some of TMA’s suggested changes in its final adopted rule.


The Texas Medical Board proposed rules in July 2018 to amend its rules on out-of-network claims mediation in response to Senate Bill 507 enacted in 2017. In large part, the proposed amended rules closely followed changes made by that legislation.

TMA provided comment to encourage the TMB to add clarity on a few points, including ensuring that the appropriate advisory boards were properly identified, that the applicability of certain
provisions of the rules was limited to only out-of-network facility based providers, and to ensure that required notice provisions applied only to claims eligible for mediation under Chapter 1467 of the Insurance Code.

TMB held a stakeholder meeting on Aug. 24, 2018 to discuss adoption of proposed rule amendments and rule review to 187.87-89. As of March 4, 2019, the proposed changes are still withdrawn.


In June 2018, the Health and Human Services Commission published rules authorizing nurse practitioners and physician assistants to make medical necessity determinations for hearing aids “under physician delegation.” TMA and the Texas Association of Otolaryngology commented to encourage HHSC to amend the proposed rules to clarify that these medical necessity determinations should be done under physician delegation and supervision. TMA stated that this amendment would clarify that these allied health professionals must be under a physician’s supervision when making medical necessity determinations and would thus be consistent with state law.

HHSC adopted these rules to be effective Nov. 20, 2018. HHSC declined making the amendment and stated that the amendments as proposed reinforce the physician’s ability to delegate tasks.

27. Texas Health and Human Services Commission Proposed Rules Concerning the Office of Ombudsman (1 Tex. Admin. Code Chapter 87)

In June 2018, the Health and Human Services Commission published rules relating to the HHSC’s Office of Ombudsman (OO). The rules would organize the OO into different divisions with different emphases. The roles would generally be to solicit and receive complaints from consumers relating to services provided by HHSC.

TMA provided comment for two general purposes: to ensure that, as authorized in underlying statute, physicians and other health care providers could play a role in the fulfillment of the mission of the OO, and to ensure that physicians could interact with the OO in a manner that is compliant with applicable privacy laws and regulations.

Underlying statute suggests that HHSC’s OO could solicit and receive feedback from any interested party who would raise a matter within the HHS system, but the proposed rules did not seem to include physicians in the OO’s function. TMA noted that physicians have a unique and important perspective on services provided within the HHS system, and that physicians should also be permitted to take advantage of the outlet that the OO would provide. TMA further suggested that HHSC make it clear providing information to the OO would not be a violation of privacy laws and regulations.

As of Jan. 11, 2019, HHSC finalized these proposed rules. HHSC accepted some of TMA’s proposed recommendations on privacy laws and regulations.


In June 2018, the Texas State Board of Pharmacy proposed rules intended to provide to pharmacists guidance for considerations to make when determining the legitimacy of a
prescription. This guidance was in the form of a list of “red flag factors” that a pharmacist was to observe and consider in order to reduce the incidence of drug abuse and diversion.

TMA along with the Texas Pain Society and the Texas Orthopaedic Association noted problems with these factors in comments submitted to the board. The comments recognized that while the red flag factors had a noble purpose, TMA was concerned that the proposed rules undermined the shared responsibility between physicians and pharmacists, and also that the rules were drafted so vaguely that they may cause pharmacists to erroneously reject legitimate prescriptions. The comments went through many of the listed red flag factors and pointed out how a factor either unjustifiably scrutinized the prescriber’s actions or the prescriber themselves, or how the factor was so vague that it risked including many legitimate prescriptions.

TMA, TPS, and TOA thus encouraged the Pharmacy Board to postpone adoption of the rules to allow for a stakeholder forum where prescribers and pharmacists could together articulate factors and indicators for which both populations could monitor.

In response to the submitted comments, Pharmacy Board staff proposed some amendments to the initially proposed version and solicited TMA feedback. In response, TMA and TPS submitted written comments which again pointed out flaws in even the revised factors. To be sure, the revisions made incremental improvements, but, according to TMA comments, the factors still placed too much blame on prescribers and would risk capturing legitimate prescriptions.

In August 2018, the Pharmacy Board made some other small changes in response to TMA’s second round of comments, and ultimately adopted the rules with revisions without holding a stakeholder meeting.
REPORT OF BOARD OF TRUSTEES

BOT Report 5-A-19

Subject: Investments

Presented by: Diana L. Fite, MD, Chair

TMA and Separate Fund Investments
Members of the TMA Board of Trustees serve as trustees or as the board of trustees for two library funds, two student loan funds, one student and resident loan fund, the Physicians Benevolent Fund, and the TMA Special Funds Foundation. The investment portfolios for TMA, and for the funds for which members of the TMA Board of Trustees serve as trustees or as the board of trustees, are invested by the Board of Trustees by way of designated investment managers. The board acts on recommendations of its Investments Committee, which meets three times a year. The committee and the board review quarterly reports from: TMA’s equity investment manager, Luther King Capital Management; TMA’s fixed income investment manager, Vaughan Nelson Investment Management, LP; and TMA’s international stock fund managers, Dodge & Cox. The board establishes investment performance objectives for the investment portfolios of TMA and seven separate funds, and sets policy for the mix of investment media (equities, fixed income, alternative mutual funds, and cash equivalents).

TMA’s investments monitor is The Quantitative Group at Graystone Consulting, and the board’s Investments Committee meets with W. Joseph Sammons, senior vice president, and Ronald Kern, executive director. The Quantitative Group is the investment monitor for TMA funds and all funds TMA manages. The committee and the board review quarterly composite reports prepared by The Quantitative Group.

The Dec. 31, 2018, net assets of the funds managed by these investment managers were reported as follows: TMA, $29,443,359; Texas Medical Association Library, $2,440,883; Annie Lee Thompson Library Trust Fund, $3,228,039; May Owen Irrevocable Trust, $2,926,728; Dr. S.E. Thompson Scholarship Fund, $5,667,946; Physicians Benevolent Fund, $4,047,574; and Texas Medical Association Special Funds Foundation, $2,436,824.

Dec. 31, 2018, Investment Manager Performance Report
Since Dec. 31, 1993, the composite annualized performance for all equity investments has been 8.04 percent versus the equity composite index annualized rate of return of 8.63 percent. The one-year rate of return was -8.74 percent versus the equity composite index return of -6.66 percent. Equity investment allocation by manager is approximately 54 percent at Luther King Capital Management, 40 percent in iShares blended mutual funds, 4 percent in Dodge & Cox International Stock Fund, and 2 percent in the Invesco Developing Markets mutual fund.

Fixed income investment manager Vaughan Nelson Investment Management achieved a 5.23 percent annualized return versus the Barclays Aggregate annualized return of 5.34 percent for the period of June 30, 1992, through Dec. 31, 2018. The one-year rate of return was 0.64 percent versus the index return of 0.01 percent. Fixed income investment allocation by manager is approximately 51 percent at Vaughan Nelson, 23 percent in the Metropolitan West Intermediate Bond Fund, 13 percent in the JP Morgan Strategic Income Bond Fund, and 13 percent in the FPA New Income Bond Fund.

Alternative mutual fund investments have experienced an annualized return of -4.05 percent versus the HFRI Fund of Funds Composite Index annualized return of 1.50 percent for the three-year period through Dec. 31, 2018. The one-year rate of return was -10.52 percent versus the benchmark return of -4.43 percent. Alternatives investment allocation by manager is 100 percent in the FPA Crescent Fund.
REPORT OF BOARD OF TRUSTEES

BOT Report 6-A-19

Subject: Audit of 2017 Financial Statements and 2018-19 Operating Budgets

Presented by: Diana L. Fite, MD, Chair

**Audit of 2017 Financial Statements**
The *Audit of 2017 Financial Statements* report was presented to the TMA Board of Trustees at its Sept. 28, 2018, meeting. Independent auditor Holtzman Partners, LLP, determined that 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.

**2018 Operating Budget**
For 2018, operating income was $26,251,818 and operating expenses were $26,404,429. At year-end, total actual operating income for the year exceeded the budgeted operating income by $23,708 (0.09 percent). Total actual operating expenses were over budget by $176,319 (0.67 percent), resulting in an actual net operating deficit of $152,611. This actual net operating deficit was greater than the budgeted net operating deficit by $152,611. An unaudited report on 2018 operations is attached.

The *Audit of 2018 Financial Statements* report by Holtzman Partners, LLP, will be completed and presented to the Board of Trustees at its 2019 fall meeting. The board will present the audit reports to the House of Delegates in 2020.

**2019 Operating Budget**
In November 2018, the Board of Trustees approved a 2019 operating budget projecting an income of $26,611,060 and expenses of $26,611,060, with a 2019 capital expenditure budget of $477,000. The operating budget will be presented to the house by Board of Trustees Chair Diana Fite, MD. The board also approved direct financial support of related organizations in 2019 as follows: TEXPAC request for support totaling $373,080; TMA Alliance request for support totaling $259,670; TMA Foundation request for support totaling $115,000; and Association Management Services request for support totaling $1,197,950. Offsetting these expenses are: projected 2019 TMA special society administration fees totaling $1,172,250; corporate contributions of $50,000 to TEXPAC; and $15,000 in grant revenue received for TMA Foundation programming.

The 2019 expense budget of $26,611,060 represents an increase of $382,950 from the final 2018 expense budget. Supporting this expense budget is a projected income budget of $26,611,060. This represents an increase of $382,950 from the final 2018 income budget of $26,228,110. As a result, a break-even budget is projected for 2019.

The 2019 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 2019 Operating Budget adopted by the board is as follows:
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<tr>
<th>Income</th>
<th>Total Income</th>
<th>Building Fund Income</th>
<th>Actual Income</th>
<th>Budgeted Income</th>
<th>Variance</th>
<th>% Variance</th>
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<tr>
<td>Advocacy and Public Policy</td>
<td>79,522</td>
<td>79,522</td>
<td>60,000</td>
<td>19,522</td>
<td>32.54%</td>
<td></td>
</tr>
<tr>
<td>Legal</td>
<td>27,681</td>
<td>27,681</td>
<td>30,600</td>
<td>(2,919)</td>
<td>(9.54%)</td>
<td></td>
</tr>
<tr>
<td>Boards, Councils, Committees</td>
<td>23,476</td>
<td>23,476</td>
<td>0</td>
<td>23,476</td>
<td>0.00%</td>
<td></td>
</tr>
<tr>
<td>Information Systems</td>
<td>19,000</td>
<td>19,000</td>
<td>19,000</td>
<td>0</td>
<td>0.00%</td>
<td></td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td><strong>$26,370,331</strong></td>
<td><strong>$118,513</strong></td>
<td><strong>$26,251,818</strong></td>
<td><strong>$26,226,110</strong></td>
<td><strong>$23,708</strong></td>
<td><strong>0.90%</strong></td>
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<table>
<thead>
<tr>
<th>Expense</th>
<th>Total Expense</th>
<th>Building Fund Expense</th>
<th>Actual Expense</th>
<th>Budgeted Expense</th>
<th>Variance</th>
<th>% Variance</th>
</tr>
</thead>
<tbody>
<tr>
<td>Communications</td>
<td>$2,866,193</td>
<td>$2,866,193</td>
<td>$2,950,220</td>
<td>(83,775)</td>
<td>-2.97%</td>
<td></td>
</tr>
<tr>
<td>Organizational Support Activities</td>
<td>4,560,769</td>
<td>4,560,769</td>
<td>4,280,500</td>
<td>272,269</td>
<td>6.35%</td>
<td></td>
</tr>
<tr>
<td>Building Operations</td>
<td>2,256,472</td>
<td>2,256,472</td>
<td>2,232,820</td>
<td>23,652</td>
<td>1.06%</td>
<td></td>
</tr>
<tr>
<td>Related Organizations</td>
<td>2,031,792</td>
<td>2,031,792</td>
<td>1,963,050</td>
<td>68,742</td>
<td>3.50%</td>
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</tr>
<tr>
<td>Legal</td>
<td>1,282,860</td>
<td>1,282,860</td>
<td>1,306,510</td>
<td>(22,651)</td>
<td>(1.75%)</td>
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<tr>
<td>Advocacy and Public Policy</td>
<td>2,215,896</td>
<td>2,215,896</td>
<td>2,331,160</td>
<td>(115,264)</td>
<td>(4.94%)</td>
<td></td>
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<tr>
<td>TexMed and Conferences</td>
<td>1,754,532</td>
<td>1,754,532</td>
<td>1,664,010</td>
<td>100,522</td>
<td>6.08%</td>
<td></td>
</tr>
<tr>
<td>Depreciation</td>
<td>1,162,144</td>
<td>1,162,144</td>
<td>1,116,900</td>
<td>45,244</td>
<td>4.05%</td>
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<tr>
<td>Health Policy - Regulation</td>
<td>1,070,176</td>
<td>1,070,176</td>
<td>1,066,760</td>
<td>3,416</td>
<td>0.32%</td>
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<tr>
<td>Information Systems</td>
<td>1,843,917</td>
<td>1,843,917</td>
<td>1,723,050</td>
<td>120,867</td>
<td>7.01%</td>
<td></td>
</tr>
<tr>
<td>Membership Recruitment &amp; Retention</td>
<td>2,305,334</td>
<td>2,305,334</td>
<td>2,226,650</td>
<td>78,684</td>
<td>3.53%</td>
<td></td>
</tr>
<tr>
<td>Marketing and Member Services</td>
<td>865,494</td>
<td>865,494</td>
<td>945,720</td>
<td>(80,226)</td>
<td>(8.92%)</td>
<td></td>
</tr>
<tr>
<td>Public Health - Quality - Science</td>
<td>1,038,424</td>
<td>1,038,424</td>
<td>953,580</td>
<td>84,844</td>
<td>8.90%</td>
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</tr>
<tr>
<td>Boards, Councils, Committees</td>
<td>449,880</td>
<td>449,880</td>
<td>483,390</td>
<td>(33,510)</td>
<td>(6.93%)</td>
<td></td>
</tr>
<tr>
<td>Medical Education</td>
<td>462,434</td>
<td>462,434</td>
<td>475,650</td>
<td>(13,216)</td>
<td>(2.78%)</td>
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</tr>
<tr>
<td>Educational Programs</td>
<td>248,473</td>
<td>248,473</td>
<td>503,500</td>
<td>(255,027)</td>
<td>(50.65%)</td>
<td></td>
</tr>
<tr>
<td><strong>Total Expense</strong></td>
<td><strong>$26,404,429</strong></td>
<td><strong>$0</strong></td>
<td><strong>$26,404,429</strong></td>
<td><strong>$26,226,110</strong></td>
<td><strong>$176,319</strong></td>
<td><strong>0.67%</strong></td>
</tr>
</tbody>
</table>

| Net Income (Loss)              | $ (34,098)   | $ 118,513            | $ (152,611)    | $ 0             | (152,611) |
| Realized Investment Gain (Loss)| 1,598,153    | 224,158              | 1,373,995      | $ (34,158)      | $ (34,158) |
| Unrealized Gain (Loss) on Investments | (3,677,395) | (628,123)            | (3,049,262)    |               |           |
| Other Gain (Loss)              | (18,327)     | (18,327)             |               |                |           |
| **Net Balance**                | **$ (2,131,657)** | **$ (285,452)**       | **$ (1,846,205)** | **$ (1,846,205)** | **$ (0.67%)** |
## Texas Medical Association
### 2019 Operating Budget

<table>
<thead>
<tr>
<th></th>
<th>2019 Budget</th>
<th>2018 Budget</th>
<th>Change</th>
<th>% of Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Income</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Membership Recruitment and Retention</td>
<td>$16,800,000</td>
<td>$16,550,000</td>
<td>$250,000</td>
<td>1.5%</td>
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<tr>
<td>Marketing and Member Services</td>
<td>3,571,220</td>
<td>3,606,270</td>
<td>(35,050)</td>
<td>(1.0%)</td>
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<td>Building Operations</td>
<td>1,642,960</td>
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<td>86,910</td>
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<td>Related Organization Support</td>
<td>1,237,250</td>
<td>1,237,250</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Organization and Support Activities</td>
<td>928,220</td>
<td>904,960</td>
<td>23,240</td>
<td>2.6%</td>
</tr>
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<td>Communications</td>
<td>832,050</td>
<td>833,050</td>
<td>(1,000)</td>
<td>(0.1%)</td>
</tr>
<tr>
<td>Educational Seminars and Publications</td>
<td>579,400</td>
<td>534,400</td>
<td>45,000</td>
<td>8.4%</td>
</tr>
<tr>
<td>Conferences</td>
<td>421,000</td>
<td>421,000</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Information Technology</td>
<td>228,960</td>
<td>228,960</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Medical Education</td>
<td>201,500</td>
<td>185,050</td>
<td>15,450</td>
<td>8.3%</td>
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<tr>
<td>Public Health - Quality - Science</td>
<td>79,500</td>
<td>79,500</td>
<td>0</td>
<td>0.0%</td>
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<tr>
<td>Advocacy and Public Policy</td>
<td>60,000</td>
<td>60,000</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Legal</td>
<td>29,000</td>
<td>30,600</td>
<td>(1,600)</td>
<td>(5.2%)</td>
</tr>
<tr>
<td></td>
<td>$26,611,060</td>
<td>$26,228,110</td>
<td>$382,950</td>
<td>1.5%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Expense</strong></th>
<th></th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Organization and Support Activities</td>
<td>$3,279,290</td>
<td>$3,586,420</td>
<td>(307,130)</td>
<td>(8.6%)</td>
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<tr>
<td>Membership Recruitment and Retention</td>
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<td>2,889,380</td>
<td>277,330</td>
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<tr>
<td>Communications</td>
<td>3,016,290</td>
<td>2,985,670</td>
<td>30,620</td>
<td>1.0%</td>
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<tr>
<td>Advocacy and Public Policy</td>
<td>2,376,570</td>
<td>2,348,100</td>
<td>28,470</td>
<td>1.2%</td>
</tr>
<tr>
<td>Building Operations</td>
<td>2,278,940</td>
<td>2,232,820</td>
<td>46,120</td>
<td>2.1%</td>
</tr>
<tr>
<td>Related Organization Support</td>
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<tr>
<td>Conferences</td>
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<td>(10.2%)</td>
</tr>
<tr>
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</tr>
<tr>
<td>Marketing and Member Services</td>
<td>1,347,330</td>
<td>1,363,400</td>
<td>(16,070)</td>
<td>(1.2%)</td>
</tr>
<tr>
<td>Information Technology</td>
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<td>57,860</td>
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</tr>
<tr>
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<td>953,580</td>
<td>180,810</td>
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</tr>
<tr>
<td>Health Policy - Regulation</td>
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<td>1,069,230</td>
<td>(13,950)</td>
<td>(1.3%)</td>
</tr>
<tr>
<td>Depreciation on Furniture and Equipment</td>
<td>628,900</td>
<td>584,800</td>
<td>44,100</td>
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</tr>
<tr>
<td>Depreciation on Building</td>
<td>567,100</td>
<td>532,100</td>
<td>35,000</td>
<td>6.6%</td>
</tr>
<tr>
<td>Boards, Councils and Committees</td>
<td>522,390</td>
<td>483,390</td>
<td>39,000</td>
<td>8.1%</td>
</tr>
<tr>
<td>Educational Seminars and Publications</td>
<td>508,150</td>
<td>503,500</td>
<td>4,650</td>
<td>0.9%</td>
</tr>
<tr>
<td>Medical Education</td>
<td>492,390</td>
<td>475,650</td>
<td>16,740</td>
<td>3.5%</td>
</tr>
<tr>
<td></td>
<td>$26,611,060</td>
<td>$26,228,110</td>
<td>$382,950</td>
<td>1.5%</td>
</tr>
</tbody>
</table>

**Net Budget Surplus**

$ 0 $ 0 $ 382,950 1.5% 100.0%
Texas Medical Association Bylaws provide that the board shall organize by electing a chair, a vice chair, and a secretary, and that the chair shall appoint committees as needed. In May 2018, the board elected Diana L. Fite, MD, as chair; E. Linda Villarreal, MD, as vice chair; and Gary W. Floyd, MD, as secretary. Keith A. Bourgeois, MD, and G. Ray Callas, MD, were elected to fill the at-large positions on the board’s executive committee. Ex officio members of the board’s executive committee are the chair and vice chair of the board and the president of the association, Douglas W. Curran, MD. The board also welcomed Lindsay K. Botsford, MD, as the young physician member for 2018-20, and William Estes as the medical student member for 2018-19.

Board committees for 2018-19 are:

- **Investments** (Dr. Floyd, chair; Michelle A. Berger, MD; Dr. Bourgeois; Dr. Callas; Dr. Curran; Dr. Fite; David C. Fleeger, MD; Richard W. Snyder, MD; Dr. Villarreal; and TMA Foundation liaison Craig Norman, RPh),
- **Educational Scholarship and Loan** (Sue S. Bornstein, MD, chair; Carlos J. Cardenas, MD; Dr. Fite; Jayesh B. Shah, MD; Joseph S. Valenti, MD; Arlo F. Weltge, MD; Justin M. Bishop, MD; Mr. Estes; Dr. S.E. Thompson Scholarship Fund Trustee Raymond S. Greenberg, MD; Medical Student Section (MSS) representative Jordan McKinney; MSS alternate representative Joseph Camarano; and TMA Alliance representatives Pam Abernathy and James P. Davis), and
- **Finance** (Dr. Berger, chair; Dr. Botsford; Dr. Fleeger; Dr. Floyd; Dr. Shah; and Dr. Valenti).

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

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

J. Marvin Smith III, MD, chairs the board’s History of Medicine Committee. Members are Joel S. Dunnington; Mark J. Kubala, MD; Mellick Sykes, MD; Mac Sykes, MD; Margaret Vu grin, MSLS, AHIP; and J. Patrick Walker, MD. J.J. Waller, MD, serves as the TMA Alliance representative; George Parker as the MSS representative; and Colleen O’Neill as the MSS alternate representative.

The TMA board also appoints the *Texas Medicine* Editorial Board. Owen E. Winsett, MD, chairs the board. Members are Chelsea I. Clinton, MD; Christopher J. Garrison, MD; John C. Jennings, MD; Roger S. Khetan, MD; Charlotte H. Smith, MD; Gary Ventolini, MD; and Alexis A. Wiesenthal, MD. Vastal Patel, MD, serves as the Resident and Fellow Section representative and Pranati Pillutla as the MSS representative.
REPORT OF BOARD OF TRUSTEES

BOT Report 8-A-19

Subject: Medical Student and Resident Physician Loan Funds

Presented by: Diana L. Fite, MD, Chair

TMA Board of Trustees members serve as trustees or as members of the boards of trustees for five student loan funds: Dr. S.E. Thompson Scholarship Fund, May Owen Irrevocable Trust, Texas Medical Association Alliance Student Loan Fund, and, through the TMA Special Funds Foundation, Durham Student Loan Fund and Medical Student Loan Fund. From July 1 through Dec. 31, 2018, 64 loans totaling $270,500 were disbursed from the five funds, and additional applications remain in process.

The Dr. S.E. Thompson Scholarship Fund and the Patricia Lee Palmer, MD, Memorial Resident Loan Fund offer loans to resident physicians. Four resident loans totaling $18,000 were disbursed from July 1 through Dec. 31, 2018.

In January 2019, the board approved allocations for the 2019-20 school year totaling $561,000, including $38,000 for residents. The loan allocations to the 13 medical schools are based on availability of funds and the history of each school’s utilization.
The TMA Minority Scholarship Program has given one hundred and one (101) $5,000; thirty-four (34) $10,000; and one (1) $2,500 scholarships to underrepresented minority medical students in Texas since it was established in 1998. Twelve Texas medical schools have received an award, and the rotation schedule will continue as funds are available. As of Jan. 25, 2019, the TMA Foundation has collected $6,000 in cash and pledges for the 2019 scholarships. All shortfalls will be covered by 2016 donations received from two private donors: Robert J. Bayardo, MD, and Patrick Leung, MD.

This year, the program will award thirteen (13) $10,000 scholarships to students matriculating at Texas Tech University Health Sciences Center School of Medicine, Texas A&M College of Medicine, Texas Tech University Health Sciences Center Paul L. Foster School of Medicine, UT Southwestern Medical School, UT Health San Antonio Long School of Medicine, The University of Texas Medical Branch School of Medicine, Baylor College of Medicine, McGovern Medical School at UTHealth, University of North Texas Health Science Center at Fort Worth Texas College of Osteopathic Medicine, The University of Texas at Austin Dell Medical School, The University of Texas Rio Grande Valley School of Medicine, The University of the Incarnate Word School of Osteopathic Medicine, and the new Texas Christian University School of Medicine. The TMA Office of Trust Fund Administration must have received candidate applications by Feb. 23, 2019. TMA will notify scholarship recipients in April and make the presentation ceremony at TexMed 2019 on May 17 in Dallas.

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), few have altered their financial aid policies to reestablish minority-specific programs. This leaves the TMA scholarship program as one of the few available in the state for underrepresented minority students seeking a career in medicine. Title VI restrictions generally do not apply to private scholarship programs when not administered by an academic institution.
Subject: Revision of Section 165.155(a) of the Texas Occupations Code, Res. 105-A-18

Presented by: Diana L. Fite, MD, Chair

At the 2018 Annual Session, the House of Delegates referred Resolution 105-A-18, Revision of Section 165.155(a) of the Texas Occupations Code, Solicitation of Patients (Bexar CMS), to the TMA Board of Trustees for decision. That resolution’s resolve clause states:

That the Texas Medical Association work to pass legislation that would rewrite Section 165.155 of the Texas Occupations Code, in particular, part (a) of the section, in order to eliminate the great potential for selective regulatory abuse, to eliminate any competitive burdens that are now placed on some groups of physicians, and to eliminate the present situation where physicians are unknowingly breaking the law.

As the house referred Resolution 105-A-18 to the board “for decision,” the board has 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.

According to Parker v. Texas Medical Association, an “unreported” case, the purpose of Section 165.155 of the Texas Occupations Code is to prohibit physicians from paying for or rewarding referrals. This statutory provision states:

Sec. 165.155. SOLICITATION OF PATIENTS; PENALTY.

a) A physician commits an offense if the physician employs or agrees to employ, pays or promises to pay, or rewards or promises to reward any person, firm, association, partnership, or corporation for securing or soliciting a patient or patronage.

b) Each payment, reward, or fee or agreement to pay or accept a reward or fee constitutes a separate offense.

c) A physician commits an offense if the physician accepts or agrees to accept a payment or other thing of value for securing or soliciting patronage for another physician.

d) This section does not prohibit advertising except that which:
   (1) is false, misleading, or deceptive; or
   (2) advertises professional superiority or the performance of professional service in a superior manner and which is not readily subject to verification.

e) An offense under this section is a Class A misdemeanor.

It is important to note that the above-referenced statutory provision addresses both payments for referrals and fee splitting. Each of these topics has ethical implications and, accordingly, has been the subject of ethics opinions by both the TMA Board of Councilors and the AMA Council on Ethical and Judicial Affairs. (See ethics opinions below.)

Under the TMA Constitution and Bylaws, the Board of Councilors has jurisdiction over questions pertaining to medical ethics. Article VII of the TMA Constitution states that all questions of medical ethics shall be referred to this board, as provided in the bylaws. TMA Bylaw 3.721 specifies that “all questions pertaining to medical ethics shall be referred to the Board of Councilors without debate.”
Resolution 105 was debated by the TMA House of Delegates at TexMed 2018 because it was drafted with legislative directives; however, as its subject matter (1) is closely tied to medical ethics, and (2) implicates current TMA Board of Councilors ethics opinions and TMA Bylaws provisions regarding fee splitting, the Board of Trustees approved a recommendation to refer Resolution 105-A-18 to the Board of Councilors.

The jurisdiction of the Board of Councilors on this topic is reinforced by TMA Bylaw 15.30, which provides that “It shall be considered unprofessional and unethical to engage in the practice commonly known as ‘fee splitting’ in any of its forms as defined by the Board of Councilors” (emphasis added).

TMA Board of Councilors’ Ethics Opinions:

FEE SPLITTING. Payment by or to a physician for the referral of a patient is fee splitting and is improper. The payment for referrals violates the requirement to deal honestly with patients and colleagues. The patient relies upon the advice of the physician on matters of referral. All referrals and prescriptions must be based on the skill and quality of the physician to whom the patient has been referred or the quality and efficacy of the drug or product prescribed.

HEALTH FACILITY OWNERSHIP, INCENTIVE PAYMENTS AND CONFLICTS OF INTEREST.

It is not unethical, as a general rule, for a physician to own or have a financial interest in a for-profit hospital, nursing home, or other health facility, such as a free-standing surgical center or emergency clinic, even where the physician refers patients to such facility. The Board of Councilors recognizes that many health care facilities would not exist and that many medical services would not be available to patients except for the fact that responsible physicians invested in these facilities and services, thereby rendering a valuable public service. Such actions are consistent with the Principle of Medical Ethics that physicians recognize an ethical responsibility to participate in activities contributing to an improved community. However, when the holding of such business interests is influenced more by profit motive than appropriate patient care, such actions are unethical.

However, due to the potential for abuse of such arrangements, the Board of Councilors recommends that physicians be mindful of the following considerations:

Resolve conflicts of interest. The prime objective of the medical profession is to render service to humanity; reward or financial gain is a subordinate consideration. Under no circumstances may the physician place his own financial interest above the welfare of his patients. For example, it would be unethical or a physician to unnecessarily hospitalize a patient or prolong or reduce a patient's stay in the health facility for the physician's financial benefit. When a conflict develops between the physician's financial interests and the physician's responsibilities to the patient, the conflict must be resolved to the patient's benefit.

Additionally, a physician should not be influenced in the prescribing of drugs, devices, or appliances by a direct or indirect financial interest in a pharmaceutical firm or other supplier. Whether the firm is a manufacturer, distributor, wholesaler, or repackager of the products involved is immaterial. Reputable firms rely on quality and efficacy to sell their products under competitive circumstances and do not appeal to physicians to have financial involvements with the firm in order to influence their prescribing. Thus, a physician may own or operate a pharmacy if there is no resulting exploitation of patients.

Furthermore, any remuneration or return on investment should be based on the physician's percentage of capital investment and not on utilization, or the volume or value of referrals of patients to a particular facility. It is not unethical for a physician to recover his or her investment in such a facility and earn a reasonable rate of return.
Do not engage in fee splitting. Payment by one physician to another solely for the referral of a patient is fee splitting and is improper both for the physician making the payment and the physician receiving the payment. Fee splitting violates the requirement to deal honestly with patients and colleagues. The patient relies upon the advice of the physician on matters of referral.

All referrals and prescriptions must be based on the skill and quality of the physician to whom the patient has been referred or the quality and efficacy of the drug or product prescribed. The Board of Councilors reminds physicians that fee splitting is a violation of TMA Bylaws and may subject a member to disciplinary action.

Ensure that the facility renders the best possible service. The Board of Councilors believes that the physician's ethical duty to place the patient's interest above his own interest is served where the health care facility to which the physician refers patients has an effective quality assurance and utilization review program to assess the quality of care provided and guard against unnecessary utilization. Additionally, the Board of Councilors believes that the opportunity for abuse is lessened when the investing physician refers patients to a health care facility in which the physician will personally render medical care to the patient. While these are not absolute requirements, they are examples of indications that the referring physician participates in a facility which has the patient's best interests in mind.

Disclose ownership to patients. The physician has an affirmative ethical obligation to disclose his ownership of a health facility to his patient, prior to admission or utilization. Upon request, a physician should give the patient a list of alternative facilities, if such are available, and inform the patient that they have the option to use one of the alternative facilities.

Comply with applicable law. Federal and state law prohibits incentive payments designed to induce physicians to admit patients to a hospital or other health care facility. Physicians may not lawfully or ethically accept such payments. Physicians may not ethically accept any payment, directly or indirectly, overtly or covertly, in cash or in kind, from a health care facility for services delivered by the facility. Further, the Medical Practice Act, as interpreted by the Office of the Attorney General of Texas, may prohibit the direct division on a percentage basis of a physician's professional income with lay persons or to lay shareholders in a corporation or other business enterprise.

Duty to seek responsible change. Physicians recognize an ethical responsibility to seek changes in those requirements which are contrary to the best interests of the patient. The Board of Councilors believes that physicians have a right to seek changes in those laws which unduly restrict physician participation in health care facilities which primarily exist to serve the interest of the patient, do not result in exploitation of patients, do not involve fee splitting or other improper incentive payments, and do not present unresolvable conflicts of interest. It is in the best interest of the patient and community, not the physician, that such arrangements be allowed to continue.

CEJA Ethics Opinions:

11.3.4 Fee Splitting. Patients must be able to trust that their physicians will be honest with them and will make treatment recommendations, including referrals, based on medical need, the skill of other health care professionals or facilities to whom the patient is referred, and the quality of products or services provided. Payment by or to a physician or health care institution solely for referral of a patient is fee splitting and is unethical.
Physicians may not accept:

(a) Any payment of any kind, from any source for referring a patient other than distributions of a health care organization’s revenues as permitted by law.
(b) Any payment of any kind, from any source for prescribing a specific drug, product, or service.
(c) Payment for services relating to the care of a patient from any health care facility/organization to which the physician has referred the patient.
(d) Payment referring a patient to a research study.

Physicians in a capitated primary care practice may not refer patients based on whether the referring physician has negotiated a discount for specialty services.

AMA Principles of Medical Ethics: II

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

9.6.9 Physician Self-Referral: Business arrangements among physicians in the health care marketplace have the potential to benefit patients by enhancing quality of care and access to health care services. However, these arrangements can also be ethically challenging when they create opportunities for self-referral in which patients’ medical interests can be in tension with physicians’ financial interests. Such arrangements can undermine a robust commitment to professionalism in medicine as well as trust in the profession.

In general, physicians should not refer patients to a health care facility that is outside their office practice and at which they do not directly provide care or services when they have a financial interest in that facility.

Physicians who enter into legally permissible contractual relationships—including acquisition of ownership or investment interests in health facilities, products, or equipment; or contracts for service in group practices—are expected to uphold their responsibilities to patients first.

When physicians enter into arrangements that provide opportunities for self-referral they must:

(a) Ensure that referrals are based on objective, medically relevant criteria.
(b) Ensure that the arrangement:
   (i) is structured to enhance access to appropriate, high quality health care services or products; and
   (ii) within the constraints of applicable law:
      a. does not require physician-owners/investors to make referrals to the entity or otherwise generate revenues as a condition of participation;
      b. does not prohibit physician-owners/investors from participating in or referring patients to competing facilities or services; and
      c. adheres to fair business practices vis-à-vis the medical professional community—for example, by ensuring that the arrangement does not prohibit investment by nonreferring physicians.
(c) Take steps to mitigate conflicts of interest, including:
   (i) ensuring that financial benefit is not dependent on the physician-owner/investor’s volume of referrals for services or sales of products;
   (ii) establishing mechanisms for utilization review to monitor referral practices; and
   (iii) identifying or if possible making alternate arrangements for care of the patient when conflicts cannot be appropriately managed/mitigated.
(d) Disclose their financial interest in the facility, product, or equipment to patients; inform them of available alternatives for referral; and assure them that their ongoing care is not conditioned on accepting the recommended referral.
AMA Principles of Medical Ethics: II, III, VIII

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

9.6.3 Incentives to Patients for Referral: Endorsement by current patients can be a strong incentive to direct new patients to a medical practice and physicians often rely on word of mouth as a source of referrals. However, to be ethically appropriate, word-of-mouth referrals must be voluntary on the part of current patients and should reflect honestly on the practice. Physicians must not offer financial incentives or other valuable incentives to current patients in exchange for recruitment of other patients. Such incentives can distort the information patients provide and skew the expectations of prospective patients, thus compromising the trust that is the foundation of patient-physician relationships.
The TMA Education Center was launched in January 2012 to offer Texas physicians convenient and on-demand access to live and online CME. TMA’s course catalog is under constant review to keep it up to date with new and current topics; there are currently more than 100 courses available.

The TMA Education Center is one of the few CME platforms to offer a wide array of practice management CME with ethics credits. Courses are available in a variety of formats, including webcasts, live and on-demand webinars, electronic and hard-copy publications, CDs, and podcasts. Within the education center, courses are grouped into the following key subject areas:

- Billing and Coding,
- Communications,
- Ethics,
- HIPAA,
- Medicare and Medicaid,
- Nonphysician Practitioners,
- Patient Safety,
- Physician Health,
- Practice Operations,
- Public Health,
- Risk Management, and
- Technology.

The courses provide much-needed education, tools, and resources that can be accessed on handheld devices, tablets, and computers. Course content is relevant to physicians across all specialties, as well as practice staff with varying levels of experience and knowledge. A new marketing campaign will launch in 2019 to more directly market select courses to practice staff to supplement their efforts in keeping practices regulatory compliant, up to speed on hot topics, and to fulfill mandatory training requirements.

The association develops new courses based on need as determined by calls to the TMA Knowledge Center, information gathered in the field, and input from various TMA councils and committees. This year, more than 50 topics already have been identified for CME programming, of which approximately 80 percent will be newly developed courses.

Due to a generous $500,000 sponsorship from the Texas Medical Association Insurance Trust, approximately 75 percent of the TMA Education Center catalog became free for TMA members and their staff effective March 1, 2018. Because of this new member benefit, the percentage of TMA membership utilizing the platform in 2018 increased 31 percent. Course registrations increased 164 percent, with the number of unique users increasing 233 percent.
On Sept. 27, 2018, Louis J. Goodman, PhD, CAE, TMA executive vice president/chief executive officer, announced his intention to retire as the EVP/CEO of the Texas Medical Association after a 32-year career at the association. His retirement date will depend on the timing, process, appointment, and selection of a new EVP/CEO. To assist the board in this action, the board secured the national search firm of Tuft & Associates, Inc., to begin the search for a new TMA EVP/CEO.

In December 2018, the board approved a recommendation to rename the TMA building in honor of Dr. Goodman, the “Louis J. Goodman Texas Medical Association Building,” and to plan a celebration ceremony in honor of Dr. Goodman at the 2019 annual meeting.

At the March 2019 First Tuesdays event, held on March 5, the board hosted a building dedication ceremony to honor and recognize the dedication and commitment of his hallmark career and steadfast commitment to the integrity of the practice of medicine and patient care in Texas. New building markers were unveiled during the ceremony. The event was attended by more than 320 people and was live-streamed at texmed.org/Lou. Guest speakers included TMA Board of Trustees Chair Diana Fite, MD; U.S. Rep. Michael Burgess, MD (R-Texas); State Sen. Jane Nelson (R-Flower Mound); and TMA President Doug Curran, MD.

The board also is hosting a reception to honor Dr. Goodman at the 2019 annual meeting. A celebration will take place on Thursday, May 16, 2019, from 5 to 6:30 pm to allow all TexMed attendees to visit with Lou and congratulate him on his accomplishments as the EVP/CEO of the association.
At the 2018 Annual Session, the House of Delegates referred Resolution 405-A-18, Compensation to Physicians for Authorizations and Preauthorizations, to the TMA Board of Trustees for decision. This resolution was introduced to the TMA House of Delegates by Ori Z. Hampel, MD, a physician from Pasadena.

As the house referred Resolution 405-A-18 to the board “for decision,” the board has 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 recommends:

That insurance and managed care companies ("payers") compensate physicians for the time that physicians and their staff spend on authorization and preauthorization procedures. Such compensation shall be paid in full by payers to physicians without deductible, coinsurance, or copayment billable to patients; thus, patients will not bear the burden for such processes imposed by payers. The fee schedule shall be based on the compensation due physicians for patient evaluation and management according to the Current Procedural Terminology (CPT) coding system. For physicians contracted with payers, the payers shall compensate the physician at the contracted fee schedule. For out-of-network physicians, the payers shall compensate physicians at 60 percent of billed charges. The physician and/or physician staff shall track the time spent per patient per day performing tasks related to authorization and preauthorization, and round the time spent per task up to the nearest five-minute increment. The physician shall bill the payer in accordance with the CPT coding system based on the time spent. If necessary, multiple codes shall be used and payable to account for the time spent. Billable minutes for authorization and preauthorization include, but are not limited to, time spent filling out forms, making telephone calls (including time spent negotiating phone trees and hold time), documenting in the patient’s medical record, communicating with the patient, printing, copying, and faxing. Texas laws pertaining to payment timeliness by third-party payers shall apply to payers for such billing as well.

Also at the 2018 Annual Session, the Council on Socioeconomics presented reports on two prior authorization resolutions that were referred to it in 2017. Those reports were approved by the House of Delegates and form the basis for the Board of Trustees’ decision not to proceed with Resolution 405-A-18.

Resolution 406-A-17, Transparency and Payments for Prior Authorizations, required the Council on Socioeconomics to review:

- Amending TMA Policy 235.034, Authorizations Initiated by Third-Party Payers;
- Allowing physicians to charge subscribers if payers and third parties do not compensate physicians for the prior authorization burdens, as these burdens are not a covered service;
• Allowing prior authorizations for only new medications and not for medications that patients have been receiving previously and continuously;
• Pursuing new Texas laws that incorporate the American Medical Association’s Ensuring Transparency in Prior Authorizations Act model bill, including provisions that prior authorization requirements and restrictions be readily accessible on payers’ websites for physicians and subscribers, and that statistics regarding prior authorization approvals and denials be available on payers’ websites;
• Supporting legislation that mandates payers accept and respond to standard electronic prior authorization (ePA) transactions, such as the National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard ePA transactions; and
• Asking the Texas Delegation to the AMA to take this resolution to the AMA for a national unified movement.

Resolution 408-A-17, Compensation of Physicians for Authorizations and Preauthorizations, requested:

That insurance and managed care companies (“payers”) compensate physicians for the time that physicians and their staff spend on authorization and preauthorization procedures. Such compensation shall be paid in full by payers to physicians without deductible, coinsurance, or copayment billable to patients. The fee schedule shall be based on the compensation due physicians for direct patient care according to the Current Procedural Terminology (CPT) coding system. For physicians contracted with payers, the payers shall compensate the physician at the contracted fee schedule. For out-of-network physicians, the payers shall compensate physicians at 60 percent of billed charges. The physician and/or physician staff shall track the time spent per patient per day performing tasks related to authorization and preauthorization. The physician shall bill the payer in accordance with a specific conversion table of time spent to CPT code. Billable minutes for authorization and preauthorization include, but are not limited to, time spent filling out forms, making telephone calls (including time spent negotiating phone trees and hold time), documenting in the patient’s medical record, communicating with the patient, printing, copying, and faxing. Texas laws pertaining to payment timeliness shall apply to payers for such billing as well.

The Council on Socioeconomics expressed concern that shifting costs associated with prior authorizations to patients, as suggested in Resolution 406-A-17, could disrupt the patient-physician relationship and potentially cause patients to forgo necessary care. The council noted that last year, the 85th Texas Legislature passed and the governor signed into law SB 680, which provides a more standardized process for physician exception requests for step therapy drug protocols. Additionally, TMA endorsed 21 principles for reforming prior authorization and utilization reviews developed by a coalition of national and state medical organizations at the beginning of 2018. The principles cover the broad categories of clinical validity, continuity of care, transparency and fairness, timely access and administrative efficiency, and alternatives and exemptions.

The TMA House of Delegates adopted CSE Report 3-A-18, Transparency and Payments for Prior Authorizations, in lieu of Resolution 406-A-17, and existing TMA policy was amended as follows:

235.034 **Authorities Initiated by Third-Party Payers, Benefit Managers, and Utilization Review Entities**: The Texas Medical Association supports policy and legislation that (1) third-party payers, benefit managers, and utilization review entities may not implement prior authorization mechanisms unless these payers compensate physician practices for work required independent of any payment for patient care; specifically, medical practices must be compensated for the burden of added staff and resources required to navigate payer-initiated prior authorizations for medications, studies, or procedures; (2) third-party payers, benefit
managers, and utilization review entities should disclose all prior authorization requirements
and restrictions on their websites in both the subscriber section and the physician section with
neither location requiring a log-in or password; (3) third-party payers, benefit managers and
utilization review entities should confirm patient eligibility, payment determinations, medical
policies and subscriber specific exclusions as part of the prior authorization process; and (4)
third-party payers, benefit managers, and utilization review entities should make detailed
statistics regarding prior authorization approval and denial rates available on their website

CSE Report 3-A-18 also established TMA policy on standardized electronic prior authorizations:

235.038 **Standardized Electronic Prior Authorization Transactions**: The Texas Medical
Association supports policy and legislation that third-party payers, benefit managers, and any
other party conducting utilization management be required to accept and respond to (1)
standard electronic prior authorization (ePA) transactions for pharmacy benefits that use a
nationally recognized format, such as the National Council for Prescription Drug Programs
(NCPDP) SCRIPT Standard; and (2) standard electronic transactions for review and response
to prior authorization requests for medical service benefits that use a nationally recognized
format, such as the ASC X12N 278 Health Care Service Review Request (CSE Report 3-A-
18).

In its report, the council identified concerns that implementing Resolution 408-A-17 would require revisions
to both state and federal statutes governing:

- How health insurance coverage policies are designed;
- How administrative services physicians provide are applied to deductibles, coinsurance, and copayments;
- How health plans calculate and pay prompt payment penalties to contracted physicians;
- How out-of-network physicians are compensated for the services they provide; and
- How out-of-network physicians are not required to accept assignment on insurance claims.

The council expressed concern that efforts to modify Texas’ prompt payment law could result in the loss of
other provisions in the law currently favorable to physicians and that any modifications to the CPT codes
would require review by the American Medical Association.

CSE Report 3-A-18 was approved by the House of Delegates and forms the basis for the board’s decision that
TMA not proceed with Resolution 405-A-18. The board approved not adopting Resolution 405-A-18 and
reaffirming current TMA Policy 235.034 and Policy 235.038.
REPORT OF EXECUTIVE VICE PRESIDENT

EVP Report 1-A-19

Subject: 2018-19 Update

Presented by: Louis J. Goodman, PhD

State of the Association
Your association had another successful year in 2018, closing with a total of 52,387 members, a net gain of 855, and a membership retention rate of 93 percent. The following is a list of major TMA accomplishments for 2018 and goals for 2019.

Practice Viability
• Assisted physicians in recovering more than $1.6 million from third party payors through the Hassle Factor Log.
• Secured $500,000 grant from TMA Insurance Trust (TMAIT) to fund free continuing medical education (CME) for TMA members. Gained high visibility for both TMA and TMAIT, and tripled member usage of the TMA Education Center over the course of just eight months.
• Filed amicus curiae briefs in cases with favorable holdings for physicians: (1) Regarding whether a primary surgeon must tell a patient that a resident will be assisting in a surgery, and what that resident's education, training, and experience is in the surgery, and what parts of the surgery the resident is going to perform. (2) Regarding whether a physician employed by a Texas governmental entity but having staff privileges and performing employee duties at another facility is entitled to immunity for actions that occurred at the other facility.
• Submitted extensive response to the Centers for Medicare & Medicaid Services' proposed 2019 Medicare Payment Schedule and Quality Payment Program rules.
• Advocated for American Board of Medical Specialties to provide greater clarity across member boards for consequences of administrative actions and due process for physicians.
• Advocated against maintenance of certification (MOC) requirements in administrative rules and in physician ratings.
• Increased the number of practice management consulting projects by 16 percent.

Healthy Environment
• Enjoyed positive 2018 election cycle.
• Produced all-new Healthy Vision 2025 to promote TMA's advocacy agenda to legislators, news media, and opinion leaders.
• Educated legislators and doctors on issues important to medicine in the 2019 session.
• Texas reached the 1.1:1 goal for the ratio of first-year residency positions per Texas medical school graduate.
• Due to TMA's advocacy efforts that have strengthened the practice environment, Texas set another new record for the number of medical license applications.
• Convened the first summit among all key players to identify opportunities to improve Medicaid managed care. Recommendations from the summit will be presented to the Texas Health and Human Services Commission and serve as the basis for Medicaid managed care reform legislation.
• Produced numerous advocacy documents for the 2019 Texas Public Health Coalition, representing more than 30 statewide health stakeholders.
Trusted Leader

- Cohosted TMA’s Presidential Maternal Health Congress. Recommendations from this report resulted in new TMA policy, CME opportunities, close collaboration with the Texas Department of State Health Services, and The University of Texas System, and set a framework for TMA legislative advocacy in 2019.
- TMA Foundation (TMAF) funded all requests from TMA science, population health, and quality initiatives, including Walk With a Doc, Be Wise – ImmunizeSM, Distinguished Speaker Series in Population Health, and Hard Hats for Little Heads.

One Voice

- Membership reached 52,387 (+855 members), with retention of 93 percent.
- Collected $16.48 million in dues of a goal of $16.55 million, or 99.6 percent.
- TMA and TMA Trust funds received an unqualified or "clean" audit opinion for 2017 audits.
- Attained 98 percent of TexMed revenue goal; 142 percent of leadership conferences revenue goal; 118 percent of sponsorship goal. Maintained strong advertising sales in spite of slow print ad market.
- Launched redesigned and revamped Texas Medicine magazine and hugely successful Texas Medicine Today personalized, digital news delivery system.
- Brought Grayson County Medical Society back to life over a six-month period.
- Solved financial issues in four different county medical societies. Forty-eight different county medical societies and AMS organizations are tracked in QuickBooks online.
- Strengthened use of all TMA social media accounts.
- Enhanced digital and social media marketing, reaching current and potential members with nearly 1.15 million digital impressions through Facebook, Google Ads, and other channels.
- TMA Knowledge Center received, processed, and answered 12,150 inbound calls and emails.
- Power BI financial dashboards are currently in the final stages of development to enable the presentation of high level dashboards for CEO, COO, and VP level TMA staff.
- Tennessee and Alabama have joined the states currently being hosted as TMA technology clients in 2018 for a total of 11.

2019 Goals

- Meet or exceed 2019 dues budget of $16,800,000 and membership goal of 53,160.
- Meet 2019 operating income and expense budget.
- Successful Executive Vice President search.
- Achieve successful legislative session, including:
  - Reduce burdensome red tape and establishing competitive physician payments to improve physician participation in Medicaid.
  - Renew Medical Practice Act to continue agency and seek reforms to assure just, fair, and prompt Texas Medical Board action in licensing and enforcement.
  - Improve prior authorization process, health plan network adequacy, and provider directory accuracy.
  - Pass TMA package of legislation to improve maternal and child health.
  - Reduce administrative hassles of physician drug monitoring program compliance.
  - Maintain the 1.1:1 ratio of residency positions per medical school graduate.
  - Improve access to care in underserved areas through physician loan repayment and rural training tracks for resident physicians.
  - Achieve Texas Public Health Coalition goals regarding tobacco, immunization, public health infrastructure, and chronic disease.
  - Protect 2003 liability reforms.
- Receive unqualified or "clean" audit opinion for 2018 TMA and TMA Trust Fund audit.
- Improve engagement scores for young physicians and women in medicine by 20 percent. Improve engagement scores overall by 15 percent.
• Use newly upgraded TMA Grassroots Action Center to increase effectiveness of member involvement in the legislative process – including First Tuesdays at the Capitol activities.
• Use year one Texas Medicine Today data to enhance customization of daily e-newsletter and increase member engagement.
• Work with task force to revitalize inactive county societies and implement virtual county society meetings.
• Earn marketing and member services revenue of $3.6 million; Education Center revenue of $579,400; advertising income of almost $600,000; and TexMed and conference revenue of $420,000.
• Increase visibility of consulting services using content marketing.
• Increase usage of TMA Education Center as a member benefit, adding new products and packaging products by topic.
• Endorse one or more affinity credit card to replace current royalty relationship.
• Develop additional revenue of $100,000 in net new marketing contracts, including service to TMA member practices in small and medium sized markets.
• Launch revenue-producing, self-publishing business directory.
• Expand CME MOC offerings.
• Increase employee engagement.
• Audit and update TMA's Policies and Procedures manual.
• Reduce the increasing administrative hassles in Medicare Advantage plans.
• Continue efforts to help physicians transition to value-based payment models within Medicaid managed care as a means of improving patient care and physician satisfaction.
• Significantly increase news media (both traditional and new media) coverage of TMA, TMA's key policy issues, and Texas physicians.
• Increase TMAF fundraising goals and develop stronger evaluations of existing grants.
• Develop a formal education program for physicians, nurses, and hospitals on best practices to reduce maternal morbidity and mortality. This will include physician education to recognize substance use disorders and find treatment options.
• Increase the number of state medical societies currently being hosted as TMA technology clients.
• Fully implement Power BI financial and membership dashboard enhancement and deploy to TMA executive staff.

TMA Fall and Winter Conferences
In total, 485 physicians and medical students attended 2018 TMA Fall Conference; the theme of the conference was Taking Back Medicine. At the general session, Jason Terk, MD, moderated a panel discussion on Opioids: A Legislative Perspective, with State Rep. Four Price and U.S. Rep. Michael Burgess, MD; Brian Sayers, MD, chair of the Travis CMS Physician Health and Rehabilitation Committee, presented True North: Rethinking Physician Wellness; and Kyu Rhee, MD, Chief Operating Officer for IBM, presented on Predicting and Inventing a New Era of Health with Augmented Intelligence (AI).

The Dawn Duster session featured a panel discussion titled Venture Capitalists and the Impact on the Health Care Marketplace moderated by TMA PracticeEdge COO Dave Spalding, with Kevin Wood, JD, of Strasburger & Price, and Jay Zdunek, DO, MBA, chief medical officer of Austin Regional Clinic.

There were 568 physicians and medical students in attendance at 2019 TMA Winter Conference. The program began with TMAF Awards and Donor Recognition and an update on the AMA presented by AMA President Barbara L. McAneny, MD. Steve Murdock, PhD, presented Change is Coming: Texas Demographics. Sen. Lois Kolkhorst gave an overview on the Legislative Health Care Agenda. TMA President Douglas Curran, MD, led a panel discussion on Access Expansion with Sue Börnstein, MD, TMA Board of Trustees member, Stephanie Muth, Texas state Medicaid director; and Ryan Van Ramshorst, MD, chair of the TMA Select Committee on Medicaid, CHIP, and the Uninsured. John Carlo,
MD, concluded the General Session by leading a second panel discussion on Keeping Texas Strong:
TMA Strategies for Maternal Health and Immunizations with Emily Briggs, MD, chair of the TMA
Reproductive, Women’s, and Perinatal Health Committee; and C. Mary Healy, MD, director of
vaccinology and maternal immunization, Center for Vaccine Awareness and Research, Texas Children’s
Hospital.

The Dawn Duster featured Kimberly Monday, MD, neurologist from Houston, moderating a discussion
on DNR and Advance Directives with Missy Atwood, JD, partner at Germer Beaman & Brown, PLLC,
and Jason Morrow, MD, PhD, medical director of inpatient palliative medicine at University Health
System.

Human Resources
The association has 145 regular full-time and six part-time equivalent positions, 11.25 of which are
funded by outside sources. TMA Insurance Trust has 20 full-time equivalent positions.

The following significant staff changes occurred in 2018:

• Alan Atwood was promoted to associate vice president, TIS and association management services;
• Loretto Koepsel, TMA Alliance, retired after 30 years of service;
• Pam Hale, House of Delegates, retired after 30 years of service; and
• Pam Udall was rehired to executive director, TMA Alliance.

Consistent with House of Delegates policy on health insurance, TMA continues to offer health and dental
insurance to employees and their dependents. Each of the options renewed for the 2019 plan year with no
cost increase for TMA or staff.

TMA also offers a health savings account and a flexible spending account, which allows eligible
employees to set aside a certain amount of their paycheck into a reimbursement account before paying
income taxes. Reimbursement of medical expenses not covered by insurance includes deductibles,
copays, prescription drugs, dental services, and the like.

Staff are honored for service to the association every five years with a luncheon and presentation of a
service award. This year, we are celebrating the following staff anniversaries:

Five Years
• Morgan Cotham, TMA Membership and Business Development
• Liz Sansom, TMA Conference Management
• Keri Swanson, TMA Conference Management
• Lindsey Toms, TMA Conference Management

10 Years
• David Wilhelm, TMA Advocacy

15 Years
• Darren Whitehurst, TMA Advocacy

20 Years
• Cheryl Krhovják, TMA Membership and Business Development
• Alan Atwood, TMA Technology and Information Systems
• Kristina Haley, TMA Conference and Association Management
• Gay Anderson, TMA Communications
• Patricia Overton, TMA Communications
• Shannon Vogel, TMA Membership and Business Development
The Physicians Foundation

In 2018, the Physicians Foundation continued to focus on enhancing physician leadership skills while raising awareness about physician wellness. This support was needed more than ever as physicians were particularly strained this year. Many trends in health care persisted – especially as tax and health reform remained in the forefront, and the opioid epidemic continued growing.

The Physicians Foundation continued to produce research to better understand and address the new and unmet needs in the evolving health care industry. In 2018, the foundation’s sixth biennial Physician Survey gathered responses from nearly 9,000 U.S. physicians to examine the impact of poverty on health care outcomes, practice patterns, career plans, how physicians are responding to the opioid crisis and perspectives of today’s physicians. This survey revealed a growing number of physicians dealing with symptoms of burnout (78 percent), with 80 percent of physicians reporting that they have no time to see new patients or take on more duties, making the foundation’s commitment to raising awareness about physician wellness ever more important.

The Physicians Foundation invested over $3.1 million in 2018 to support grants that empower the nation’s physicians in their delivery of care. In the devastating aftermath of hurricanes Michael and Florence, the Physicians Foundation stepped into action to provide disaster relief funding amounting to over $1 million. The funding aided thousands of affected physicians in North Carolina, South Carolina, and Florida, in rebuilding practices and continuing to care for patients.

As America continues to consider changes in health care policy, the perspectives of practicing physicians and their patients are ever more important, and must be addressed. The Physicians Foundation will continue to be a leading voice for practicing physicians to help them navigate the changing health care system, to strengthen the patient-physician relationship, and to support physicians in sustaining their medical practices through decreasing autonomy and increasing administrative burdens. The year ahead will be vital. In 2019, the foundation will field and report its third biennial patient survey, use its new collaboration with The Health Initiative to elevate physicians’ and medical societies’ voices around the impact of poverty on health, and continue to support the timely research of Lawrence Casalino, MD, PhD, through the Physicians Foundation Center for the Study of Physician Practice and Leadership in collaboration with Weill Cornell Medical College, among other core initiatives. All of these efforts, and more, will continue supporting physicians as they navigate the changing health care landscape.

Coalition of State Medical Societies

Founded by TMA in 2012, the coalition now comprises 10 state medical associations with more than 180,000 physician and medical student members. The Coalition of State Medical Societies wrote a formal comment letter to the Centers for Medicare & Medicaid Services in opposition to its plan to collapse Medicare’s evaluation and management (E/M) payment and coding levels. The coalition also arranged for member society leaders and staff to visit Capitol Hill to lobby senators, representatives, and key
congressional staff on the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), regulatory relief, balance billing, the Affordable Care Act, graduate medical education, and physician-owned hospitals. The coalition works with a contract lobby firm to monitor important health care issues in Congress and the administration, and to coordinate responses as necessary.

TMA PracticeEdge
Now in its fourth year, TMA PracticeEdge entered 2019 in a strong position with a portfolio of 15 accountable care organization (ACO) clients providing care for more than 230,000 patients in value-based contracts. And while shared savings and quality incentives for the 2018 performance year have not yet been reconciled, the TMA PracticeEdge family of ACOs has generated approximately $9 million in earned incentives for member physicians from 2016 to 2018. That result could be doubled in 2019 as the maturing networks move into risk-based contracts in Medicare, Medicare Advantage, and commercial contracts.

TMA Specialty Services
TMA Specialty Services (TMASS) began operations in the first half of 2018 with the successful launch of a proprietary data warehouse to support independent specialists as leaders in value-based care. The company integrates clinical and claims data from more than 15 unique sources including electronic health records, payers, hospitals, health information exchanges, and a patient-reported outcomes application. A total of 500 physicians from eight specialties contract to utilize the TMASS analytics toolset to advance quality outcomes and value-based care opportunities. Discussions continue with multiple payers to develop scalable episodic payment models for specialists based upon shared savings concepts commonly utilized in the ACO market.
TMA Membership

TMA ended 2018 with 52,634 members, a net gain of 1,102 members and a year-over-year membership increase of 2.1 percent. Compared with this same time last year, membership in the active dues-paying categories (including active and first year in practice) increased by 31 members or .1 percent. Residents increased by 306 members or 4.6 percent. Students also increased by 584 members or 9.6 percent.

Additionally, TMA collected $16.48 million in dues on a dues revenue budget goal of $16.55 million, or 99.6 percent. TMA’s retention rate was 93 percent.

TMA 2019 Membership Goals

• Increase membership in the association to 53,792, an increase of 1,158 or 2.2 percent,
• Achieve or exceed dues revenue goal of $16.8 million, and
• Retain 94 percent of recruitable members.

Key Priorities

Of note is the ongoing engagement of the Committee on Membership in addressing TMA priorities and helping implement the recommendations of the November 2016 member survey.

Women in Medicine: Better serving the unique needs of women in medicine has been a priority of TMA. The association has hosted special programming and events, hosted tables at the TMA Foundation gala, and supported the efforts of county medical societies, many of which have strong Women in Medicine committees.

In 2018-19, a series of three Women in Medicine events held in conjunction with TMA conferences were at capacity and had a waitlist of those who wanted to attend. During the 2018 TMA Fall Conference event, the focus was on how TMA might enhance its activities to better serve and represent female physicians. Linda Villarreal, MD, vice chair of the TMA Board of Trustees, and Robin Rather, CEO of Collective Strength, guided the conversation.

Participants reviewed current TMA and other medical society policies on nondiscrimination. Participants made four recommendations for TMA to consider, including the need for member training and policy on inherent bias and creation of a women’s section within TMA. Additionally, participants discussed needed programming, advocacy, and services such as professional and leadership development; improving female representation within TMA; more point-of-entry and leadership opportunities for women; creation of implicit bias training; a campaign to address gender pay inequity; and creation of watchdog function at TMA to identify discrimination and propose direct action.

The Council on Socioeconomics was charged with looking at the recommendations and suggesting policy to the House of Delegates for action during TexMed 2019. The committee will recommend creation of a Women in Medicine Section at that time. Plans for 2019 include another series of events and help implementing any recommendations approved by the TMA Board of Trustees and the House of Delegates.
Image Campaign: Another research finding from the member survey was the need to boost physician image. Members of the committee expressed keen interest in this campaign to help boost physician image in a time when legislators, insurance companies, hospital administrators, and others are hoping to expand nonphysician practitioners’ scope of practice. The committee envisions ads that feature individual physicians, the role they play in their communities, their strong connection to their patients, and their everyday heroic acts. TMA, with the help of the committee, could solicit story ideas and physicians to highlight. The audience would be Texas patients and the general public. Another suggestion was to build on the success of the TMA Takeover Tuesdays, which feature a day in the life of a Texas physician by putting more advertising dollars behind it, increasing the frequency of the ads, and expanding the reach of the current program.

Additionally, Committee Chair Dr. Philip met with Steve Levine, vice president (VP), TMA Communications, on how TMA might mobilize physicians to become advocates for TMA and increase the reach of TMA messaging. Following this discussion, TMA launched TMA Leading Advocates to identify and recruit potential TMA champions to help spread TMA messages via social media. Dr. Philip has volunteered to work with the TMA Communications team to implement these ideas.

Professional and Leadership Development Track: TMA regularly fields calls from members who do not meet the age requirement to participate in the TMA Leadership College but would like to do so. TMA also has heard from physicians interested in Women in Medicine leadership development offerings. TMA recently received a request from a 100-percent membership large group to provide a comprehensive leadership program for its physicians.

The TMA Leadership College is a respected program and continues to be a sought-after experience by TMA membership; demand is expected to grow. The program has made admirable strides towards its goal of developing a strong pipeline of future leaders for organized medicine. To serve more physician members, their varied interests and needs, and a changing health care landscape, staff are researching ways to develop TMA’s leadership offerings to cover a continuum of career stages and leadership competencies.

To help meet increased demand, the TMA Young Physician Section and the TMA Leadership College Alumni under the supervision of the Committee on Membership hosted a Professional and Leadership Development Track during TexMed 2018. The target audience was young and female physicians, TMA Leadership College alumni, and other health care professionals in all areas of practice. The speakers and the subject matter for TexMed 2019 were chosen based on feedback from members:

- Managing Your Online Reputation, Steve Levine, VP of Communications, Texas Medical Association; and
- Intergenerational Team Communications, Amanda Veesart, PhD, RN, CNE, Texas Tech University Health Sciences Center School of Nursing

2019 Recruitment and Retention Campaigns
Annually, TMA membership development and marketing staff develop a marketing plan meant to help maintain the visibility of Texas Medical Association including its value, benefits, and services. Key recruitment and retention campaigns are noted here for your review.

Newly licensed: This campaign targets physicians for the year following licensure. It is primarily a print campaign due to the lack of email addresses for this population. Each first-class postcard contains a URL directing members to custom landing pages with more details and information on highlighted benefits. Edits to this campaign continue each year to refine messaging and reduce costs.
**Texas Medicine Today:** This campaign will provide nonmembers with a three-month trial subscription to TMA’s daily members-only e-newsletter. Each issue will arrive once a week and contain the top stories from the week prior, content marketing, and ads featuring TMA services, practice management consulting case studies, and a “join today” call to action. In the first quarter, the target will be former members. In the second quarter, the target will be those who have never been a member.

**CME purchasers:** TMA targets nonmembers who purchase CME in the TMA Education Center in this campaign. Emails offering a $125 credit toward the cost of their membership is offered. If the applicant chooses the auto-renew option, the credit is doubled to $250. In 2018, just over three percent of those targeted joined TMA. Most appear to be previous members.

**Practice managers:** The TMA membership field team suggested a monthly message to practice managers highlighting a service/product. They cited group practice visits that demonstrated more and more practice managers are tasked with payment of dues and deciding which memberships are important. The practices that were most knowledgeable about the benefits of TMA membership and were tapping into these benefits were more likely to renew. Monthly emails will be sent to practice managers highlighting a specific benefit or service. The email will target both current 100-percent membership group managers and large group managers in TMA’s targeted recruitment lists. Services to be highlighted are:

1. Compliance (HIPAA, Medicare Access and CHIP Reauthorization Act, DocbookMD secure messaging, Third Rock cyber security, and the like);
2. New practice/transition to independent practice (TMA services case study);
3. Coding and documentation (billing and coding hotline, Hassle Factor Log, TMA services case study);
4. Staff recruitment/management (TMA services case study);
5. Revenue cycle management/billing (Centers for Medicare & Medicaid Services Quality Payment Program, TMA services case study);
6. Nonphysician practitioners (general management, billing, delegation of duties/supervision);
7. Custom projects (strategic planning case study);
8. Customer service (Best Front Desk or Crash Course for First Time Managers – practice CME that serves as professional development);
9. TMA Insurance Trust and Texas Medical Liability Trust products and services;
10. Discounts: endorsed vendors, group discount program, Practice Management Consulting, career center;
11. TMA Knowledge Center; and
12. TMA white papers.

Targeting of potential members via various digital channels (Facebook ads, retargeting website visitors, and tracking user actions to identify those most likely to join) will supplement these efforts. Additionally, TMA membership development and marketing staff will continue focused in-the-field efforts to engage potential members and encourage renewal of TMA’s 100-percent membership group practices. Plans also include highlighting TMA legislative efforts in recruitment and retention messaging.
Acting upon a nomination by the Dallas County Medical Society, the Board of Councilors selected Don R. Read, MD, of Dallas to receive the association’s Distinguished Service Award. The award will be presented on Friday, May 17, 2019, at the opening session of the House of Delegates.

As a colon and rectal surgeon in Dallas for more than 40 years, Dr. Read is a fellow of the American College of Surgeons, the American Society of Colon and Rectal Surgeons, and the Texas Society of Colon and Rectal Surgeons. Upon graduating from Austin College in 1964, Dr. Read received his medical degree in 1968 from The University of Texas Medical Branch at Galveston.

Dr. Read has been a leader in medicine for decades, having joined TMA and DCMS in 1979. Dr. Read served in leadership capacities for both organizations, serving as president of DCMS in 2002 and as president of TMA in 2016-17. His other leadership roles include chair of the TMA Board of Trustees, founding chair of the TMA PracticeEdge Board of Managers, chair of TMA’s Patient-Physician Advocacy Committee, and president of the Texas Society of Colon and Rectal Surgeons. As one of the most respected physician leaders in the Dallas community, DCMS awarded Dr. Read with the Charles Max Cole, MD, Leadership Award in 2010.

Dr. Read exemplifies integrity, honesty, compassion, and servant leadership. He has provided exceptional and distinguished service to his patients, DCMS, and TMA.
Pursuant to Texas Medical Association Bylaw 5.217, the Board of Councilors may issue opinions on matters of medical ethics. Opinions the board adopts shall be reported to the TMA House of Delegates.

At TMA’s 2018 Fall Conference meeting, the board adopted the following opinions, replacing existing opinions on the same respective subjects.

**SEXUAL AND ROMANTIC RELATIONSHIPS AND MISCONDUCT.** Sexual contact that occurs concurrent with the patient-physician relationship constitutes sexual misconduct and is unethical. A physician must terminate the patient-physician relationship before initiating a dating, romantic, or sexual relationship with a patient. But even after a patient-physician relationship has been terminated, sexual or romantic relationships with former patients or even key third parties are fraught with potential harm to all involved because of the patient-physician relationship. Because of the risk of harm to both participants, sexual or romantic relationships with former patients or key third parties should always be approached with caution and are unethical if the physician uses or exploits trust, knowledge, emotions, or influence derived from the professional relationship. Key third parties include, but are not limited to, a patient’s spouse or partner, parent, guardian, or proxy. *AMA Principles of Medical Ethics I, II, IV* (Adopted February 2002; Amended September 2018)

**CHAPERONES DURING PHYSICAL EXAMS.** Although not legally required, from the standpoint of ethics and prudence, the protocol of having chaperones available on a consistent basis for patient examinations, where appropriate, is strongly encouraged. Physicians aim to respect the patient’s dignity and to make a positive effort to secure a comfortable and considerate atmosphere for the patient. Physicians may do this by actions including the following:

1. providing appropriate gowns and private facilities for undressing;
2. sensitive use of draping;
3. clear explanations on various components of the physical examination; and
4. establishing a policy that patients are free to make a request for a chaperone in each health care setting. This policy should be communicated to patients, either by means of a well-displayed notice or preferably through a conversation initiated by the intake nurse or the physician. The request by a patient to have a chaperone should be honored.

An authorized health professional should serve as a chaperone whenever possible. In their practices, physicians should establish clear expectations about respecting patient privacy and confidentiality to which chaperones must adhere. If a chaperone is provided, a separate opportunity for private conversation between the patient and the physician should be allowed. The physician should keep inquiries and history-taking, especially those of a sensitive nature, to a minimum during the course of the chaperoned examination. *AMA Principles of Medical Ethics I, IV* (Adopted May 2006; Amended September 2018)
GIFTS FROM PATIENTS. Gifts that patients offer to physicians are often an expression of appreciation and gratitude or a reflection of cultural tradition, and can enhance the patient-physician relationship.

Some gifts signal psychological needs that require the physician’s attention. Some patients may attempt to influence care or to secure preferential treatment through the offering of gifts or cash. Acceptance of such gifts is likely to damage the integrity of the patient-physician relationship.

There are no definitive rules to determine when a physician should or should not accept a gift. No fixed value determines the appropriateness or inappropriateness of a gift from a patient.

Physicians should be cautious if patients discuss gifts in the context of a will. Such discussions must not influence the patient’s medical care.

When deciding to accept a patient’s gift, a physician should:

1. Consider whether accepting the gift is in the patient’s best interest;
2. Understand that gifts given to secure preferential treatment compromise the physician’s ability to provide services in a fair manner;
3. Be sensitive to the gift’s value relative to the patient’s or the physician’s means and whether the physician would be comfortable if acceptance of the gift were known to colleagues or the public. Physicians should decline gifts that are disproportionately or inappropriately large relative to the patient’s or the physician’s means.
4. Consider declining a gift bequeathed after a patient’s death if the physician believes that its acceptance would present a significant hardship (financial or emotional) to the family.

The interaction of these various factors is complex and requires the physician to consider them sensitively. *AMA Principles of Medical Ethics I, II* (Adopted May 2005; Amended September 2018)

TERMINATION OF THE PATIENT-PHYSICIAN RELATIONSHIP. The patient-physician relationship is wholly voluntary in nature and therefore may be terminated by either party. However, physicians have an ethical obligation to support continuity of care for their patients. Thus, it is unethical for a physician to unilaterally terminate the patient-physician relationship without first providing an adequate medical attendant or reasonable notice under existing circumstances of the physician’s intent to terminate the professional relationship. *AMA Principles of Medical Ethics I, VI* (Adopted April 2003; Amended September 2018)

PATIENT DISCLOSURE. Physicians should sensitively and respectfully disclose all relevant medical information to patients. The quantity and specificity of this information should be tailored to meet the preferences and needs of individual patients. Physicians need not communicate all information at one time, but should assess the amount of information patients are capable of receiving at a given time and present the remainder when appropriate. *AMA Principles of Medical Ethics I, III, V, VIII* (Adopted February 2007; Affirmed without amendment September 2018)

At TMA’s 2018 Fall Conference meeting, the board also approved the deletion of the following current opinion:

ABANDONMENT. The unilateral severance by the physician of the patient-physician relationship without providing an adequate medical attendant or reasonable notice under existing
circumstances of the physician’s intent to terminate the patient-physician relationship is abandonment and is unethical. (Adopted April 2003)

At TMA’s 2019 Winter Conference meeting, the board adopted the following opinion, replacing the opinion entitled “DRUGS”:

**GENERIC PRESCRIPTIONS.** A physician must ensure the physician’s patient is dispensed the drugs and medications best suited for the patient’s individual needs by directing a pharmacist to dispense brand name products when it is medically necessary to do so. *AMA Principles of Medical Ethics I, II, VIII* (Amended January 2019)

At TMA’s 2019 Winter Conference meeting, the board adopted the following opinion, replacing the opinion entitled “PRESCRIPTIONS-ELECTRONIC”:

**FILLING PRESCRIPTIONS.** Patients have the right to have a prescription filled wherever they wish and physicians should respect the patient’s freedom of choice to the extent allowed by law. *AMA Principles of Medical Ethics I, IV, VI, VIII* (Amended January 2019)

At TMA’s 2019 Winter Conference meeting, the board adopted the following opinions, replacing existing opinions on the same respective subjects:

**IMPAIRED PHYSICIANS.** It is unethical for a physician to practice medicine while under the influence of a controlled substance, alcohol, or any other chemical agents that impair the ability to practice medicine.

Medical staffs have a right and an obligation to ensure that members of their medical staff are both mentally and physically able to practice in a competent manner and that drug testing for reasonable cause is within that purview. Drug testing based on adequate cause should only be undertaken when the medical staff has reasonable policies to ensure confidentiality, accuracy, and fairness. Random drug testing is not supportable in the absence of reasonable cause for testing. *AMA Principles of Medical Ethics I, II, IV* (Amended January 2019)

**INTERNET PRESCRIBING.** Although the development of telecommunications technology now makes it possible for physicians to prescribe medications by means of the internet, such prescription writing may not always be ethical. Connection with a patient through the internet has inherent limitations on communications and interactions with the patient that may not be present in a traditional office setting. However, there may be situations in which internet prescribing may be appropriate. A physician issuing a prescription to a patient seen remotely should be prudent in doing so by establishing the patient’s identity; confirming that remote services are appropriate for that patient’s individual situation and medical needs; evaluating the indication, appropriateness, and safety of the prescription in keeping with best practice guidelines and any formulary limitations that apply to the electronic interaction; and documenting the clinical evaluation and prescription. *AMA Principles of Medical Ethics I, IV, VI, IX* (Adopted February 2006; amended January 2019)

**DO-NOT-RESUSCITATE ORDERS.** When a patient suffers cardiac or respiratory arrest, attempts should be made to resuscitate the patient, except when cardiopulmonary resuscitation (CPR) is not in accord with the patient’s expressed desires or is clinically inappropriate.
All patients should be encouraged to express in advance their preferences regarding the extent of treatment after cardiopulmonary arrest, especially patients at substantial risk of such an event. During discussions regarding patients’ preferences, physicians should include a description of the procedures encompassed by CPR. Patients’ preferences should be documented as early as possible and should be revisited and revised as appropriate.

Advance directives stating patients’ refusals of CPR should be honored whether patients are in or out of the hospital. When patients refuse CPR, physicians should not permit their personal value judgments to obstruct implementation of the refusals.

If a patient lacks the ability to make or cannot communicate a decision regarding the use of CPR, a surrogate decision maker may make a decision based upon the previously expressed preferences of the patient. If such preferences are unknown, decisions should be made in accordance with the patient’s best interests. If no surrogate decision maker is available, a physician contemplating a “do-not-resuscitate” order (DNR) for a patient should consult another physician or a hospital ethics committee, if either is available.

If a patient (either directly or through an advance directive) or the patient’s surrogate requests resuscitation that the physician determines would not be medically effective, the physician should seek to resolve the conflict through a fair decision-making process, when time permits. In hospitals and other health care organizations, medical staffs or, in their absence, medical directors should adopt and disseminate policies regarding the form and function of DNR orders and a process for resolving conflicts.

Before placing a DNR order in a patient's medical record, the physician or the facility's personnel should inform the patient or, if the patient lacks appropriate capacity, the patient’s surrogate.

DNR orders and a patient’s advance refusal of CPR preclude only resuscitative efforts after cardiopulmonary arrest and should not influence other medically appropriate interventions, such as pharmacologic circulatory support and antibiotics, unless they also are specifically refused. (Amended January 2019)
Subject: County Medical Societies Constitution and Bylaws and Name Change

Presented by: Steven Petak, MD, Chair

Nueces County Medical Society Constitution and Bylaws
The Board of Councilors approved amendments to the Nueces County Medical Society’s constitution and bylaws.

Lamar-Delta County Medical Society Constitution and Bylaws
The Board of Councilors approved amendments to the Lamar-Delta County Medical Society’s constitution and bylaws.

El Paso County Medical Society Constitution and Bylaws
The Board of Councilors approved amendments to the El Paso County Medical Society’s constitution and bylaws.

Wichita-Archer-Baylor-Clay-Knox County Medical Society Name Change
The Board of Councilors approved the request from Wichita-Archer-Baylor-Clay-Knox County Medical Society to change its name to Wichita County Medical Society.

Hill Country County Medical Society Constitution and Bylaws
The Board of Councilors approved amendments to the Hill Country County Medical Society’s constitution and bylaws.

Bowie County Medical Society Constitution and Bylaws
The Board of Councilors approved amendments to the Bowie County Medical Society’s constitution and bylaws.
REPORT OF TEXAS DELEGATION TO THE AMA

TEXDEL Report 1-A-19

Subject: AMA House of Delegates Meetings in 2018

Presented by: David N. Henkes, MD, Chair

2018 ANNUAL MEETING
More than 100 Texas physicians, residents, medical students, and alliance members representing the Texas Medical Association, including various sections, and national specialty societies participated in the June 9-13 American Medical Association meeting in Chicago. The Texas delegation left the meeting with a clean sweep by all the candidates who ran for AMA office and with a positive reception for the three policy proposals TMA brought forward.

Elections
Sue Bailey, MD, was reelected to her fourth term as speaker of the house by acclamation. Shortly before the meeting concluded, Dr. Bailey announced she will run for AMA president-elect next year. Russel Kridel, MD, won his bid for a second, three-year term on the AMA Board of Trustees. Dr. Lockhart won his bid for reelection to another three-year term on the AMA Council on Medical Service; John Flores, MD, was elected to the governing council of the AMA Organized Medical Staff Section; Hilary Fairbrother, MD, won her race for chair-elect of the AMA Young Physicians Section and will ascend to the chair in June 2019; Emily Dewar of the McGovern Medical School at UTHealth in Houston was elected speaker of the AMA Medical Student Section; Aaron Wolbrueck from the University of North Texas Health Science Center at Fort Worth Texas College of Osteopathic Medicine was elected chair of Region 3 of the AMA Medical Student Section; and Texas A&M Health Science Center College of Medicine student Rebecca Haines won her race for Region 3 secretary/treasurer.

Policy
All three of the policy proposals Texas took to the meeting won support from the house. The delegates:

- Approved a Texas resolution asking AMA to support changes in U.S. Drug Enforcement Administration regulations so that psychiatrists can e-prescribe medications to a patient with whom the physician has established a valid telemedicine relationship,
- Called for further study of a Texas resolution asking AMA to push Medicare to improve access to complex rehabilitation technology for patients with chronic and disabling conditions, and
- Reacted to a joint resolution from Texas and Missouri by reaffirming AMA’s existing “prudent layperson” policy on health insurance companies’ payment for emergency medical services.

TMA Asks AMA to Stay Out of Affordable Care Act Suit
TMA leaders publicly objected to AMA’s decision to get involved in a high-profile federal lawsuit challenging the constitutionality of the Affordable Care Act (ACA).

Other Business of the House
Delegates addressed various other economic, legislative, and public health topics. The house:

- Celebrated the installation of Barbara L. McAneny, MD, as the new AMA president;
- Chose Patrice A. Harris, MD, as AMA president-elect;
• Called for expanding eligibility for Affordable Care Act premium tax credits to families earning up to 500 percent of the federal poverty level;
• Directed AMA to prepare a report on the effects of corporate investors acquiring a controlling interest in physician practices;
• Voted to oppose the sale of individual and small-group health insurance plans (other than short-term plans) that do not guarantee preexisting condition protections or cover essential health benefits;
• Said state licensing boards should require physicians to disclose a physical or mental health condition only when that condition “currently impairs” their judgment or ability to practice;
• Deemed that young people’s use of products containing any form of nicotine, including e-cigarettes, “is unsafe and can cause addiction,” and also said the federal government should require e-cigarette packages to display the products’ nicotine content and full list of ingredients;
• Supported evidence-based practices to reduce maternal morbidity and mortality in ethnic and racial minorities;
• Approved spending up to $1 million per year to establish an AMA center on health equity to address disparities in delivery and outcomes that affect patient populations that often lack political, social, or economic power;
• Voted to oppose the criminalization of self-induced abortion;
• Adopted policy stating that patients should have no cost-sharing responsibilities for all colorectal cancer screening including colonoscopies that involve biopsies or polypectomies;
• Said AMA should support full insurance coverage, with no cost sharing, of all prescription and over-the-counter contraceptives; and
• Adopted an ethics opinion saying physicians should encourage patients to participate in clinical trials, where applicable, rather than seek access to investigational therapy through the Food and Drug Administration’s expanded access program.

2018 INTERIM MEETING
About 100 Texas physicians, residents, and medical students representing the Texas Medical Association, including various sections, and national specialty societies participated in the Nov. 10-14 AMA meeting near Washington, D.C. Although the Texas delegation brought no action items to the meeting, Texans played prominent behind-the-scenes roles influencing policy decisions.

Elections
Five Texas students won election as regional representatives in the house. Ankita Brahmaroutu of Texas A&M Health was elected a regional delegate. Chosen as alternate regional delegates were Jonathan Eledge of The University of Texas Medical Branch at Galveston (UTMB Health) School of Medicine, Neha Ali of Texas A&M; Amanda Arreola of The University of Texas Rio Grande Valley (UTRGV) School of Medicine, and Joseph Camarano of UTMB Health. Two more Texans won similar positions through the Resident and Fellow Section. Ellia Ciammaichella, DO, of Houston, who is training in physical medicine and rehabilitation, was elected a delegate. San Antonio surgery resident Michael Metzner, MD, was elected an alternate.

Honors
Ray Callas, MD, received the AMA Medal of Valor for his work on behalf of patients and his community in the wake of Hurricane Harvey. The award recognizes physicians who demonstrate courage under extraordinary circumstances in nonwartime situations.

Francisco G. Cigarroa, MD, the former chancellor of The University of Texas System, received the AMA Foundation’s Award for Health Education. The foundation particularly cited his work overseeing the creation of The University of Texas at Austin Dell Medical School and UTRGV School of Medicine.
Greg Bernica, the longtime CEO of the Harris County Medical Society, received the AMA’s Medical Executive Lifetime Achievement Award. The award honors a medical association executive who has contributed substantially to the goals and ideals of the medical profession.

“Zero Tolerance” for Harassment
AMA delegates unanimously adopted an emergency resolution directing AMA to “immediately engage outside consultants to … implement new processes for the evaluation and adjudication of sexual and non-sexual harassment claims involving staff, members, or both.”

Texans Shine Brightly
Ray Callas, MD, persuaded the house to adopt an amendment based on a state law that TMA got passed that says that physicians seeking participation in managed network care be paid immediately if they are part of a group practice with an existing contract with the health plan. The Texans also helped to defeat resolutions that would have undermined Texas’ landmark 2003 medical liability reforms and the state’s successful mediation approach for patients who want to contest “surprise bills” for services from out-of-network physicians.

The AMA House:

• Declared e-cigarettes and vaping “an urgent public health epidemic” and “just days before the Food and Drug Administration (FDA) announced new restrictions” urged FDA to ban flavoring agents in tobacco products;
• Voted to support “gun violence restraining orders” and “red-flag” laws that would allow law enforcement personnel to confiscate firearms from people arrested or convicted of domestic violence or who have “demonstrated significant signs of potential violence”;
• Called for a ban on 3D-printed firearms and their digital blueprints;
• Adopted new AMA policy in support of insurance coverage for supplemental screening for patients with “dense breast” tissue, and calling for research on the risks and benefits of supplemental screening for women who have otherwise negative mammograms;
• Directed AMA to advocate for “the expansion of broadband and wireless connectivity to all rural and underserved areas” of the country;
• Once again rejected an AMA Council on Ethical and Judicial Affairs (CEJA) report establishing ethical guidelines for physicians to continually self-assess their professional competence, and a Council on Medical Education report on guidelines for assessing the competency of senior and late-career physicians;
• Continued the multiyear stalemate over whether AMA policy, which opposes physician-assisted suicide, should take a neutral stance on “medical aid in dying” in states that allow that for terminally ill people. Impassioned debate once again centered around the still-in-force CEJA ethics opinion that says “physician-assisted suicide is fundamentally incompatible with the physician’s role as healer”; and
• Adopted new AMA policy opposing government policies separating undocumented immigrant parents or guardians from their children, and opposing the medically inappropriate administration of psychotropic drugs to those children. But delegates voted to direct the AMA board to decide the organization’s position on U.S. policies that prohibit unaccompanied, undocumented minors access to the country.
As of Dec. 31, 2018, American Medical Association membership in Texas totaled 18,002 compared with 16,189 at year-end 2017, an increase of 1,813 members. The physician category (which includes non-dues-paying retired, exempt, and honorary in addition to dues-paying active physicians) saw an increase of 1,027 members for a total physician membership of 10,415; resident members increased by 1,050 for a total resident membership of 4,031; and student members decreased by 264 for a total student membership of 3,556.

Representation in AMA
With the increase in membership, the Texas Delegation to the AMA saw an increase of two elected delegates and alternate delegates to the AMA House of Delegates; 19 physician delegates now represent Texas. Numerous Texas physicians and medical students hold positions of leadership within the AMA organizational structure: Susan R. Bailey, MD, reelected to her fourth one-year term as speaker of the AMA House of Delegates, Gary W. Floyd, MD, reappointed to the AMA Council on Legislation; Asa Lockhart, MD, reelected to the AMA Council on Medical Service; Russell W.H. Kridel, MD, reelected to the AMA Board of Trustees and serving as board secretary; Lyle S. Thorstenson, MD, reappointed to the American Medical Association Political Action Committee and serving as chair; Michelle A. Berger, MD, appointed to the AMA Council on Long Range Planning; and Diana L. Fite, MD, appointed to the AMA House of Delegates Compensation Committee. Texans serving as ex officio members of the AMA House of Delegates are AMA past presidents J. James Rohack, MD, and Nancy W. Dickey, MD.

Additional Texas physicians holding elected or appointed positions on AMA entities are:

- John T. Carlo, MD, Council on Science and Public Health;
- Jose M. de la Rosa, MD, chair-elect, Academic Physician Section;
- Hilary Fairbrother, MD, chair-elect, Young Physicians Section;
- John G. Flores, MD, member, Organized Medical Staff Section Governing Council;
- Robert T. Gunby, MD, president, Organization of State Medical Association Presidents;
- James Guo, MD, member, Organized Medical Staff Section;
- Lynne M. Kirk, MD, Council on Medical Education;
- Cynthia A Jumper, MD, Council on Medical Education;
- Susan Pike, MD, member-at-large, Integrated Physician Practice Section;
- Monique A. Spillman, MD, PhD, Council on Ethical and Judicial Affairs;
- Surendra K. Varma, MD, member, Academic Physician Section and section liaison to the Council on Medical Education; and
- Paul Wick, MD, immediate past chair and member, Senior Physicians Group Governing Council.

Texans serving as resident representatives are: Ellia Ciammaichella, DO, Houston, regional delegate, and Michael Metzner, MD, San Antonio, regional alternate delegate.

Texans serving as student representatives are: Emily Dewar, McGovern Medical School at UTH, Houston, speaker, AMA Medical Student Section; Aaron Wolbrueck, University of North Texas Health
Science Center at Fort Worth Texas College of Osteopathic Medicine, Region 3 chair; Rebecca Haines, Texas A&M College of Medicine, Region 3 secretary/treasurer; Ankita Brahmaroutu, Texas A&M, Region 3, delegation chair; and Joseph Camarano, The University of Texas Medical Branch at Galveston School of Medicine; Amanda Arreola, The University of Texas Rio Grande Valley School of Medicine; and Neha Ali, Texas A&M, as Region 3 alternate delegates.

In addition to the 19 delegates and alternate delegates representing the Texas Medical Association in the AMA House of Delegates in 2018, many other Texas physicians serve in the AMA house as specialty society delegates and alternate delegates:

- C. Bob Basu, MD, alternate delegate, American Society of Plastic Surgeons;
- Brittany Bickelhaupt, MD, alternate delegate, American Academy of Physical Medicine and Rehabilitation;
- Donna Bloodworth, MD, alternate delegate, American Academy of Pain Medicine;
- Sue Bornstein, MD, delegate, American College of Physicians;
- Ronald J. Crossno, MD, alternate delegate, National Medical Association;
- Seemal Desai, MD, alternate delegate, American Academy of Dermatology;
- Tilden L. Childs III, MD, delegate, American College of Radiology;
- John Early, MD, delegate, American Society of Ophthalmic Plastic and Reconstructive Surgery;
- Hilary E. Fairbrother, MD, delegate, American College of Emergency Physicians;
- Melissa J. Garretson, MD, delegate, American Academy of Pediatrics;
- John N. Harrington, MD, delegate, American Society of Ophthalmic Plastic and Reconstructive Surgery;
- Lisa Hollier, MD, alternate delegate, American College of Obstetricians and Gynecologists;
- Lynne M. Kirk, MD, delegate, American College of Physicians;
- Robert C. Kramer, MD, alternate delegate, American Society for Surgery of the Hand;
- Keagan H. Lee, MD, alternate delegate, United States and 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 Society for Surgery of the Hand;
- Sealy Massingill, MD, delegate, American College of Obstetricians and Gynecologists;
- Daniel M. Meyer, MD, delegate, American Association for Thoracic Surgery;
- Vineet Mishra, MD, alternate delegate, American College of Phlebology;
- Hernando J. Ortega Jr., MD, MPH, delegate, Aerospace Medical Association;
- Ray D. Page, DO, PhD, delegate, American Society of Clinical Oncology;
- Harry Papaconstantinou, MD, alternate 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;
- Susan M. Strate, MD, delegate, College of American Pathologists; and
- Crystal C. Wright, MD, alternate delegate, American Society of Anesthesiologists.

**2018 Officers**

At the Texas Delegation’s Jan. 25, 2019, meeting, David N. Henkes, MD, was reelected chair; Michelle A. Berger, MD, and Gary W. Floyd, MD, were reelected co-vice chairs; and G. Ray Callas, MD, and Gregory M. Fuller, MD, were reelected as at-large members of the Delegate Review Committee.
The International Medical Graduate Section (IMG) was originally established by the House of Delegates (HOD) to promote diversity and integration of international medical graduates in Texas medicine. During the 2017 sunset review process, the Board of Trustees recommended continuing the IMG section for two years, with a report back to the HOD at the 2019 Annual Session with information on specific contributions of the IMG Section.

Beginning in 2017 the section decided to discontinue meeting during TMA Fall Conference due to low attendance. Instead, the section now meets at Winter Conference and TexMed. The section also implemented a mixer during Winter Conference. The section mixer has grown in attendance every year, and has become a popular section activity. Additionally, since these changes to the schedule, the section has seen a slight increase in meeting participation as well as a quorum at every meeting.

The section has taken a keen interest in advocacy initiatives including licensing issues related to unmatched international and U.S. medical graduates, as well as refugee and displaced medical graduates. To assist these physicians, who are also potential TMA members, the IMG Section created an online portal for non-licensed IMG physicians where they match with an IMG physician member to serve as a resource in navigating the licensing boards or for support to integrate into American society and within the family of medicine. Over 20 non-licensed physicians have utilized the site since it launched in May 2018.

The section also created an award that recognizes IMG physicians who have taken steps beyond their regular workday to improve the health of their community. The section announced the award in 2018 and accepted nominations through January 2019 for the inaugural award. The chair of the IMG Section will present the award at the Annual Session.

Future plans include a focus on increasing IMG membership, engagement, and meeting participation.
The TMA Council on Health Care Quality oversees and supports the direction for TMA activities on health care quality, including policy, advocacy, and education on quality improvement, patient safety, performance measurement, and clinical effectiveness. The council has been very active in a number of activities, summarized below.

**CMS Quality Payment Program**

Since the Medicare Access and CHIP Reauthorization Act (MACRA) was enacted in 2015, the council continues to have an ongoing focus on physician advocacy and education concerning the provisions of the law, specifically the Quality Payment Program (QPP), that affect practicing physicians in the areas of health care quality and performance measurement.

The QPP is a framework of integrated policies the Centers for Medicare & Medicaid Services (CMS) uses to implement the two payment tracks required by MACRA: the Merit-Based Incentive Payment System (MIPS) and advanced alternative payment models (APMs). The program undergoes annual updates through federal rulemaking that provide a comment period on proposed rules. As part of TMA’s ongoing advocacy and policy analysis, staff from the TMA MACRA Task Force, with input from the councils on Health Care Quality and Socioeconomics and the ad hoc Committee on Health Information Technology, composed a 58-page TMA comment letter recommending improvements to the policies governing the QPP. Additionally, the TMA MACRA Task Force contributed to a separate comment letter by the Physicians Advocacy Institute (PAI) and Healthsperien, a Washington, D.C.-based health care consulting firm, to amplify our recommendations.

While CMS approved several of our recommendations in whole or in part, it also adopted rules that demonstrate the QPP is advancing with more complex policies and rigorous performance measurement methodologies at a faster pace than TMA recommends. Additional concerns include data requirements for measures that are meaningful to physicians, lack of appropriate risk adjustment for quality and cost measures, disruptive upgrades to physicians’ electronic health records systems, and requiring practices to accept more risk than they can manage financially if they wish to earn bonus payments under the APM track, among others.

In 2019, CMS estimates that more physicians will continue to participate in MIPS than in APMs. The most favorable QPP policy continues to be the low-volume threshold, which decreases the percentage of physicians in small practices who have to participate in the program. However, the threshold exception does not exempt all physicians who continue to face administrative, technological, and financial challenges. In addition to the final rule, CMS’ recent publication of performance results for the first year of the QPP showed that small and rural practices scored lower than large practices. Although the published data were limited, the initial results validate TMA’s concerns that the budget neutrality requirement under MACRA would result in a very large shift of Medicare payments away from small and rural practices to large, mostly urban physician organizations and health care systems.

Of note, CMS has not published any data to date that show whether the QPP is meeting its aims as envisioned by MACRA and Congress, such as improving the care and population health of Medicare beneficiaries, lowering Medicare costs, and minimizing burden on practicing physicians.
QPP Education and Resources
Because we know the QPP program has an adverse impact on small and rural practices, and due to the complexity of the program along with annual changes that occur as a result of federal rulemaking, developing physician education and resources to help physicians learn about and stay abreast of program requirements is an ongoing priority of the council. For example, immediately after the final rule was published, TMA developed an on-demand webinar that offers free CME credit to help physicians prepare their practices and succeed in the 2019 QPP performance year.

Under the direction of the council, staff from the TMA MACRA Task Force will continue to participate in workgroups facilitated by PAI and Healthsperien to update and produce in-depth educational materials for the 2019 performance year that will help physicians and groups succeed in the QPP and avoid Medicare payment penalties.

In addition, TMA continues to offer a comprehensive array of education and resources to help physicians learn about and navigate the QPP. All information is located in the TMA MACRA Resource Center, including where to get MACRA CME at no cost, information about TMA’s MACRA readiness assessment and customized on-site assistance by TMA Practice Consulting, free access to a separate MACRA QPP Resource Center and physician education initiative located on the PAI website (created by Healthsperien and TMA), free QPP education and technical assistance by the TMF Health Quality Institute (TMF), a list of MACRA resource centers by national specialty societies, a list of federally funded initiatives that offer education and technical assistance to help physicians transition to MIPS or APMs at no or low cost, and TMA PracticeEdge services for physician-led accountable care organizations/APMs.

Lastly, the council will continue to provide physician education on MACRA and the QPP during its annual quality track at TexMed 2019 and offer CME credits at no cost to all attendees. All QPP education offerings, clinical tools, resources, and technical assistance are routinely promoted via TMA communication channels.

TMF Health Quality Institute
TMF is under a multiyear contract by CMS to serve as the state’s Quality Innovation Network-Quality Improvement Organization. TMF provides Texas physicians no-cost technical assistance and education on quality improvement and patient safety through the following networks: antibiotic stewardship, behavioral health, cardiovascular health and Million Hearts, Health for Life-Everyone with Diabetes Counts, immunizations, nursing home quality improvement, medication safety, quality improvement initiative, readmissions, and value-based improvement and outcomes.

Specific to the QPP, TMF also 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.

TMF Physician Practice Quality Improvement Award Program
TMF established the Physician Practice Quality Improvement Award Program in 2012, and it has since expanded beyond Texas to include practices in Arkansas, Missouri, Oklahoma, and Puerto Rico. The award program is offered to physicians annually and is cosponsored by TMA, the Texas Osteopathic Medical Association, and others. The purpose of the award program is to recognize physician practices for their dedication and commitment to providing high-quality patient care and improving outcomes. The
council has been involved in the award program since its inception and ensures promotion of the program through TMA communication channels. The deadline for the current award program is May 31, 2019.

**Texas Alliance for Innovation on Maternal Health (AIM) Initiative**

A 2018 report by then-TMA President Carlos J. Cardenas, MD, *Physician-Led Initiatives to Address Maternal Mortality and Morbidity*, recommended that the council, along with the Council on Science and Public Health, develop CME programs on “quality-based initiatives with standardized protocols and best practices to improve prenatal, labor and delivery and postpartum health outcomes; and implementation of hospital-based quality improvement initiatives that reduce maternal mortality and morbidity, based on best practice and standardized protocols.”

As part of TMA’s ongoing promotion of, and education on, the Texas AIM Initiative and its AIM Maternal Safety Bundles, the council will include a presentation on the initiative during its quality track at TexMed 2019, with CME credit at no cost to all attendees.

In brief, the Texas AIM Initiative is a program hospitals and communities use to improve maternal safety through best practices. The AIM Maternal Safety Bundles is a collection of best practices, vetted by experts in the field to ensure their effectiveness, to improve maternal care and maternal health outcomes. Each bundle focuses on a specific maternal health and safety topic: obstetric hemorrhage, obstetric care for women with opioid use disorder, and severe hypertension in pregnancy. The overall goal of the initiative is to end preventable maternal death and severe maternal morbidity in Texas.

**TMA Value-Based Initiatives Workgroup**

In 2018, the Board of Trustees tasked the Council on Socioeconomics with convening a cross-divisional value-based payment workgroup with three primary goals: (1) respond to Resolution 403-A-17, adopted in May 2017, calling upon TMA to support the concept and implementation of community-based health care delivery models and to collaborate with the county medical societies to advocate for the adoption of such models; (2) survey Texas’ value-based payment landscape, particularly pertaining to models serving low-income, uninsured, or other vulnerable populations; and (3) develop TMA policy, education, and toolkits not only to spur formation of physician-led, community-based organizations but also to help physicians who serve low-income populations successfully transition their practices to participate in new payment arrangements. At TMA Fall and Winter conferences, Sue Bornstein, MD, trustee and chair of the TMA Value-Based Initiatives Workgroup, presented to the council the workgroup’s goals and work to date. Jeffrey Kahn, MD, serves on the workgroup and led discussions at each council on Health Care Quality meeting to solicit physician input.

**TexMed 2019 Quality Activities and Quality Track**

Through generous sponsorship from TMF, the council will again host quality activities at TexMed 2019: quality quick tips (mini-presentations) and a four-hour quality track with CME credits at no cost to attendees. Dr. Kahn will chair the quality track. Quality quick tips will provide a “best practices” exchange in the field of quality improvement. Ultimately, such a dialogue will meet the needs for improving patient care, safety, and satisfaction in practices across Texas.

The quality track will provide physicians with current information on changes in the health care landscape and their implications on quality and patient safety nationally and in Texas. The program will begin with a presentation on, and evaluation of, Medicare’s QPP. Speakers will address data on health care utilization and quality performance, value-based care initiatives and strategies, best practices to improve maternal health and end preventable maternal death and severe maternal morbidity across Texas, and practice strategies for successful participation in physician-led accountable care organizations and innovative health care delivery models.
In addition, the TexMed 2019 meeting app will provide physicians with quality and practice management resources, information about education and clinical tools on quality that they can use throughout the year to establish protocols and improve health care for their patients and to spur best practice discussions for their practice staff.

**CMS Qualified Entity**

In 2017, CMS approved UTHealth School of Public Health (UTSPH) in Houston establishing a “Qualified Entity” (QE) to research claims data by Medicare and other payers to evaluate physician performance and regional variations in Texas. Cecilia Ganduglia-Cazaban, MD, DrPH, codirector of the UTSPH Center for Health Care Research Data, routinely presents at council meetings to update members on the QE’s research progress. In March, the QE will launch its new The Health of Texas website and make research data accessible to physicians and the public. TMA will inform membership of the new website through TMA communication channels. Council member Marina C. George, MD, serves as a volunteer on the QE’s physician work group to provide physician input and guidance for the QE’s ongoing research. She will keep the council apprised of QE updates and solicit physician feedback, as needed.

**TMA Publications on Health Care Quality**

Council members regularly contribute to articles published in *Texas Medicine* on health care quality, stemming from topics discussed at its meetings. During 2018-19, several council members were interviewed for topics on MIPS performance feedback, TMA advocacy on the CMS-proposed rules for the Medicare physician fee schedule and QPP, and the 2019 Medicare and QPP final rule. Specific articles are, “The Results Are In: Physicians Finally See How They Fared in First Year of MIPS,” “Cornered: Proposed Medicare Fee Overhaul Could Box in Doctors,” and “Buying Time: Medicine’s Warnings Prompt CMS to Delay Dramatic Coding and Payment Changes.”

**New Council Subcommittee**

At 2019 TMA Winter Conference, the council approved the formation of a new subcommittee to evaluate quality programs and clinical metrics used by commercial health plans. The goal of the subcommittee is to establish stronger relationships around quality efforts and identify areas for improvement, collaboration, and education. In general, the subcommittee’s scope of work will include meeting with large employers to discuss relevant data needed for health care and value-based purchasing. It is anticipated that in late summer 2019, council members will meet with medical directors of commercial health plans to discuss quality programs, quality measures, outcomes, and performance improvement initiatives.
TMA’s 2018 CME Program
TMA’s 2018 CME program offered 352 CME activities, which reached 7,630 physicians and 1,140 nonphysician participants. In 2017, the CME Program offered 221 activities, which reached 8,923 physicians and 740 nonphysician learners.

Update on CME Providers in TMA’s Intrastate Accreditation Program
TMA’s current roster of CME-accredited organizations includes 53 entities. The breakdown for type of organization is as follows: 40 hospitals or hospital systems, 1 physician group, 3 state specialty societies, 1 state agency, 2 regional health education centers, 1 university student health center, 1 quality improvement organization, 1 hospice, 1 regional medical staff organization for emergency services, 1 county medical examiner’s office, and 1 regional advisory council in emergency preparedness.

2018 Texas CME Professional Development Conference
TMA offers an annual two-day conference for physicians and staff who plan and implement CME activities. The program provides updates on CME issues, trains CME providers to meet accreditation requirements, and provides networking opportunities for CME providers. The 2018 Texas CME Professional Development Conference was held June 13-15 at the Sheraton Austin at the Capitol, and was attended by 130 CME professionals. The conference focused on preparing CME professionals to address the new menu of criteria for accreditation with commendation, CME that counts for Maintenance of Certification (MOC), and CME in Merit-Based Incentive Payment System.

Dr. Larry Driver Appointed to ACCME Committee for Review and Recognition
Larry C. Driver, MD, chair of TMA’s Committee on Continuing Education, was elected to the Accreditation Council for Continuing Medical Education (ACME) Committee on Review and Recognition (CRR) for a three-year term beginning January 2019. The CRR is a volunteer committee comprising nine members; all members are nominated by ACCME-recognized accreditors and elected by the ACME Board of Directors. The CRR is part of ACCME’s network of volunteers, which provides the foundation for the accreditation system. As a member of the CRR, Dr. Driver will be instrumental in formulating recommendations to the Board of Directors regarding the recognition status of state medical societies that wish to accredit intrastate providers of CME. The CRR also makes recommendations to the Board of Directors regarding recognition policy development.

CME in Support of MOC
The American Board of Ophthalmology was added to the list of member boards that collaborate with ACCME to increase the number and diversity of accredited CME activities that meet the requirements for MOC and streamline the process for accredited CME providers and physicians. Collaborations are in place with: American Board of Anesthesiology, American Board of Internal Medicine, American Board of Ophthalmology, American Board of Otolaryngology - Head and Neck Surgery, American Board of Pathology, and American Board of Pediatrics.

State Medical Boards Pilot
The ACCME is collaborating with the Tennessee Board of Medical Examiners and North Carolina Medical Board on a pilot program that will enable CME providers to report physician participation in accredited CME
to the state medical boards via ACCME’s Program and Activity Reporting System. The ACCME and the
boards are engaging in this collaboration because they share the goal of reducing regulatory burdens on
physician learners. If the pilot is successful, ACCME’s goal is to explore similar collaborations with other
state boards.
The Committee on Physician Distribution and Health Care Access is charged with the responsibility of monitoring and reporting on the status of the state’s physician workforce (TMA Policy 185.001, Physician Workforce Texas). This report provides a summary of the committee’s latest assessments, findings, and activities for promoting greater access to medical care.

**Committee Findings on Physician Workforce Trends**

To assess the latest trends for the state’s physician workforce, the committee obtained physician supply data for 2018 from the Health Professions Resource Center at the Texas Department of Health Services. These data were added to the committee’s historical workforce files for assessments of shifts in historical trends as well as changes from the previous year.

In conducting these assessments, the committee learned:

- All pathways into the state’s physician workforce are continuing to grow at historically high levels:
  - Medical school enrollments, residents in training, and applications for medical licenses.
  - Three medical schools are in the development process through 2020, raising the composite class size to 2,247 in 2020. This will place additional pressures on clinical training sites for medical students in the state, which already are stretched.
  - The number of medical graduates is projected to have a net increase of 433 from 2018 to 2024. This increase will result in additional strain on residency program capacity and accelerate the need for more residency positions.

- Texas has led the nation in population growth since 2000. The state’s physician supply, however, is growing at an even faster rate than the state’s population and has done so for the past nine consecutive years – the longest growth period since the data have been collected.

- More women, 1,053, entered Texas medical schools in 2018 than any time in the state’s history, with the highest percentage of women ever among first-year enrollments, at 52.3 percent.

- Residents in training in the state have grown by 23 percent over the past decade to 7,953, and the number of programs increased 29 percent. This is a faster rate of growth than changes at the national level.

**FINDING:** Texas reached another historic peak in the number of new medical license applications received in Fiscal Year 2018. The annual number of applications more than doubled since the passage of the 2003 state tort reform laws.

New records continue to be set in the state for the number of new medical license applications, as reported by the Texas Medical Board. As shown in Figure 1, more than 5,700 medical license applications were received by the board in the state fiscal year that ended Aug. 31, 2018. The annual number of applications has more than doubled since tort reform laws were passed in 2003, from about 2,600 to 5,700.
The number of newly licensed physicians for Texas also is continuing to show strong growth, reaching 4,514 in Fiscal Year 2018, the second highest in the state’s history (Figure 2). This number was just 4 percent below the peak reached the prior year. The fact that applications came in at the highest rate ever in 2018 indicates physicians continue to have a strong interest in practicing medicine in Texas. Three out of four newly licensed physicians in the past year were graduates of medical schools outside of Texas, with 47.5 percent graduates of other U.S. states and 26.9 percent graduates of international medical schools.

Texas has attracted physicians to the state at a much higher rate since the 2003 state tort reform laws were passed. In the 15 years preceding tort reform, Texas averaged 1,325 newly licensed physicians each year. Since 2003, the average annual net increase is 1.5 times that amount, at 3,561. A cumulative total of more than 53,000 new physicians have been licensed in Texas since 2003.
FINDING: Physician workforce continues to grow at a faster rate than the state’s population.

About 80,000 physicians have a current Texas medical license. Of this number, 54,233 report a practice in direct patient care in the state. Physician supply has been growing at a steady rate for decades (Figure 3), and in the past 10 years, the annual growth in physician supply ranged from 3 to 5 percent.

As a basic indicator of general access to physician services, the committee tracks changes each year for the ratio of patient care physicians per 100,000 population. This ratio has shown steady growth over the past decade, rising from 158 in 2009 to 184.7 in 2018, as shown in Figure 4. The ratio only grows if the physician supply is increasing at a faster rate than the state’s population. Given the longstanding shortage of physicians in the state, this is a positive trend. Growth in the ratio is an extraordinary achievement when it is considered that Texas led the nation in population growth during this time period.

During the past nine years, the ratio of physicians per 100,000 population saw the longest sustained increase during the 28 years since these data have been collected. As shown in Figure 3 on the previous page...
page, the ratio grew for nine consecutive years. There was a slight decline in the ratio between 2008 and 2009 of less than 1 percent, but a quick rebound in 2010 and consistent growth thereafter.

The committee wanted to know more about how growth in the physician supply compared with the state’s robust population growth. It was learned that physician supply, both total supply (all specialties) and primary care, was growing at a much faster rate than the population (Figure 5). Total physician supply grew at two times the rate as the population during the past decade, and primary care physician supply also beat population growth, growing 1.6 times faster.

Figure 5: Texas Physician Supply Growing Faster Than Population
Comparison of % Change for Population and Physician Supply, 2009 to 2018

Although there are numerous positive trends for the state’s physician workforce, the committee recognizes that serious challenges remain. Much of the state continues to experience geographic and specialty maldistributions. For example, 34 of the state’s 254 counties do not have a family/general physician; 102 do not have an internist; 138 do not have a pediatrician; 157 (two-thirds) are without an OB/Gyn; and 176 counties (69 percent) do not have a psychiatrist. Texas ranks 41st in a ranking of states by patient care physicians (all specialties) per capita, 47th for primary care physicians per capita, and 48th for general surgeons per capita (2017).

TMA continues to advocate for various state policies to help improve geographic disparities in access to care. This includes a concentrated effort to restore the recent funding cut of $8.45 million to the State Physician Education Loan Repayment Program in the state’s 2020-21 biennial budget, as well as support for increasing the loan repayment amount. Other legislative bills such as House Bill 1065/Senate Bill 1084 would establish a new state grant program for the creation of rural training tracks.

In addition to efforts to expand the state’s physician supply, the committee also is looking for innovative programs to increase access to care in medically underserved areas. The committee joined forces with the Committee on Medical Home and Primary Care and the Committee on Rural Health to propose new TMA policies that promote greater implementation of Project ECHO (Extension for Community Healthcare Outcomes). See CM-PDHCA Report 1-A-19, Improving Access to Care for Medically Underserved Areas Through Project ECHO and the Child Psychiatry Access Project Model behind the Reference Committee on Medical Education and Health Care Quality tab in this handbook.

**FINDING: The Texas population is considerably more diverse than the state’s physician workforce.**

Currently, there is considerably more diversity among the Texas population than the physician workforce, as shown in the comparisons presented in Figure 6.
Findings from a comparison of diversity among the Texas population and Texas physicians:

- 5 times more Hispanic Texans than Hispanic physicians,
- 2 times more African-American Texans than among physicians,
- 1.5 times more white Texas physicians than white Texans, and
- Women make up 50.3 percent of Texans, but only 34 percent of Texas physicians.

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 these data have been collected starting in 1987. (Data are not available for some years, as noted in Figure 7.) The percentage of women in medicine has tripled since then, now representing about one-third of Texas physicians.
This steady pace of growth is expected to continue, based on the percentage of women in Texas medical schools and the number of women among newly licensed Texas physicians (45 percent). Women make up slightly more than half of the first-year medical students (52.3 percent) in 2018, the highest ever for Texas. It is difficult to predict whether women will remain the majority because the numbers fluctuated over the past two decades, ranging from 44.5 to 52.3 percent and averaging 47.9 percent, as shown in Figure 8, making it difficult to project what will happen in the future. Regardless of whether women remain the majority, women are expected to represent about one-half of entering students.

Figure 8: Texas % Female First-Year Medical School Enrolments, 2000 to 2018

Three Texas schools had the highest percentages of women among the 2018 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 percent (33 women to 18 men). Texas Tech University Health Sciences Center (TTUHSC) School of Medicine in Lubbock followed with 57.9 percent (103 women to 75 men), and The University of the Incarnate Word Osteopathic Medical School (UIWSOM) in San Antonio at 57.6 percent (91 women to 67 men).

**FINDING: Three more medical schools are in development in the state.**

When the TTUHSC Paul L. Foster School of Medicine opened in 2009 in El Paso, it was the first medical school in Texas in almost four decades. Since 2016, the number of medical schools in Texas increased by three, including the opening of two University of Texas allopathic schools in 2016. Both are small schools: Dell Medical School with 51 students and Rio Grande Valley Medical School in Edinburg with 55 students. In fall 2017, UIWSOM opened an osteopathic medical school in San Antonio with an inaugural class of 160 students. The combined growth from the three schools lifted the number of medical schools in the state from nine to 12 and added 265 students to the state’s 2018 composite medical school class size, raising the total to 2,013, the highest number ever in the state. Since then, three more medical schools have been announced for Texas for 2019-20, as shown in Table 1.
Table 1: Three New Medical Schools Under Development in Texas

<table>
<thead>
<tr>
<th>Medical School</th>
<th>Inaugural Class Size</th>
<th>Opening Year</th>
</tr>
</thead>
<tbody>
<tr>
<td>UNTHSC/TCU MD School, Fort Worth</td>
<td>60</td>
<td>2019</td>
</tr>
<tr>
<td>University of Houston MD School, Houston</td>
<td>30</td>
<td>2020</td>
</tr>
<tr>
<td>Sam Houston State DO School, Conroe</td>
<td>150</td>
<td>**</td>
</tr>
</tbody>
</table>

Texas Christian University (TCU) and the University of North Texas Health Science Center at Fort Worth (UNTHSC) are jointly developing a new allopathic medical school in Fort Worth. The new school plans to admit 60 medical students in July, with 20 slots reserved for TCU students, and then build over time to a class size of 240. Philanthropic support has been secured to cover tuition for the first year. In partnership with Medical City Healthcare, a part of HCA Healthcare, TCU and UNTHSC are working to create 500 new residency positions at 14 hospitals in the Dallas/Fort Worth Metroplex over seven years.

University of Houston (UH) plans to open with 30 students in 2020 and add 30 more students each year from 2021 to 2023, to reach a peak class size of 120. Philanthropic support will cover tuition for all four years for the inaugural class and a portion of the second class. UH is collaborating with HCA Healthcare’s Gulf Coast Division to create 389 residency positions by 2025.

Sam Houston State University in Huntsville is developing an osteopathic medical school in Conroe, north of Houston, to open in 2020 with an inaugural class of 150. This will increase the number of medical schools in Texas to 15, the same number as California, and the second highest in the nation (including existing and proposed). New York leads with 17 medical schools.

The new schools will place additional pressure on the state’s capacity for clinical training and graduate medical education (GME). TMA’s Council on Medical Education is in support of a study by the Texas Higher Education Coordinating Board on the need for more medical schools in the state. The council is proposing new TMA policy in support of the study; see CME Report 4-A-19 Study of Projected Need for More Medical Schools, behind the Reference Committee on Medical Education and Health Care Quality in this handbook.

FINDING: Texas will continue to be challenged to expand GME capacity at the same rate as medical school enrollments with three new medical schools in development.

The number of residents training in the state is at historic levels, with 7,953 residents at 648 residency programs. Texas had an increase of 23 percent in the number of residents and 29 percent more residency programs over the past decade. The growth in Texas was greater than the increases at the national level.

From 2014 to 2017, 237 new GME positions were created in the state through state grants provided to residency programs by the Texas Higher Education Coordinating Board. The Texas Legislature authorized a total of $97 million to provide continued support for the newly created residency positions in the state budget for 2019-20. Monies were not available to create additional positions. The initial state budgets for 2020-21 proposed by both the House and the Senate (House Bill 1 and Senate Bill 1) are proposing an additional $60 million for the state’s GME Expansion Grant program, for a total of $157 million. This is to enable the state to maintain the current ratio of 1.1 to 1 and allow for the potential funding of an estimated 100 new GME positions.
Projected GME Needs
Texas reached the state’s GME goal of 1.1 entry-level training positions for each Texas medical school graduate in 2018. Last year, a total of 1,904 entry-level training positions were offered in the residency matches (1,863 allopathic and 41 osteopathic). In comparison, there were 1,734 Texas medical school graduates last year, resulting in a ratio of 1.1 to 1.

In looking forward, there is a need to add more entry-level residency positions to keep pace with the opening of the new medical schools and other projected enrollment growth. All three schools are expected to graduate their first class by 2024, adding a projected combined total of 433 graduates (a 25-percent increase) by that year. As shown in Table 2, unless additional residency positions are created, the state’s GME ratio will drop below 1.1 to 1 in 2019 and continue declining thereafter, resulting in a ratio of 0.88 to 1 by 2024, or a deficit of 263 entry-level residency positions in comparison to graduates.

Table 2: Comparison of Entry-Level Residency Positions and Medical School Graduates for Texas

<table>
<thead>
<tr>
<th>Actual Data for 2015-2018, Projected Data from 2019-2024</th>
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<tbody>
<tr>
<td>Academic Year</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>Medical School Graduates</td>
</tr>
<tr>
<td>1,690</td>
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<tr>
<td>----------------------------------------------------------</td>
</tr>
<tr>
<td>1st-Yr Residency Positions Offered</td>
</tr>
<tr>
<td>NRMP</td>
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<tr>
<td>AOA</td>
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<tr>
<td>----------------------------------------------------------</td>
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<tr>
<td>TOTAL 1st-Yr GME Positions Offered</td>
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<tr>
<td>1,730</td>
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<tr>
<td>----------------------------------------------------------</td>
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<tr>
<td>Ratio of GME Positions to Graduates</td>
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<tr>
<td>1.02</td>
</tr>
<tr>
<td>----------------------------------------------------------</td>
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<tr>
<td>NET DIFFERENCE:</td>
</tr>
<tr>
<td># Med Schl Grads and 1st-Yr. GME Pos.</td>
</tr>
<tr>
<td>40</td>
</tr>
</tbody>
</table>

Sources: National Resident Matching Program Main Residency Match®, 2015-2018; American Osteopathic Association; and University of North Texas Health Science Center. 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 three medical schools in development will be the first schools affected by this law, and TMA will monitor the law’s impact.

Texas Medical School Graduates Who Do Not Match to Residency Positions
Since 2014, the Council on Medical Education has worked with Texas medical schools to monitor the number of Texas medical school graduates who do not match to a residency position. An annual average of 37 Texas medical school graduates (2 percent) were unable to match to a residency position in the year of their medical school graduation during the years of 2014-2018. Only 13 of Texas’ 2017 medical school graduates were not able to match to a residency position in the second year after graduation. See Resolution 205-A-18, Study of Unmatched Candidates for U.S. Residency Programs.

Summary
The committee recognizes numerous positive trends in expanding the state’s physician workforce. All pipelines into the physician workforce are at the highest levels in the state’s history, and this high rate of growth has been sustained for several years. This includes the record-high number of physicians who are seeking medical licensure in the state. Physician shortages remain, however, as a result of geographic and specialty maldistributions.
During the 2019 Texas Legislative Session, TMA continues to advocate for various state policies to help improve access to care. This includes a concentrated effort to restore the recent funding cut of $8.45 million to the State Physician Education Loan Repayment Program in the state’s 2020-21 biennial budget, as well as support for legislative bills such as House Bill 1065/Senate Bill 1084, which would establish a new state grant program for the creation of rural training tracks.

In addition to efforts to expand the state’s physician supply, the committee also is looking for innovative programs to increase access to care in medically underserved areas including greater implementation of Project ECHO to improve access to specialty services in the state.

The committee will continue to report its findings on trends for the physician workforce and distribute this report among state policymakers in addition to TMA’s membership.
Subject: EMS and Trauma Activities Update

Presented by: Veer Vithalani, MD, Chair

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**Resolution 302: Appropriate Physician Oversight of EMS Medical Practices**

At TexMed 2018, the House of Delegates referred Resolution 302 for additional discussion. The resolution called on TMA to determine appropriate physician oversight of emergency medical services (EMS) medical practices. There is evidence that errors in emergency settings such as emergency departments and emergency medical services can lead to poor outcomes for patients. One method of reducing these errors is to require physician staffing ratios per number of prehospital providers.

Proponents of the resolution contend that staffing ratios would create greater oversight for EMS systems and decrease the likelihood of critical errors. After discussion with the resolution author, committee members, and the Governor’s EMS and Trauma Advisory Council (GETAC) leadership, the committee determined that the resolution’s recommendation should be adopted as amended by the committee. The committee will submit a report to the house in May on its recommendations. In the meantime, it will continue to work with the author and other stakeholders to discuss.

**Stroke and Trauma Facility Rulemaking**

In September and October 2018, the committee coordinated TMA comments on draft revisions to the state’s stroke and trauma facility designation rules. The committee held three conference calls with specialty societies to ensure broad physician input on the association’s comments. Specialty societies engaged in the discussion included the Texas College of Emergency Physicians, Texas Society of Anesthesiologists, Texas Neurological Society, and the American Heart Association Southwest Affiliate.

TMA and specialty societies submitted a letter on the draft rules in October 2018 and will participate in the upcoming formal rulemaking process in 2019.

**Trauma Funding and the Driver Responsibility Program**

The Drivers Responsibility Program (DRP) funds a majority of the state’s trauma system. The DRP collects surcharges from Texans who violate driving laws, including driving while intoxicated (DWI) and driving without a valid license or insurance. If an individual does not pay the fees within 105 days, his or her license is suspended.

Lawmakers of both parties agree that there are problems with the DRP but recognize that eliminating the program would greatly impact the state’s trauma system. Legislators filed several bills to change or eliminate the program. As of Feb. 1, 2019, no bills had received a committee hearing. While the committee supports efforts to ameliorate the impact of the program on low-income drivers, it opposes reductions in trauma funding. The committee will continue to work within a coalition of specialty societies and hospitals to protect funding for the program.

**Travel Screening Guidelines**

Historically, there has not been a standard list of travel screening questions used by hospital or clinic EMS. During the 2017 TMA Fall Conference, the committee determined the need for a collective list of these questions. The committee collected questions from members and shared the list with the TMA Committee on Infectious Diseases (CID). At the 2018 TexMed meeting, the committee collaborated with the CID and the Committee on Health Information Technology to research hospital emergency infectious disease screening protocols for patients who have traveled to foreign countries recently.
The committee will hold additional discussions this spring on whether or how to standardize the protocols and incorporate them into electronic health records.

**Governor’s EMS and Trauma Advisory Council**

TMA staff closely track GETAC’s activities, including participation in quarterly meetings. Robert Greenberg, MD, GETAC chair, is a consultant to the committee. Dr. Greenberg provided GETAC updates at the May and September committee meetings.
Primary Care in Texas
Over the past year, the committee collaborated with the state’s four primary care specialty societies to develop an educational document on the status of primary care in Texas. The societies include the Texas Academy of Family Physicians, Texas Pediatric Society, American College of Obstetricians and Gynecologists District XI (Texas)/Texas Association of Obstetricians and Gynecologists, and the Texas Chapter of the American College of Physicians.

The report provides an overview of primary care in Texas and its importance to a high-functioning health care delivery system, as well as statistics on the prevalence and distribution of primary care physicians in the state, their reimbursement, and the practice management challenges they face.

The report was distributed in late February and disseminated at the April First Tuesdays at the Capitol event in conjunction with student, resident, and physician visits to the Capitol.

Project ECHO (Extension for Community Healthcare Outcomes)
The committee has collaborated with the Committee on Physician Distribution and Health Care Access and the Committee on Rural Health to bolster efforts related to Project ECHO. Project ECHO was established by the University of New Mexico in 2003. It is a unique model that utilizes “hub-and-spoke” video conferencing to provide telemonitoring on best-practice specialty care by bringing together physician specialists at academic health centers (hubs) and community-based primary care physicians (spokes) in areas of physician shortage and medical underservice. See CM-PDHCA 1-A-19 in this handbook.
The Patient-Physician Advocacy Committee presents the following informational report regarding the committee’s recent activities.

State Office of Administrative Hearings Issues
The committee discussed challenges faced by physicians who are successful before the State Office of Administrative Hearings (SOAH). The committee received general information about SOAH procedures from an administrative law attorney. The committee also heard from an affected physician. The committee later reviewed draft bill language prepared by TMA staff to address concerns brought before the committee and recommended that the Council on Legislation consider proceeding with the draft bill, relating to overturning and vacating certain temporary suspensions or restrictions of an individual’s medical license by the Texas Medical Board (TMB).

Texas Medical Board
The committee invited Texas Medical Board representatives to its meetings to learn more about its processes and procedures and to offer improvements. The committee met with the board’s president, executive director, and general counsel on various occasions to discuss a variety of concerns, ranging from sunset issues to the need for a TMB form for lodging complaints against TMB-certified nonprofit health care corporations (formerly known as 5.01[a]s).

Board Certification
In a letter to the American Board of Medical Specialties (ABMS), the committee had encouraged ABMS and its member boards to adopt a safe harbor for minor licensure actions, so that if a physician agrees to certain actions by TMB, the physician can be more aware of the possible consequences of that agreement with respect to board certification. The committee was informed that, in response to its letter, ABMS had drafted a revised ABMS licensure policy that was being reviewed by the ABMS Committee on Certification and the Ethics and Professionalism Committee. If the draft policy continues to advance, the aforementioned ABMS committees will work together to create a draft for consideration by the ABMS Board of Directors.
As the 86th Texas Legislative Session begins, the Interspecialty Society Committee (ISC) is focused on discussing legislative issues that directly affect the many specialty societies that comprise the ISC.

The Texas Pediatric Society discussed concerns on immigration and the separation of children from parents/guardians at the U.S.-Texas border.

The Texas Allergy, Asthma and Immunology Society is sponsoring bills requiring food allergy posters to be posted in restaurants and to be available online for free. These issues also are being presented to the House of Delegates through Resolution 304-A-19.

The Texas Society of Anesthesiologists is concerned about rules published in the Texas Registry allowing nurses to be exempt from telemedicine and Prescription Management Program regulations.

The Texas Dermatological Society is concerned about med spa regulation compliance; the Texas Pediatric Society desires more funding for prenatal testing to keep Texas in compliance with federal regulations; and the Texas Society of Pathologists is anticipating the refiling of the Beacon Labs bill from previous legislative sessions.

**Delegates and Alternate Delegates in Attendance of the ISC January 26, 2019 meeting:**

- Sarah Avery, MD – Texas Radiological Society
- Louise H. Bethea, MD – Texas Allergy, Asthma and Immunology Society
- Tilden Childs, MD – Texas Radiological Society
- Charles Cowles, Jr., MD – Texas Society of Anesthesiologists
- Troy T Fiesinger, MD – Texas Academy of Family Physicians
- Allen Flack, MD – Texas Society Pathologists
- Michael Graves, MD – Texas Dermatological Society
- Charleta Guillory, MD – Texas Pediatric Society
- Jeffrey B. Kahn, MD – Texas Association of Otolaryngology
- Heidi Knowles, MD – Texas College of Emergency Physicians
- Megan Kressin, MD – Texas Society of Pathologists
- Pradeep Kumar, MD – Texas Society of Gastroenterology and Endoscopy
- Richard L. Noel, MD – Texas Society of Psychiatric Physicians
- Stacey Norrell, MD – Texas Society of Anesthesiologists
- Debra Pratt, MD – Texas Society of Medical Oncology
- Jack W. Pierce, MD – Texas Ophthalmological Association
- C.M. Schade, MD, PhD – Texas Pediatric Society
- Ryan Van Ramshorst, MD – Texas Pediatric Society
- Stanley Wang, MD – Texas Chapter of American College of Cardiology
The Medical Student Section (MSS) was established by the House of Delegates (HOD) to shape the future of medicine in Texas by active medical student involvement in the affairs of the various Texas county medical societies, the Texas Medical Association, and the American Medical Association. Its purpose is to foster dialogue between individuals and organizations within medicine, promote and aid in programs 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 medical students in Texas.

Membership

Medical student membership reached an all-time high in the association. As of Dec. 31, 2018, student membership in the TMA was 6,673, a 584-student increase over the same time in 2017. These numbers include eight of the 12 medical school chapters who joined TMA at 100 percent membership. TMA is anticipating medical school growth within Texas to reach 15 schools by 2020.

Leadership

With the continued addition of new medical schools in Texas, the section has seen tremendous growth in student participation and interest in leadership positions. In 2018, this was even more evident when over 115 students applied for approximately 60 TMA board, council, and committee positions available. Additionally, several Texas students served at the national level including:

- AMA-MSS Speaker, Emily Dewar (McGovern Medical School);
- Region 3 Chair, Aaron Wolbrueck (University of North Texas Health Science Center at Fort Worth);
- Region 3 Secretary/Treasurer, Rebecca Haines (Texas A&M College of Medicine);
- Region 3 Delegate, Ankita Brahmaratou (Texas A&M College of Medicine);
- Region 3 Alternate Delegates, Joseph Camarano (The University of Texas Medical Branch at Galveston), Amanda Arreola (The University of Texas Rio Grande Valley), Jonathan Eledge (UTMB), and Neha Ali (Texas A&M);
- Student Representative on the AMA Minority Affairs Section Governing Council, Luis E. Seija (Texas A&M); and
- Medical Student Section Councilor and Representative, Luis E. Seija.

Along with positions listed above, several students from Texas also were appointed or elected to leadership positions in various American Medical Association-MSS Standing Committees, as well as other state and national specialty societies.

During the MSS Business Meeting at TexMed 2018, the section recognized eight members to be part of the Leadership Honor Society which recognizes fourth-year medical students who have actively participated in Texas organized medicine.

Finally, Texas Gov. Greg Abbott appointed Jane Gilmore as student regent for the Texas Tech University System Board of Regents for the 2018-19 school year.

Advocacy
MSS Delegates from across the state collaborated to write and submit 12 resolutions to the House of Delegates at 2018 Annual Session. Of these resolutions, six were adopted or adopted as amended. Resolution topics included opposition to pain score as a contributing factor to hospital financial incentives, prescription drug monitoring, and creation of a synthetic cannabis educational resource for providers, among others. The MSS also updated its bylaws, which the House adopted at the 2018 meeting.

Section leaders also worked with TMA staff to develop an advocacy internship program which will give students an opportunity to work closely with TMA advocacy staff on policy and legislative priorities by attending hearings and briefings, participating in meetings, and gaining a basic understanding of government function on a variety of health-related issues.

Awards
The MSS Executive Council recognized The University of Texas Medical Branch at Galveston as the 2018 Chapter of the Year and Sinan Ali Bana, Texas A&M University, as Student of the Year. Stephen L. Brotherton, MD, Fort Worth, was selected as the recipient of the 2018 C. Frank Webber, MD, Award for providing outstanding service to the TMA Medical Student Section. These awards were officially presented at the 2018 Annual Session.

Chapter Service
Multiple chapters participated in one or more of TMA’s outreach programs: Walk with a Doc, Be Wise – Immunize℠, and Hard Hats for Little Heads. Two chapters, UT Health San Antonio and Texas Tech University Health Sciences Center-Lubbock, were awarded the Service Project of the Year award by the TMA-MSS Executive Council. The service projects recognized for these awards were, Head Start Physicals for School Children (UTHSCSA) and Anti-Human Trafficking Alliance (TTUHSC-Lubbock).

Multiple grants were awarded by the TMA Foundation to chapters for the work they have implemented within their communities, including:

- Alliance Refugee Wellness Fair (Baylor University);
- Aggie Health Project: Hepatitis C (Texas A&M);
- Carnaval de Salud: United to Serve Health Fair (UT Southwestern Medical School);
- Community Health Day (Baylor University);
- HOPE Health Fair (UTMB); and
- Implementing a Smoking Cessation Program in a Dallas Homeless Population (UT Southwestern)

The foundation also awarded the Paul L. Foster School of Medicine the 2019 John P. McGovern Champion of Health Award for providing health care to El Paso County’s uninsured population through the school’s medical student run clinic.
The Resident and Fellow Section (RFS) was established by the House of Delegates to encourage participation in shaping the future of medicine in Texas by active involvement in Texas county medical societies, the Texas Medical Association, and the American Medical Association. Its purpose is to foster dialogue between individuals and organizations within medicine; promote and aid in programs 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 residents and fellows in Texas.

Section Activities
The RFS meets three times annually in conjunction with all TMA meetings. During Winter and Fall Conferences, the RFS has joint meetings with the Young Physician Section (YPS). These joint meetings continue to be well received and attended. Additionally, the RFS and YPS host a mixer at all three conferences that are very popular.

During its meeting at TexMed 2018, elections were held for RFS Executive Council positions and the following residents were elected for a term of one year:

- Chair-Elect, Arindam Sarkar, MD
- Secretary, Carla Khalaf McStay, MD
- TMA Delegates: Fatma Ahmed, MD; Michael Dakkah, DO; Dara Grieger, MD; and Jaya Kasaraneni, MD
- TMA Alternate Delegates: Steven Blake Baker, MD; Patrick Crowley, DO; Collin Juergens, MD; and Sujan Reddy, MD.

The section meeting at the 2018 Fall Conference featured a presentation on integrated leadership for hospital and health care systems and was presented by J. James Rohack, MD, a TMA past president.

During the 2018 Winter Conference meeting, the section held discussions on supporting resolutions introduced by section members. The section also held elections, and Kayla Riggs, MD, was elected to be the Board of Trustees resident representative. Theresa Phan, MD, was elected to be the resident AMA alternate delegate on the TMA delegation.

During the AMA RFS meeting at AMA’s 2018 Interim Meeting, Ellia Ciammaichella, MD, was elected to be a delegate and Michael John Metzner, MD, was elected to be an alternate delegate.

Planned activities
The section plans to continue conducting joint meetings with the YPS. Future plans include focusing on increasing Texas resident attendance and participation at meetings.
The Texas Medical Association Young Physician Section (YPS) met in conjunction with the Resident and Fellow Section (RFS) twice in the course of 2018-19, at the TMA Fall and Winter Conferences. Joint meetings with the RFS continue to be well-received and attended. The fall meeting featured a presentation on integrated leadership for hospital and health care systems by James Rohack, MD. During the winter meeting, new AMA-YPS delegates were elected to one-year terms:

- Gates Colbert, MD (re-elected)
- Matthew Brooker, DO (re-elected)
- Laura Faye Gephart, MD (re-elected)
- Marcial Oquendo, MD

The remaining members of the Executive Council are listed below along with applicable terms:

**Officers (one-year terms):**

- Chair: Jessica Best, MD
- Chair-Elect: Gates Colbert, MD
- Immediate Past Chair: Lindsay Botsford, MD

**TMA Delegates (two-year staggered terms):**

- Anna Allred, MD (2017-19)
- Jessica Best, MD (2017-19)
- Clay Cessna, DO (2018-20)
- Gates Colbert, MD (2017-19)
- Jennifer Liedtke, MD (2018-20)
- Sachin Mehta, MD (2018-20)

**TMA Alternate Delegates (two-year staggered terms):**

- Andy Chen, MD (2018-2020)
- Sara Woodward Dyrstad, MD (2018-20)
- William Fox, MD (2018-20)
- Samuel Mathis, MD (2018-20)
- Paraag Kumar, MD (2017-19)
- Jimmy Widmer, MD (2018-20)

In 2019, the section plans to continue conducting joint meetings with the RFS and hopes to increase member participation in section meetings.
The Texas Medical Association Insurance Trust (TMAIT) operates under the authority of an eight-member board composed of five trustees appointed by TMA and three trustees elected by the Trust’s subscribers. The five appointed trustees include the executive vice president of TMA and a member of the TMA’s Young Physician Section. During 2018, the trustees met in person in January, May, and September in conjunction with TMA conferences and the House of Delegates meeting. In addition, the trustees held their annual three-day planning session in August.

The Board of Trustees is assisted by the TMAIT Advisory Committee, made up of nine TMA physicians and a TMA Alliance member appointed by the trustees to review claims and underwriting decisions appealed by the membership. The advisory committee, which includes a variety of medical specialists, provides a member the opportunity for a panel of his or her peers to review insurance carrier decisions concerning underwriting and claim matters. The advisory committee is one of the principal strengths of TMAIT, as it gives each member a forum for further consideration of decisions that affect insurance coverage.

To expand the insurance market for the trust and our members, TMAIT in 2000 established its own insurance agency, TMAIT Financial Services, Inc., to assist those members who feel they need to shop for coverage. Through the agency, we are able to offer a TMA member any insurance plan available on the open market.

TMAIT maintains a 21-person staff at TMA’s Austin headquarters. TMAIT staff are involved in every phase of the program: marketing, enrollment, billing, and claims assistance. With direct access to all membership information, TMAIT staff can supply an immediate response to a member’s inquiry about insurance benefits. Staff are assisted by actuarial, legal, financial, tax, and technology advisors who offer advice on a broad range of technical issues. Staff serve as a liaison between the membership and the insurance carriers, and provide a member service generally not available to an individual purchasing coverage through the commercial insurance market.

The TMAIT life, business overhead, and long-term disability (LTD) plans are underwritten by Prudential Insurance Company of America. The health insurance plans are underwritten by Blue Cross and Blue Shield of Texas. In addition to providing financial security, the insurers are important members of the TMAIT administrative team. Working in partnership with the trustees, the advisory committee, and TMAIT staff, the insurers provide TMAIT the high level of insurance expertise and administrative assistance required to operate a cost-effective, state-of-the-art insurance program. TMAIT staff communicate throughout each day with our insurance representatives; this close contact allows TMAIT to provide first-class service to its membership.

Through the combined resources of TMAIT and the agency, we are able to offer TMA members access to an extremely broad range of insurance products – from the cost-effective group insurance plans offered through the trust to individual insurance products tailored to specific needs.

**2018 Financial Results**

Overall, the insurance program experienced a gain of about $5 million in 2018 compared with a gain of about $10 million in 2017. The results by plan, with comparative information for 2018, are presented below.
The life insurance plan gained about $500,000 for 2018 compared with a gain of about $2.7 million in 2017. There were 23 death claims in 2018 compared with 20 in 2017. The total payments in 2018 were $4.6 million compared with $2.4 million paid in 2017.

The business overhead plan gained about $675,000 during 2018 compared with a gain of about $125,000 during 2017.

The LTD plan gained $3.5 million in 2018 compared with a $7.2 million gain in 2017. For the second year in a row, only eight new claims were incurred in 2018.

In 2018, the health plans produced a loss of about $250,000 compared with a loss of $600,000 in 2017. In both years, the loss was expected as a result of the trustees’ decision to subsidize rates and reduce the impact of the high cost of health insurance on plan participants.

In years like 2018 in which the experience is favorable, gains are credited to the Trust’s Premium Stabilization Funds (PSFs), which provide added security and stability for the insurance program. At the close of the 2018 policy year (Oct. 31, 2018), the insurance program had a combined PSF balance of $83 million.

2018 Program Initiatives and Accomplishments

TMAIT’s partnership with the TMA Education Center to fund no-cost or reduced-cost access to TMA’s online CME courses has been a success for TMA members and TMA.

TMAIT launched an online enrollment platform for trust products with our long-standing partner, Prudential Insurance Company of America. This online platform expands members’ choice of how they can interact with TMAIT and provides them with the convenience of online access to participate in our products.

Two new trust products were introduced in 2018: TMA Member Critical Illness and TMA Member Accident Insurance plans. These plans are underwritten by Prudential.

TMAIT leveraged in-house data to target our marketing to specific member segments. This allowed us to make our marketing messages more relevant to the members who received them. This approach resulted in an increase in all key online metrics and an increase in sales leads over the previous year.

For the second year in a row, TMAIT was recognized by the Professional Insurance and Marketing Association (PIMA) for excellence in marketing at the 2018 Marketing Methods Competition. PIMA convenes the leaders and leading companies in affinity benefits distribution and direct marketing. TMAIT was awarded the Gold Award for New Media and the Best of PIMA for Excellence in Marketing.

Based on input we received from the membership, we replaced the LTD Loyalty program (in effect since Nov. 1, 2016), which provides a 25-percent premium discount for all LTD participants who are aged 50 or over and have been insured 10 or more years, with a 25-percent premium reduction for all participants aged 50 and over, effective Nov. 1, 2018.

2019 Initiatives

TMAIT will launch a new website that will support our segmentation strategy so members who interact with TMAIT online will have a more relevant and valuable experience.

Our online enrollment platform will be enhanced so that members will be able to apply for TMA Member Life Insurance and have a decision in minutes. Our launch version will enable members to apply quickly for up to $500,000 of coverage and receive a decision in minutes.

During 2018, TMAIT staff and their consultants followed the developing Association Health Plan (AHP) Executive Order. On June 19, 2018, the U.S. Department of Labor issued a final rule designed to facilitate
creation of an ERISA-compliant multi-employer welfare plan (MEWA) under significantly less restrictive
requirements related to rating rules and essential health benefits. Even though it has been nearly one year
since the final rule was issued, almost everything about new AHPs remains unclear. At this time, the staff and
the advisors believe it is best to table any discussion of a TMAIT-created MEWA until the ongoing
uncertainty is resolved. We can revisit this issue at any time if circumstances change.

The Affordable Care Act (ACA) has prevented new enrollment in the association group health plans since
Nov. 1, 2013. Fortunately, the ACA allowed us to “grandfather” coverage for members who began
participation prior to that date. While operating on a closed-group basis presents significant challenges, those
plans remain financially viable and continue to provide the same quality coverage as they have in the past.
The association group health plans and the assistance we provide in securing coverage in the individual and
small-group markets have allowed our staff to maintain a high level of expertise in the health insurance
business. This places TMAIT and the agency in a great position to respond to any changes that may arise
from any changes to the ACA or expansion of AHPs.
Funds Raised and New Fund Established in 2018
The TMA Foundation raised more than $2 million in 2018, the third highest amount in its history. Included in this total is a generous gift from Roberto J. Bayardo, MD, Houston, to establish his second trust within the TMAF Family of Funds: the Medical Student Scholarship and Grant Trust Fund of Dr. Roberto J. and Agniela (Annie) M. Bayardo. This new fund has two purposes: (a) to support TMAF’s Medical Student Community Leadership Grant program, and (b) to enable TMA county medical societies to apply for a matching medical student scholarship administered through the society’s own scholarship program.

Grants Support 2018 Programs
The generosity of donors, plus investment earnings from endowments, enabled TMAF to grant more than $670,000 to support programs primarily carried out in 2018.

Included among these grants is support for 10 TMA health improvement, quality-of-care, and science initiatives; 12 county medical society, and alliance and medical student chapter health improvement and scholarship initiatives; and TMAF’s Champion of Health Award.

This means that for every $1 TMA provides in support of TMAF, the foundation and donors provide TMA a six-fold benefit in community health improvement and positive physician image.

TMA programs:

• Be Wise – ImmunizeSM,
• Hard Hats for Little Heads,
• Walk With a Doc Texas,
• Ernest and Sarah Butler Awards for Excellence in Science Teaching,
• Minority Scholarship Program,
• University of Health Forums,
• HPV social media campaign,
• History of Medicine traveling exhibits,
• Call Your Doctor First pilot program, and
• Texas Two Step: How to Save a Life CPR training event.

County medical society/alliance/medical student programs (2018 Medical Community Grant programs):

• Drive Thru, Prevent Flu/Lamar Delta County Medical Society,
• Texas BookShare/Bell County Medical Society Alliance,
• Project Access Tarrant County/Tarrant County Medical Society,
• Alliance Refugee Wellness Fair/Baylor College of Medicine TMA Medical Student Chapter,
• Aggie Health Project: Hepatitis C/Texas A&M Health Science Center TMA Medical Student Chapter,
• HOPE Health Fair/The University of Texas Medical Branch TMA Medical Student Chapter,
• Implementing a Smoking Cessation Program in a Dallas Homeless Population/UT Southwestern TMA Medical Student Chapter
• Immunization Collaboration of Tarrant County/Tarrant County Medical Society Alliance Foundation,
• Carnaval de Salud: United to Serve Health Fair/UT Southwestern TMA Medical Student Chapter, and
• Community Health Day/Baylor College of Medicine TMA Medical Student Chapter.

John P. McGovern Champion of Health Award:

• Heal the City Free Clinic, Alan Keister, MD, Amarillo, and
• The Kind Clinic by Texas Health Action, Austin.

TMAF Family of Funds grants: TMAF’s Family of Funds was launched as an umbrella for TMAF funds and endowments that support the charitable health improvement and education goals of TMA and TMAA members, and the related efforts of TMA county medical societies and TMA alliance and medical student chapters.

• The TMAF Hispanic Nursing Scholarship Trust Fund of Dr. Roberto J. and Agniela (Annie) M. Bayardo supported $31,600 in grants for seven scholarships awarded by the Harris County Medical Society Alliance and the Travis County Medical Society Alliance.

Additional TMAF achievements:

• Raised nearly $395,000 through the 2018 gala, thanks to generous sponsors, more than 550 guests, and the efforts of the TMA Foundation Board of Trustees. Top sponsors were H-E-B; Pfizer, Inc.; and Texas Medical Liability Trust.
• Added expertise to its board of trustees with new members David Fleeger, MD, Austin, TMA president-elect; Curtis Eric Grey, MD, Athens; and Debra Pitts, Tyler; and TMA section representatives Arindam Sarkar, MD, Houston, Resident and Physician Section; Shannon Hancher, MD, Bellaire, Young Physician Section; and Sinan Bana, Medical Student Section.
• Approved grants for TMA’s 2019 health improvement, quality-of-care, science, and education initiatives as well as Family of Medicine community programs. See Attachment A.
• Twenty-one individuals became new or upgraded Major Donors; each were recognized at 2019 TMA Winter Conference, and their names will be added or moved up on the Major Donor displays at the TMA building. This brings the total number of Major Donors to 241 as of Dec. 31, 2018. Major Donor status begins at $10,000 in cumulative donations with additional levels for subsequent increased giving; see Attachment B.
• Presented the 2018 TMAF John P. McGovern Champion of Health Award; grants of $5,000 and $2,500 were presented for winning programs that improve student health and nutrition.

TMAF’s 26th Gala on Friday, May 17, 2019

TMA Foundation’s 26th annual gala, BIG & BRIGHT, celebrates the Texas State Fair of the 1930s and ’40s on Friday, May 17, at the Hilton Anatole Dallas during TexMed. Dr. Samuel and Cheryl Chantilis, Dallas, are Host City chairs and Metroplex co-chairs are Drs. Sejal and Saumil Mehta from Allen; Drs. Leena and Nick Shroff of Plano; Lisa and John Queralt, MD, Fort Worth; and Joseph Valenti, MD, Denton. The lead sponsor for the event is H-E-B. Confirmed sponsors at the $30,000-$2,000 level as of March 20, 2019, are H-E-B; Pfizer, Inc.; Drs. Nick and Leena Shroff; Texas Medical Liability Trust; Baylor Scott & White Health; Cook Children’s Health Care System; Texas Health Resources; Radiology Associates of North Texas, PA; TMA Insurance Trust; UnitedHealthcare; Dallas County Medical Society; DFW Fertility Associates/Cheryl and Sam Chantilis, MD; HeartPlace; Prudential; Steward Health Care; Texas MedClinic; University of North Texas Health Science Center; UT Health San Antonio Long
In the predinner receptions, guests will have the opportunity to enjoy retro games plus a silent auction. In the ballroom, guests may bid in the live auction and donate to the Make-A-Difference drive, which supports TMA’s Hard Hats for Little Heads.

The event is the single largest fundraising effort of TMAF and makes TMA health improvement, science, and quality-of-care programs possible.

Through April 30, regular individual tickets are $250 each and special VIP access tickets are $300; after April 30 these increase to $275 and $325 respectively. Individuals may sponsor a table of eight for $2,200. For more information and to purchase tickets, contact TMA Foundation at (800) 880-1300, ext. 1466, or (512) 370-1466.

Be Wise – Immunize is a service mark of the Texas Medical Association.
TMA GRANTS – *In support of TMA’s public health and science priorities*

**TMA’s Be Wise – Immunize (BWI):** BWI is a public health initiative that promotes the importance, safety, and effectiveness of vaccinations. The program combines education for physicians and patients with hands-on vaccination clinics (sponsored by physicians, TMA Alliance members, and medical students) to increase Texas’ vaccination rates. Since its beginning in 2004, Be Wise – Immunize has provided nearly 360,000 vaccinations to Texas children, adolescents and adults. The program supports TMA and TMA Alliance (TMAA) members with grants to fund local shot clinics aimed at Texas’ underserved and uninsured populations.

**TMA’s Hard Hats for Little Heads (HHLH):** HHLH encourages exercise and fitness and helps prevent life-altering or fatal brain injuries in Texas children. Since inception in 1994, more than 320,000 free helmets have been given to youths aged 14 and younger at community events such as bicycle safety rodeos and health fairs. TMA and TMAA members educate parents and their 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 (MSP):** Established in 1998, TMA’s MSP 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, African-American, 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 (WWAD):** WWAD engages physicians and their patients and the community in healthy physical activity to reverse the consequences of a sedentary lifestyle, especially obesity. Sixty-four TMA physician members are leading walks in 2019 that engage patients in walking with them at least once a month for 12 months. Participants enjoy a healthy snack and a brief health-related presentation before each 45-90 minute walk.

**Distinguished Speaker Series (DSS):** DSS is a forum for public health educators, physicians, community leaders, researchers, and thought leaders to share ideas, research, and policy options with public policy decisionmakers, lawmakers, and health stakeholders in Texas. The forum permits an opportunity to disseminate evidence, information, and expert opinions about the relationship between public health and Texans’ well-being, safety, and economic opportunity. DSS reinforces the importance of population health policy as a leading statewide priority and empowers stakeholders to advocate for evidence-based approaches to public health threats.

**NEW! History of Medicine Banner Program:** This program will enable TMA’s History of Medicine Committee to offer its seven exhibit banner sets to schools, libraries, and other venues that 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 banners promote TMA’s patient health advocacy goals through education and historical content. With TMAF support, the recent museum exhibit, “Deep Roots: Botanical Medicine From Plants to Prescriptions,” will be added to the catalog of banners available.

**Texas Two Step CPR:** This initiative established by Texas medical students, the Texas College of Emergency Physicians, and HealthCorps provided skills training to community participants in hands-only CPR. The program expanded in 2018 to replicate the event on a national level. The project has trained more than 27,800 individuals on how to save lives with hands-only CPR.
COUNTY MEDICAL SOCIETIES AND ALLIANCE CHAPTERS – Medical Community Grants

**Drive Thru, Prevent Flu/Lamar Delta County Medical Society.** The Paris-Lamar County Health District partners 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 to both the elderly and a vast majority of the rural community who find it difficult to visit a regular, walk-in clinic.

**Immunization Collaboration of Tarrant County (ICTC)/Tarrant County Medical Society Alliance Foundation.** With a membership of more than 35 organizations, this program provides (1) low-cost vaccine events that help more than 7,000 eligible children and adults annually to receive required vaccines for kindergarten, seventh grade, and college school registrations; (2) vaccine education for parents, the community, and health care workers and providers through 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.

**NEW! Texas BookShare/Bell County Medical Society Alliance.** The Texas BookShare literacy program is a partnership with Texas Medical Association Alliance, Bell County Medical Alliance, Give More HUGS, and Baylor Scott & White Health. The program promotes early literacy and health and wellness during well check-up visits for children at six Baylor Scott & White Health clinics that serve low-income communities. Physicians prescribe books to promote language development and healthy habits for a better future, and to help every child read.

**Project Access Tarrant County/Tarrant County Medical Society.** Project Access Tarrant County (PATC) is a community collaboration that provides compassionate specialty care for Tarrant County’s uninsured. A network of volunteer TMA member physicians collaborate with hospitals, ancillary service providers, charitable community clinics, and other providers to serve the target population of 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 that this population otherwise would have been unable to obtain.

TMA MEDICAL STUDENT CHAPTERS – Medical Student Community Leadership Grants

**Alliance Refugee Wellness Fair/Baylor College of Medicine.** This annual event addresses health care disparities in the underserved refugee population that has resettled in Harris County by providing direct medical and preventive health services, education about health and well-being, and resources for greater access to medical care. In partnership with several area not-for-profit refugee resettlement agencies, this initiative provides refugees with culturally competent resources to navigate the Harris Health System.

**Aggie Health Project: Hepatitis C/Texas A&M Health Science Center College of Medicine.** In conjunction with Martha’s Clinic, Texas A&M’s student-run free clinic, this initiative aims to add hepatitis C to current health maintenance screenings and, when applicable, appropriate referral to community partners for the homeless and indigent of the city of Temple and Bell County. The addition of this screening addresses a disparity in available preventive services, creating opportunities for care and cure.

**NEW! Carnaval de Salud: United to Serve Health Fair/UT Southwestern Medical Center (UTSW) TMA Medical Student Chapter.** Established in 2004, Carnaval de Salud was created to organize services that cater to the health care and education needs of the local underserved community. The UTSW Medical Center students promote community wellness by providing free health screenings and creating engaging activities that entertain and deliver health information, introducing children to the general functions of the human body and connecting families to local resources.

**NEW! Community Health Day/Baylor College of Medicine (BCM) TMA Medical Student Chapter.** Community Health Day is a student-organized health fair held in the Sunnyside community in southeast Houston, a socioeconomically and medically underserved urban neighborhood. Each year, nearly all of BCM’s student organizations conduct health screenings, improve health literacy, and provide social resources to families and individuals with limited access to primary and specialty health care and other social services.
Attachment A (continued)

**HOPE Health Fair/The University of Texas Medical Branch (UTMB).** This collaborative event will provide vaccines, health screenings, and a meal to homeless and uninsured individuals in Galveston. The UTMB TMA Medical Student Chapter, 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. Last year, more than 200 vaccines were provided to this community, and in 2019, HOPE expects to serve at least 250 individuals.

**NEW! Implementing a Smoking Cessation Program in a Dallas Homeless Population/UT Southwestern (UTSW).** Medical students from UTSW are addressing tobacco use by homeless people at a local shelter, Union Gospel Mission, by implementing support groups, pharmacotherapy, and health education. This program is an immersive educational opportunity for medical students in preventive and community medicine who build a future commitment to these communities by interacting with vulnerable populations and gaining knowledge about health disparities and cultural competency.
TMA Foundation Major Donors

Visionaries
Dr. Roberto J. and Agniela (Annie)* M. Bayardo
Dr. and Mrs. Ernest C. Butler

Innovators
Pon Satitpunwaycha, MD

Ambassadors
John P. McGovern, MD*

Stewards
Dr. Mark J. and Mrs. Betty* Kubala
Dr. G. Sealy and Debbie Massingill

Benefactors
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Josie R. Williams, MD, MMM, CPE
Mr. and Mrs. Ronald W. Woliver/CRC Foundation

*Deceased
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Dr. Paul and Mrs. D’Anna* Wick  
Mr. and Mrs. Clarence* Woliver  
Dr. Dale and Mrs. Mertie L. Wood

*Deceased
Subject: TMA Alliance Activities and Accomplishments

Presented by: Sunshine Moore, President

**Public Health Outreach**

The TMA Alliance (TMAA), partnering with community organizations including local health departments and immunization coalitions, has contributed to 360,000 immunizations administered to Texas children since the inception of the Be Wise – Immunize℠ program in October 2004.

As a major participant in the Hard Hats for Little Heads program, TMAA helped give away nearly 30,000 helmets to Texas children in 2018. Since 1994, TMA and TMAA have distributed more than 320,000 helmets.

Walk With a Doc events are now held in 41 communities across the state. In 2018, 63 walking events were held. County alliances participate in the promotion and logistics for these events.

County alliances also customize local programs to address health care issues in their communities, such as health care literacy and book share programs, sex trafficking awareness, and opioid abuse. Members also hold health and book fairs, Jump-A-Thons, and provide coats and shoes to underprivileged children. In addition, county alliances conduct a wide variety of fund raisers for medical and allied health professional scholarships.

**Legislation/Political Action**

First Tuesdays at the Capitol continues to be a premier program that brings more than 1,000 physicians, alliance members, and medical students to Austin every legislative session. The 2019 First Tuesdays is already surpassing attendance levels for past sessions. A new program was added to First Tuesdays for members who didn’t have scheduled meetings and/or were new to grassroots advocacy by Patty Loose, First Tuesdays at the Capitol chair and past TMAA president (2015-16). It’s called the Advocacy Ambassador program and it has been a huge hit. Each First Tuesday, more than 50 people join teams and conduct meet and greets at the Capitol. Each team is led by an Alliance member.

Plans are underway to initiate and implement “First Tuesdays in the District” after the 2019 session. Every month, Alliance members will schedule coffee, lunch, or dinner visits with local legislators and their staff with TMA and TMAA members. The program will encourage more TMA and TMAA engagement in advocacy.

Alliance members continue to support TEXPAC with approximately 400 members. Initiatives are underway to double TEXPAC/Alliance membership in 2019.

**TMA Foundation**

TMA Alliance leaders were instrumental in key TMA Foundation achievements including the gala held in San Antonio. Neha and Jayesh Shah, MD, and Gigi and Sheldon Gross, MD, of San Antonio co-chaired the event. Members that participated on the gala event committee included Anna Allred, MD; Shannon Hancher, MD; Jennifer Lewis; Shania Sheppard, MD; Angie Donahue; Monica Lee, MD; Jenny Shepherd; and Jennifer Zaragoza. Many other TMAA members rolled up their sleeves and assisted with
event and auction set up and numerous county alliance chapters contributed manpower, funds, and raffle
items to support the annual benefit event.

Four Alliance chapters received community health improvement grants to launch and/or enhance their
programs. Lubbock Anti-Sex Trafficking Project/Lubbock County Medical Society raises awareness
about the problem of human sex trafficking of minors in Texas. Immunization Collaboration of Tarrant
County (ICTC)/Tarrant County Medical Society Alliance Foundation provides low-cost vaccine events to
ensure eligible children and adults receive required vaccines for kindergarten, 7th grade, and college with
more than 7,000 served. The collaboration also provides vaccine education for parents, community, health
care workers, and providers through website and social media channels so that ICTC becomes a go-to
source for information about the importance and safety of immunizations. Texas BookShare/Bell County
Medical Society Alliance is a new program, and is a partnership with TMAA, Bell County Medical
Alliance, Give More HUGS, and Baylor Scott & White Health. Texas BookShare promotes early literacy
and health and wellness during well check visits for children at six Baylor Scott & White Health clinics
which serve low-income communities. Physicians will prescribe books to promote language development,
healthy habits, and that help every child in Texas read.

The TMAA official family holiday sharing card was repeated in 2018, raising $2,885. Currently, Angela
Donahue and Debbie Pitts represent TMAA as members of the TMA Foundation Board of Trustees.
Hundreds of TMA Alliance members and their spouses are donors to the foundation, helping to make
signature programs such as Hard Hats for Little Heads, Be Wise – Immunize, and Walk With a Doc
Texas possible.
TMF Health Quality Institute has worked with Texas physicians for more than 46 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, Missouri, Oklahoma, and Puerto Rico, TMF is contracted to conduct various health care initiatives. These initiatives include improving cardiac health; reducing disparities in diabetes care; increasing screening and awareness of chronic kidney disease; improving rapid recognition and proper self-management of chronic obstructive pulmonary disease (COPD) exacerbation thereby reducing COPD emergency department utilization and subsequent inpatient hospital admissions; improving prevention efforts through meaningful use of health information technology; reducing harm in nursing homes; enhancing the coordination of care for patients to reduce unnecessary hospital readmissions; improving drug safety practices; promoting appropriate use of antimicrobials (including antibiotics); ensuring that eligible clinicians can easily comply with Merit-Based Incentive Payment System (MIPS) requirements and smoothly transition into Alternative Payment Models; assisting providers with quality reporting; improving immunization rates; increasing screening of depression and alcohol use disorders; and supporting the Transforming Clinical Practice Initiative.

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 now include more than 26,000 U.S. and international users. These networks provide a forum for positive interaction, learning, 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 vaccines 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 10 years ago, we have successfully managed and completed more than 37,000 provider site reviews in multiple states. Through the CMS Civil Money Penalty (CMP) Reinvestment Program, TMF is collaborating with others to help drive large-scale national improvements in quality of care and life across skilled nursing facilities. Separately, TMF was awarded a CMP contract to improve oral hygiene for nursing home residents in Texas and Oklahoma. TMF received an additional CMP contract focused on educating staff in Texas nursing homes about the signs and symptoms of sepsis as well as evidence-based treatments for optimal resident outcomes.
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 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.

We are honored to be partnered with the Texas Medical Association and the Texas Osteopathic Medical Association (TOMA) in offering the Texas Physician Practice Quality Improvement Award Program. The awards recognize Texas practices for their dedication and commitment to providing high-quality patient care. Please visit https://award.tmf.org/ for information about this noncompetitive recognition program. 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.
In addition to the report on expanding availability of broadband internet access to rural Texas and collaboration with the Committee on Physician Distribution and Health Care Access about Project ECHO, the Committee on Rural Health also has worked on:

**Texas Department of Agriculture - Rural Policy Plan**

Committee staff participated in a workgroup to draft the State Office of Rural Health’s Rural Policy Plan. The office, housed at the Texas Department of Agriculture, submitted its report to the Texas Legislature in December 2018. Other stakeholders who participated in drafting the report included the Texas Nurses Association, Texas Association of Rural Health Clinics, Texas Organization of Rural & Community Hospitals, the AgriSafe Network, Texas Rural Health Association, and the Texas Dental Association.

The plan, vetted by the committee last year, contains many TMA-backed proposals, including promoting use of telemedicine, focus on the rural health care workforce shortage, and broadband access.

**Texas Rural Funders Collaborative**

The committee, led by Dr. Sandra Dickerson, Dr. Lucia Williams, and Alison Mohr Boleware, is participating in the Texas Rural Funders Collaborative. The collaborative is a group of stakeholders that are collectively interested in improving rural Texas. Some stakeholders are philanthropic funders, while others work for state agencies, university systems, or private associations. While the collaborative’s mission is broader than rural health, it is focused on ways to strengthen health care availability and quality in rural counties.

In September 2018, Dr. Williams participated in a roundtable to provide real-world physician perspective on the collaborative’s rural health priority issues: strengthening rural hospitals, expanding telemedicine and telehealth, and improving broadband availability. Committee staff will continue to monitor the collaborative’s efforts.
AGENDA
REFERENCE COMMITTEE ON FINANCIAL AND ORGANIZATIONAL AFFAIRS
Friday, May 17, 2019
Tower Lobby, Topaz - Hilton Anatole

1. TMA President Report 1 – Nominations for Board of Governors, Texas Medical Liability Trust
2. Board of Councilors Report 4 – Emeritus Nomination
3. Board of Councilors Report 5 – Honorary Nominations
4. Board of Councilors Report 6 – Sunset Policy Review
5. Board of Trustees Report 14 – Inactive County Medical Societies
7. Council on Constitution and Bylaws Report 1 – Inactive Specialty Societies
8. Committee on Membership Report 2 – Women in Medicine Section
9. Committee on Physician Health and Wellness Report 1 – Policy Review and Amendment to Committee Charge
15. Council on Socioeconomics Report 4 – Establishing a Standing Committee on Medicaid, CHIP, and the Uninsured
17. Texas Delegation to the AMA Report 3 – Texas Delegation Operating Procedures Changes
18. Resolution 101 - Saturday-Sunday Meeting Schedule for the Texas Medical Association
19. Resolution 102 - Written Testimony at TMA Reference Committees
20. Resolution 103 – Gratitude for Continuing Medical Education Courses

Late Business
21. Resolution 104 – Alternate Delegates May Address the House of Delegates
22. Resolution 105 – Pharmacies Practicing Medicine
23. Resolution 106 – Establish a Coalition of Medical Societies to Protect Competition and Sustainability in the Health Insurance Marketplace
24. Resolution 107 – Physician Dispensing of Prescriptions
25. Resolution 108 – Initial Assessment and Treatment Recommendation by Specialists
26. Resolution 109 – Licensure Status on TMA Membership Applications
27. Resolution 110 – Blue Cross and Blue Shield of Texas Charitable Requirements as a Not-for-Profit Corporation
29. Resolution 112 – Equal Pay for Equal Work
The trust instrument that controls the operations of the Texas Medical Liability Trust (TMLT) requires that nominations for the Board of Governors be made by the TMLT board and submitted to the Texas Medical Association House of Delegates by the TMA president. When the house approves the nominations, they will be placed before TMLT policyholders for election.

Positions on the TMLT board are slotted.

John Holcomb, MD, will fulfill his term and board tenure at the end of 2019. The TMLT Board of Governors recommends the following nomination for one three-year term beginning in 2020:

Luis M. Benavides, MD, Laredo, family medicine, for election to Place 6.

Recommendation: Approval of Dr. Luis M. Benavides, nominee of the TMLT Board of Governors, to be placed before TMLT policyholders for election.
Subject: Emeritus Nomination

Presented by: Steven M. Petak, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

The House of Delegates, upon nomination by the county medical society in which the member belongs and approval by the Board of Councilors, may elect a member of the association who has rendered exceptional and distinguished service to scientific or organized medicine, or both, to the status of member emeritus.

The Board of Councilors has approved the nomination of Mary C. Spalding, MD, and Josie R. Williams, MD, for emeritus membership and recommends their election to such by the House of Delegates. A brief sketch follows for Drs. Spalding and Williams.

Mary C. Spalding, MD (El Paso County Medical Society)

Dr. Spalding has been a professor at Texas Tech University Health Sciences Center-El Paso from 1996 to present in the Department of Family Medicine. During her career, she has mentored many residents and medical students to become outstanding physicians in the El Paso community, as well as throughout the United States.

During her career, she received many prestigious awards such as Faculty of the Year Best Doctors in America 2005-17, Who's Who Among American Higher Education, and Cambridge Who's Who Executive and Professional Women.

Dr. Spalding is active within the professional organizations she belongs to, as has done a lot of work throughout her community. She has always led the charge to improve Texas health care throughout her career.

Josie R. Williams, MD (Lamar-Delta County Medical Society)

Dr. Williams developed a reputation as an excellent physician and served as a physician leader in the field of gastroenterology in Paris, Texas for many years. After much success, she decided to pursue opportunities to make an impact at the state and national levels.

Dr. Williams began her career after becoming the first female graduate of Texas A&M to attend medical school. Following her practice in Paris, she facilitated and created multiple research programs and services at Texas A&M Health Science Center. Dr. Williams also contributed substantial work to the founding of the Knowledge, Skills, Training, Assessment and Research (KSTAR) program in her area to assist physicians with health and wellness issues. She has spent a great deal of time making the voice of medicine heard before committees and panels at the state and federal levels, including as a past president of the Texas Medical Association.

Recommendation: Elect Mary C. Spalding, MD, and Josie Williams, MD, to emeritus membership in TMA.
REPORT OF BOARD OF COUNCILORS

Subject: Honorary Nominations

Presented by: Steven M. Petak, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

The Texas Medical Association Board of Councilors has approved the nominations of Richard M. Holt, MD; Wesley Stafford, MD; Jane Stafford, MD; Harris M. Hauser, MD; Milton Altschuler, MD; and John D. Milam, MD for honorary membership and recommends their election by the House of Delegates. A brief sketch follows for each member.

Richard M. Holt, MD (Travis County Medical Society)
Dr. Holt received his undergraduate education at Yale University before receiving his medical degree at The University of Texas Medical Branch at Galveston. Upon completion of his postgraduate training, Dr. Holt and his family moved to Austin, where he entered private practice in 1973. Dr. Holt has served in various leadership positions, including the Central Texas Medical Foundation Board, the Travis County Medical Society Community and Public Health Committee, the Disaster Preparedness Committee, and the Wrong Site Wrong Procedure Committee. Dr. Holt’s 44-year career has been characterized by his devotion to his profession and his patients.

Wesley Stafford, MD (Nueces County Medical Society)
Dr. Stafford received his medical degree from The University of Texas Medical Branch at Galveston. He has served as Nueces County Medical Society president, a TMA delegate, a member of the TMA Council Scientific Program, and as chair of the TMA Continuing Education committee. Dr. Stafford has written several scientific papers and publications.

Jane Stafford, MD (Nueces County Medical Society)
Dr. Stafford received her medical degree from The University of Texas Medical Branch at Galveston and her Bachelor of Arts in Biology and English from Southwestern University. She has been a member of TMA, the American Medical Association, and the Nueces County Medical Society for 30 years. Dr. Stafford served as the Nueces County Medical Society president and within the TMA House of Delegates. She is an associate medical director with a demonstrated history of working in the hospital and health care industry.

Harris M. Hauser, MD (Harris County Medical Society)
Dr. Hauser received medical degree with honors at Baylor College of Medicine. Upon completion of his postgraduate training, Dr. Hauser entered private practice in 1962 as co-founder of the Hauser Clinic in Houston. Dr. Hauser has served in numerous leadership positions, including president of the Houston Academy of Medicine, Vice President of the Harris County Medical Society, and HCMS Delegate to the TMA. He has had numerous administrative and civic appointments and many professional memberships including president of the Houston Psychiatric Society. He has been a member of the Texas Medical Association, American Medical Association and Harris County Medical Society for 63 years. Dr. Hauser has had a career of distinguished service and outstanding achievements in medicine.

Milton Altschuler, MD (Harris County Medical Society)
Dr. Altschuler received his medical degree from the University of Texas Branch at Galveston. He has served on the TMA Physicians Benevolent Fund Committee, Houston Psychiatric Society, and the Steering
Committee of the HCMS Retired Physicians Organization. He has been a member of the Texas Medical Association and Harris County Medical Society for 59 years. Dr. Altschuler has written several scientific papers and publications.

John D. Milam, MD (Harris County Medical Society)
Dr. Milam received his medical degree from the Louisiana State University School of Medicine and had a teaching appointment at the University of Texas Health Science Center at Houston. Dr. Milam has been a member of the Texas Medical Association and Harris County Medical Society for 53 years. Dr. Milam served as an HCMS alternate delegate to the TMA, HCMS Membership Committee and president of the Texas Society of Pathologists. Dr. Milam has also received several medical awards, including the George T. Caldwell Distinguished Service Award. He has written numerous scientific papers and publications.

Recommendation: Elect Richard M. Holt, MD; Wesley Stafford, MD; Jane Stafford, MD; Harris M. Hauser, MD; Milton Altschuler, MD; and John D. Milam, MD to honorary membership in TMA.
The Texas Medical Association periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness. Following are policies reviewed by the Board of Councilors with recommendations for retention, amendment, and deletion.

The Board of Councilors recommends retention of the following policies:

245.010 **Physician Discrimination.** Discrimination Against International Medical Graduates: The Texas Medical Association supports and promotes the right of every licensed physician to be treated meritoriously without discrimination based on national origin or geographic location of medical school (Amended Res. 301-I-99; amended BOC Rep. 6-A-09).

160.019 **Temporary Texas License for Medical Opinion or Testimony:** The Texas Medical Association will seek legislation and/or rule making to establish a temporary license for any non-Texas-licensed physician seeking to provide medical opinion or testimony associated with any action, court proceeding, arbitration hearing, mediation proceeding, or other action or negotiation taking place within Texas (Amended Res. 104-A-09).

160.012 **Antitrust Laws:** The Texas Medical Association, along with other state medical associations, the American Medical Association and national medical specialty societies, supports national efforts to address appropriate federal antitrust reforms and to provide the foundation for fair contract negotiations designed to preserve clinical autonomy and patient interest and to redirect medical decision making to patients and physicians (Res. 410-A-99; reaffirmed BOC Rep. 6-A-09).

The Board of Councilors recommends retaining the policies because the basis for each of the policies remains valid.

**Recommendation 1:** Retain.

The Board of Councilors recommends deletion of the following policies:

195.029 **Registry for Advance Directives:** The Texas Medical Association supports a Centers for Medicare & Medicaid Services requirement for all Medicare patients to register the advance directive of their choice to facilitate their end-of-life preferences being respected (Res. 307-A-09).

TMA Policy 195.029 (Registry for Advance Directives) expresses support for a requirement by the Centers for Medicare & Medicaid Services for Medicare patients to register advance directives. Upon review, the Board of Councilors found this policy to be unclear and also developed concerns about the relevance of this policy. For instance, the Centers of Medicare & Medicaid Services does not currently have a requirement for advance directive registries, but also a central registry for these directives could be operationally difficult to implement and could be
The Board of Councilors found that underlying this policy is the importance of education about advance directives – a topic already addressed and expressed in TMA Policy 85.003. Accordingly, the Board of Councilors recommends deletion of this policy.

**105.017 Privacy of Medical Records:** The Texas Medical Association opposes any weakening of state laws protecting medical privacy, any establishment of a new corporate right to own, collect, or use medical databases, and any funding or implementation of a national patient identifier pursuant to the Health Insurance Portability and Accountability Act (Res. 105-A-99; amended BOC Rep. 6-A-09).

TMA Policy 105.017 (Privacy of Medical Records) expresses opposition to issues being addressed in federal legislation that was being considered in the late 1990s. Because the fate of that federal legislation is now well-settled, the Board of Councilors recommends deletion of this policy. Further, the Board also notes that several other TMA policies address the principles behind this policy relating to the privacy of medical records. TMA Policies 105.006, 105.019, 118.004, and 235.019 all address aspects of privacy of medical records that were addressed to a limited extent in Policy 105.017. Because Policy 105.017 is redundant and does not as clearly state TMA’s positions on privacy issues as other polices do, the Board recommends deletion.

**Recommendation 2:** Delete.

The Board of Councilors recommends amending the following:

**165.004 Government Competency Checks:** The Texas Medical Association vigorously opposes any attempt by the federal government to establish boards which would oversee state licensure bodies and impose federal competency checks through onsite inspection, chart reviews, or periodic written examination (Res. 106-A-99; reaffirmed BOC Rep. 6-A-09).

The Board of Councilors finds that the basis for this policy remains valid, but that federal competency checks through *any means* – not just chart reviews, written examinations, or onsite inspection – should be opposed.

**Recommendation 3:** Retain as amended.
The Board of Trustees has continued to study the issue of inactive county medical societies. In 2019, the board reviewed reports on the organizational challenges of inactive small to medium-sized county medical societies. It was determined that if these challenges remained unchecked, the inactive societies could lose viability and membership. To address the challenges and increase engagement of these societies, TMA Board of Trustees Chair Diana Fite, MD, appointed an ad hoc Committee on Inactive County Medical Societies.

The ad hoc committee consisted of five members from the TMA Board of Trustees (Ray Callas, MD; David Fleeger, MD; Susan Strate, MD; Joseph Valenti, MD; and Arlo Weltge, MD). TMA President-Elect Dr. Fleeger chaired the committee. The committee met at TMA’s 2018 Advocacy Retreat on Nov. 30 and by conference call on Jan. 8.

The ad hoc committee discussed minimum requirements to be an active county medical society; the number of leaders required for small county societies; at-large counties; ways TMA can support at-large members and small county societies; and other matters.

**Minimum Requirements to Be an Active County Medical Society**

One of the issues discussed was using TMA’s collection of dues on behalf of a county medical society as an incentive for the society to maintain a basic level of activity. Currently TMA collects dues for all but two county medical societies. The ad hoc committee discussed the possibility of continuing to do so only for a county society that meets a basic threshold of activity.

The committee recommended that to be considered active, a county medical society would have to provide the following information annually to TMA:

1. A list of currently elected officers and delegates with their terms of office. Elections must be held by each society annually.
2. A list of the reporting year’s meetings with attendance noted.
3. Confirmation of the society’s annual membership dues rate.
4. Evidence of filing the society’s annual nonprofit tax returns, such as Form 990.

An inactive county medical society would be one that fails to satisfy this reporting requirement. The TMA Board of Councilors would be the TMA component to designate a county medical society as inactive. The ad hoc committee recommended discontinuing the collection of dues from a county society determined to be inactive and to collect dues only on behalf of an active society. Members of an inactive county medical society would still be treated as members of the society for purposes of eligibility for TMA membership.
Reducing the Number of Leaders Required for Small County Medical Societies

Fifty-seven county medical societies have 50 or fewer members. Of those, 28 have five to 20 members. Expecting a large percentage of members of these societies to serve as leaders is unrealistic.

Currently, the minimum requirement of officers for a county medical society is a president, secretary/treasurer, and board of censors made up of three physicians for a total of five leaders. The ad hoc committee recommends changing the TMA Bylaws to allow a county society with fewer than 50 members to have the option to reduce the number officers to three: president, president-elect, and secretary/treasurer.

For those societies with fewer than 50 members that choose not to have a board of censors, the officers could assume the functions of the county’s board of censors, including membership application processing and disciplinary investigations. In this circumstance, any action performed by a board of censors that is otherwise reviewed by or appealed to a county medical society’s executive board could be reviewed or appealed to the district councilor.

Enhanced County Medical Society Leadership Development

County medical society leaders often are elected to serve in the same position more than once. Often, when an engaged leader moves, retires, or no longer wants to be involved, a small society becomes inactive. TMA needs to support smaller county medical societies in developing new leaders. A healthy county society increases member engagement and membership numbers. In 2019, the board approved enhancing TMA-sponsored leadership development for county medical societies.

In addition, TMA Practice Management Education is scheduling a free webinar with CME for the first half of 2019 on leadership training. It will teach best practices for chairing a council or committee, becoming more involved at the local and state levels, and the expectations of leadership.

TMA also hosts a leadership forum targeting newly elected county medical society officers and newly hired county society staff to provide best practices and education on TMA resources, support for county medical societies, and strategies for membership recruitment and retention. In the past, this forum has been held in person, but for 2019 it will be offered as a virtual meeting.

Virtual CMS Meetings and Support of the Lone Star Caucus’ Virtual Meeting Efforts

Members who live in rural counties may not have opportunities for engagement with their county medical society or TMA. To provide greater services to these members, TMA will offer virtual meetings highlighting the latest legislative, legal, or other business-of-medicine topics. Tentative plans for 2019 are:

- April – Legislative update
- June – Recap of the 2017 legislative session and actions from the TMA 2019 Annual Meeting
- September – Leadership and organized medicine
- November – Legal issues

At-Large Member Representation

In 2012, the TMA House of Delegates amended TMA Bylaws by adding a section on “at-large members.” TMA Bylaws allows at-large members to elect delegates to the TMA House of Delegates. TMA currently has 91 at-large members.

Acting upon the ad hoc committee’s recommendation, the board instructed TMA to schedule a 2019 meeting for at-large members to elect a delegate to represent this membership category in the house.
there is interest and participation by the at-large members, the Board of Councilors will help them adopt bylaws so they may elect officers and function as a virtual county medical society. The ad hoc committee reported its study and findings to the Board of Trustees at its September 2018 meeting, and the committee was discharged. As a result of the committee’s work, the board makes the following recommendations to the House of Delegates.

Recommendation 1: Define an active county medical society as one that provides the following annually: (a) a list of the reporting year’s elected officers and delegates with their terms of office; (b) a list of the reporting year’s meetings with attendance noted; (c) confirmation of the county medical society annual membership dues rate; and (d) evidence of filing county medical society annual federal nonprofit tax returns, such as IRS Form 990.

Recommendation 2: Allow county medical societies with 50 or fewer members to reduce the number of required officers to three: president, president-elect, and secretary/treasurer.

Recommendation 3: Referral of Board of Trustees Report 14-A-19 to the Council on Constitution and Bylaws for recommended bylaws amendments to implement recommendations 1 and 2.
Subject: Sunset Policy Review

Presented by: Diana L. Fite, MD, 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. The board reviewed the following two policies and recommends retention.

105.018 Fraud and Abuse Initiative: The Texas Medical Association approves continued fraud and abuse advocacy for members through implementation of educational services and practice support programs (BOT 22-A-99; reaffirmed BOT 14-A-09).

160.018 Statute of Limitations for Administrative Violations: The Texas Medical Association supports legislation and/or rulemaking to enact a reasonable statute of limitations for administrative violations (Amended Res. 103-A-09).

Recommendation: Retain.
Background
The House of Delegates recognizes Texas specialty societies as voting members of the house based on several criteria outlined in the Texas Medical Association’s Bylaws, as well as delegate representation on the Interspecialty Society Committee (ISC), which is a standing committee of the TMA Board of Trustees. Specialty society representation in the house requires board certification and formal approval by the house to qualify for delegate representation.

Criteria in TMA Bylaws, Chapter 3, House of Delegates, Section 3.20, Composition, Subsection 3.221, Selection of specialty societies for representation, outlines requirements for certification of a Texas specialty society by the board as follows:

1. Represent only a medical society of subspecialty for which there is a national examining board listed in Directory of Graduate Medical Education Programs Accredited by the Accreditation Council for Medical Education.
2. Be a Texas specialty society of at least 100 physician members, with at least 60 percent of its physician membership TMA members. A society that meets all other criteria but has less than 100 members may be considered for delegate representation if it can be demonstrated that it is not otherwise represented and is recommended by the Board of Trustees.
3. Be an active organization as manifested by an established constitution and bylaws, a slate of periodically elected officers, and yearly meetings.

TMA Bylaws Subsection 3.222, Board of Trustees certification, provides that the board may certify specialty societies who meet all but the first (1) criteria listed in Subsection 3.221 with the advice and consent of the Council on Medical Education. Currently, 27 specialty societies are approved for representation in the House of Delegates and are listed in Subsection 3.227. Approved specialty societies are eligible to participate on the ISC and designate a delegate and alternate delegate.

The board continually monitors inactive specialty societies, and part of these efforts included appointing a Task Force on Specialty Societies Represented in the TMA House of Delegates in May 2015. The task force determined there were a number of societies that did not participate in house or ISC meetings. It was noted that some of the societies and/or state chapters may no longer be in existence. ISC and House of Delegates staff were directed by the board to reach out to inactive societies to determine continued interest in delegate representation in the house and, if not, communicate the names of those societies to the Council on Constitution and Bylaws for proposed amendments removing them from the TMA Bylaws.

Inactive Specialty Societies
The following specialty societies have been identified as being inactive with the House of Delegates and ISC:
1. **Texas Association of Physicians in Nuclear Medicine**: The last recorded delegate was Donald A. Podoloff, MD, who served from 1992-2013. The last recorded alternate delegate was Ramesh D. Dhekne, MD, who served from 1992-2004. There is no longer a Texas Chapter of the national society. TMA currently has 33 physician members in the Nuclear Medicine specialty.

2. **Texas Thoracic Society**: Texas no longer has an active chapter within the American Thoracic Society (ATS), but the ATS is in the process of forming a Texas chapter. There is no set date for completion. The last recorded delegate for this society was Raymond C. Perkins II, MD, who last attended a TMA House of Delegates meeting in 2001.

**Discussion**

During a recent review of inactive specialty societies in September 2018, the board recommended the Council on Constitution and Bylaws be asked to propose amendments to the TMA Bylaws removing the following specialty societies from Chapter 3, House of Delegates, Section 3.20, Composition, Subsection 3.227, Specialty societies qualifying for delegate representation: Texas Thoracic Society and Texas Association of Physicians in Nuclear Medicine. The option to reapply for representation in the house is clearly outlined in the TMA Bylaws by seeking certification by the board (Bylaws subsection 3.222).

**Recommendation**: Amend Chapter 3, House of Delegates, Section 3.20, Composition, Subsection 3.227, Specialty societies qualifying for delegate representation and renumber the listing accordingly:

**CHAPTER 3. HOUSE OF DELEGATES**

**3.20 Composition**

**3.227 Specialty societies qualifying for delegate representation.** The following Texas specialty societies are approved for delegate representation:

1. American College of Surgeons, North and South Texas Chapters (American Board of Surgery);
2. Texas Academy of Family Physicians (American Board of Family Medicine);
3. Texas Allergy, Asthma and Immunology Society (American Board of Allergy and Immunology);
4. Texas Association of Neurological Surgeons (American Board of Neurological Surgery);
5. Texas Association of Obstetricians and Gynecologists (American Board of Obstetrics and Gynecology);
6. Texas Association of Otolaryngology-Head and Neck Surgery (American Board of Otolaryngology);
7. Texas Association of Physicians in Nuclear Medicine (American Board of Nuclear Medicine);
8. Texas Chapter of the American College of Cardiology (American Board of Internal Medicine);
9. Texas Chapter of the American College of Physicians-American Society of Internal Medicine (American Board of Internal Medicine);
10. Texas College of Emergency Physicians (American Board of Emergency Medicine);
11. Texas Dermatological Society (American Board of Dermatology);
12. Texas Geriatrics Society (American Board of Family Medicine and American Board of Internal Medicine);
13. Texas Neurological Society (American Board of Psychiatry and Neurology);
14. Texas Ophthalmological Association (American Board of Ophthalmology);
15. Texas Orthopaedic Association (American Board of Orthopaedic Surgery);
16. Texas Pain Society (American Board of Anesthesiology);
17. Texas Pediatric Society (American Board of Pediatrics);
18. Texas Physical Medicine and Rehabilitation Society (American Board of Physical Medicine and Rehabilitation);
Texas Radiological Society (American Board of Radiology);
Texas Society for Gastroenterology and Endoscopy (American Board of Internal Medicine);
Texas Society of Anesthesiologists (American Board of Anesthesiology);
Texas Society of Medical Oncology (American Board of Internal Medicine);
Texas Society of Pathologists (American Board of Pathology);
Texas Society of Plastic Surgeons (American Board of Plastic Surgery);
Texas Society of Psychiatric Physicians (American Board of Psychiatry and Neurology); and
Texas Thoracic Society (American Board of Thoracic Surgery);
Texas Urological Society (American Board of Urology).
REPORT OF COMMITTEE ON MEMBERSHIP

Subject: Women in Medicine Section

Presented by: Tina J. Philip, DO, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

Background

Among the reasons that the Texas Medical Association established sections for specific segments of the membership was to provide opportunities for participation, influence association policy, foster dialogue, and provide relevant services to meet the unique needs of section members. Each section contributes to the success and effectiveness of TMA and provides a representative forum for its members.

TMA Female Physician Membership Data

The percent of active female physician members has seen a steady increase, from 29 percent in 2013 to 31 percent in 2018. Male physician membership has decreased from 71 percent in 2013 to 68 percent in 2018. The number of female physicians in the United States has greatly increased in recent years. In 1981, females comprised only 12 percent of all physicians. Today, approximately 50 percent of medical students are female. Additionally, 40 percent of nonmembers are female physicians. Thus, the opportunity to increase membership and engagement for this key membership segment remains strong.

<table>
<thead>
<tr>
<th>TMA Membership</th>
<th>Male</th>
<th>Female</th>
<th>Total</th>
<th>% Male</th>
<th>% Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Member</td>
<td>27,311</td>
<td>11,364</td>
<td>38,675</td>
<td>71%</td>
<td>29%</td>
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<tr>
<td>Resident Member</td>
<td>3,983</td>
<td>3,022</td>
<td>7,005</td>
<td>57%</td>
<td>43%</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>31,294</strong></td>
<td><strong>14,386</strong></td>
<td><strong>45,680</strong></td>
<td><strong>69%</strong></td>
<td><strong>31%</strong></td>
</tr>
</tbody>
</table>

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<thead>
<tr>
<th>TMA Membership</th>
<th>Male</th>
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<th>Total</th>
<th>% Male</th>
<th>% Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physician Nonmember</td>
<td>16,019</td>
<td>10,846</td>
<td>26,865</td>
<td>60%</td>
<td>40%</td>
</tr>
</tbody>
</table>

Discussion

No such section currently exists for women in medicine. However, in November 2016 TMA conducted a survey to better understand member and nonmember needs, and perception of and overall satisfaction with TMA and its county medical societies. TMA also retained Robin Rather, CEO, Collective Strength, to validate the results and delve into the quantitative findings by conducting in-depth physician interviews.

TMA sought to know how changes in the marketplace are affecting the attitudes of members of varied demographics and how these might affect TMA membership. The research findings pointed to six areas of focus that require TMA attention, including the need to better serve female physicians. Additionally, the research noted that female physicians have lower membership and less engagement with TMA.

As a result, TMA revisited the idea of establishing Women in Medicine events and programming and made better serving women in medicine a top priority. TMA hosted special programming, events, and tables at the TMA Foundation gala, and supported the efforts of county medical societies, many of which
have strong Women in Medicine committees. TMA hopes to continue supporting these local outreach efforts.

In 2018-19, a series of three Women in Medicine events held in conjunction with TMA conferences were at capacity and had a waitlist of those who wanted to attend. During 2018 TMA Fall Conference, the focus of the Women in Medicine program was on how TMA might enhance its activities to better serve and represent female physicians. Linda Villarreal, MD, vice chair of the TMA Board of Trustees, and Robin Rather guided the conversation.

Participants reviewed current TMA and other medical society policies on nondiscrimination and made four recommendations for TMA to consider, including the creation of a women’s section within TMA. Additionally, participants discussed needed programming, advocacy, and services, such as professional and leadership development; improving female representation within TMA; more point-of-entry and leadership opportunities for women; creation of implicit bias training; a campaign to address gender pay inequity; and creation of a watch dog function at TMA to identify discrimination and propose direct action.

Conclusion
The Committee on Membership believes that due to the overwhelming popularity of these “sold out” events and the recommendation from program attendees to create a Women in Medicine section, there is sufficient evidence to support the creation of such a section. The TMA Board of Trustees supports the recommendations in this report.

Recommendation 1: Establish a TMA Women in Medicine Section.

Recommendation 2: Approve the following charge to the section:

The purpose of the Women in Medicine Section is to strengthen engagement and representation of female physicians in organized medicine through the development of relevant policy, programming, and services.

Recommendation 3: Amend Chapter 3, House of Delegates, Section 3.25, Sections, as follows:

3.25 Sections

3.255 Women in Medicine Section: The House of Delegates shall have a section named the Women in Medicine Section. Any TMA physician member may become a member of the section, and female physicians who are TMA members are members of the section automatically. The section shall have the authority to elect one voting delegate to serve in the House of Delegates. The section shall elect an alternate delegate who may serve as provided in 3.32. The section will be directed by an elected governing council and governed by operating procedures approved by the House of Delegates. The operating procedures shall provide the purposes, organization, and procedures of the Women in Medicine Section.
The Committee on Physician Health and Wellness recently evaluated its function and programs, including the drug screen program, established in 1996.

Upon the conclusion of the evaluation, the committee moved to refine its purposes and administered programs. The recommended changes will ensure that the TMA Bylaws and TMA policy accurately reflect these purposes and programs, and will enhance the Committee on Physician Health and Wellness programs’ compliance positioning. Additionally, the recommended changes will strengthen the committee’s commitment to providing and advocating for prevention and educational resources to improve the wellness of medical students, resident physicians, and physicians in Texas.

The committee voted to discontinue the drug screen program, which has only 11 current participants. This change will make it necessary to repeal House of Delegates policy relating to the existence of the drug screen program.

The committee recommends deletion of the following policy:

95.014 Drug Screening of Physicians: The Texas Medical Association will continue to maintain a service at the state level for drug screening of physicians under contract with county medical society physician health and wellness committees, district coordinators, and hospital-based peer assistance committees.

Recommendation 1: Delete.

The committee recommends amending its charge in the TMA Bylaws as follows:

10.621 Committee on Physician Health and Wellness. It shall be the duty of this committee to promote healthy lifestyles in Texas to medical students, residents, and physicians; to provide advocacy and support for and education on physician wellness; and to promote prevention of potentially impairing conditions. and to identify, strongly urge evaluation and treatment of, and review rehabilitation provided to physicians with potentially impairing conditions and impairments. The committee shall be required to report its activities to the Board of Councilors. The committee shall maintain liaison with the Texas Medical Board and the Texas Physician Health Program. The committee shall be responsible also for making recommendations to the Council on Legislation in instances where there are needed changes in the laws relative to physician wellness and potentially impairing conditions. The committee shall provide responsible advocacy and support, provide education on physician health and wellness topics, and promote prevention of potentially impairing conditions.

Recommendation 2: Amend TMA Bylaws Section 10.621.
The Texas Medical Association periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness.

The Committee on Physician Health and Wellness recommends retention of the following policy:

**265.019 Physician Behavior Standards.** The Texas Medical Association encourages bylaws and policies that promote a safety culture and asserts that standards for physician behavior should not use ambiguous terms that can be used against physicians for retaliation or for economic gain.


**Recommendation:** Retain.
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 policy:

**245.009 Disciplinary Investigation Reporting.** The Texas Medical Association supports the reporting of final disciplinary actions only and prohibiting health care entities from requiring physicians to report pending investigations by the Texas Medical Board, and supports legislation to prohibit such reporting (Res. 102-A-99; amended BOC Rep. 6-A-09).

**Recommendation:** Retain.
Subject: Patient-Centered Medical Responsibilities, Resolution 101-A-18

Presented by: D. Allen Schultz, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

Resolution 101-A-18, introduced by the Webb-Zapata-Jim Hogg County Medical Society, was referred to the Council on Practice Management Services, Ad Hoc Committee on Health Information Technology, and Division of Public Affairs. It addresses the promotion of patients accessing their own health records as part of a medical record checkup day, especially as related to disaster preparedness.

The resolution recommended that the Texas Medical Association (1) encourage appropriate organizations, e.g., disaster preparedness agencies, utility companies, and county health departments, to educate Texans on the importance of having access to or possession of an accurate summary of their medical record whenever and wherever it is needed; and (2) support a legislative proclamation that designates a Texans Medical Record Checkup Day at the beginning of hurricane and tornado season to encourage Texans to have access to or possession of an accurate summary of their medical record should it be needed.

Status

Testimony at the reference committee indicated concerns regarding the implementation and need to tighten up the language of the resolution. The intent of the resolution was not to overburden practices with a rush of patients seeking a copy of their medical record, but rather to educate patients on the importance of having a care summary that includes up-to-date:

- Demographics,
- Allergies and medications,
- Immunizations,
- Medical problems,
- Recent hospitalizations and relevant lab results,
- Primary care/specialty physicians, and
- Other key information needed for care such as special medical equipment or supplies.

If a patient is displaced and needs care or medications replaced, having a medical record summary is immensely helpful to physicians and other care providers. Legislative action could focus on hurricane preparedness and an annual proclamation day including activities that patients should take in preparing for a natural disaster including making sure that individuals have a summary of their medical record.

Implementation

A partial medical record summary, in most cases, can be accessed through the patient’s online portal, which is typically available with physicians using an electronic health record (EHR). A medical record checkup campaign, similar to TMA’s Be Wise – Immunize and Walk With a Doc outreach initiatives, could be developed that educates patients on how to access and download their medical record summary. The Ad Hoc Committee on HIT compiled ideas for implementation that are listed in the attachment. Patients having a copy or a summary of their medical record is helpful in any situation, but especially during times of disaster.
Recommendation: That the house adopt the following revised Resolution 101-A-18:

RESOLVED, That the Texas Medical Association support a medical record checkup campaign encouraging individuals to ensure they have an up-to-date medical record summary in the month of May that is accessible in a disaster; and be it further

RESOLVED, That the Texas Medical Association support a legislative proclamation each May encouraging individuals to have access to or possess an accurate summary of their medical record in the event of a disaster.
PATIENT-CENTERED MEDICAL RESPONSIBILITIES

A Medical Record Checkup campaign could be modeled after existing TMA public health campaigns such as Be Wise – Immunize and Walk With a Doc.

**Audience:** Individuals of all ages.

**Support:** Support could be sought from numerous entities such as:

- Disaster preparedness agencies,
- State and local health departments,
- Local health coalitions,
- Educational institutions at all levels,
- Health systems and medical schools, and
- Other nonprofits expressing interest in wellness education.

**Events:** Designed to educate patients on how to download information from their patient portal. These can be hosted by local nonprofits expressing an interest in disaster preparedness activities.

**Creatives:**

- Flyers that can be repurposed with practice-specific instructions for accessing the patient portal,
- Patient-facing webpage urging patients to access their portal and download their medical information, and
- T-shirts for events – can be worn by organizers and given to attendees.

**Slogan ideas:**

- I have my medical information.
- I downloaded my medical information.
- I got my medical information. Do you have yours?
- Sharing is caring. I have my medical information.
- Power of sharing my medical information to improve my health care.
- Disaster doesn’t have a schedule, so make sure your medical record is up-to-date, accessible, and available.
REPORT OF COUNCIL ON PRACTICE MANAGEMENT SERVICES

CPMS Report 3-A-19

Subject: Establish a Standing Committee on Health Information Technology

Presented by: Dean A. Schultz, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

In recognition of the rapid move towards electronic systems, at its May 2005 meeting, the TMA Board of Trustees approved establishing a health information technology task force. It has since become known as the Ad Hoc Committee on Health Information Technology (HIT). The ad hoc committee reports to the Council on Practice Management Services. The charge for the new task force was to:

- Guide the research project to determine member needs in the area of HIT,
- Determine and initiate TMA’s strategies for in-office support for HIT,
- Oversee TMA’s role in the development of regional health information organizations in Texas, and
- Host TMA’s HIT Summit.

At the time, approximately 22 percent of Texas physicians used an electronic health record (EHR). TMA’s 2018 survey of Texas physicians indicates that number has grown to 85 percent. Through the committee, TMA continues to meet the charge to provide robust resources that support and guide TMA members.

The need remains to support members in fulfilling one of the TMA’s strategic goals and strategy:

TMA 2020 Goal: Practice Strength: Protect, improve, and strengthen the viability of medical practices in Texas.

Strategy C: Promote effective use of technology that supports practice efficiency, quality improvement activities, and management of population health.

Because of this need, it is recommended that the ad hoc committee be established as a standing Committee on Health Information Technology.

Now that the majority of physicians use an EHR, their needs have changed since the original charges were developed for the task force. The following revised charges are recommended for the new standing committee:

1. Promote the safe and effective use of technology that supports practice efficiency, quality care, and management of population health;
2. Monitor and influence state and federal laws, regulations, and programs impacting physician and patient use of technology;
3. Develop association policy related to health technology;
4. Collaborate with other professional organizations and governmental agencies working on health technology issues and serve as the association’s voice and advocate; and
5. Oversee development of health information technology education and resources for physicians.
The Council on Practice Management Services will remain as the parent council. The committee shall be composed of nine physicians who have expertise or experience with health information technology and relevant issues. Consultants would be appointed as needed to augment the committee.

The following bylaw amendments are proposed to section 10.52, Council on Practice Management Services, to include a new section, 10.521, Committee on Health Information Technology. The TMA Board of Trustees supports the recommendations in this report.

**Recommendation 1:** Establish a standing Committee on Health Information Technology.

**Recommendation 2:** That TMA Bylaws Chapter 10, Committees, Section 10.52 be amended to include a new section for the Council on Practice Management Services, with a new subsection, 10.521, Committee on Health Information Technology to read as follows, and the remainder of the chapter be renumbered accordingly:

**10.52 Committee on Science and Public Health, Council on Practice Management Services**

**10.521 Committee on Cancer, Committee on Health Information Technology:** The purpose of this committee shall be to (1) Promote the safe and effective use of technology that supports practice efficiency, quality improvement activities, and management of population health; (2) monitor and influence state and federal laws, regulations, and programs impacting physician and patient use of technology; (3) develop association policy related to health technology; (4) collaborate with other professional organizations and governmental agencies working on health technology issues and serve as the association’s voice and advocate; and (5) oversee development of health information technology education and resources for physicians.
**REPORT OF COUNCIL ON SOCIOECONOMICS**

Subject: Gender Disparities in Physician Compensation

Presented by: John G. Flores, MD, Chair

Referred to: Reference Conference Committee on Financial and Organizational Affairs

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**Background**

In September 2018, the Board of Trustees directed the Council on Socioeconomics to look into the challenges of discrimination and gender disparities in physician compensation and present policy language to the House of Delegates at TexMed 2019. This topic also was discussed at the Women in Medicine Fall Conference luncheon, and the council received recommendations from that event.

Thirty-one percent of Texas Medical Association’s physician members and 44 percent of our resident members are women. These figures track national data compiled by the American College of Physicians (ACP) showing women representing 34 percent of the active physician workforce and 46 percent of all physicians in training in 2015.

Data from a recent TMA Workforce Study, focused on Texas physicians licensed in 2015 who had received their first Texas medical license in 2013, found more newly licensed female than male physicians in one-third of the 100 counties where new physicians practiced. The data also showed women were less likely to practice in nonmetro and border counties than were men.

<table>
<thead>
<tr>
<th>Comparison of New Physicians, by Gender</th>
<th>Female</th>
<th>Male</th>
</tr>
</thead>
<tbody>
<tr>
<td>MD</td>
<td>45%</td>
<td>55%</td>
</tr>
<tr>
<td>DO</td>
<td>48%</td>
<td>52%</td>
</tr>
<tr>
<td>Metro County</td>
<td>46%</td>
<td>54%</td>
</tr>
<tr>
<td>Non-Metro County</td>
<td>38%</td>
<td>62%</td>
</tr>
<tr>
<td>Border County</td>
<td>39%</td>
<td>61%</td>
</tr>
<tr>
<td>Non-Border County</td>
<td>46%</td>
<td>54%</td>
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Increasing numbers of female physicians in the workforce represent great progress for medicine and for patients receiving care. The increasing numbers also have made gender disparities in physician experiences more pronounced and visible. This is especially evident in the area of compensation.

An ACP study published in 2018 concluded that gender inequities in physician compensation persist, with reported gender-based pay gaps of 16 to 37 percent. The study identified several factors frequently cited as causes of the compensation inequity for women physicians. These include specialty choice, years of experience, number of hours worked, choice made to balance work and family, and scarcity of mentors/senior role models. Researchers concluded that even after accounting for those factors, the disparities continue to exist. The disparities were even greater for minority female physicians.

The Council on Socioeconomics considered two additional academic studies on gender disparities in physician compensation. “Sex Differences in Physician Salary in US Public Medical Schools” concluded that among physicians with faculty appointments at 24 U.S. public medical schools, significant gender differences
in salary and faculty rank exist even after accounting for age, experience, specialty, faculty rank, and
measures of research productivity and clinical revenue. “Differences in Incomes of Physicians in the U.S. by
Race, and Sex: Observational Study” found substantial differences in annual income between black and white
male physicians in the United States and between male and female physicians overall that persist after
adjustment for several characteristics of physicians and practices, including specialty and work hours.

Several national physician organizations have conducted extensive study and policy development on the
disparities in compensation between female and male physicians. The Council on Socioeconomics reviewed
some of the work at ACP and the American Medical Association.

ACP has adopted an official statement affirming that physician compensation (pay; benefits; clinical and
administrative support; clinical schedules; institutional responsibilities; and where appropriate, lab space and
support for researchers) should be equitable; based on comparable work at each stage of physicians’
professional careers in accordance with their skills, knowledge, competencies, and expertise; and not based on
characteristics of personal identity, including gender. ACP also has policy encouraging organizations
employing physicians to conduct routine assessments of the equity of physician compensation arrangements
and to provide regular and recurring implicit bias training.

The American Medical Association adopted new policy and a plan to address the gender gap in physician
compensation at its June 2018 Annual Meeting as follows:

D-65.989 Advancing Gender Equity in Medicine:
1. Our AMA will draft and disseminate a report detailing its positions and recommendations for gender equity
in medicine, including clarifying principles for state and specialty societies, academic medical centers and
other entities that employ physicians, to be submitted to the House for consideration at the 2019 Annual
Meeting.

2. Our AMA will: (a) advocate for institutional, departmental and practice policies that promote transparency
in defining the criteria for initial and subsequent physician compensation; (b) advocate for pay structures
based on objective, gender-neutral objective criteria; (c) encourage a specified approach, sufficient to identify
gender disparity, to oversight of compensation models, metrics, and actual total compensation for all
employed physicians; and (d) advocate for training to identify and mitigate implicit bias in compensation
determination for those in positions to determine salary and bonuses, with a focus on how subtle differences
in the further evaluation of physicians of different genders may impede compensation and career
advancement.

3. Our AMA will recommend as immediate actions to reduce gender bias: (a) elimination of the question of
prior salary information from job applications for physician recruitment in academic and private practice; (b)
create an awareness campaign to inform physicians about their rights under the Lilly Ledbetter Fair Pay Act
and Equal Pay Act; (c) establish educational programs to help empower all genders to negotiate equitable
compensation; (d) work with relevant stakeholders to host a workshop on the role of medical societies in
advancing women in medicine, with co-development and broad dissemination of a report based on workshop
findings; and (e) create guidance for medical schools and health care facilities for institutional transparency of
compensation, and regular gender-based pay audits.

4. Our AMA will collect and analyze comprehensive demographic data and produce a study on the inclusion
of women members including, but not limited to, membership, representation in the House of Delegates,
reference committee makeup, and leadership positions within our AMA, including the Board of Trustees,
Councils and Section governance, plenary speaker invitations, recognition awards, and grant funding, and
disseminate such findings in regular reports to the House of Delegates and making recommendations to support gender equity.

5. Our AMA will commit to pay equity across the organization by asking our Board of Trustees to undertake routine assessments of salaries within and across the organization, while making the necessary adjustments to ensure equal pay for equal work.

TMA Women in Medicine Fall Conference Luncheon
A facilitated, well-attended discussion on issues affecting women in TMA occurred during the Women in Medicine Luncheon at 2018 TMA Fall Conference. Participants adopted and shared with this council four recommendations to forward to the Board of Trustees for evaluation and consideration:

- Create a watchdog function at TMA to identify discrimination and propose direct action,
- Create a women’s section within TMA,
- Create implicit bias training for both male and female TMA members, and
- Create an education campaign designed to unify TMA around improving conditions for women.

Summary
Thirty-one percent of TMA physician members and 44 percent of our resident members are women. The American Medical Association reports that over the past 10 years, the total number of female physicians has grown by 43 percent.

Increasing numbers of women physicians in the workforce represent great progress in medicine and have raised awareness of gender disparities in physician experiences. Studies conducted by several physician-led organizations have identified gender disparity in physician compensation (including pay; benefits; clinical and administrative support; clinical schedules; institutional responsibilities; and where appropriate, lab space and support for researchers) to be especially evident and in need of addressing.

The council reviewed recent academic studies on gender disparities in physician compensation and policy work by national physician-led organizations. The council also considered recommendations from the Women in Medicine Luncheon held during 2018 TMA Fall Conference. Because of liability implications expressed by the TMA Office of General Council, the council voted not to forward a recommendation to create a watchdog function at the TMA.

Recommendation 1: The council recommends adopting new Texas Medical Association policy opposing discrimination in physician compensation:

**Discrimination in Physician Compensation.** The Texas Medical Association (1) affirms that physician compensation should be based on merit; equitable; transparent; and based on comparable work at each stage of physicians’ careers in accordance with their skills, knowledge, competencies, and expertise; and (2) opposes discrimination in compensation on the basis of gender, age, race, ethnicity, gender identity, sexual orientation, disability or religion; and (3) opposes discrimination in compensation based on national origin or geographic location of medical schools.

Recommendation 2: That the Texas Delegation to the AMA closely monitor and report back on the recommendations for improving gender equity in medicine (including principles for state and specialty societies, academic medical centers, and other entities that employ physicians) that will be presented at the AMA Annual Meeting in June 2019.
**Recommendation 3:** That the Board of Trustees appoint a special task force of representatives from the Committee on Membership, Council on Health Service Organizations, Council on Medical Education Committee on Continuing Education, and Board of Councilors, with input from the TMA Office of the General Counsel and the TMA Division of Communications, to develop and/or recommend (1) policy; (2) advocacy options; and (3) communication strategies stemming from the recommendations adopted at the Women in Medicine Luncheon to:

1. Create a Women’s Section within TMA,
2. Create implicit bias training for both male and female TMA members, and
3. Create an education campaign designed to unify TMA around improving conditions for women.

**Recommendation 4:** That TMA policy containing references to “sex” or “gender” reflect the proper usage of the words. The *AMA Journal of Ethics* suggests “sex” be used when referencing the biological differences between males and females and “gender” be used when referencing the complex psychosocial self-perceptions, attitudes, and expectations people have about members of both sexes.

**Sources:**

3. Ly, DP; Seabury, SA; Jena, AB; and Newhouse, RL. Differences in incomes of physicians in the United States by race and sex: observational study. *BMJ.* 2016; 353; i2923 [https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4897176/](https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4897176/).
Subject: Establishing the Standing Committee on Medicaid, CHIP, and the Uninsured

Presented by: John G. Flores, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

Background

In 1999, the Council on Socioeconomics and the Council on Legislation jointly appointed an Ad Hoc Committee on Medicaid and Access to Care to develop TMA policy recommendations on Medicaid, the Children’s Health Insurance Program (CHIP), and the uninsured population. This ad hoc committee was given the charge to:

- Identify and develop TMA regulatory and legislative policy relating to Medicaid, CHIP, and the uninsured, including efforts to reduce the administrative complexity or “hassle factor.”
- Monitor and respond to regulatory and legislative issues pertaining to these programs as well as issues pertaining to safety net providers and systems.
- Coordinate and collaborate with appropriate state agency officials to ensure the efficient and sensible implementation of legislation relating to Medicaid, CHIP, and uninsured and to develop TMA positions and/or policy as appropriate.
- Monitor the impact of legislative and budget decisions on the Medicaid physician network, patient access to services, and quality of care.
- Collaborate, as appropriate, with provider associations, consumer groups, Medicaid/CHIP managed care plans, and external research organizations to improve Medicaid and other publicly-financed mhealth care programs.
- Assist the association in efforts to promote the economic value of Medicaid and CHIP to employers, local governmental officials, state policy makers, and the public.
- Collaborate with county medical societies to track and assess innovative health coverage options.
- In 2010, the councils affirmed that the unique policy and financing issues associated with these programs are ever evolving and that the ad hoc committee should continue its work. They renamed it the select committee on Medicaid, CHIP, and the Uninsured. Over the years, the select committee has successfully developed strong TMA policy, identified legislative priorities, and worked closely with state agencies and outside stakeholder groups to implement new program initiatives.

In October 2018, the Board of Trustees directed all councils with ad hoc committees under their purview to study and consider establishing them as standing committees or amending the council’s charge to incorporate the duties of the ad hoc committee. In response to this directive, the Council on Socioeconomics received and discussed a draft report from the select committee on Medicaid, CHIP, and the Uninsured during the 2019 Winter Conference. The report included a recommendation that its status be changed to standing committee. Ryan Van Ramshorst, MD, outgoing chair of the select committee, verbally informed the council that the committee had since voted to rescind that recommendation and preferred retaining its ad hoc status. Select committee members were concerned about bylaws language limiting service tenure and the number of members for standing committees, as well as the restriction against serving simultaneously on other boards, councils, or standing committees. TMA Bylaws provide:
**TMA Bylaws 10.22 Ad Hoc Committees**
Ad hoc committees for specific tasks are encouraged at all association levels. These committees shall consist of as many members as the president, appointing board, council, or standing committee deem necessary. The tenure of an ad hoc committee shall be for a limited period, normally not to exceed one year.

**TMA Bylaws 10.21 Standing Committees**

**10.212 Membership**

a. **Number of members.** There shall be nine members of each standing committee, with the exception that, according to Section 10.211, the House of Delegates, acting upon recommendation of the Board of Trustees, may specify a greater or lesser number of members for certain committees.

b. **Term and tenure.** Except as provided in this subsection, the term of service shall be for three years, and the terms shall be staggered. Tenure of service shall not exceed two terms; serving as much as two years shall be considered a full term.

c. **Appointment; vacancies.** At the time the president assumes office, he or she shall make committee member appointments, except for Interspecialty Society Committee members, who are selected by the specialty society they represent. Interim vacancies shall be filled by presidential appointment.

d. **Attendance.** If any member of a standing committee fails to attend two consecutive scheduled meetings, the position shall be declared vacant.

e. **Dual service.** No committee member shall serve simultaneously as a member of another association board, council, or standing committee. Committee members may serve as delegates or alternate delegates to the American Medical Association.

**Summary**
The select committee on Medicaid, CHIP, and the Uninsured has been in ad hoc status for twenty years. TMA Bylaws specify the tenure of ad hoc committees should be for a limited time, normally not to exceed one year. The focus of the select committee’s work remains a very high priority for the association. There is an ongoing need for a policymaking body to: develop and maintain expertise in Medicaid and indigent care policy, financing, and operations; develop TMA policy and advocacy initiatives for improving care for low-income populations; track state and federal initiatives related to these issues; and collaborate closely with state agencies on regulatory efforts.

The specific purpose of the Committee on Medicaid, CHIP, and the Uninsured shall be to research and formulate TMA policy on Medicaid, CHIP, and indigent care; track regulatory initiatives related to these programs; research and develop legislative recommendations to improve patient care and service delivery for recipients of Medicaid and CHIP services and for the uninsured.

Specific programs of the Committee on Medicaid, CHIP, and the Uninsured shall include efforts to: improve patient outcomes and quality; sensibly constrain Medicaid costs; reduce the administrative complexity for physicians and patients; track the impact of legislative and budget decisions on the Medicaid physician network, patient access to services, and quality of care; develop initiatives to help physician practices successfully implement Medicaid value-based payment initiatives/alternative payment models; coordinate with TMA policy making councils and committees with policy interests that intersect with Medicaid.

Specific expected results of activities of the Committee on Medicaid, CHIP, and the Uninsured shall include: constructive and regular engagement with the Health and Human Services Commission on TMA policy objectives to strengthen and simplify Medicaid, ensure pragmatic, evidence-informed approaches towards delivery system reform; continuation of TMA efforts to ameliorate or eliminate undue Medicaid and CHIP programmatic red tape hassles; development of TMA policy regarding Medicaid, CHIP, and
the uninsured; and development of TMA resources to help Medicaid participating physicians implement
value-based payment initiatives.

The Council on Socioeconomics recommends membership of the Committee on Medicaid, CHIP, and the
Uninsured should include representatives from state specialty societies, county medical societies, TMA
policy components with interest in Medicaid, and affiliated organizations, such as the Border Health
Caucus and the Texas Medical Group Management Association. Members shall be drawn from all regions
of the state, represent diverse practice backgrounds, and include physicians not participating in the
Medicaid program. The number of members should be 15 members. The TMA Board of Trustees supports
the recommendations in this report.

**Recommendation 1:** That the select committee on Medicaid, CHIP, and the Uninsured be made a
standing committee called the Committee on Medicaid, CHIP, and the Uninsured, reporting to the
Council on Socioeconomics.

**Recommendation 2:** That the number of members of the committee be set at 15 to allow broad
representation to address the programs and activities of the committee.

**Recommendation 3:** That TMA Bylaws Chapter 10, Committees, Section 10.53 be amended to include a
new subsection, 10.531, Committee on Medicaid, CHIP, and the Uninsured to read as follows, and to
renumber the remainder of the chapter accordingly:

10.531 Committee on Medicaid, CHIP, and the Uninsured. The committee shall: (1) research and
formulate TMA policy on Medicaid, CHIP, and indigent care; (2) track regulatory initiatives
related to these programs; and (3) research and develop legislative recommendations to improve
patient care and service delivery for recipients of Medicaid and CHIP services and for the
uninsured.
REPORT OF COUNCIL ON SCIENCE AND PUBLIC HEALTH

CSPH Report 6-A-19

Subject: Task Force on Behavioral Health

Presented by: Alice Gong, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

The Council on Science and Public Health conducted a sunset review of the Task Force on Behavioral Health as directed by the Board of Trustees.

The Task force on Behavioral Health was established by the council in 2014 and charged with guiding TMA’s activities on behavioral health and substance use disorder legislation. The Task force was also directed to review and make recommendations on Texas Medical Association’s mental/behavioral health policies. Les Secrest, MD, was appointed as chair and other appointments were made in consultation with the council. Membership on the Task force on Behavioral health is diverse and includes representation of multiple specialty areas.

The task force has met regularly at TMA conferences and has completed reviews and made recommendations on TMA policies related to behavioral health. It has prepared two House of Delegates reports on substance use and mental health: CSPH Report 1-A-15, Addressing Prescription Drug Abuse and Drug Overdoses; and CSPH report 7-A-18, Evidence-based Management of Substance Use Disorders; the recommendations in each report were adopted. The task force prepared a report on adverse childhood events, which will be considered by the House at TexMed 2019 (CSPH Report 4-A-19, Early Childhood Adversity).

Most recently, the task force has been a consultant on TMA’s behavioral health care and policy development for pregnant and postpartum women and also conducted a CME program on adverse childhood experiences at TMA’s 2017 Fall Conference; Adversity and Toxic Stress, what does it mean for your patients? The task force has also convened several meetings with statewide stakeholders in behavioral health to identify common concerns on behavioral health care.

Discussion and Recommendations

Over several sessions, the Texas state legislature has dedicated significant state resources in order to better understand and develop effective measures to address mental illness and substance use disorders. Mental illness and addiction impair individual functioning and typically at great cost to individuals, families, and the community. The task force has actively monitored legislative proposals to ensure that physician expertise on behavioral health is informing legislative decision making. The council strongly encourages that TMA continue its proactive and measured approach in studying and advocating on the physician’s role in caring for persons with mental illness or addiction.

The council believes the council’s charge should be amended to clearly identify behavioral health as part of its charge. The council will also recommend to each committee that reports to the council that they have access to consultation and support from physicians with expertise on behavioral health issues. The TMA Board of Trustees supports the recommendations in this report. Therefore, the council recommends that:
Recommendation 1: The Task Force on Behavioral Health be designated a subcommittee of the Council on Science and Public Health, renaming the task force as the Subcommittee on Behavioral Health.

Recommendation 2: Amend the charge of the council in the TMA Bylaws Section 9.808 as follows:

The purposes of this council shall be to (1) advance the scientific basis of medical practice; (2) anticipate high-priority public health, behavioral health, and medical science issues and develop policy on these issues; (3) advance the association as a leader in medical science and advocacy in public and behavioral health; (4) provide physicians with evidence-based public health and scientific information; and (5) communicate association policy and expertise on public health, behavioral health, and medical science.
Changes to the Operating Procedures of the Texas Delegation’s Policy and Procedures Manual require approval from the House of Delegates.

Section 5.3 addresses the evaluation of candidacy for the reelection of each delegate based upon certain criteria. One of the criteria focuses on any physician who is past the age of 75 at the time of reelection. The delegation views this policy as age discrimination and recommends amending the policy by removing the language.

The delegation recommends the following amendment to its operating procedures:

5.0 Delegate Review Committee

5.3 The committee shall evaluate the candidacy for reelection of each delegate who has (1) served six (6) terms, or (2) who will be past the age of 75 at the time of reelection, or (3) who, in the judgment of the committee, is substantially retired from his or her activities in the profession of medicine, whether that be clinical practice, teaching, or administration.

Recommendation: Approve amendment to Section 5.3 of the Texas Delegation’s Operating Procedures.
Subject: Saturday-Sunday Meeting Schedule for the Texas Medical Association

Introduced by: Lone Star Caucus

Referred to: Reference Committee on Financial and Organizational Affairs

Whereas, the House of Delegates is the policymaking arm of the Texas Medical Association; and
Whereas, the Texas Medical Association has nearly 53,000 members; and
Whereas, the widest possible representation is desirable; and
Whereas, the participation at reference committees on Fridays is significantly less than the participation in the House of Delegates on Saturdays; and
Whereas, participation in the House of Delegates requires a significant commitment out of the office, especially for younger physicians; and
Whereas, the change to a Saturday and Sunday schedule for the House of Delegates has not been debated in several years; and
Whereas, plans are made years in advance for the TexMed meetings; therefore be it
RESOLVED, That all meetings of the Texas Medical Association be moved to a Saturday-Sunday format from the current Friday-Saturday format; and be it further
RESOLVED, That this resolution be referred to the Board of Trustees to study the feasibility and economic impact on physicians and the association and report back to the House of Delegates in 2020.

Related TMA Policy:
None.

Related AMA Policy:
None.
Subject: Written Testimony at TMA Reference Committees

Introduced by: Lone Star Caucus

Referred to: Reference Committee on Financial and Organizational Affairs

Whereas, The House of Delegates of the Texas Medical Association at its annual meeting refers to the reference committees on Financial and Organizational Affairs, Science and Public Health, Medical Education and Health Care Quality, and Socioeconomics all resolutions submitted to the House of Delegates; and

Whereas, The House of Delegates refers to the reference committees all recommendations from the Texas Medical Association’s various committees, councils, and boards; and

Whereas, Reference committees provide an opportunity for all members of the Texas Medical Association to testify on, suggest changes to, and speak in favor or not in favor of any resolutions or recommendations by appearing in person; and

Whereas, Reference committees hear all the comments on each resolution and recommendation before making recommendations on each of its assigned items to the House of Delegates; and

Whereas, The membership of the Texas Medical Association is nearly 53,000 members in 2019; and

Whereas, The number of members attending the annual meeting of the Texas Medical Association may be less than 5 percent of its total membership; and

Whereas, All four reference committees are meeting at the same time, making it difficult for a member to speak at more than one or two reference committees, even though late testimony is allowed; and

Whereas, The Handbook for Delegates contains all the resolutions and recommendations and is published early enough for all members of the Texas Medical Association to know what items each of the four reference committees will address; therefore be it

RESOLVED, That the reference committees may receive written testimony prior to the meeting of the House of Delegates for resolutions and recommendations assigned to the reference committees from any member of the Texas Medical Association in a format to be determined by the speaker of the House of Delegates; and be it further

RESOLVED, That written testimony received on resolutions and recommendations before the reference committee should be considered carefully by the reference committee along with in-person testimony prior to the formation of its recommendations to the House of Delegates.

Related TMA Policy:
Written comments are encouraged after members have provided verbal testimony at reference committee hearings.
Related AMA Policy:
The AMA is conducting a pilot use of online member forums whereby testimony is accepted online from AMA members in advance of the HOD meeting. Following verbal testimony at a reference committee hearing, the wording for alternative language or a proposed substitute resolution also should be submitted in writing to reference committee staff, but not in any special format. Handwritten comments are acceptable. Other written material that accompanies the testimony may also be presented to the reference committee staff for discussion at the committee’s executive session.
WHEREAS, The Texas Medical Association offers many benefits to its membership; and
WHEREAS, The Texas Medical Association has become the largest state medical society in the United States in part because of its service to its membership in the many areas of medicine; and
WHEREAS, The Texas Medical Association has offered excellent educational opportunities to its membership in the past; and
WHEREAS, Recently, the Texas Medical Association’s Knowledge Center began offering an educational opportunity to its membership at no cost, compliments of the Texas Medical Association Insurance Trust; and
WHEREAS, This educational opportunity consists of hundreds of hours of continuing medical education courses, including 54 courses on ethics, 14 on physician health, 42 on practice operations, and 29 on risk management; therefore be it

RESOLVED, That the Texas Medical Association House of Delegates express its gratitude for the continuing medical education courses offered to TMA members courtesy of the TMA Insurance Trust.

Related TMA Policy:
None.

Related AMA Policy:
None.
Subject: Alternate Delegates May Address the House of Delegates

Introduced by: Lone Star Caucus

Referred to: Reference Committee on Financial and Organizational Affairs

Whereas, Alternate delegates may be new members to the House of Delegates; and

Whereas, New members receive an orientation on the workings of the House of Delegates; and

Whereas, Alternate delegates can address reference committees on any pending subject before the reference committees, as can any member of the Texas Medical Association; and

Whereas, It often takes several sessions to become familiar with the workings of the House of Delegates; and

Whereas, Addressing the House of Delegates can be a daunting experience to some members of the Texas Medical Association; and

Whereas, Delegates usually address the House of Delegates to help further discussion and debate on items before the house; therefore be it

RESOLVED, That alternate delegates to the Texas Medical Association House of Delegates be allowed to address the house on matters pending before the House of Delegates without being credentialed as a delegates and that under these circumstances may suggest but cannot make any changes to the content of any resolution or recommendation being considered by the House of Delegates.

**Related TMA Policy:**
Nonseated alternate delegates and vice councilors do not have the privilege to speak on the floor of the House of Delegates. (Texas Medical Association House of Delegates Guide)

12.443 Credentials: Credentials certifying their right to membership in the House of Delegates shall be issued to all delegates. An alternate delegate may serve in the place of a delegate by presenting verification to the Credentials Committee as provided in 3.32 of the TMA Bylaws.

**Related AMA Policy:**
2.8.5 Rights and Privileges: An alternate delegate may substitute for a delegate, on the floor of the House of Delegates, at the request of the delegate by complying with the procedures established by the Committee on Rules and Credentials. While substituting for a delegate, the alternate delegate may speak and debate on the floor of the House, offer an amendment to a pending matter, make motions, and vote.

2.8.6 Status: The alternate delegate is not a “member of the House of Delegates” as that term is used in these Bylaws. Accordingly, an alternate delegate may not introduce resolutions into the House of Delegates, nor vote in any election conducted by the House of Delegates. An alternate delegate is not eligible for nomination or election as Speaker or Vice Speaker of the House of Delegates. The alternate delegate must immediately relinquish his or her position on the floor of the House of Delegates upon the request of the delegate for whom the alternate delegate is substituting.
Resolutions 105
A-19

Subject: Pharmacies Practicing Medicine

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Financial and Organizational Affairs

Whereas, Certain large pharmacy chains are developing policies that require physicians to provide diagnostic information about a patient before they will fill a prescription; and

Whereas, Certain pharmacies are unilaterally making changes to physicians’ prescriptions, including dosage and amounts, without first confirming with the prescribing physician; and

Whereas, Pharmacists who have a concern about a prescription they are being asked to fill need only contact the prescribing physician’s office to get their questions answered; and

Whereas, The Texas Medical Board considers setting medication dosage and amounts as the practice of medicine; and

Whereas, The practice of medicine is reserved to physicians in order to protect the health and safety of patients; therefore be it

RESOLVED, That the Texas Medical Association work with the state legislature to pass a law declaring that pharmacies in Texas may not require physicians to disclose any patient medical records information beyond basic diagnoses as a condition for filling a prescription; and be it further

RESOLVED, That TMA work with the Texas Medical Board and the Texas State Board of Pharmacy to prevent pharmacists from engaging in conduct that is defined as “the practice of medicine,” including, but not limited to, alteration of dosage, duration, frequency, or quantity of a prescription while in the execution of their duties; and be it further

RESOLVED, That pharmacists may not rely on corporate policy as justification to usurp the orders of a physician lawfully acting under the Texas Medical Practice Act.

Related TMA Policy:

30.007 Prescribing by Pharmacists: The Texas Medical Association re-affirms its position in opposition to independent prescribing by pharmacists. TMA affirms its readiness to work with the Texas Pharmaceutical Association and the American Medical Association to review prescription drugs for appropriate transfers to “over the counter” status (Board of Councilors, p 44, A-93; reaffirmed BOC Rep. 5-A-10).

95.012 Drug Antisubstitution Laws and Generic Prescriptions: Compulsory generic prescribing should be opposed because generic equivalency in drugs does not necessarily mean therapeutic equivalence. The patient’s right to receive the drugs and medications best suited for his or her individual needs should be protected by preserving the current system of brand name prescribing. Legislation and regulations which prohibit generic drug substitution without prior agreement between the pharmacist and the physician should be supported (Council on Socioeconomics, p 177, I-94; reaffirmed CSE Rep. 3-A-04; reaffirmed CSE Rep. 2-A-14).
95.018 Physician Pharmacy Interactions: Pharmacy employees who are in contact by phone with physician offices should be properly trained in the nomenclature of prescription medications and protocols of handling and confirming physician prescriptions in order to minimize the risk of error in making these products available to patients (Amended Res. 29W, p 161A, A-98; reaffirmed CSA Rep. 4-A-08; reaffirmed CSPH Rep 5-A-18).
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 106
A-19

Subject: Establish a Coalition of Medical Societies to Protect Competition and Sustainability in the Health Insurance Marketplace

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 in the near future; and

Whereas, Such legislation would further damage a private health insurance marketplace rendered significantly less stable and competitive since the passing of the Affordable Care Act and the implementation of onerous federal regulations that have not been proven to improve patient outcomes; and

Whereas, In the absence of a competitive health insurance marketplace, the integrity of the patient-physician relationship is undermined and the patient-centered practice of medicine becomes secondary to the whims of government; and

Whereas, The creation of a national single-payer system, or one that further undermines a competitive health insurance marketplace, would directly conflict with the principles of responsible and incremental health care reform as described in Texas Medical Association Policy 120.010; and

Whereas, The need for more robust political advocacy and public education is evidenced by the growing popularity of policies that are in direct conflict with those supported by past TMA and American Medical Association resolutions; and

Whereas, The political advocacy efforts of separate medical societies are inherently fractured and less effective than joint ones, and a clear and consolidated message from the medical community can better advocate for favorable health care policies, the medical community, and the well-being of our patients; therefore be it

RESOLVED, That the Texas Medical Association, 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; and be it further

RESOLVED, That 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; and be it further

RESOLVED, That 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 be it further

RESOLVED, That the Texas Delegation to the American Medical Association carry this resolution to the AMA House of Delegates.

**Related TMA Policy:**

**60.004 Freedom of Choice:** Free and open competition of physicians and free choice of physicians for the primary benefit of patients is a goal which public and private policy should support. Hospital governing bodies should (1) seek the advice and expert opinion of their hospital medical staffs in making policy decisions regarding medical coverage and privileges; and (2) honor the commitments expressed in adopted and approved medical staff bylaws when considering action to limit or restrict the patient’s free choice of physicians and the right of qualified physicians to diagnose and treat patients who seek their services utilizing all hospital facilities and equipment for which they are qualified.

A variety of health care delivery plans offers to patients the greatest freedom of choice and the best opportunity for further improvements in health care.

A patient should be free to select the physician, insurance company, or type of policies which he or she prefers. The physician, in turn, except in an emergency, is free to select the patients whom he or she will serve, to accept or not accept reimbursement from a third party, and to participate or not participate in any type of legal insurance contract.

Multiple systems of medical care delivery, such as fee-for-service and prepaid, and multiple kinds of insurance contracts (i.e., indemnity, service, or participating physician) are acceptable arrangements between physicians and third parties for delivery of and payment for medical services (Council on Socioeconomics, p 178, I-94; reaffirmed CSE Rep. 3-A-04; reaffirmed CSE Rep. 2-A-14).

**110.003 Private Individualized Medical Care:** The Texas Medical Association reaffirms its position that private, individualized medical care and free enterprise insurance mechanisms which involve a specific degree of direct patient responsibility within and allow pluralistic, free choice options offer the highest quality of medical care at the lowest possible cost (CSE, p 144, A-93; reaffirmed CSE Rep. 6-A-03; reaffirmed CSE Rep. 1-A-13).

**110.009 Health Care Coverage:** The Texas Medical Association supports tax law reforms which (1) increase the tax-preferenced insurance and spending choices available to patients; (2) encourage individuals to buy insurance and set aside funds for medical needs; (3) provide subsidies to those who are most in need; and (4) encourage personal responsibility and participation of patients in the financing and benefit design decisions that ultimately determine their health benefit coverage. TMA supports efforts to develop viable policies that can improve the provision of care for the uninsured population. If federal standards are relaxed or revised to allow risk rating and coverage exclusions for preexisting conditions, the State of Texas should act immediately to create a new high-risk health insurance pool to provide insurance coverage for individuals who cannot otherwise secure it (CSE Rep. 6-I-01; amended CSE Rep. 8-A-11; amended CSE Rep. 5-A-17).

**120.001 Health Care Reform:** The Texas Medical Association weighs heavily in its evaluation of health care reform proposals the following concepts:

Make health insurance benefits part of the gross wage of employees and allow tax credits for premiums on individual tax returns so that employees, rather than employers, bear the cost of waste and reap the benefits of prudence;
Allow individuals who are otherwise uninsured the same tax credit incentive as the above to purchase health insurance;

Make tax credits refundable for low income families;

Allow insurers to sell no-frills, catastrophic group insurance not subject to state-mandated benefits, premium taxes, risk pool assessments, and other costly regulations;

Allow each employee or individual to choose a health insurance policy tailored to individual and family needs;

Limit favorable tax treatment for health insurance to catastrophic policies;

Allow each employee to choose between wages and health insurance coverage so that employees who choose less expensive coverage will have more take home pay;

Establish tax credits for deposits to individual Health Savings Accounts from which individuals would use their own money to pay small medical expenses without penalty;

Allow private insurers to repackage Medicare benefits and establish diverse policies tailored to the different needs of Medicare beneficiaries;

Give the elderly and future elderly and their employers tax incentives to self insure through Health Savings Accounts;

Allow Medicare patients to negotiate outside Medicare for more fair prices to both patient and physician;

Allow Medicaid patients to draw on an account, negotiate prices, and add their own money, if necessary, in order to purchase certain types of medical services--particularly prenatal care;

Encourage hospitals to negotiate a predmission package price with patients, particularly on elective cases, and to make their bills understandable;

Allow patients to avoid the costly effects of the tort system through voluntary contract;

Establish and support not-for-profit endowed family health clinics in local communities to care for the office visits of the poor, with all physicians volunteering a portion of their time to support these clinics.

Health System Reform Quality Improvement Organization: Under health system reform, the quality improvement organization should be retained as an essential, local base for patient-focused quality assurance activities, and the scope of QIO review should be expanded beyond Medicare to include patients treated under private sector health plans.

Health System Reform Establishment of National Health Board: The Texas Medical Association opposes establishment of a national health board under health system reform and supports continued oversight of health services through state and local agencies.

Health System Reform and Fee for Service Options: Under any health system reform plan, managed care organizations should be required to offer an out-of-network benefit. The Texas Medical Association opposes cuts in the Medicare and Medicaid programs to finance any health system reform plans. In addition, TMA voted to take appropriate actions to assure that rural physicians are not excluded from physician networks.
Health System Reform: The Texas Medical Association endorses inclusion of public health funding and plans to meet public health needs in any health system reform proposals.

Health System Reform: The emphasis of Health Access America should be an incremental approach based on a defined set of AMA priorities. Any proposals for health system reform must address economic, demographic, and regional differences in the health care needs of the states. TMA voted to seek an incremental approach to directed-by-patient care needs and guided by a set of priorities that includes but is not limited to insurance reform, ERISA reform, tort reform, antitrust relief, opposition to Medicare and Medicaid cuts, and support for the Patient Protection Act.

Prompt Access to Benefits: Waiting periods to receive health care coverage in any insurance program in Texas should be eliminated.

Managed Care and Fee for Service: The Texas Medical Association opposes present and proposed managed health care plans that place third party business contracts and other intermediaries between the patient and the physician. TMA believes that medical care for American citizens can best be provided by reinstituting a simple fee for service contract between the patient and the physician with due respect for the patient’s ability to pay, directly or through their individual insurance. In addition, TMA believes that insurance companies should be directed to offer individuals affordable, transportable, community-rated health care plans using appropriate actuarial data to provide coverage for preexisting conditions at equitable rates which ideally should cover high end or catastrophic health care costs (Council on Socioeconomics, p 150, I-92; amended CSE Rep. 3-A-04; amended CSE Rep. 3-A-14).

120.002 Health System Reform Cost Control: The Texas Medical Association emphasizes health system reform with cost control reform measures that protect the freedom of access and the quality of medical care to patients and leaves government in the subordinate position and role of taxation and funding (Res. 28Z, p 179D, A-93; reaffirmed CSE Rep. 6-A-03; reaffirmed CSE Rep. 1-A-13).

120.003 Health System Reform Managed Care: To provide a basic framework for association policies and activities in health system reform, the Texas Medical Association: (1) supports the concept of universal access to appropriate health care; (2) supports freedom of patients to select their own physicians; (3) supports meaningful professional liability reform for physicians as a key element of health system reform; (4) supports genuine relief from red-tape hassles and excessive administrative costs of health care; (5) supports freedom from unreasonable restrictions, including antitrust prohibitions, that prevent physicians from conducting peer review of quality and fees; (6) continues to support a health care system that includes a multiplicity of funding sources and payment mechanisms; (7) supports the right of a physician organization to negotiate at the federal or state level for payment of physician services, quality and utilization review, professional liability reform, and to reduce the hassle and cost of regulation; (8) continues to support sufficient autonomy for physicians to be advocates for patients and to make decisions in the best interests of their patients; (9) supports efforts to control costs in an efficient and effective manner that considers the needs of patients and allows the exercise of good medical judgment; (10) supports the funding of research and medical education in any health system reform proposal and believes that all corporate payers of health care share in the costs of graduate medical education; (11) supports quality assurance through practice parameters and outcomes research; (12) supports patient responsibility for first dollar coverage to allow patients to make individual decisions regarding their own health care spending with consideration given to patients’ ability to pay.

In addition, TMA offers the following principles for managed care for adoption as AMA policy: (1) physician participation in any managed care organization he or she chooses, (2) patient freedom to select his or her own physician, (3) physician autonomy and freedom to be patient advocates (Second Supplemental BOT, p 36P-36S, A-93; amended CSE Rep. 6-A-03; reaffirmed CSE Rep. 1-A-13).
120.010 Principles for Evaluating Health System Reform: The Texas Medical Association will use the following principles as evaluation criteria in examining all national health system reform proposals. These principles are not ranked in order of importance; all are viewed as high priorities.

Promote portable and continuous health care coverage for all Americans using an affordable mix of public and private payer systems.

Promote patient safety as a top priority for reform, recognizing an effective mix of initiatives that combine evidence-based accountability standards, committed financial resources, and rewards for performance that incent and ensure patient safety.

Adopt physician-developed, evidence-based tools for use in scientifically valid quality/patient safety initiatives that incentivize the physician-led health care delivery team, and include comparative effectiveness research used only to help patient-physician relationships choose the best care for patients.

Preserve patient and physician choice and the integrity of the patient-physician relationship.

Incorporate physician-developed, evidence-based measures and preventive health and wellness initiatives into any new or expanded health benefits package as a means to promote healthier citizens.

Recognize and support the role of safety-net and public health systems in delivering essential health care services within our communities, to include essential prevention and health promotion public health services.

Support the development of a well-funded, nationwide emergency and trauma care system that provides appropriate emergency and trauma care for all Americans.

Support public policy that fosters ethical and effective end-of-life care decisions, to include requiring all Medicare patients to have an advance directive that a Medicare enrollee can discuss as part of a covered Medicare visit with a physician.

Provide sustainable financing mechanisms that ensure the aforementioned affordable mix of services, and create personal responsibility among all stakeholders for financing and appropriate utilization of the system.

Invest needed resources to expand the physician-led workforce to meet the health care needs of a growing and increasingly diverse and aging population.

Provide financial and technological support to implement physician-led, patient-centered medical homes for all Americans, including increased funding and compensation for services provided by primary care physicians and the services provided by non-primary care, specialist physicians as part of the patient-centered medical home continuum.

Through public policy enactments, require accountability and transparency among health insurers to disclose how their premium dollars are spent, eliminate preexisting condition exclusions, simplify administrative processes, and observe fair and competitive market practices.

Reform the national tort system to prevent non-meritorious lawsuits, keeping Texas reforms in place as enacted by the Texas Legislature and constitutionally affirmed by Texas voters.

Abolish the Medicare Sustainable Growth Rate annual update system and initiate a true cost of practice methodology that provides for annual updates in the Medicare Fee Schedule as determined by a credible, practice expense-based, medical economic index.
Support the implementation of an interoperable National Electronic Medical Records System, financed and implemented through federal funding.

Require payers to have a standard, transparent contract with providers that cannot be sold or leased for any other payer purposes without the express, written consent of the contracted physician.

Support efforts to make health care financing and delivery decision making more of a professionally advised function, with appropriate standard setting, payment policy, and delivery system decisions fashioned by physician-led deliberative bodies as authorized legislatively (SC-HSR Rep. 1-A-09).


145.007 Competitive Insurance Models: A system of health care delivery free of burdensome and unnecessary government regulations is a goal which all patients and physicians should support. No national competitive health insurance model should be implemented irrevocable prior to pilot test studies which would identify and minimize problems of any new system. The Texas Department of Insurance should control the state’s insurance industry and its insurance policies and programs. Health care expenditures should remain tax deductible (Council on Socioeconomics, p 177, I-94; amended CSE Rep. 1-A-10).

145.009 Individual Responsibility for Health Care: The Texas Medical Association encourages employers, employee groups, and other public policy advocates to work together to design and introduce innovative and cost-effective mechanisms to finance health insurance coverage that could be owned and selected by individuals, flexible for each individual’s and family’s needs, and available as part of or as an alternative to traditional employer-sponsored health plans. TMA is committed to working with business and government to preserve the private sector and to establish an insurance market that is understandable and affordable, as well as portable for individuals (Amended Res. 29X, p 161B, A-98; reaffirmed CSE Rep. 1-A-08; reaffirmed CSE Rep. 1-A-18).

145.012 Health Insurance Individual Ownership: The Texas Medical Association supports operational strategies that provide control of health care purchasing and financing to individual patients, efforts that focus on strategies that offer equal tax deductibility to persons who purchase individual policies, the use of health savings accounts with tax-deductible contributions, and consumer choice provisions as modeled by the Federal Employees Health Benefits Program and believes that these efforts include a study of the issue of individually chosen, individually purchased basic health insurance with a system of premium support for the uninsured and lower income wage earners (Amended Res. 413-A-99; amended CSE Rep. 1-A-10).


190.032 Medicaid Coverage and Reform: It is the vision of the Texas Medical Association to improve the health of all Texans. Too many Texans, too many of our patients, cannot afford the health care they need. This hurts their health, the economic growth and prosperity of our state, and taxpayers all across Texas.
We currently have a tremendously cost-effective opportunity to improve access to health care for these Texans. Unfortunately, that federal offer comes in the form of expanding before reforming our Medicaid program to cover the working poor.

Medicaid provides essential health services for millions of Texans. But many parts of the current Texas Medicaid system are broken. It offers the promise of coverage without adequate funding to ensure access to care. It is fraught with exasperating, unyielding red tape. Its overzealous "fraud inspectors" are getting in the way of taking care of patients. Physicians should not accept the option of simply expanding that broken program.

On the other hand, we cannot reject the federal government's offer to help us care for the working poor of Texas. Physicians need to take this money and use it for our people, our patients.

We must look beyond the federal government's expansion solution to design a remedy that works for Texas and for Texans. The people of this state are ingenious and innovative problem-solvers. We are confident that state leaders and lawmakers with input from employers, physicians, taxpayers, and others can design a comprehensive solution that:

- Draws down all available federal dollars to expand access to health care for poor Texans;
- Gives Texas the flexibility to change the plan as our needs and circumstances change;
- Clears away Medicaid's financial, administrative, and regulatory hurdles that are driving up costs and driving Texas physicians away from the program;
- Relieves local Texas taxpayers and Texans with insurance from the unfair and unnecessary burden of paying the entire cost of caring for their uninsured neighbors;
- Provides Medicaid payments directly to physicians for patient care equal to at least those of Medicare payments; and
- Continues to uphold and improve due process of law for physicians in the State of Texas as it relates to the Office of Inspector General.

The Texas Medical Association calls on the American Medical Association to advocate for Medicaid payments to all physicians for patient care to be at least equal to Medicare payments (Amended BOT/COL/CSE/SC-MCU Joint Rep. 3-A-13).

**Related AMA Policy:**

**H-165.838 Health System Reform Legislation:**

1. Our American Medical Association is committed to working with Congress, the Administration, and other stakeholders to achieve enactment of health system reforms that include the following seven critical components of AMA policy:
   a. Health insurance coverage for all Americans
   b. Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps
   c. Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials
   d. Investments and incentives for quality improvement and prevention and wellness initiatives
   e. Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care
   f. Implementation of medical liability reforms to reduce the cost of defensive medicine
g. Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs
and administrative burdens

2. Our American Medical Association advocates that elimination of denials due to pre-existing conditions
is understood to include rescission of insurance coverage for reasons not related to fraudulent
representation.

3. Our American Medical Association House of Delegates supports AMA leadership in their unwavering
and bold efforts to promote AMA policies for health system reform in the United States.

4. Our American Medical Association supports health system reform alternatives that are consistent with
AMA policies concerning pluralism, freedom of choice, freedom of practice, and universal access for
patients.

5. AMA policy is that insurance coverage options offered in a health insurance exchange be self-
supporting, have uniform solvency requirements; not receive special advantages from government
subsidies; include payment rates established through meaningful negotiations and contracts; not require
provider participation; and not restrict enrollees' access to out-of-network physicians.

6. Our AMA will actively and publicly support the inclusion in health system reform legislation the right
of patients and physicians to privately contract, without penalty to patient or physician.

7. Our AMA will actively and publicly oppose the Independent Medicare Commission (or other similar
construct), which would take Medicare payment policy out of the hands of Congress and place it under
the control of a group of unelected individuals.

8. Our AMA will actively and publicly oppose, in accordance with AMA policy, inclusion of the
following provisions in health system reform legislation:
   a. Reduced payments to physicians for failing to report quality data when there is evidence that
      widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid
      Services
   b. Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation
      for physicians who are already subject to an expenditure target and potential payment reductions under
      the Medicare physician payment system
   c. Medicare payments cuts for higher utilization with no operational mechanism to assure that the Centers
      for Medicare and Medicaid Services can report accurate information that is properly attributed and risk-
      adjusted
   d. Redistributed Medicare payments among providers based on outcomes, quality, and risk-adjustment
      measurements that are not scientifically valid, verifiable and accurate
   e. Medicare payment cuts for all physician services to partially offset bonuses from one specialty to
      another
   f. Arbitary restrictions on physicians who refer Medicare patients to high quality facilities in which they
      have an ownership interest

9. Our AMA will continue to actively engage grassroots physicians and physicians in training in
   collaboration with the state medical and national specialty societies to contact their Members of Congress,
   and that the grassroots message communicate our AMA’s position based on AMA policy.

10. Our AMA will use the most effective media event or campaign to outline what physicians and patients
    need from health system reform.

11. AMA policy is that national health system reform must include replacing the sustainable growth rate
    (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running
a practice and is backed by a fair, stable funding formula, and that the AMA initiate a "call to action" with
the Federation to advance this goal.

12. AMA policy is that creation of a new single payer, government-run health care system is not in the
best interest of the country and must not be part of national health system reform.

13. AMA policy is that effective medical liability reform that will significantly lower health care costs by
reducing defensive medicine and eliminating unnecessary litigation from the system should be part of any
national health system reform.

H-165.844 Educating the American People About Health System Reform: Our AMA reaffirms
support of pluralism, freedom of enterprise and strong opposition to a single payer system.

H-165.888 Evaluating Health System Reform Proposals:
1. Our AMA will continue its efforts to ensure that health system reform proposals adhere to the
following principles:
   A. Physicians maintain primary ethical responsibility to advocate for their patients' interests and needs.
   B. Unfair concentration of market power of payers is detrimental to patients and physicians, if patient
freedom of choice or physician ability to select mode of practice is limited or denied. Single-
payer systems clearly fall within such a definition and, consequently, should continue to be opposed by
the AMA. Reform proposals should balance fairly the market power between payers and physicians or be
opposed.
   C. All health system reform proposals should include a valid estimate of implementation cost, based on
all health care expenditures to be included in the reform; and supports the concept that all health system
reform proposals should identify specifically what means of funding (including employer-mandated
funding, general taxation, payroll or value-added taxation) will be used to pay for the reform proposal and
what the impact will be.
   D. All physicians participating in managed care plans and medical delivery systems must be able without
threat of punitive action to comment on and present their positions on the plan's policies and procedures
for medical review, quality assurance, grievance procedures, credentialing criteria, and other financial and
administrative matters, including physician representation on the governing board and key committees of
the plan.
   E. Any national legislation for health system reform should include sufficient and continuing financial
support for inner-city and rural hospitals, community health centers, clinics, special programs for special
populations and other essential public health facilities that serve underserved populations that otherwise
lack the financial means to pay for their health care.
   F. Health system reform proposals and ultimate legislation should result in adequate resources to enable
medical schools and residency programs to produce an adequate supply and appropriate
generalist/specialist mix of physicians to deliver patient care in a reformed health care system.
   G. All civilian federal government employees, including Congress and the Administration, should be
covered by any health care delivery system passed by Congress and signed by the President.
   H. True health reform is impossible without true tort reform.

2. Our AMA supports health care reform that meets the needs of all Americans including people with
injuries, congenital or acquired disabilities, and chronic conditions, and as such values function and its
improvement as key outcomes to be specifically included in national health care reform legislation.
3. Our AMA supports health care reform that meets the needs of all Americans including people with mental illness and substance use / addiction disorders and will advocate for the inclusion of full parity for the treatment of mental illness and substance use / addiction disorders in all national health care reform legislation.

4. Our AMA supports health system reform alternatives that are consistent with AMA principles of pluralism, freedom of choice, freedom of practice, and universal access for patients.
RESOLVED, That physicians licensed by the Texas Medical Board (TMB) be allowed to prescribe, dispense, and sell prescriptions, over-the-counter medications, and medical devices to patients in Texas with regulation only by TMB.

Related TMA Policy:

95.034 Legislation to Allow Physicians to Dispense Pharmaceuticals: The Texas Medical Association supports legislation that will allow physicians to dispense and charge for dispensing pharmaceuticals other than Schedule I through V controlled substances, as defined in the Texas Health & Safety Code, Chapter 483 (2010) (Res 302-A-11).

95.041 Ensuring Patient Access to Affordable Prescription Medications: The Texas Medical Association will: (1) support programs whose purpose is to contain the rising costs of prescription drugs provided that the following criteria are satisfied: (a) physicians must have significant input into the development and maintenance of such programs; (b) such programs must encourage optimum prescribing practices and quality of care; (c) all patients must have access to medically indicated prescription drugs necessary to treat their illnesses; (d) physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and (e) such programs should promote an environment that will give pharmaceutical manufacturers the incentive for research and development of new and innovative prescription drugs; (2) study the issue of drug pricing, including whether large price increases impact patient access to critical medications; (3) support the application of greater oversight to the establishment of closed distribution systems for prescription drugs; (4) support the mandatory provision of samples of approved out-of-patent drugs upon request to generic manufacturers seeking to
perform bioequivalence assays; (5) work with interested parties to support legislation or regulatory
changes that streamline and expedite the FDA approval process for generic drugs; and (6) support
measures that increase price transparency for generic and brand-name prescription drugs. (Substitute Res.

170.008 Physician Relief from Product Class Actions: The Texas Medical Association supports federal
legislation to preempt naming the treating physician as a party to product liability lawsuits when the
treating physician has used an FDA approved drug or device (Res. 107-A-01; reaffirmed COL Rep. 1-A-
17).

Related AMA Policy:
H-285.965 Managed Care Cost Containment Involving Prescription Drugs: (1) Physicians who
participate in managed care plans should maintain awareness of plan decisions about drug selection by
staying informed about pharmacy and therapeutics (P&T) committee actions and by ongoing personal
review of formulary composition. P&T committee members should include independent physician
representatives. Mechanisms should be established for ongoing peer review of formulary policy.
Physicians who perceive inappropriate influence on formulary development from pharmaceutical industry
consolidation should notify the proper regulatory authorities.

(2) Physicians should be particularly vigilant to ensure that formulary decisions adequately reflect the
needs of individual patients and that individual needs are not unfairly sacrificed by decisions based on the
needs of the average patient. Physicians are ethically required to advocate for additions to the formulary
when they think patients would benefit materially and for exceptions to the formulary on a case-by-case
basis when justified by the health care needs of particular patients. Mechanisms to appeal formulary
exclusions should be established. Other cost-containment mechanisms, including prescription caps and
prior authorization, should not unduly burden physicians or patients in accessing optimal drug therapy.

(3) Limits should be placed on the extent to which managed care plans use incentives or pressures to
lower prescription drug costs. Financial incentives are permissible when they promote cost-effectiveness,
not when they require withholding medically necessary care. Physicians must not be made to feel that
they jeopardize their compensation or participation in a managed care plan if they prescribe drugs that are
necessary for their patients but that may also be costly. There should be limits on the magnitude of
financial incentives, incentives should be calculated according to the practices of a sizable group of
physicians rather than on an individual basis, and incentives based on quality of care rather than cost of
care should be used. Physician penalties for non-compliance with a managed care formulary in the form
of deductions from withholds or direct charges are inappropriate and unduly coercive. Prescriptions
should not be changed without physicians having a change to discuss the change with the patient.

(4) Managed care plans should develop and implement educational programs on cost-effective prescribing
practices. Such initiatives are preferable to financial incentives or pressures by HMOs or hospitals, which
can be ethically problematic.

(5)Patients must fully understand the methods used by their managed care plans to limit prescription drug
costs. During enrollment, the plan must disclose the existence of formularies, the provisions for cases in
which the physician prescribes a drug that is not included in the formulary and the incentives or other
mechanisms used to encourage physicians to consider costs when prescribing drugs. In addition, plans
should disclose any relationships with pharmaceutical benefit management companies or pharmaceutical
companies that could influence the composition of the formulary. If physicians exhaust all avenues to
secure a formulary exception for a significantly advantageous drug, they are still obligated to disclose the
option of the more beneficial, more costly drug to the patient, so that the patient can decide whether to
pay out-of-pocket.
(6) Research should be conducted to assess the impact of formulary constraints and other approaches to containing prescription drug costs on patient welfare.

(7) Our AMA urges pharmacists to contact the prescribing physician if a prescription written by the physician violates the managed care drug formulary under which the patient is covered, so that the physician has an opportunity to prescribe an alternative drug, which may be on the formulary.

(8) When pharmacists, insurance companies, or pharmaceutical benefit management companies communicate directly with physicians or patients regarding prescriptions, the reason for the intervention should be clearly identified as being either educational or economic in nature.

(9) Our AMA will develop model legislation which prohibits managed care entities, and other insurers, from retaliating against a physician by disciplining, or withholding otherwise allowable payment because they have prescribed drugs to patients which are not on the insurer's formulary, or have appealed a plan's denial of coverage for the prescribed drug.

(10) Our AMA urges health plans including managed care organizations to provide physicians and patients with their medication formularies through multiple media, including Internet posting.

(11) In the case where Internet posting of the formulary is not available and the formulary is changed, coverage should be maintained until a new formulary is distributed.

(12) For physicians who do not have electronic access, hard copies must be available.

H-120.991 Sample Medications: Our AMA (1) continues to support the voluntary time-honored practice of physicians providing drug samples to selected patients at no charge; (2) reiterates that samples of prescription drug products represent valuable benefits to the patients; (3) continues to support the availability of drug samples directly to physicians through manufacturers' representatives and other means, with appropriate safeguards to prevent diversion; and (4) endorses sample practices that: (a) preclude the sale, trade or offer to sell or trade prescription drug samples; (b) require samples of prescription drug products to be distributed only to licensed practitioners upon written request; and (c) require manufacturers and commercial distributors of samples of prescription drug products and their representatives providing such samples to licensed practitioners to: (i) handle and store samples of prescription drug products in a manner to maintain potency and assure security; (ii) account for the distribution of prescription drug samples by maintaining records of all drug samples distributed, destroyed or returned to the manufacturer or distributor; and (iii) report significant thefts or losses of prescription drug samples.

D-120.958 Federal Roadblocks to E-Prescribing: 1. Our AMA will: work with the Centers for Medicare and Medicaid Services and states to remove or reduce barriers to electronic prescribing of both controlled substances and non-scheduled prescription drugs, including removal of the Medicaid requirement in all states that continue to mandate that physicians write, in their own hand, “brand medically necessary” or the equivalent on a paper prescription form.

2. It is AMA policy that physician Medicare or Medicaid payments not be reduced for non-adoption of e-prescribing.

3. Our AMA will work with the largest and nearly exclusive national electronic pharmacy network, all related state pharmacy regulators, and with federal and private entities to ensure universal acceptance by pharmacies of electronically transmitted prescriptions.

4. Our AMA will advocate for appropriate financial and other incentives to physicians to facilitate electronic prescribing adoption.
5. Our AMA will work to substantially reduce regulatory burdens so that physicians may successfully submit electronic prescriptions for controlled substances.

6. Our AMA will work with representatives of pharmacies, pharmacy benefits managers, and software vendors to expand the ability to electronically prescribe all medications.

7. Our AMA will work with the Centers for Medicare & Medicaid Services and the federal government to have all pharmacies, including government pharmacies, accept e-prescriptions for prescription drugs.
Whereas, Primary care physicians care for a broad spectrum of patients; and
Whereas, Primary care physicians sometimes refer patients to specialists seeking their expertise in the evaluation, diagnosis, and treatment of their patients; and
Whereas, A patient’s initial assessment and thorough evaluation by a board-certified specialist is what primary care physicians need and patients need and deserve when referred to a specialist; and
Whereas, Nurse practitioners and physician assistants do not have the same level of training as a physician; and
Whereas, Nurse practitioners and physician assistants can switch “specialties” without any clinical training whatsoever in their chosen “specialty;” and
Whereas, A nurse practitioner or physician assistant assessment and treatment plan for an initial evaluation does not provide the level of expertise that primary care physicians seek and patients deserve when patients are referred to a physician specialist; and
Whereas, Optimal patient care can be compromised through delays in diagnosis and treatment resulting from initial evaluations by nurse practitioners or physician assistants rather than specialist physicians; therefore be it

RESOLVED, That Texas Medical Association recognize that the best practice of patient care dictates that it is the responsibility of the physician to develop the diagnosis and treatment in the evaluation of a patient, while it is recognized under limited circumstances that an initial evaluation may be conducted by a nurse practitioner or physician assistant.

Related TMA Policy:
255.001 Primary Care Physician Definition: The Texas Medical Association defines physician primary care as first contact care, longitudinal and continuous care, comprehensive health services, preventive health care, and coordinated services (Committee on Manpower, p 98, A-94; reaffirmed CME Rep. 1-A-05; reaffirmed CM-PDHCA Rep. 1-A-15)

105.002 Patient and Physician Relationship: If a physician does not have the training or expertise to treat the patient’s health concerns, the physician should refer the patient to a physician or other health care professional with the appropriate training and experience (Council on Communication, p 73, I-92; reaffirmed CSE Rep. 3-A-04; reaffirmed CSE Rep. 2-A-14)

30.012 Nursing and Nurses with Advanced Training: While recognizing the value of nurses who have obtained advanced training, the concept of independent delivery of health care by nurses is opposed.
Nurses should, however, be encouraged to obtain advanced education and training. The nurse with such training engages in decision making about the nursing care of patients under the supervision of a physician. The nurse collaborates with social workers, nutritionists, and others in making decisions about nursing needs. The nurse plans and institutes nursing programs as a member of the health care team. The nurse is directly accountable and responsible to the patient for the quality of nursing care rendered under the Nurse Practice Act of Texas (Council on Medical Education, p 92, A-94; amended CME Rep. 4-A-04; reaffirmed CM-PDHCA Rep. 2-A-14).

30.016 Physician Assistants and Allied Health Personnel: A physician assistant is a skilled person, qualified by academic training in an accredited program and by practical training to provide patient services under the supervision and direction of a licensed physician who is ultimately responsible for the performance of that assistant. Reimbursement for services performed by a physician assistant should be made directly to the responsible physician. While greater use of non-physician personnel can improve the system, responsibility for care must be clearly defined if various personnel are to work together effectively to provide high quality services for the patient (Council on Medical Education, p 97, and Council on Socioeconomics, p 181, I-94; reaffirmed CME Rep. 4-A-04; reaffirmed CM-PDHCA Rep. 2-A-14).

Related AMA Policy:
H-360.987 Principles Guiding AMA Policy Regarding Supervision of Medical Care Delivered by Advanced Practice Nurses in Integrated Practice: Our AMA endorses the following principles: (1) Physicians must retain authority for patient care in any team care arrangement, e.g., integrated practice, to assure patient safety and quality of care. (2) Medical societies should work with legislatures and licensing boards to prevent dilution of the authority of physicians to lead the health care team. (3) Exercising independent medical judgment to select the drug of choice must continue to be the responsibility only of physicians. (4) Physicians should recognize physician assistants and advanced practice nurses under physician leadership, as effective physician extenders and valued members of the health care team. (5) Physicians should encourage state medical and nursing boards to explore the feasibility of working together to coordinate their regulatory initiatives and activities. (6) Physicians must be responsible and have authority for initiating and implementing quality control programs for nonphysicians delivering medical care in integrated practices.

H-160.936 Comprehensive Physical Examinations by Appropriate Practitioners: AMA policy supports the position that performance of comprehensive physical examinations to diagnose medical conditions be limited to licensed MDs/DOs or those practitioners who are directly supervised by licensed MDs/DOs; and the AMA will actively work with state medical societies and medical specialty associations, both in the courts and in the legislative and regulatory spheres, to oppose any proposed or adopted law or policy that would inappropriately expand the scope of practice of practitioners other than MDs/DOs.
Subject: Licensure Status on TMA Membership Applications

Presented by: Tarrant County Medical Society

Referred to: Reference Committee on Financial and Organizational Affairs

Whereas, The Texas Medical Association (TMA) and County Medical Society Membership Application is a unified application for membership in both TMA and county medical societies; and

Whereas, TMA generally requires for physician membership a license to practice medicine in the state of Texas that is not permanently revoked, canceled, or permanently suspended; and

Whereas, An otherwise qualified physician may be denied membership or continued membership in a county medical society only for a violation of the TMA or county medical society constitution and bylaws; a violation of the AMA Principles of Medical Ethics; criminal conduct; or unprofessional conduct likely to deceive, defraud, or injure the public; and

Whereas, The membership application includes a section entitled, “Membership Qualification and Authorization,” which is an aid in screening applicants by including questions about the applicant’s disciplinary and criminal history; and

Whereas, The Texas Medical Board (TMB) considers similar criteria upon application for medical licensure in the state of Texas, and, therefore, applicants who have a medical license to practice in the state of Texas can be considered eligible for membership in TMA and county medical societies; and

Whereas, Local county medical society boards of censors have little or no resources to investigate and research applicants other than verifying current medical licensure by the TMB; therefore be it

RESOLVED, That a county medical society board of censors’ examination of an applicant be limited only to the applicant’s licensure status with the TMB; that the membership application be updated to reflect the examination of only the applicant’s licensure status (when applicable); and that TMA bylaws be amended accordingly.

Related TMA Policy:

1.12 Application. Application for membership in a component county society 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 component county society may require. The county society shall retain any original applications it 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 county society.

1.14 Board of Censors examination and report. The boards of censors of component county societies shall examine and report on the qualifications of applicants for membership in their respective organizations.
Within 60 days of the date an application is completed, the Board of Censors shall complete its examination of the applicant’s qualifications; approve or disapprove the application; and provide to the executive board (or to the other officers if there is no executive board) its report on the applicant’s qualifications and on the Board of Censors’ decision to approve or disapprove membership.

Related AMA Policy: None.
WHEREAS, Texans founded Blue Cross and Blue Shield of Texas in 1929 as a nonprofit, charitable organization with the intention of providing affordable health care coverage with a community focus, acting in the public benefit; and

WHEREAS, in the early 1980s, many of the commercial insurers began to challenge the fully tax-exempt status of the BCBS plans, which BCBS rebuffed by arguing that the plans provide "a unique community service"; and

WHEREAS, in June 1994, the national BCBS association changed its policies so that its licensees could convert to for-profit status and distribute earnings to those who exercise control over the company; and

WHEREAS, in 1996, BCBS Texas submitted a proposal to merge with Illinois BCBS, operated by Health Care Service Corporation (HCSC), a mutual insurance company, owned by its policyholders; and

WHEREAS, following a lawsuit by the Texas Attorney General to block the merger on grounds the merged entity would no longer be "nonprofit," in 1998, the trial court issued a letter opinion against the Attorney General and in favor of the merger; and

WHEREAS, after the merger was approved, HCSC remained unwilling to admit that BCBS Texas had a charitable asset obligation to the people of Texas; and

WHEREAS, HCSC acquired Blue Cross Blue Shield of New Mexico in May 2001 and Blue Cross Blue Shield of Oklahoma in 2005. HCHS now has more than 15 million members in Oklahoma, Illinois, Texas, and New Mexico; and

WHEREAS, in 2015 HCSC had reserves in excess of $9.9 billion in surplus funds; and

WHEREAS, in 2017 HCSC made $1.3 billion in net profit on $32.6 billion of revenue; and

WHEREAS, BCBS Texas recently announced plans to open 10 primary care medical centers in Dallas and Houston to provide a range of services beyond primary care, including urgent care, lab and diagnostic imaging, care coordination, and wellness and disease management programs; and

WHEREAS, BCBS Texas will open these clinics in partnership with Sanitas, a foreign-based multinational health care firm with no experience in Texas; and
Resolution 110-A-19
Page 2

Whereas, BCBS Texas has decided to compete against Texas primary care physicians rather than partner
with them, despite more than a decade of claiming to support physician-led, community-based primary
care initiatives and patient-centered medical homes; and

Whereas, the economic viability of independent physician owned primary care practices is increasingly at
risk due to the rapid consolidation and vertical integration of health plans, health systems, and corporate
health organizations into direct patient care delivery; and

Whereas, these consolidations and vertical integrations threaten to limit, if not eliminate, clinical choice,
practice setting choice, and patient choice; and

Whereas, these consolidations and vertical integrations may evolve into anticompetitive oligopolies that
compete over price and market share rather than value of clinical services; and

Whereas, current state law will likely prove inadequate to protect patients from and provide antitrust
barriers against these new corporate-backed delivery models; therefore be it

RESOLVED, That the Texas Medical Association express its disappointment to Blue Cross Blue Shield
of Texas on its decision to contract with a foreign-based, multinational health care firm to open 10
primary care medical centers in Dallas and Houston to compete against local primary care practices
owned and operated by TMA members; and

RESOLVED, That the Texas Medical Association collaborate with primary care specialty organizations
and other specialty societies to conduct a comprehensive study of these market developments to assess
their current and prospective positive and negative influences on the delivery of health care in Texas; and
be it further

RESOLVED, That the study include, but not be limited to, an analysis of geographic market
concentration of health insurers doing business in Texas; how vertical integration of Texas’ health care
markets are impacting clinical practice choices, patient choice, and the viability of physician owned,
community-based practices; and how predatory and anticompetitive managed care business practices are
hurting the stability and viability of physician-owned practices; and be it further

RESOLVED, That, as part of the aforementioned study, the Texas Medical Association develop a multi-
year strategy to include any public policy options that assure fair business practices and enforceable
protections from predatory behavior and adverse patient consequences, and that empowers physicians to
compete and thrive in Texas’ health care markets; and be it further

RESOLVED, that such study be prepared and submitted to the House of Delegates no later than May
2020.

Related TMA Policy: None.

Related AMA Policy: None.
Supplement

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 111
A-19

Subject: Opposing Legislation That Mandates Physician Discrimination

Introduced by: Travis County Medical Society, Texas Pediatric Society, and Texas Chapter of the American Academy of Pediatrics

Referred to: Reference Committee on Financial and Organizational Affairs

Whereas, The Texas Medical Association does not discriminate, opposes discrimination, and encourages nondiscrimination policies within health care settings; and

Whereas, TMA upholds the right and best medical practice of adolescents accessing sexual and reproductive health care either confidentially or with family involvement as determined by the adolescent; and

Whereas, TMA supports a health care environment that encourages adolescent and family access to care without involvement by law enforcement officials, except in cases of suspected child abuse or neglect as identified by health care professionals using their best judgment; and

Whereas, Texas Family Code § 261.101 (b) requires professionals to report child abuse or neglect; Texas Family Code § 261.001(1)(E) defines abuse to include conduct constituting an offense under Texas Penal Code § 21.11; Texas Penal Code § 21.11 makes it a crime to engage in sexual contact with or in view of a child younger than 17; Texas Penal Code § 21.11(b) establishes an affirmative defense to prosecution with several factors including only if the actor is of the “opposite sex”; physicians and other health professionals are accordingly positioned to discriminate against LGBTQ+ adolescents between the ages of 14 and 17, with possible prosecution and imprisonment of the health care professional under Texas Family Code § 261.109(c) for failure to report; and

Whereas, Pursuant to Texas Department of State Health Services (DSHS) Rider 24 and Texas Health and Human Services Commission (HHSC) Rider 215, 2018-2019 General Appropriations Act, 85th Legislature, recipients of public health funds are required to show good faith efforts to comply with all child abuse reporting guidelines and requirements, and therefore, clinics and health care facilities under audit receiving public health funding for lower-income communities are disproportionately at risk of enforcement of these laws; and

Whereas, Mandated reporting exposes LGBTQ+ adolescents to prosecution under Texas Penal Code § 21.11, while their peers in “opposite sex” relationships may qualify for the affirmative defense; and

Whereas, This reporting requirement creates an undue and unnecessary burden on physicians and their staff, and the child protection system; and

Whereas, This reporting requirement creates barriers for adolescents and families seeking health care and is an example of health-harming legislation that negatively affects patient and community health and reduces access to health care; therefore be it

RESOLVED, That the Texas Medical Association support removal of “opposite sex” as a requirement for affirmative defense to prosecution within the Texas Penal Code; and be it further
RESOLVED, That TMA oppose legislation or regulation that mandates physicians and other health professionals discriminate against or limit access to health care for a specific patient population.

Related TMA Policy:
60.008 The Texas Medical Association 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 (CSHP Rep. 1-A-18).

55.035 Right to Confidential Care: The Texas Medical Association upholds the right of adolescents to receive confidential care to protect their health. Evidence indicates 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. In addition, TMA supports a health care environment that encourages adolescent access to care without involvement by law enforcement officials, except in cases of suspected child physical or sexual abuse as identified by the health care provider using his or her professional judgment (CM-MPH Rep. 2-A-03; reaffirmed CM-CAH Rep. 4-A-10).

Related AMA Policy:
H-160.991 Health Care Needs of Lesbian Gay Bisexual and Transgender Populations:
1. Our AMA: (a) believes that the physician's nonjudgmental recognition of patients' sexual orientations, sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well as in illness. In the case of lesbian gay bisexual and transgender (LGBT) patients, this recognition is especially important to address the specific health care needs of people who are or may be LGBT; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBT Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBT patients; (iii) encouraging the development of educational programs in LGBT Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBT people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBT communities to offer physicians the opportunity to better understand the medical needs of LGBT patients; and (c) opposes, the use of "reparative" or "conversion" therapy for sexual orientation or gender identity.

2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for women who have sex with women to undergo regular cancer and sexually transmitted infection screenings due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; and (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases. 3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBT health issues. 4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBT people.

Sources:

Texas Family Code § 261.101 Persons Required to Report, Time to Report:
(a) A person having cause to believe that a child's physical or mental health or welfare has been adversely affected by abuse or neglect by any person shall immediately make a report as provided by this subchapter.
(b) If a professional has cause to believe that a child has been abused or neglected or may be abused or neglected, or that a child is a victim of an offense under Section 21.11, Penal Code, and the professional has cause to believe that the child has been abused as defined by Section 261.001, the professional shall make a report not later than the 48th hour after the hour the professional first suspects that the child has been or may be abused or neglected or is a victim of an offense under Section 21.11, Penal Code. A professional may not delegate to or rely on another person to make the report. In this subsection, "professional" means an individual who is licensed or certified by the state or who is an employee of a facility licensed, certified, or operated by the state and who, in the normal course of official duties or duties for which a license or certification is required, has direct contact with children. The term includes teachers, nurses, doctors, day-care employees, employees of a clinic or health care facility that provides reproductive services, juvenile probation officers, and juvenile detention or correctional officers.

(b-1) In addition to the duty to make a report under Subsection (a) or (b), a person or professional shall make a report in the manner required by Subsection (a) or (b), as applicable, if the person or professional has cause to believe that an adult was a victim of abuse or neglect as a child and the person or professional determines in good faith that disclosure of the information is necessary to protect the health and safety of:

(1) another child; or

(2) an elderly person or person with a disability as defined by Section 48.002, Human Resources Code.

c) The requirement to report under this section applies without exception to an individual whose personal communications may otherwise be privileged, including an attorney, a member of the clergy, a medical practitioner, a social worker, a mental health professional, an employee or member of a board that licenses or certifies a professional, and an employee of a clinic or health care facility that provides reproductive services.

d) Unless waived in writing by the person making the report, the identity of an individual making a report under this chapter is confidential and may be disclosed only:

(1) as provided by Section 261.201; or

(2) to a law enforcement officer for the purposes of conducting a criminal investigation of the report.

Texas Family Code § 261.001(1)(E) Definitions:

(1) “Abuse” includes the following acts or omissions by a person . . .

(E) sexual conduct harmful to a child's mental, emotional, or physical welfare, including conduct that constitutes the offense of continuous sexual abuse of young child or children under Section 21.02, Penal Code, indecency with a child under Section 21.11, Penal Code, sexual assault under Section 22.011, Penal Code, or aggravated sexual assault under Section 22.021, Penal Code;

Texas Penal Code § 21.11 Indecency with a Child:

(a) A person commits an offense if, with a child younger than 17 years of age, whether the child is of the same or opposite sex and regardless of whether the person knows the age of the child at the time of the offense, the person:

(1) engages in sexual contact with the child or causes the child to engage in sexual contact; or

(2) with intent to arouse or gratify the sexual desire of any person:

(A) exposes the person's anus or any part of the person's genitals, knowing the child is present; or

(B) causes the child to expose the child's anus or any part of the child's genitals.

(b) It is an affirmative defense to prosecution under this section that the actor:

(1) was not more than three years older than the victim and of the opposite sex;
(2) did not use duress, force, or a threat against the victim at the time of the offense; and

(3) at the time of the offense:

(A) was not required under Chapter 62, Code of Criminal Procedure, to register for life as a sex offender; or

(B) was not a person who under Chapter 62 had a reportable conviction or adjudication for an offense under this section.

(b-1) It is an affirmative defense to prosecution under this section that the actor was the spouse of the child at the time of the offense.

(c) In this section, “sexual contact” means the following acts, if committed with the intent to arouse or gratify the sexual desire of any person:

(1) any touching by a person, including touching through clothing, of the anus, breast, or any part of the genitals of a child; or

(2) any touching of any part of the body of a child, including touching through clothing, with the anus, breast, or any part of the genitals of a person.

(d) An offense under Subsection (a)(1) is a felony of the second degree and an offense under Subsection (a)(2) is a felony of the third degree.

Texas Family Code § 261.109(c) Failure to Report Penalty:

(a) A person commits an offense if the person is required to make a report under Section 261.101(a) and knowingly fails to make a report as provided in this chapter.

(a-1) A person who is a professional as defined by Section 261.101(b) commits an offense if the person is required to make a report under Section 261.101(b) and knowingly fails to make a report as provided in this chapter.

(b) An offense under Subsection (a) is a Class A misdemeanor, except that the offense is a state jail felony if it is shown on the trial of the offense that the child was a person with an intellectual disability who resided in a state supported living center, the ICF-IID component of the Rio Grande State Center, or a facility licensed under Chapter 252, Health and Safety Code, and the actor knew that the child had suffered serious bodily injury as a result of the abuse or neglect.

(c) An offense under Subsection (a-1) is a Class A misdemeanor, except that the offense is a state jail felony if it is shown on the trial of the offense that the actor intended to conceal the abuse or neglect.

Department of State Health Services (DSHS) Rider 24, 2018-2019 General Appropriations Act, 85th Legislature: Reporting of Child Abuse. The Department of State Health Services may distribute or provide appropriated funds only to recipients who show good faith efforts to comply with all child abuse reporting guidelines and requirements set forth in Chapter 261 of the Texas Family Code. Located on Section II, Page 30: http://www.lbb.state.tx.us/Documents/GAA/General_Appropriations_Act_2018-2019.pdf


Additional References:

1. Statewide Intake: Source of Abuse/Neglect Reports
   https://public.tableau.com/shared/K4SMMYF8N?display_count=yes&showVizHome=no

https://www.adolescenthealth.org/SAHM_Main/media/Advocacy/Positions/Apr-14-Sexual-Repro-Health.pdf

https://www.adolescenthealth.org/SAHM_Main/media/Advocacy/Positions/Nov-04-Protecting_Adolescents_Ensuring_Access_to_Care_and_Reporting_Sexual_Activity_and_Abuse.pdf

5. Raz, Mical. Unintended Consequences of Expanded Mandatory Reporting Laws; Pediatrics April 2017
Volume 139 Issue 4 Pediatrics Perspective http://pediatrics.aappublications.org/content/139/4/e20163511
Whereas, The principle of equanimity is a firmly held virtue in the practice of medicine; and
Whereas, Inasmuch as we are called as physicians to be equitable in our approach to provision of care to our
patients, we are expected to uphold this same respect for colleagues; and
Whereas, The Texas Medical Association prides itself in being at the forefront in advancements in medicine,
whether scientific, political, or social; and
Whereas, TMA has a firm and clear nondiscrimination policy that guides its practices in issues of
nondiscrimination based on factors including sex, ethnicity, and religion; and
Whereas, Gender pay gaps exist in a variety of settings as borne out in the literature and, in some instances, as
much as a 20 percent for the equal amount of work being performed by women vs. men; and
Whereas, As Texas physicians, we understand that the way we move forward, together, as a strong and
unified house, is by being united by equanimity; therefore be it
RESOLVED, That the Texas Medical Association promote the principle of equal pay for equal work,
regardless of sex, ethnicity, and religious preference; and be it further
RESOLVED, That in upholding the principle of equal pay for equal work, TMA lends its strength and
affirmation to the efforts underway by the American Medical Association to address this issue of inequality.

Related TMA Policy:
60.005 Equal Rights: All individuals should have access to equal social, economic, and professional
opportunities (Medical Student Section, p 123, A-95; reaffirmed BOC Rep. 3-A-05; reaffirmed BOC Rep. 4-
A-15).

Related AMA Policy:
D-65.989 Advancing Gender Equity in Medicine:
1. Our AMA will draft and disseminate a report detailing its positions and recommendations for gender equity
in medicine, including clarifying principles for state and specialty societies, academic medical centers and
other entities that employ physicians, to be submitted to the House for consideration at the 2019 Annual
Meeting.
2. Our AMA will: (a) advocate for institutional, departmental and practice policies that promote transparency
in defining the criteria for initial and subsequent physician compensation; (b) advocate for pay structures
based on objective, gender-neutral objective criteria; (c) encourage a specified approach, sufficient to identify
gender disparity, to oversight of compensation models, metrics, and actual total compensation for all
employed physicians; and (d) advocate for training to identify and mitigate implicit bias in compensation
determination for those in positions to determine salary and bonuses, with a focus on how subtle differences in the further evaluation of physicians of different genders may impede compensation and career advancement.

3. Our AMA will recommend as immediate actions to reduce gender bias: (a) elimination of the question of prior salary information from job applications for physician recruitment in academic and private practice; (b) create an awareness campaign to inform physicians about their rights under the Lilly Ledbetter Fair Pay Act and Equal Pay Act; (c) establish educational programs to help empower all genders to negotiate equitable compensation; (d) work with relevant stakeholders to host a workshop on the role of medical societies in advancing women in medicine, with co-development and broad dissemination of a report based on workshop findings; and (e) create guidance for medical schools and health care facilities for institutional transparency of compensation, and regular gender-based pay audits.

4. Our AMA will collect and analyze comprehensive demographic data and produce a study on the inclusion of women members including, but not limited to, membership, representation in the House of Delegates, reference committee makeup, and leadership positions within our AMA, including the Board of Trustees, Councils and Section governance, plenary speaker invitations, recognition awards, and grant funding, and disseminate such findings in regular reports to the House of Delegates and making recommendations to support gender equity.

5. Our AMA will commit to pay equity across the organization by asking our Board of Trustees to undertake routine assessments of salaries within and across the organization, while making the necessary adjustments to ensure equal pay for equal work.
AGENDA
REFERENCE COMMITTEE ON MEDICAL EDUCATION AND HEALTH CARE QUALITY
Friday, May 17, 2019
Tower Lobby, Senator's Lecture Hall - Hilton Anatole

1. TMA President Report 2 – Improving the Quality Payment Program and Preserving Patient Access
2. Committee on Continuing Education Report 2 - Sunset Policy Review
4. Council on Medical Education Report 2 - Support of Expanded Eligibility for Inpatient Medicaid GME Funding to Teaching Hospitals
5. Council on Medical Education Report 3 - Fixing the Inequity in Medicare GME Funding for Texas Teaching Hospitals Compared to Other States
6. Council on Medical Education Report 4 - Study of Projected Need for More Medical Schools in Texas
9. Council on Health Service Organizations Report 1 - Supportive Palliative Care Policy
12. Committee on Physician Distribution and Health Care Access Report 1 - Improving Access to Care in Medically Underserved Areas through Project ECHO and the Child Psychiatry Access Project Model

18. Resolution 207-A-19 - Increasing Access to Service Learning Opportunities in Undergraduate Medical Education

19. Resolution 208-A-19 - Integration and Maintenance of Wellness Initiatives in Texas Undergraduate and Graduate Medical Education


22. Resolution 211-A-19 - The Integration of LGBTQ Health Topics into Medical Education


*Resolution 204 was moved to the Reference Committee on Financial and Organizational Affairs and renamed Resolution 112*
Subject: Improving the Quality Payment Program and Preserving Patient Access

Introduced by: Douglas W. Curran, MD, President

Referred to: Reference Committee on Medical Education and Health Care Quality

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**Quality Payment Program**

It has been four years since the passage of the Medicare Access and CHIP Reauthorization Act of 2015 (MACRA), which repealed the Sustainable Growth Rate (SGR) formula used to determine Medicare physician fee-for-service payments. In SGR’s place, MACRA requires physicians to choose between two major payment tracks that transition physicians to a value-based payment system: the Merit-Based Incentive Payment System (MIPS) and alternative payment models (APMs). These two payment tracks began in 2017 under the Quality Payment Program (QPP) framework, which the Centers for Medicare & Medicare Services (CMS) uses to implement the MIPS and APM tracks as required by law. Using this framework, physicians either participate in an advanced APM or default to the MIPS track, unless they are exempt under the low-volume threshold policy.

Simply put, the premise of the QPP is to improve the care and population health of Medicare beneficiaries, lower Medicare costs, and minimize burdens on practicing physicians. Physicians and other clinicians who participate in the APM and MIPS tracks are subject to performance measurement based on various quality, technology use, and cost metrics. Physicians can switch between the two tracks from one year to the next. Participation in the QPP requires annual quality reporting to CMS through various data collection and submission methods. Data submitted for a given performance year affect Medicare payments two years later.

It is important to note MACRA requires that MIPS be a budget-neutral program. This means bonuses are funded by practices who receive payment penalties. (Bonnuses for exceptional performance come from a separate pool of funds.) This provision of the law creates winners and losers among physicians and other clinicians who participate in the APM and MIPS tracks are subject to performance measurement based on various quality, technology use, and cost metrics. Physicians can switch between the two tracks from one year to the next. Participation in the QPP requires annual quality reporting to CMS through various data collection and submission methods. Data submitted for a given performance year affect Medicare payments two years later.

Issues

MIPS replaced three previous CMS quality programs: Physician Quality Reporting System, Electronic Health Record Incentive Program (meaningful use), and Value-Based Payment Modifier Program. Through MIPS, CMS was supposed to create policies that would streamline data requirements and reduce reporting burdens. However, those hoped-for improvements did not materialize. Other than inflicting
smaller payment penalties, MIPS after three years has not proven to be any better than the programs it replaced.

TMA analysis shows that for practices with a low volume of Medicare payments, compliance costs may exceed any likely financial return on investment through incentives and avoided penalties. Further, much of the clinical quality and cost metrics that physicians are scored on is not in physician control. Factors not in physician control often are not evenly distributed in the population, resulting in physicians being penalized if they serve disproportionate numbers of disadvantaged or high-risk patient populations.

MACRA requires that CMS, based on individuals’ health status and other risk factors, assess and implement appropriate adjustments. But after three years, the agency has not yet proposed any methodology for properly risk adjusting MIPS cost and quality measures, resulting in inadequate and/or unfair scoring methodologies. These issues may have the unintended consequence of physicians deciding not to treat certain patients.

TMA disagrees with MIPS’ one-size-fits-all approach. CMS has recognized this in past proposed rules, where it stated, “[W]e recognize that individual MIPS-eligible clinicians and groups that are small practices or practicing in designated rural areas face unique dynamics and challenges such as fiscal limitations and workforce shortages, but serve as a critical access point for care and provide a safety net for vulnerable patient populations.” Additionally, CMS has acknowledged concerns in its past proposed rules that “physicians in these practices tend to have patient populations with a higher proportion of older adults, as well as higher rates of poor health outcomes, co-morbidities, chronic conditions, and other social risk factors, which can result in the costs of providing care and services being significantly higher, compared to physicians in other areas.” CMS also has noted that “physicians may be disproportionately more susceptible to lower performance scores across all performance categories and negative MIPS payments adjustments, and as a result, such outcomes may further strain already limited resources and workforce shortages, and negatively impact access to care (reduction and/or elimination of available services).”

Moreover, because small practices are the most adversely affected by the negative cost/benefit relationship, TMA has had longstanding concerns that the budget neutrality requirement would result in a shift of Medicare payments away from small, often rural, physician practices to large, mostly urban, physician organizations and health care systems. This creates financial incentives for a massive restructuring of ambulatory care delivery systems, potentially eliminating many small practices that currently comprise 73% of physician practices in Texas per the TMA 2018 Survey of Texas Physicians (small groups defined as eight physicians or less).

It is clear that through the enactment of MACRA, Congress did not intend to penalize physicians who care for large numbers of disadvantaged or high-risk Medicare patient populations, who provide care in rural areas, or who choose to practice as solo practitioners or in small groups, but the current QPP creates incentives for physicians not to serve certain patients and not to locate their practices in areas where poverty or other specific characteristics are prevalent. For these reasons, TMA continues to advocate for improvements and a fair program for all physicians.

**Low-Volume Threshold**

MACRA requires the secretary of health and human services (HHS) to select the low-volume threshold(s) for CMS to use in defining MIPS-eligible clinicians. The law also outlines criteria CMS may use to exclude clinicians from mandatory participation. They include one or more of the following: (1) the minimum amount of Medicare Part-B allowed charges, (2) the minimum number of Medicare Part B-enrolled individuals seen, and (3) the minimum number of items and services furnished to Medicare Part B-enrolled individuals.
Prior to the first QPP performance year, TMA advocated for a low-volume threshold high enough to alleviate the threat to practice viability, particularly for small and rural practices, and to preserve patient access. The low-volume threshold policy in 2017 exempted physicians who submitted Medicare charges of less than $30,000 or saw fewer than 100 Medicare patients, but this was not sufficient for TMA. For the 2018 performance year, TMA and other medical societies around the country advocated for an even higher threshold. This advocacy resulted in an increase to $90,000 or 200 patients. For the 2019 performance year, the low-volume threshold policy changed once again because of continued advocacy and as a result of the Bipartisan Budget Act of 2018. To be excluded from MIPS in 2019, physicians and other clinicians need to meet one or more of the following three criteria.

1. Have ≤ $90,000 in Medicare Part B allowed charges for covered professional services,
2. Provide care to ≤ 200 Medicare Part B-enrolled beneficiaries, OR
3. Provide ≤ 200 covered professional services under the Medicare Physician Fee Schedule (new criterion).

The new criterion for the 2019 performance year simply allows clinicians who otherwise would have been exempt the opportunity to opt in, voluntarily report, or not report at all. Physicians who “opt in” receive a MIPS payment adjustment, and physicians who “voluntarily” report do not. TMA supported these policy changes during the last rulemaking cycle because the association supports physician choice. However, while the low-volume threshold policy decreases the percentage of physicians in small practices who have to participate in the program, it does not exempt all physicians who continue to face administrative, technological, and financial challenges. Recognizing these ongoing challenges, TMA remains vigilant in keeping the low-volume threshold policy in place while advocating for continued improvements and simplification of the program, and recommending that participation in the QPP be completely voluntary.

Some national organizations are calling on Congress, HHS, and CMS to reduce or eliminate the low-volume threshold policy because, under budget neutrality, it reduces the amount of incentive payments available. While TMA acknowledges this issue, the association maintains that even if the threshold criteria were reduced or eliminated, which would require more clinicians to participate and also boost incentive payments under budget neutrality, the current MIPS program would continue to harm small and rural practices, and many physician practices would continue to see no return on investment. TMA supports the current opt-in and voluntary participation options for practices that want to participate in MIPS, but the association strongly opposes reducing or eliminating the low-volume threshold. The solution is not to further harm small and rural practices but to make the program more clinically relevant and administratively easier to participate in. Budget neutrality in MIPS must be reformed not only to protect small and rural practices but also to provide an appropriate return on the significant investments many physicians have made to meet program compliance. For these reasons, TMA should advocate for Congress to eliminate budget neutrality and to finance payment incentives from supplemental funds that do not come from Medicare Part B payment cuts to physicians and other clinicians.

**QPP Experience Report**
Given that CMS had published experience reports for past quality programs two years after each performance year, TMA had been anticipating the complete publication of the 2017 QPP Experience Report since the beginning of 2019 to evaluate the first-year outcomes of budget neutrality and the overall program. On March 21, 2019, CMS published the 2017 QPP Experience Report with an accompanying appendix purportedly to provide a full account of clinicians’ experience, as well as to illustrate the successes and challenges in 2017. However, across the 30-page report and appendix, TMA found a lack of clarity for several data elements, numerous holes in CMS’ assessment and evaluation of the 2017 QPP, alarming results for physician practices in our state, and potentially flawed data. Analyses by staff experts...
led TMA to question the overall accuracy of the report. If left unchallenged, CMS could use the report to serve as the basis for undermining the low-volume threshold and other policies that protect physicians in small and rural practices from Medicare payment cuts in coming years.

National results showed that while some clinicians achieved full or partial qualifying APM participant status in advanced APMs (99,128), an overwhelming majority of clinicians participated in MIPS (1,006,319), either directly or as part of a MIPS APM. Because the overall performance target was set low, at three points out of 100 points in 2017, the maximum bonus to Medicare Part B payments this year is 1.88%, and the maximum payment penalty is 4%. Overall, CMS reported a 95% participation rate. Among those who participated, 71% of practices earned a positive payment adjustment and a bonus for exceptional performance, 22% earned a positive payment adjustment only, 2% received a neutral payment adjustment (no change in payment), whereas, 5% received a negative payment adjustment for nonparticipation. However, while the bonus may appear like an incentive, TMA asserts that the ongoing 2% Medicare sequestration effectively erases it.

TMA questions CMS’ claim of a 95% overall participation rate in the QPP, noting that the report showed even higher rates in Texas and several other states where large portions of the physician workforce were exempted from reporting because of natural disasters like Hurricane Harvey. Regardless, this percentage reflects the number of clinicians who simply reported the minimum amount of data or were exempt under the Extreme and Uncontrollable Circumstances Policy. The true measure of success for “overall participation” would have been the percentage of clinicians who met full data requirements across all MIPS categories, but CMS did not report that percentage.

<table>
<thead>
<tr>
<th>State</th>
<th>Eligible Clinicians</th>
<th>Participated</th>
<th>Participation Rate %</th>
<th>Participated as Individual</th>
<th>Participated as Group</th>
<th>Participated in MIPS APM</th>
<th>Did Not Participate*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Texas</td>
<td>62,731</td>
<td>69,901</td>
<td>97.08%</td>
<td>12,145</td>
<td>32,684</td>
<td>16,072</td>
<td>1,830</td>
</tr>
<tr>
<td>National Total</td>
<td>1,057,824</td>
<td>1,006,319</td>
<td>95.13%</td>
<td>122,897</td>
<td>542,200</td>
<td>341,221</td>
<td>51,505</td>
</tr>
</tbody>
</table>

*Number of MIPS-eligible clinicians who did not participate in the 2017 QPP and are receiving a 4% negative payment adjustment (penalty) in 2019. Source: 2017 Quality Payment Program Experience Report – Appendix

CMS Administrator Seema Verma stated that 2017 data “show significant success in the QPP.” However, when data are further broken down by practice designation, performance results show a different picture, even though CMS’ low-volume threshold policy exempted many physicians in small practices in 2017. Mean and median final scores for physicians and other clinicians who submitted data at the individual level, including physicians in solo practice, were lower than for group practices, and scores for small and rural practices were significantly lower than for large practices and MIPS APM participants. Most notably, among all practices, small practices fared the worst.

<table>
<thead>
<tr>
<th>Practice Designation</th>
<th>Small Practices (1-15 clinicians)</th>
<th>Small and Rural Practices</th>
<th>Rural Practices</th>
<th>Large Practices (16 or more clinicians)</th>
<th>MIPS APMs (e.g., ACOs)</th>
<th>2017 MIPS Overall National Total*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>43.46</td>
<td>44.66</td>
<td>63.08</td>
<td>74.37</td>
<td>87.64</td>
<td>74.01</td>
</tr>
<tr>
<td>Median</td>
<td>37.87</td>
<td>42.00</td>
<td>75.29</td>
<td>90.29</td>
<td>91.76</td>
<td>88.97</td>
</tr>
</tbody>
</table>

*For the 2022 QPP performance year and future years, CMS will set the overall performance target (number of points needed to avoid a 9% payment penalty) at either the national mean or median of the final scores for all MIPS-eligible clinicians from a prior performance period. Sources: 2017 Quality Payment Program Experience Report and 2017 Quality Payment Program Performance Year Data At-A-Glance
State results showed that of the 62,731 MIPS-eligible clinicians in Texas, 44,829 participated directly in MIPS and 16,072 participated in MIPS through a MIPS APM, while 1,830 did not participate at all. CMS did not provide the number of Texas clinicians who took part in an advanced APM or the number of Texas clinicians who were exempt from participation. TMA was unable to assess how Texas physicians fared compared with the rest of the nation because CMS provided limited state data. More alarming, TMA found harm to small and rural practices as evidenced by the fact that the majority of clinicians who are actively receiving the 4% payment penalty this year and funding the MIPS incentive payment for the rest of the country are from small and rural practices nationwide and in our state. Questionable, misleading, and incomplete data, along with selection bias, lack of meaningful clinical data, poor electronic health record participation, Medicare payment shift, limited to no return on investment, no data insights on vendors, and an inaccurate definition of physician are among the numerous flaws and/or troubling results found in TMA’s analysis of the 2017 QPP Experience Report. Frankly, it is disturbing that CMS had conducted such poor analyses and evaluation of the first year of MACRA implementation and did so without any regard to the serious threat the payment penalties pose to physician practices or to the potential harm to continued physician participation in Medicare and access to care. As the QPP evolves over time and as the program becomes more complex with more rigorous, yet flawed, performance measurement methodologies that do not account for factors out of physician control, TMA foresees future outcomes in which potentially thousands of Texas physician practices receive the 9% payment penalty every year.

Conclusion

After TMA’s analysis, the association led a call to action among the Coalition of State Medical Societies, and on April 25, 2019, TMA spearheaded a sign-on letter to HHS Secretary Alex M. Azar II and CMS Administrator Verma. Joining TMA on the letter were the medical societies of California, Florida, Louisiana, New York, North Carolina, Oklahoma, and South Carolina. The letter, which was also circulated to Congress and the American Medical Association, called on CMS “to rescind the report; establish a transparent approach to your analysis and reporting; and issue a revised, unbiased, and complete report that truly captures the full breadth of the 2017 QPP.” The letter further urged HHS and CMS not to use the report as the basis for future QPP changes that could harm physicians’ practices. The complete letter can be found in the TMA MACRA Resource Center at www.texmed.org/MACRA.

Recommendation 1: That the Texas Medical Association strongly advocate for Congress to make participation in the Merit-Based Incentive Payment System and alternative payment models under the Quality Payment Program completely voluntary.

Recommendation 2: That TMA strongly advocate for Congress to eliminate budget neutrality in the Merit-Based Incentive Payment System and to finance incentive payments with supplemental funds that do not come from Medicare Part B payment cuts to physicians and other clinicians.

Recommendation 3: That TMA call on the Centers for Medicare & Medicaid Services to provide a transparent, accurate, and complete Quality Payment Program Experience Report on an annual basis so the association can analyze the data to advocate for additional exemptions; flexibilities; and reductions in reporting burdens, administrative hassles, and costs.

Recommendation 4: That TMA establish formal policy that the Centers for Medicare & Medicaid Services increase the low-volume threshold for the 2020 Quality Payment Program and future years of the program for all physicians but continue to offer them the opportunity to opt in or voluntarily report.

Recommendation 5: That TMA establish formal policy that the Centers for Medicare & Medicaid Services preserve patient access by exempting small practices (one to 15 clinicians) from required
participation in the Merit-Based Incentive Payment System but continue to offer them the opportunity to opt in or voluntarily report.

**Recommendation 6:** That the Texas Delegation to the American Medical Association ask the AMA House of Delegates to adopt similar policy and calls to action.

**Related TMA Policies:**

**195.033 Medicare Payment Incentives and Penalties:** The Texas Medical Association advocates that any Medicare penalty or incentive program including the Value-Based Payment Modifier program and the Merit-Based Incentive Payment System be designed so that: (1) the measures and standards used do not result in financial penalties for physicians when their patients do not comply with orders or recommendations for testing and treatment; (2) physicians are not penalized for providing services to disadvantaged patients; (3) physicians are not penalized for noncompliance with obsolete or superseded guidelines and standards; and (4) both cost and quality measures are adequately risk adjusted to eliminate the effects of poverty, poor educational attainment, and cultural differences from the measures used to adjust payment. Until all of the above are implemented, Medicare payments should not be adjusted using these measures (CSE Rep. 2-A-12; amended CSE Rep. 6-A-17).

**265.017 Pay-for-Performance Principles and Guidelines:** Physician pay-for-performance (PFP) programs that are designed primarily to improve the effectiveness and safety of patient care may serve as a positive force in our health care system. Fair and ethical PFP programs are patient-centered and link evidence-based performance measures to financial incentives. Such PFP programs are in alignment with the American Medical Association Guidelines for Pay-for-Performance Programs and the following five American Medical Association Principles for Pay-for-Performance Programs:

1. **Ensure quality of care.** Fair and ethical PFP programs are committed to improved patient care as their most important mission. Evidence-based quality-of-care measures, created by physicians across appropriate specialties, are the measures used in the programs. Variations in an individual patient care regimen are permitted based on a physician’s sound clinical judgment and should not adversely affect PFP program rewards.

2. **Foster the patient-physician relationship.** Fair and ethical PFP programs support the patient-physician relationship and overcome obstacles to physicians treating patients, regardless of patients’ health conditions, ethnicity, economic circumstances, demographics, or treatment compliance patterns.

3. **Offer voluntary physician participation.** Fair and ethical PFP programs offer voluntary physician participation, and do not undermine the economic viability of nonparticipating physician practices. These programs support participation by physicians in all practice settings by minimizing potential financial and technological barriers including costs of start-up.

4. **Use accurate data and fair reporting.** Fair and ethical PFP programs use accurate data and scientifically valid analytical methods. Physicians are allowed to review, comment, and appeal results prior to the use of the results for programmatic reasons and any type of reporting.

5. **Provide fair and equitable program incentives.** Fair and ethical PFP programs provide new funds for positive incentives to physicians for their participation, progressive quality improvement, or attainment of goals within the program. The eligibility criteria for the incentives are fully explained to participating physicians. These programs support the goal of quality improvement across all participating physicians.

Guidelines for Pay-for-Performance Programs
Safe, effective, and affordable health care for all Americans is the American Medical Association’s goal for our health care delivery system. AMA presents the following guidelines regarding the formation and implementation of fair and ethical pay-for-performance (PFP) programs. These guidelines augment AMA’s Principles for Pay-for-Performance Programs and provide AMA leaders, staff, and members operational boundaries that can be used in an assessment of specific PFP programs.

Quality of Care

- The primary goal of any PFP program must be to promote quality patient care that is safe and effective across the health care delivery system, rather than to achieve monetary savings.
- Evidence-based quality-of-care measures must be the primary measures used in any program.

1. All performance measures used in the program must be defined prospectively and developed collaboratively across physician specialties.
2. Practicing physicians with expertise in the area of care in question must be integrally involved in the design, implementation, and evaluation of any program.
3. All performance measures must be developed and maintained by appropriate professional organizations that periodically review and update these measures with evidence-based information in a process open to the medical profession.
4. Performance measures should be scored against both absolute values and relative improvement in those values.
5. Performance measures must be subject to the best available risk adjustment for patient demographics, severity of illness, and comorbidities.
6. Performance measures must be kept current and reflect changes in clinical practice. Except for evidence-based updates, program measures must be stable for two years.
7. Performance measures must be selected for clinical areas that have significant promise for improvement.

- Physician adherence to PFP program requirements must conform with improved patient care, quality, and safety.
- Programs should allow for variance from specific performance measures that are in conflict with sound clinical judgment and, in so doing, require minimal, but appropriate, documentation.
- PFP programs must be able to demonstrate improved quality patient care that is safer and more effective as the result of program implementation.
- PFP programs help to ensure quality by encouraging collaborative efforts across all members of the health care team.
- Prior to implementation, pay-for-performance programs must be successfully pilot-tested for a sufficient duration to obtain valid data in a variety of practice settings and across all affected medical specialties. Pilot testing also should analyze for patient deselection. If implemented, the program must be phased in over an appropriate period of time to enable participation by any willing physician in affected specialties.
- Plans that sponsor PFP programs must explain these programs prospectively to the patients and communities covered by them.

Patient-Physician Relationship

- Programs must be designed to support the patient-physician relationship and recognize that physicians are ethically required to use sound medical judgment, holding the best interests of the patient as paramount.
- Programs must not cause conditions that limit access to improved care.
1. Programs must not directly or indirectly disadvantage patients from ethnic, cultural, and socioeconomic groups, as well as those with specific medical conditions, or the physicians who serve these patients.

2. Programs must neither directly nor indirectly disadvantage patients and their physicians, based on the setting where care is delivered or the location of populations served (such as inner city or rural areas).

- Programs must neither directly nor indirectly encourage patient deselection.
- Programs must recognize outcome limitations caused by patient nonadherence, and sponsors of PFP programs should attempt to minimize noncompliance through plan design.

Physician Participation

- Physician participation in any PFP program must be completely voluntary.
- Sponsors of PFP programs must notify physicians of PFP program implementation and offer physicians the opportunity to opt in or out of the PFP program without affecting the existing or offered contract provisions from the sponsoring health plan or employer.
- Programs must be designed so that physician nonparticipation does not threaten the economic viability of physician practices.
- Programs should be available to any physicians and specialties wishing to participate and must not favor one specialty over another. Programs must be designed to encourage broad physician participation across all modes of practice.
- Programs must not favor physician practices by size (large, small, or solo) or by capabilities in information technology (IT).

1. Programs should provide physicians tools to facilitate participation.
2. Programs should be designed to minimize financial and technological barriers to physician participation.

- Although some IT systems and software may facilitate improved patient management, programs must avoid implementation plans that require physician practices to purchase health-plan specific IT capabilities.
- Physician participation in a particular PFP program must not be linked to participation in other health plan or government programs.
- Programs must educate physicians about the potential risks and rewards inherent in program participation, and immediately notify participating physicians of newly identified risks and rewards.
- Physician participants must be notified in writing about any changes in program requirements and evaluation methods. Such changes must occur at most on an annual basis.

Physician Data and Reporting

- Patient privacy must be protected in all data collection, analysis, and reporting. Data collection must be administratively simple and consistent with the Health Insurance Portability and Accountability Act.
- The quality of data collection and analysis must be scientifically valid. Collecting and reporting of data must be reliable and easy for physicians and should not cause financial or other burdens on physicians and/or their practices. Audit systems should be designed to ensure the accuracy of data in a nonpunitive manner.
1. Programs should use accurate administrative data and data abstracted from medical records.
2. Medical record data should be collected in a manner that is not burdensome and disruptive to physician practices.
3. Program results must be based on data collected over a significant period of time and relate care delivered (numerator) to a statistically valid population of patients in the denominator.

- Physicians must be reimbursed for any added administrative costs incurred as a result of collecting and reporting data to the program.
- Physicians should be assessed in groups and/or across health care systems, rather than individually when feasible.
- Physicians must have the ability to review and comment on data and analysis used to construct any performance ratings prior to the use of such ratings to determine physician payment or for public reporting.

1. Physicians must be able to see preliminary ratings and be given the opportunity to adjust practice patterns over a reasonable period of time to more closely meet quality objectives.
2. Prior to release of any physician ratings, programs must have a mechanism for physicians to see and appeal their ratings in writing. If requested by the physician, physician comments must be included adjacent to any ratings.

- If PFP programs identify physicians with exceptional performance in providing effective and safe patient care, the reasons for such performance should be shared with physician program participants and widely promulgated.
- The results of PFP programs must not be used against physicians in health plan credentialing, licensure, and certification. Individual physician quality performance information and data must remain confidential and not subject to discovery in legal or other proceedings.
- PFP programs must have defined security measures to prevent the unauthorized release of physician ratings.

Program Rewards

- Programs must be based on rewards and not on penalties.
- Program incentives must be sufficient in scope to cover any additional work and practice expense incurred by physicians as a result of program participation.
- Programs must offer financial support to physician practices that implement IT systems or software that interacts with aspects of the PFP program.
- Programs must finance bonus payments based on specified performance measures with supplemental funds.
- Programs must reward all physicians who actively participate in the program and who achieve prespecified absolute program goals or demonstrate prespecified relative improvement toward program goals.
- Programs must not reward physicians based on ranking compared with other physicians in the program.
- Programs must provide to all eligible physicians and practices a complete explanation of all program facets, to include the methods and performance measures used to determine incentive eligibility and incentive amounts, prior to program implementation.
- Programs must not penalize physicians financially based on factors outside of the physician’s control.
- Programs utilizing bonus payments must be designed to protect patient access and must not financially disadvantage physicians who serve minority or uninsured patients.
• Programs must not penalize physicians financially when they follow current, accepted clinical
guidelines that are different from measures adopted by payers, especially when measures have not
been updated to meet currently accepted guidelines.

TMA opposes private payer, congressional, or Centers for Medicare & Medicaid Services pay-for-
performance initiatives if they do not meet the AMA’s Principles and Guidelines for Pay for Performance

Related AMA Policies:

H-390.837 MACRA and the Independent Practice of Medicine: 1. Our AMA, in the interest of
patients and physicians, encourages the Centers for Medicare and Medicaid Services and Congress to
revise the Merit-Based Incentive Payment System to a simplified quality and payment system with
significant input from practicing physicians, that focuses on easing regulatory burden on physicians,
allowing physicians to focus on quality patient care. 2. Our AMA will advocate for appropriate scoring
adjustments for physicians treating high-risk beneficiaries in the MACRA program. 3. Our AMA will
urge CMS to continue studying whether MACRA creates a disincentive for physicians to provide care to
sicker Medicare patients (Alt. Res. 206, A-17; Reaffirmed: BOT Action in response to referred for
decision: Res. 237, I-17).

H-390.838 MIPS and MACRA Exemption: Our AMA will advocate for an exemption from the Merit-
Based Incentive Payment System (MIPS) and Medicare Access and CHIP Reauthorization Act of 2015
(MACRA) for small practices (Res. 208, I-16 Reaffirmation: A-17 Reaffirmation: I-17 Reaffirmation: A-
18).

D-390.949 Preserving Patient Access to Small Practices Under MACRA: 1. Our AMA will urge the
Centers for Medicare and Medicaid Services to protect access to care by significantly increasing the low
volume threshold to expand the MACRA MIPS exemptions for small practices (on a voluntary basis), and
to further reduce the MACRA requirements for ALL physicians' practices to provide additional
flexibility, reduce the reporting burdens and administrative hassles and costs. 2. Our AMA will advocate
for additional exemptions or flexibilities for physicians who practice in health professional shortage areas.
3. Our AMA will determine if there are other fragile practices that are threatened by MACRA and seek
additional exemptions or flexibilities for those practices (Res. 243, A-16; Reaffirmed: I-17;

D-390.950 Preserving a Period of Stability in Implementation of the Medicare Access and
Children's Health Insurance Program (CHIP) Reauthorization Act (MACRA): 1. Our AMA will
advocate that Centers for Medicare and Medicaid Services (CMS) implement the Merit-Based Payment
Incentive Payment System (MIPS) and Alternative Payment Models (APMs) as is consistent with
congressional intent when the Medicare Access and Children's Health Insurance Program (CHIP)
Reauthorization Act (MACRA) was enacted. 2. Our AMA will advocate that CMS provide for a stable
transition period for the implementation of MACRA, which includes assurances that CMS has conducted
appropriate testing, including physicians' ability to participate and validation of accuracy of scores or
ratings, and has necessary resources to implement provisions regarding MIPS and APMs. 3. Our AMA
will advocate that CMS provide for a stable transition period for the implementation of MACRA that
includes a suitable reporting period (Res. 242, A-16).

D-395.999 Reducing MIPS Reporting Burden: Our AMA will work with the Centers for Medicare and
Medicaid Services (CMS) to advocate for improvements to Merit-Based Incentive Payment System
(MIPS) that have significant input from practicing physicians and reduce regulatory and paperwork
b) promote improved patient access to high-quality, cost-effective care; b) be designed with input from the physician community; c) ensure that physicians have an appropriate level of decision-making authority over bonus or shared-savings distributions; d) not require budget neutrality within Medicare Part B; e) be based on payment rates that are sufficient to cover the full cost of sustainable medical practice; f) ensure reasonable implementation timeframes, with adequate support available to assist physicians with the implementation process; g) make participation options available for varying practice sizes, patient mixes, specialties, and locales; h) use adequate risk adjustment methodologies; i) incorporate incentives large enough to merit additional investments by physicians; j) provide patients with information and incentives to encourage appropriate utilization of medical care, including the use of preventive services and self-management protocols; k) provide a mechanism to ensure that budget baselines are reevaluated at regular intervals and are reflective of trends in service utilization; l) attribution processes should emphasize voluntary agreements between patients and physicians, minimize the use of algorithms or formulas, provide attribution information to physicians in a timely manner, and include formal mechanisms to allow physicians to verify and correct attribution data as necessary; and m) include ongoing evaluation processes to monitor the success of the reforms in achieving the goals of improving patient care and increasing the value of health care services.

2. Our AMA opposes bundling of payments in ways that limit care or otherwise interfere with a physician's ability to provide high quality care to patients.

3. Our AMA supports payment methodologies that redistribute Medicare payments among providers based on outcomes, quality and risk-adjustment measures only if measures are scientifically valid, verifiable, accurate, and based on current data. 4. Our AMA will continue to monitor health care delivery and physician payment reform activities and provide resources to help physicians understand and participate in these initiatives. 5. Our AMA supports the development of a public-private partnership for the purpose of validating statistical models used for risk adjustment (CMS Rep. 6, A-09; Reaffirmation A-10; Appended: Res. 829, I-10; Appended: CMS Rep. 1, A-11; Appended: CMS Rep. 4, A-11; Reaffirmed in lieu of Res. 119, A-12; Reaffirmed in lieu of Res. 122, A-12; Modified: CMS Rep. 6, A-13; Reaffirmation I-15; Reaffirmation: A-16; Reaffirmed in lieu of: Res. 712, A-17; Reaffirmed: BOT Action in response to referred for decision: Res. 237, I-17).

Sources:


Subject: Sunset Policy Review

Presented by: Larry Driver, MD, Chair

Referred to: Reference Committee on Medical Education and Health Care Quality

The Texas Medical Association periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness.

The committee recommends retention of the following policy:


Recommendation: Retain.
REPORT OF COUNCIL ON MEDICAL EDUCATION

CME Report 1-A-19

Subject: Sunset Policy Review

Presented by: Ronald L. Cook, DO, Chair

Referred to: Reference Committee on Medical Education and Health Care Quality

The Texas Medical Association periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness.

The council recommends retaining Policy 185.018 and Policy 200.031.

185.018 Mitigating the Texas Physician Shortage: To keep pace with the state’s vigorous population growth, Texas needs significant increases in physician numbers, as well as maintenance of a stable practice environment to enhance physician retention. Both segments of the physician pipeline, medical education and graduate medical education (GME), need to be expanded and funded in order to educate and train more physicians for Texas. Further, GME numbers need to be aligned with medical school expansions to retain the Texas medical graduates who want to train in the state and to prepare physicians in the specialties most needed for Texas (Council on Medical Education Rep. 1-A-09).

Texas has achieved the target ratio of 1 to 1 entry-level residency positions for every Texas medical school graduate; however, three new medical schools opened since 2016, and there are plans for three more through 2020. The increased enrollments will require the creation of more than 500 residency positions through 2024 to maintain the 1:1 ratio. The council strongly endorses the continued emphasis in Policy 185.018 on the need to grow GME in sync with medical school enrollments.

Given recent and planned medical schools, the council considered the reference in the policy that supports the establishment and funding of new medical schools. Ultimately, the council made the decision to support the retention of this policy based on future physician workforce needs. This decision was based on the following assessments:

- Physician supply in Texas is growing at a healthy rate, with annual increases ranging from 3 to 5 percent over the past decade. The state’s population, however, continues to grow at a vigorous rate. This trend is expected to continue, with projected gains of 22 percent by 2030. This high rate of increase has constrained growth in the ratio of physicians per capita, and Texas ranks 41st for the ratio of physicians per 100,000 population. There remains the need to continue to recruit and train more physicians for Texas.

- The council also looked at long-term trends for medical school development in the state. It became obvious that the recent cluster of new medical schools followed four decades of extremely limited growth. From 1978 to 2016, only four new medical schools opened, with changes in medical school enrollments greatly lagging behind population gains. Texas has led the nation in net population growth since at least the year 2000. In the latest state ranking, Texas ranked at the bottom of the third quartile – at 36th – in a comparison of ratios for medical students per 100,000 population. The Texas ratio of 27.4 was considerably below the national ratio of 35.4. In a comparison of the five most-populous states, Texas ranked fourth in the ratio of students per capita.

- The council believes it would be beneficial to the state for the Texas Higher Education Coordinating Board to commission a comprehensive assessment of the projected need for more medical schools, as outlined in CME Report 4-A-19.
Because of the extremely small growth in medical schools for almost four decades and the expectation that Texas will likely experience exceptional population growth through 2030, the council recommends that Policy 185.018 be retained as written to plan for future physician workforce needs. Should the study referenced in CME Report 4-A-19 be completed, the council will monitor the outcomes and offer future updates to this policy as warranted.

**200.031 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 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).

**Recommendation:** Retain.
Before 2005, the Texas Medicaid program provided graduate medical education (GME) supplemental payments to a broad group of teaching hospitals. The supplemental payments stopped in 2005 due to a state budget shortfall. In 2008, the program was restored to a narrowly defined group, the five teaching hospitals owned by the state. These hospitals now had to put up their own money through an intergovernmental transfer to qualify for the 130-percent federal match. This means only an extremely limited number of teaching hospitals are eligible to seek matching federal funds for the inpatient Medicaid GME program, to the exclusion of hundreds of teaching hospitals. Since the loss of the broader eligibility for Medicaid GME funding in 2005, the Texas Medical Association has searched, in partnership with others, for ways to expand the program, with no success. The potential benefits to GME are significant, particularly at a time of great need for the expansion of GME capacity in the state.

In response to a state legislative directive, the Texas Health and Human Services Commission (HHSC), the state’s Medicaid authority, reevaluated the state’s Medicaid GME funding program in 2018. Because of this study, HHSC made the decision to begin the process of expanding eligibility to include additional types of teaching hospitals. The expansion is proposed to be rolled out in three phases, pending federal approval, as described below.

The first two phases would allow teaching hospitals to put up their own money as the non-federal share in order to draw down the federal match, similar to the current arrangement for state-owned hospitals. No state dollars would be used, which means no additional state appropriations are needed to implement this provision.

In the first phase, HHSC modified its rules to expand eligibility to include at least nine teaching hospitals that are owned and managed by non-state governmental entities. This amendment to the Medicaid State Plan is pending federal approval. For the second phase, HHSC will explore the potential for extending eligibility to teaching hospitals that are owned and managed by non-governmental organizations. This would enable at least 59 private hospitals, including 11 children’s hospitals, to qualify for the federal match.

In the third phase, HHSC is proposing an adjustment in the process used for determining the “medical education add-on” payments to teaching hospitals for inpatient Medicaid services. Currently, 57 hospitals are receiving these payments, for a state total of $109.3 million in FY 2018, and this program has not been updated to reflect current costs. HHSC’s proposal could require additional state appropriations, depending on how it is implemented, and this determination will be made during the 2019 state legislative session.

These proposals could serve as attractive incentives for eligible teaching hospitals to maintain and even grow their GME programs, in most cases without requiring additional state funds. The council is proposing new policy in support of all three proposals.
**Recommendation:** Adopt the following as new policy:

The Texas Medical Association supports expansion of the eligibility for the state’s inpatient Medicaid graduate medical education (GME) supplemental payments to include additional types of teaching hospitals. These monies can play a critical role in incentivizing hospitals to maintain and expand existing residency programs, as well as develop new programs. TMA recognizes that this growth is needed to maintain an adequate GME capacity that will accommodate the growing number of medical school graduates. TMA supports the specific use of the additional Medicaid GME payments for the support of GME programs.

TMA supports the proposed Medicaid GME expansion initiatives developed by the Texas Health and Human Services Commission, including:

- Extending eligibility for the inpatient Medicaid GME supplemental payments to teaching hospitals owned and managed by non-state governmental entities, such as cities or counties;
- Extending eligibility of teaching hospitals owned and managed by nongovernmental organizations, such as private hospitals; and
- Updating the inpatient Medicaid GME add-on payments to teaching hospitals based on current costs.
Texas teaching hospitals receive significantly less Medicare graduate medical education (GME) funding than similar hospitals across the country. To demonstrate the extreme disparity, the average Medicare payment per resident for Texas is $65,496 – less than half the state average of $155,135 for Connecticut or $139,126 for New York. (The Geography of GME: Imbalances Signal Need for New Distribution Policies, Mullan, F, et al, *Health Affairs* (Millwood), 2013.)

Recognizing that Medicare provides the largest amount of financial support for training the future physician workforce, by far, this disparity has a major detrimental impact on GME in Texas. The council believes this extreme discrepancy among states cannot be justified. States with high population increases such as Texas have a great need to grow their GME capacity, and Medicare GME funding can play a critically important role in improving the financial status of teaching hospitals, better enabling them to add residency positions.

The basis for the discrepancies in the average Medicare GME payment amounts by state is the “per resident base year cost amount” determined for each hospital by the Centers for Medicare & Medicaid Services. The council believes it is important for Texas teaching hospitals to seize opportunities as they arise for the recalculation of these base amounts to achieve greater equity in the distribution of GME funding across states. Further, the council believes the American Medical Association is uniquely positioned to advocate for teaching hospitals through its policies such as Policy D-305.973(c), which calls for the Medicare direct medical education per resident figure to be more equitable across teaching hospitals while ensuring adequate funding of all residency programs.

**Recommendation:** The council recommends adopting the following as new policy:

The Texas Medical Association supports equity in the “hospital-specific per resident base year cost amount” used by the Centers for Medicare & Medicaid Services to determine Medicare GME funding for teaching hospitals in Texas. Achieving equity in Medicare GME payments is particularly important to states with high population growth rates, such as Texas, to further enable expansion of the state’s GME capacity to meet the state’s growing demand for physicians’ services. This payment equity is needed for teaching hospitals that have Medicare GME funding caps as well as new teaching hospitals that are in their Medicare GME cap-building phase.

TMA urges the AMA to act on AMA Policy D-305.973(c) to make the Medicare direct medical education per resident figure more equitable across teaching hospitals while ensuring adequate funding of all residency programs.
REPORT OF COUNCIL ON MEDICAL EDUCATION

Subject: Study of Projected Need for More Medical Schools in Texas

Presented by: Ronald L. Cook, DO, Chair

Referred to: Reference Committee on Medical Education and Health Care Quality

Three new medical schools have opened in Texas since 2016 and three more are in development, with planned openings by 2020. Raymund Paredes, PhD, Texas Higher Education Coordinating Board commissioner, and state legislators have questioned the affordability of additional medical schools and the potential imbalance that could result between the rising number of medical school graduates and the state’s graduate medical education capacity. With the recent opening or planning of six medical schools and the talk of even more, the question arises as to when the state will know when the number of schools has met its needs.

In the past, the coordinating board commissioned comprehensive assessments of the need for medical schools in the state. The last assessment was released in 2002. Recognizing the extraordinary amount of resources required to build and maintain a new medical school, including financing, physical space, faculty and staff, clinical clerkship training needs, teaching hospital partners, and residency programs, the council believes it is imperative for the state to have a comprehensive plan of the projected need for more medical schools.

Recommendation: Adopt the following as new policy:

The Texas Medical Association recognizes that medical schools require extraordinary resources to meet national accreditation standards and to maintain educational excellence. With the increasing number of medical schools under development in Texas, it is in the best interest of the state for a comprehensive study to be done on the projected need for additional medical schools. The study should be commissioned by the Texas Higher Education Coordinating Board, similar to this agency’s work in 2002, which evaluated the projected need the people of Texas have for physicians’ services and the need for opportunities in the state to become a physician.

TMA supports the coordinating board’s use of the study in evaluating future proposals for the establishment of new medical schools in the state.
REPORT OF COUNCIL ON MEDICAL EDUCATION

CME Report 5-A-19

Subject: Inclusion of Medical Students in Good Samaritan Laws and Policies for Disaster Settings, Resolution 108-A-18

Presented by: Ronald L. Cook, DO, Chair

Referred to: Reference Committee on Medical Education and Health Care Quality

Resolution 108-A-18, Inclusion of Medical Students in Good Samaritan Laws and Policies for Disaster Settings (Medical Student Section) was adopted as amended by the house as follows:

That TMA: (1) support medical students volunteering inside of their institutional affiliations during times of disaster and emergency, due to both the need for and the competency of medical students, as demonstrated by previous research and disaster situations; and (2) study the involvement of medical students in natural disaster and emergency situations in order to develop TMA policy regarding medical student roles in disaster situations.

The council was asked to address the second part of Resolution 108-A-18.

Framing the Council’s Study

The council reached out to the author of the resolution to inquire about the motivation and goals in order to frame the council’s study of the issues. This resolution was drafted following medical student experiences in volunteer activities as part of the disaster response to Hurricane Harvey in Houston in 2017. From this discussion, the council identified two primary goals:

1. Scope of Medical Student Competencies in Volunteer Work

   A. The resolution, as originally written, sought support for allowing students to volunteer in disaster response activities that do not require supervision by faculty members from their respective schools due to “both the need for and the competency of medical students.”

   B. The resolution identified concerns that medical student education had not been recognized in their role as volunteers. For example, the resolution notes that medical students have the competency to perform triage activities but have not been utilized in this way.

2. Professional Liability Coverage/Indemnification for Medical Students During Volunteer Work/Emergency Response

The resolution seeks TMA’s support for applying the Good Samaritan Law to medical students as unlicensed providers of care in emergency settings.

The Council’s Study

The council focused its study on the resolution’s two primary goals, as summarized below:

Goal #1: Scope of Medical Student Competencies in Volunteer Work. There was broad consensus that medical students have the potential for serving in a highly valued role in volunteer work. TMA Policy 200.055, Maximizing Participation of Medical Students in Natural Disaster and Emergency Situations, adopted by the house in 2018, supports medical student volunteering inside their institutional affiliations during times of disaster and emergency. Students’ altruistic nature, empathy, and high energy often
motivate them to help others in times of great need. Whether that role should involve medical care such as triage activities, however, was not supported by others.

The council reached out to several physicians for their perspectives on the appropriate role of medical students in a disaster/emergency response. This included a physician who has overseen five post-hurricane relief operations in the state, including Harvey in 2017. In addition, a medical school and several faculty members at various academic health centers were consulted. When asked about the ability of medical students to perform triage activities, none of the physicians were of the opinion that medical students have the competencies to function in this role. There could be exceptions, such as students who are also certified paramedics. In that case, however, they would be acting in their role as a certified paramedic and not as a medical student.

The following comment was provided by a Texas medical school:

> It is [the medical school’s] view that generally medical students prior to 4th year would not have the demonstrated competency to provide medical services in a disaster since competency of medical students isn’t measured until after completion of the third year of medical school. Proper supervision is critical and medical students of any year should not be authorized to practice independently or supervised by physicians who are not faculty members within their institution, even in a disaster.

There was broad agreement, however, that medical students can perform many other needed and important volunteer activities that do not involve medical care. For example, medical students were highly effective in assisting with credentialing and orienting new volunteer physicians as part of the post-Harvey response in Dallas in 2017. Medical students could also seek other important leadership roles within organizations such as the American Red Cross, Medical Reserve Corps, or other key organizations that provide disaster response. These activities not only nurture altruism but also can provide greater exposure and enriching learning opportunities outside of medical school.

Texas academic health centers and medical schools in particular are encouraged to promote awareness among their students of the state’s centralized volunteer registry for disaster or public health emergency response efforts (www.texasdisastervolunteerregistry.org). Students can select their preferred responder organizations through this online process. The registry is maintained by the Texas Department of State Health Services but is used by local responder organizations as a volunteer registration and management tool. This program is designed to match a volunteer’s skills and abilities with the needs of particular emergency situations.

**Goal #2: Professional Liability Coverage/Indemnification for Medical Students During Volunteer Work/Emergency Response.** Legal officials from a prominent state university system provided information to the council about the status of professional liability coverage for medical students, confirming that medical schools provide this coverage through their self-insured plans. This coverage, however, is limited to certain settings and does not follow medical students outside of their roles as students. This means activities overseen by the medical schools, including volunteer work at student-run health clinics must be supervised by a medical school faculty member of the respective school in order to retain liability coverage. The coverage does not extend to activities that are not supervised by medical school faculty.

Further, based on input from various sources, including the TMA Office of the General Counsel, the state’s Good Samaritan Law does not apply to disaster response and is therefore not applicable to students volunteering in disaster response programs.
Medical students who provide aid in emergency situations as Good Samaritans, such as a car accident, would be indemnified by the provisions of the Good Samaritan law, the same as anyone else. This applies to “emergency services provided after the sudden onset of a medical or traumatic condition manifesting itself by acute symptoms of sufficient severity.”

The state’s Charitable Immunity and Liability law establishes indemnity for volunteer services by “direct service volunteers” to charitable organizations that are tax exempt under Section 501(c)(3) or (4) of the IRS Code of 1986 and meet certain other criteria. This provision includes medical students who volunteer to provide nonmedical care services with charitable organizations. This law also provides indemnity for “volunteer health care providers” at charitable organizations, which is defined to include physicians but not medical students.

It is important to note, however, that the scope of the services provided by medical students will dictate whether indemnification should be of concern. If a medical student is performing in a volunteer role that does not involve medical care or an activity that is supervised by a faculty member from their respective medical schools, then new state laws are not needed to encompass medical student liability, as suggested by Res. 108. Because of the lack of general support for medical students to be involved in volunteer roles that include medical care, there are not sufficient grounds for TMA to adopt new policy positions in support of indemnification of liability for medical students in volunteer roles.

In conclusion, the council applauds the strong interest of medical students to be extensively involved in volunteer activities in response to natural disaster and emergency situations. Students are encouraged to continue seeking opportunities that are a good match for their skills and interests.

**Recommendation:** Adoption of amended TMA Policy 200.055, Maximizing Participation of Medical Students in Natural Disaster and Emergency Situations, as follows:

The Texas Medical Association: (1) supports medical students volunteering inside of their institutional affiliations during times of disaster and emergency, due to both the need for and the competency of medical students, as demonstrated by previous research and disaster situations; (2) recognizes that medical students often possess the altruistic attributes that are of great benefit during critical times following natural or man-made disasters, catastrophic events, or public health crises. Students are encouraged to pursue their interests and actively participate as fully as their schedules will allow in volunteer activities that best utilize these attributes. TMA encourages participation by medical students in official responder organizations, such as the American Red Cross or Medical Reserve Corps; and (3) encourages academic health centers, and medical schools in particular, to promote awareness among their students of the Texas Department of State Health Services’ online centralized volunteer registry for disaster or public health emergency response efforts. This registry is an effective way to maximize the unique skills possessed by medical students for engaging in organized activities of the state’s responder organizations for disaster or public health emergencies.
Resolution 205-A-18, Graduate Associate Physician (International Medical Graduate [IMG] Section) was adopted as substituted by the House of Delegates as follows:

That the Council on Medical Education study the issue of unmatched candidates for U.S. residency programs and report back in 2019.

The resolution originally asked the Texas Medical Association to draft legislation for a state licensing program for “graduate associate physicians” in Texas in 2019 that would permit medical school graduates who have no residency training to practice in patient care under physician supervision. The Reference Committee on Medical Education and Health Care Quality did not support this proposal. In response, the IMG Section proposed a revision to Res. 205 to substitute the original language with a study of unmatched candidates for U.S. residency programs. The council supported this and the house adopted the revised resolution.

The council welcomed the opportunity to study the causal factors for physicians who fail to match to a residency position. This career interruption is traumatic and life-altering for physicians, and the council feels it is important to have a better understanding of how and why it happens and what can be done to prevent it.

As a first step, the council conducted a literature search on physicians who do not match and determined there was little available research. The council then compiled information on match outcomes at national and state levels to help understand the extent of the problem and the latest trends. The council devoted the majority of its meeting at the 2019 TMA Winter Conference to panel discussions with experts from the National Resident Matching Program® (NRMP® or The Match®). Small group discussions were held to identify methods for maximizing Match outcomes. The results of that meeting were incorporated into this report. An executive summary and the council’s study are provided in this report, with recommendations to adopt new policy and amend current policy.

Recommendation 1: Adopt new policy as follows:

Maximizing Match Rates for Candidates to U.S. Residency Programs: The Texas Medical Association:

1. Should continue to set as a priority advocating for graduate medical education (GME) capacity that maintains the state’s goal of 1.1 to 1 for the ratio of entry-level GME positions per Texas medical school graduate.
2. Supports data collection and projections by the Texas Higher Education Coordinating Board that monitor and project the state’s aggregate GME needs for graduates of existing and new medical schools. The outcomes should continue to be provided to state policymakers and medical school leadership.
3. Supports activities by Texas medical schools to reduce the number of graduates who do not match. This includes periodic assessments of the processes used for advising and counseling
medical students in developing their strategic plans for participation in the match, as well as back-up plans, which should be strongly encouraged for students with lower academic performance.

4. Through its Council on Medical Education, will look for opportunities to promote additional research on match outcomes, including statistical analysis and reporting of final match outcomes.

5. Should continue to serve as a convener of the state’s medical school leadership in efforts to maximize match outcomes for every Texas medical school graduate and reduce the number who do not match. This activity should include:

a. Collecting statistical information on annual match outcomes for the state’s medical school graduates and tracking the annual aggregate number of graduates who:
   i. Match only to preliminary positions without a corresponding categorical residency position.
   ii. Secure a training position after reapplication in the second year following medical school graduation, or
   iii. Do not match in the second year following graduation; and

b. Collaborating with medical schools to identify effective methods for achieving high match rates and monitoring career outcomes for Texas medical school graduates who fail to match.

6. Supports effective financial planning resources for medical students.
   a. Medical schools are encouraged to carefully consider the potential for high tuition rates that result in high education-related debt for graduates.
   b. There should be adequate funding for loan repayment programs such as the federal Public Service Loan Forgiveness Program, the state Physician Education Loan Repayment Program, and state Loan Repayment Program for Mental Health Professionals, which includes psychiatrists.
   c. Repayment amounts for these programs need to correlate to rising levels of physician loan obligations.

**Recommendation 2:** Amend the title of TMA Policy 30.036, New Licensing Category for Assistant Physicians to more accurately reflect the policy statement, as follows: **Opposition to New State Licensing Category for Assistant Physicians Who Do Not Complete Residency Training.**
COUNCIL ON MEDICAL EDUCATION
STUDY OF UNMATCHED CANDIDATES FOR U.S. RESIDENCY PROGRAMS, 2019

The Council on Medical Education was charged to study the issue of unmatched candidates for U.S. residency programs and to report back in 2019.

Executive Summary
Currently, only a very small percentage of U.S. medical school graduates are unable to secure a residency position – about 2 percent – and the number and proportion of unmatched graduates has been stable in recent years. There are common misconceptions that the number is growing, and the growth is a result of a shortage of residency training positions. There are presently 60 percent more residency positions than U.S. allopathic medical school seniors in the national match and 10 percent more in Texas than medical school graduates. But given the recent openings of medical schools and plans for additional schools, it is a valid concern that due diligence is needed to maintain the current ratio of 1.1 to 1 in Texas for entry-level residency positions per medical school graduate. Growth in GME capacity must be commensurate with medical school enrollment increases to maintain the state’s target ratio.

Even if the number of unmatched graduates is not increasing, the council strongly believes every effort should be made to prevent an avoidable non-match. In most cases, graduating medical students fail to secure a match due to lower scores on Step/Level 1 of the United States Medical Licensing Exam (USMLE) or Comprehensive Osteopathic Medical Licensing Exam of the United States (COMLEX). This is often a reflection of a poor strategy for the Match, including not having a back-up plan in place before Match Day. It is expected that medical schools have made substantial and sustained commitments to guide and assist students in preparing for the Match. It may be that more can be done to help students prepare for potential participation in the post-Match process.

Although few do not match as a result of nonacademic issues, this small group may have the greatest challenges to finding success as a physician. Texas medical schools are asked to consider whether there are sufficient processes in place, including an exit plan from medical school when needed, to achieve the best possible outcomes.

There is a need for better data collection and research on match outcomes and for ready access to final match statistics in order to prevent misconceptions about the extent of the problem. The circulation of inflated numbers is resulting in pressures to create alternative practice models, such as state licensing programs for graduate associate physicians, as presented in the original version of Res. 205. It is important to consider whether it is good public policy to advocate for a new state licensing program for the greatly limited number of medical students in Texas who do not match each year – an average of 37 medical students in the year of graduation from medical school and 13 in the second year after graduation.

Finally, it is hoped that medical schools in Texas will collaborate to share best practices for maximizing the match for each medical student, including the prevention of non-matches; participate in state efforts to collect and report statistics on match outcomes; and work together to achieve the common goal of producing well-qualified physicians for the state.

Framing the Council’s Study
To help frame the council’s study, it is important to understand the goals of the IMG Section in calling for the study as presented in Res. 205. Res. 205 cited:

- The projected national physician shortage;
- The greater number of applicants to the 2018 Match than available entry-level residency positions;
- The many graduates, United States and IMGs, who are unable to secure a match because of limited slots;
• The large number of U.S. medical graduates and IMGs with specific U.S. legal status who may be available to provide medical care with appropriate supervision; and
• The fact that advanced practice registered nurses (APRNs) are able to practice with only 700 hours of training, while medical graduates with 15,000 hours of medical education are not able to provide medical care.

Issues Related to Unmatched Graduates
When a medical student does not match, this type of career interruption has far-reaching consequences for students, medical schools, and society. From an education perspective, residency training is considered an inseverable component of the three-part continuum for the education and training of a physician, between medical school and CME. A minimum of one year of residency training is required for a Texas medical license for graduates of U.S. and Canadian medical schools and two years for IMGs. In addition, board eligibility depends on the completion of residency training, and board eligibility/certification is often required to participate on health plan provider panels, to be hired by physician groups and hospitals, and to qualify for hospital admitting privileges.

There also is a financial impact when a graduate does not match. Students have invested considerably in tuition and have foregone potential income during their extended years in school. Society’s financial investment in the student’s education also will likely see less return. This includes the considerable amount of state support for the infrastructure and operations of health science centers, and the total state formula funding of almost $180,000 per medical student over four years.

Graduates who fail to match do not generally reflect positively on their medical schools. However, as with any educational/training program, it is not reasonable to expect a success rate of 100 percent. Yet, based on the limited amount of research, and what appears to be limited collaboration among medical schools, the question arises whether more can be done to both prevent unmatched graduates and to help students when it does happen.

It is difficult to accurately assess the extent of the problem of unmatched graduates. Data on final match rates are not readily available. These data are not reported by school and are not routinely available in aggregate form at the state level. Given the common misconception that unmatched graduates number in the thousands, it can be expected that there will be continued pressure for the creation of alternative practice models for unmatched graduates, such as state licensing programs for graduate associate physicians as originally proposed in Res. 205.

Study Questions
For the study of unmatched candidates to U.S. residency programs, the council sought to answer the following key questions:

1. How many U.S. medical school graduates do not match to a residency position?
2. What are the reasons for not finding a match?
3. What resources are available to facilitate a good match?
4. Can more be done to improve match rates?
5. What happens to those who fail to match?

The council’s efforts to find answers to each of these questions are summarized in the report, followed by policy recommendations. Recognizing the significant role that graduates of medical schools outside of Texas have in the U.S. physician workforce, representing one of four, the council also studied the challenges they face in securing residency positions. The results are presented in Attachment 1.
Question 1: How Many U.S. Medical School Graduates Do Not Match to a Residency Position?
It is a common misperception that thousands of U.S. medical school graduates do not match. The number is considerably less, as shown below.

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<thead>
<tr>
<th></th>
<th>2018</th>
<th>2014-18 (Five-Year Average)</th>
</tr>
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<tbody>
<tr>
<td>U.S.:</td>
<td>620</td>
<td>583</td>
</tr>
<tr>
<td>Texas:</td>
<td>39</td>
<td>37</td>
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About 2 percent of U.S. medical school seniors (MS4s) do not enter residency training directly after graduation from medical school, and the percentage is the same for Texas seniors. The 2018 NRMP Main Match was one of the most successful ever. Both the number of positions offered and the number of active applicants were the largest in NRMP history.

A total of 33,167 positions were offered in the 2018 Match, and 96.2 percent of these were filled on Match Day. Only 1,268 positions (3.8 percent) were still open after Match Day, and 1,171 of these were offered in the post-Match Day process, called the Match Week Supplemental Offer and Acceptance Program (SOAP). The final fill rate was 99.4 percent. There were 213 unfilled positions at the end of the Match process, and while it is not exactly known how many ultimately filled, anecdotal information indicates only very few did not fill.

Improved Unmatched Rates for U.S. Allopathic Medical School Seniors, 2004-18
Although the match rate was strong in 2018, the council also wanted to assess whether the rate has been going up or down in recent years. The council looked at unmatched rates for allopathic MS4s on the Annual Match Days for 2004-18. Match rates for the end of the post-Match processes were preferable but not readily available.

The unmatched rates for allopathic seniors, as shown in Chart 1 below, improved over the 15-year period, from 7.1 percent in 2004 to 5.7 percent in 2018. This occurred despite the increased number of medical school seniors. Rates for unmatched students in the most recent years, at 5.7 percent, are the third lowest in the past 15 years.

Chart 1: % Unmatched U.S. Allopathic Medical School Seniors on Match Day, 2004-18, NRMP

Note: Match statistics in the chart represent match rates on the first day of Match Week and do not reflect final match results, which were higher.
Prepared by: Texas Medical Association, Medical Education Department, January 2019.
Source: NRMP Results and Data, 2018 Main Residency Match®, 2004-18
All types of applicants who participated in the NRMP Match during this time period also showed improved unmatched rates, including osteopathic medical school seniors and prior graduates, graduates of allopathic medical schools in prior years, and IMGs, both U.S.-born and non-U.S.-born. Osteopathic applicants saw the biggest improvement in match rates for this time period, dropping from 32.1 percent unmatched in 2006 to 18.3 percent in 2017 and 2018.

Research published in the *Journal of the American Medical Association* in 2015 tracked 186,937 U.S. medical school graduates from 2005 to 2015. The percentage of unmatched (during the year of their graduation from medical school) for these cohorts ranged from 2.6 to 3.5 percent, with a mean of 3 percent. African-American, Hispanic, and non-U.S.-citizen U.S. graduates were consistently less likely to enter residency soon after graduation than white graduates were. These distinctions diminished over time, and within six years, more than 99 percent of all graduates entered GME or were found to be in medical practice in the United States. In this study, the percentage of U.S. allopathic graduates who entered residency training in the year of their graduation remained stable, despite the increase in the number of graduates. Differences in residency start time by race/ethnicity diminished over time.

**Texas Match Rates**

TMA’s ad hoc Council of Medical School Deans has had a longstanding interest in monitoring match rates and maximizing match outcomes. This council has been working with TMA for five years to collect data on the number of Texas MS4s who do not match. There is no other known source for this data.

The ad hoc council reviews and discusses unmatched statistics for Texas each year; these data are distributed to the deans of student affairs at each medical school. The survey results are reported using an anonymous format because there is no interest in calling out individual schools. Rather, the goals are to gain a better understanding of match outcomes for Texas medical schools for the purposes of monitoring the number of unmatched and partial matches, and harnessing the collective wisdom of Texas medical schools in identifying effective methods for maximizing match outcomes.

The five-year annual average for Texas MS4s who did not match on the first day of Match Week for 2014-18 was 112. (Survey results for 2014-18 are provided in Attachment 2.) Two-thirds of the 112 were able to secure a residency position through the post-Match processes each year, and the five-year annual average number of those who were unmatched at the end of Match Week in Texas was only 37. The numbers of unmatched by school were quite small; most Texas schools each had less than five graduates per year who went unmatched.

**Question 2: What Are the Reasons for Not Finding a Match?**

When students do not match to a residency position, they are not required to report the potential reasons. National surveys are conducted to allow medical students to provide this information on a voluntary basis. TMA conducted the first-ever survey for Texas in November 2018 of the perceptions of deans of student affairs at Texas medical schools on why students did not match. Both the national and Texas surveys had similar outcomes: Lower academic performance was cited most often, primarily lower scores for Step/Level 1 of the USMLE and COMLEX.

Graph 2 shows the responses to the survey for Texas (six of nine schools reported). The deans reported 60.5 percent likely did not match due to lower academic performance. The second most likely reason was other factors, such as a medical condition and deferral of residency due to childrearing (19.5 percent). This was followed by unsuccessful decisionmaking by seniors in the Match, such as applying to only one specialty or one residency program for which they were not sufficiently competitive and without a solid back-up plan (15.8 percent). Small percentages likely did not match due to poor interviewing skills (3.3 percent), and nonacademic issues, such as professionalism (1 percent).
Emphasis on Test Scores by Residency Program Directors

The number of applications for residency positions, particularly in highly competitive specialties, has increased to levels that limit the feasibility of in-depth reviews by residency program directors. To demonstrate this, NRMP reported an average of 129 applications per offered residency position for 2018. This has influenced residency program directors to rely more heavily on objective indicators such as board scores. In fact, 98 percent of program directors reported in a 2018 NRMP survey that they use USMLE Step 1 scores for identifying applicants for interviews, and 88 percent of program directors said they would seldom/never consider an applicant who failed Step 1 on the first attempt. In addition, program directors said they rejected 48 percent of applications.

Other Factors Used by Residency Program Directors in Selecting Interview Candidates

Residency program directors are increasingly placing an emphasis on the medical student performance evaluation, or dean’s letter, in selecting candidates for interviews, as reported in the biennial NRMP Program Director Survey. The directors stressed that the letters need to be meaningful and should reflect specifics about each graduate. Some specialties, for example, emergency medicine, are using standardized video interviews to assist in the selection of candidates. A 2017 study in Academic Medicine found that program directors are considering additional measures to assess an applicant’s degree of interest in the specialties and programs they apply to, and are looking for indices of maturity, patient commitment, and a sense of team spirit.

Controversy About Emphasis on USMLE and COMLEX Step/Level 1 Scores for Selection of Residency Interview Candidates

Some academic leaders question the heavy reliance on exam scores as objective criteria for selecting residency interview candidates. In a commentary in Academic Medicine in January 2016, the authors take the position that the exams were developed for use by individual medical licensing authorities in evaluating applicants for licensure and were “not designed to be a primary determinant of the likelihood of success in residency.” They believe evidence is lacking of its potential predictive value, and the argument is made that many other factors may be equally or even more predictive of performance during residency. The study finds it is “ill advised” to use the exam scores for a purpose for which they were not developed and have not been validated. It is stressed that the test is intended to differentiate students with adequate knowledge, not to infer substantial differences in knowledge between students. Further, the scores are used to “make career-changing decisions about medical school graduates based on
overweighting a screening test in a manner not supported by strong evidence and for which the test was not specifically designed.”

To reduce the reliance on board scores, some recommend the exams be converted to pass/fail. There are concerns, however, that this would take away the medical school’s ability to use the scores to target needed improvements. Obviously, this would greatly diminish the ability of residency program directors to utilize the scores as a screening tool.

The study suggests that the heavy use of exam scores by residencies influences a student’s specialty choice based on the strength of his or her scores and the perceived likelihood of matching to more or less competitive specialties, even though the student may have other attributes that are suitable for a given specialty.

It is further noted that the overemphasis on Step/Level 1 scores adds another layer of stress for students. The authors argue that the “undue emphasis” on the scores “could distort faculty perceptions of the relative importance of the medical knowledge competency over the other five important general competencies, potentially creating an adverse impact on curriculum change.”

Critics emphasize that exams do not measure many clinical aptitudes and skills, qualities of professionalism, or competencies specific to the planned training program. Alternatively, it is recommended that more attention be given to clinical reasoning, patient care, professionalism, and ability to function as a member of a health care team. Further, weight should be given to factors shown empirically to predict performance in the relevant specialty, such as evaluation during the core clerkship, performance during specialty-specific subinternships and electives, and other activities, such as research. The authors argue this information needs to be made available to program directors.

**Emphasis on Life-Style Specialties**

While the competitiveness of a select number of specialties has likely always played a role in the challenges of matching to a residency program, the current “squeeze” appears to be heavily influenced by the recent focus on lifestyle specialties, those specialties with work schedules that are likely to give physicians more work/life balance. Although not within the purview of TMA nor the council, this raises the question whether more could be done to improve the work schedules for additional specialties. The growing amount of concern about physician burnout and physician health and wellness are another motivating factor for improving work/life balance for all physicians.

**Potential Influence of Debt Levels**

High levels of medical education debt have been cited as influencing medical student specialty choice, with those with large loans being drawn to higher paying specialties. The median medical education-related debt for allopathic medical students reached $195,000 in 2018, with a growing number (9.5 percent) having debt above $300,000. Osteopathic graduates have even higher average debt, at $240,000.

Sources: Association of American Medical Colleges 2018 Medical School Graduation Questionnaire, All Schools Report; and 2015-16, American Association of Colleges of Osteopathic Medicine.

**More Training Slots Than Medical School Seniors**

Res. 205 states “many graduates, U.S. and IMGs, are unable to secure a match because of limited slots.” With the recent opening of new medical schools, this is a common concern. It is not borne out, however, by historic NRMP Match statistics, which show a consistently high ratio of GME positions per MS4. In fact, since 2003, there have been at least 5,000 more slots each year than MS4s. The ratio of first-year GME positions per U.S. MS4 in 2018 was 1.6 to 1 – the highest on record. This means there were 60 percent more offered positions than MS4s. Recent U.S. trends are shown in Graph 3.
The ratio of entry-level GME positions to medical school graduates for Texas reached the state target of 1.1 to 1 in 2018, with a total of 1,904 GME positions (allopathic and osteopathic) for 1,734 graduates. Entry-level GME positions grew by 34.5 percent, while graduates increased 26 percent from 2010 to 2018. (See Graph 4.) With three new medical schools since 2016 and plans for three more through 2020, a net increase of 433 (25 percent) is projected for total graduates from 2018 to 2024. Unless GME grows at a commensurate rate, there will be fewer entry-level residency positions than the number of Texas medical school graduates.

Note: Includes Texas osteopathic medical graduates.
Sources: NRMP Main Residency Match®, 2010-18; American Osteopathic Medical Association; and Texas Higher Education Coordinating Board.
Prepared by: Texas Medical Association, Medical Education Department, January 2019
GME Expansions

A total of 237 new GME positions were created in the state from 2014 to 2017 through state grants to residency programs by the Texas Higher Education Coordinating Board (THECB). Both initial state budget bills for 2020-21, House Bill 1 and Senate Bill 1, show a proposed total of $157.2 million for the GME Expansion Grant program. This is an increase of $60.15 million (62 percent) over the previous state appropriation and reflects the amount requested by THECB to maintain the state’s target ratio of 1.1 to 1 for entry-level residency positions per Texas medical school graduate.

Additional residency positions have been created in the state in recent years with funding sources other than state grants. As shown in Graph 4, the number of entry-level GME match positions grew from 1,416 in 2010 to 1,904 in 2018, a net increase of 488 (34.5 percent).

Question 3: What Resources Are Available to Facilitate a Good Match?

Obviously, medical students are not alone in navigating the pathway to residency. Their goal of maximizing a successful match is shared by medical schools, residency programs, match programs, and other organizations. All are committed to achieving high match rates and the best possible outcomes.

Medical School Accreditation Standards Related to Match Outcomes

It is fully expected that each medical school dedicates considerable resources to help students maximize their potential in preparing for the transition to residency training, including preparation for exams, and selecting and matching to residency positions. (See Council on Medical Education’s Principles on Medical School and Medical Student Responsibilities in Regard to Maximizing Match Potential in Attachment 3.)

The two U.S. medical school accrediting bodies, Liaison Committee on Medical Education (LCME) and American Osteopathic Association’s Commission on Osteopathic College Accreditation (COCA), do not have specific accreditation standards on match outcomes for graduates. There are standards on preparing students for the match and providing related career counseling. The standards are not specific to a targeted number of matched graduates (the previous osteopathic accreditation standard for a 100-percent match has been rescinded), or for how long a school should assist a physician in securing a residency position after graduation.

The schools’ responsibilities in preparing students for the match are defined in the following accreditation standards:

- LCME Accreditation Standard 11.2 Career Advising
  A medical school has an effective career advising system in place that integrates the efforts of faculty members, clerkship directors, and student affairs staff to assist medical students in choosing elective courses, evaluating career options, and applying to residency programs.

- COCA Accreditation Element 9.6: Career Counseling
  A college of medicine must provide career counseling to assist its students in evaluating career options and applying to GME training programs.

- COCA Accreditation Standard 10: GME
  The faculty of a college of medicine must ensure that the curriculum provides content of sufficient breadth and depth to prepare students for entry into a GME program for the subsequent practice of medicine. The college of medicine must strive to develop GME to meet the needs of its graduates within the defined service area, consistent with the mission of the school.

Several national organizations, including the Association of American Medical Colleges (AAMC), NRMP, and AMA also offer resources for students, as summarized below.
AAMC
Careers in Medicine® Online Guide
This extensive resource helps students maximize the match, including the following examples (with hyperlinks):

1. Understanding the wide range of specialty and practice options available to physicians.
2. Gauging their competitiveness and candidacy.
3. Determining which specialty or specialties are right for them.
4. Researching residency programs in their preferred specialty or specialties.
5. Determining how many and to which residency programs they should apply.
6. Creating an effective residency application and preparing for interviews.

Optimizing GME Initiative: Transition to Residency
This initiative offers resources and tools for all key players in the Match process, including medical students, medical school advisors, and residency program directors.

NRMP
NRMP provides technical guidance on the Match and a series of videos designed to inform students and maximize Match outcomes, as well as an extensive series of historical reports on Match statistics and surveys of residency program directors.

AMA
The association’s Career Planning Resource provides guidance on selecting clinical clerkships, applying for residency, choosing a specialty, finding a residency program, and interviewing for residency positions.

All fellowship and residency programs accredited by the Accreditation Council for Graduate Medical Education (ACGME) are searchable on the AMA’s Fellowship and Residency Electronic Interactive Database Access system (FREIDA™). Descriptive information is available for each program, and tools are available to help students and physicians make a program selection.

Question 4: Can More Be Done to Improve Match Rates?
To answer this question, the council looked at the reasons students did not match. In the TMA ad hoc council survey of Texas medical schools in 2018, the following reasons were identified (in order), with similar findings at the national level, as presented in more detail under question 2.

1. Weak academic performance, including USMLE/COMLEX exam scores:
   Schools are encouraged to consider sharing methods they have found effective for identifying contributing factors to a student’s poor performance or even failure of a Step/Level exam. It is important to catch students who are struggling early in medical school and apply specialized support services and counseling. The literature further suggests that students with weak scores should have a strategic plan for the match and a well-thought-out advance back-up plan. In particular, they should be advised about selecting a highly competitive specialty. (See more under #3.)

2. Personal reasons, such as medical conditions or childrearing responsibilities:
   Life events are to be expected. These are individual cases, but often the delay in entering residency training is short term.

3. Unsuccessful decisionmaking in the Match:
   Medical students need to be coached on specialty selection beginning in the first year, not the third year, of medical school. Further, they need to be aware of the cadre of resources that are available to them within their medical school as well as external organizations to help them develop an effective match strategy.
4. Poor interviewing/interpersonal skills:
This category applied to only 3.3 percent of Texas MS4s. Data should be available to medical schools and students about the screening criteria used by residency program directors/faculty in the resident selection process. Regular advisor meetings are critical, along with individualized counseling and mock interviews.

5. Non-academic issues, e.g., professionalism:
Only 1 percent of students likely did not match due to non-academic issues, but this represents the most challenging impediment to success. The literature indicates most, if not all, students with non-academic issues, such as professionalism or maturity concerns, were known to the medical schools prior to the match. The council encourages the medical schools to evaluate whether processes should be refined to determine when a medical student does not have the needed qualifications for a career in patient care.

LCME Accreditation Standards include a description of the characteristics of accepted applicants, as follows:

LCME Accreditation Standard 10.4 Characteristics of Accepted Applicants
A medical school selects applicants for admission who possess the intelligence, integrity, and personal and emotional characteristics necessary for them to become competent physicians.

In the rare event remediation is not feasible or is unsuccessful, although difficult for all involved, the literature suggests promotion policies at medical schools should include an exit plan and counseling for alternative careers. Resources are available, including information on nonclinical careers for physicians. An example is AAMC’s web-based Careers in Medicine, with references on careers in public health and service, public policy and government, communications and journalism, informatics, pharmaceutical research, and consulting.

A study referenced in multiple professional journals, including New England Journal of Medicine (2005) and Virtual Mentor (2007), presents data on the potential correlation between unprofessional behavior during medical school and disciplinary issues for physicians in later years.

In this case–control study, disciplinary action among practicing physicians by medical boards was strongly associated with unprofessional behavior in medical school. Students with the strongest association were those who were described as irresponsible or as having diminished ability to improve their behavior. Professionalism should have a central role in medical academics and throughout one’s medical career.

Physicians who were disciplined by a medical board were three times more likely to have a record of unprofessional behavior during medical school than were the controls [in the study]. In particular, they were more likely to have demonstrated irresponsibility, diminished capacity for self-improvement, poor initiative, impaired relationships with students, residents and faculty, impaired relationships with nurses, and unprofessional behavior associated with being anxious, insecure, or nervous.

MCAT scores appeared to be loosely linked with disciplinary behavior, with a trend towards lower test scores in physicians disciplined by the board. Furthermore, disciplined physicians were also twice as likely to have failed at least one course on their first attempt during medical school…but the association with these variables was less strong than that with unprofessional behavior.
Divergent Trends Toward Holistic Evaluations Between Some Medical Schools and Residency Programs

Residency program directors appear to be placing a heavy emphasis on USMLE/COMLEX test scores at a time when an increasing number of medical schools are de-emphasizing standardized scores as part of their admissions criteria. Some schools have moved to a more holistic assessment process that places less priority on GPAs and MCAT scores. This raises the question whether the medical school admissions trends are potentially divergent from the high priority being placed on test scores in the residency application process.

Increased Need for Understanding COMLEX Exam Scores by Allopathic Residency Program Directors

Given that the ACGME will become the single national accrediting body for GME in 2020 and the resulting increase in the number of osteopathic medical students participating in the NRMP, it is increasingly important for allopathic residency program directors to have an understanding of the COMLEX testing series and the correlation between COMLEX and USMLE scores.

Question 5: What Happens to Those Who Fail to Match?

For graduates who fail to match the first year:

1. Those who continue to search for a residency position: 67.1%
2. Those who seek employment, such as a research position: 22.7%

Similar patterns were seen at the national level and in Texas, with a majority of unmatched MS4s reporting plans to continue their search for an open position. Additionally, almost a quarter said they planned to work in paid research positions or to pursue additional degrees.

United States

In the survey conducted by LCME of U.S. medical schools in 2016-17 (most recent available), the majority of MS4s who did not match reported plans to continue looking for an open residency position (67.1 percent), as shown below:

Post-Match Plans for Unmatched U.S. MS4s (2017):

1. 44.4% (246) continue to search for a residency position in 2017;
2. 22.7% (120) continue to search for a residency position in 2016;
3. 5.8% (32) seek an additional degree;
4. 5.4% (30) not known by the medical school; and
5. 0.1% (5) seek a career outside of medicine.

In addition, 28.5 percent reported plans to either seek employment, such as a research position, or an additional degree. Less than 1 percent planned to seek a career outside of medicine.

Texas

Data for Texas MS4s is similar to the national statistics. In the TMA ad hoc council survey for 2018, it was learned that the majority of the 2017 Texas medical school graduates who did not match (21 of 34, or 62 percent) were able to secure a match a year later in 2018. (See Attachment 2.) This indicates that almost two-thirds of those who did not match were able to find a residency position a year later. In fact, four of the nine schools participating in the survey reported that 100 percent of their 2017 graduates were matched by 2018 (one year later). Only 13 graduates remained unmatched in the second year following graduation.
**Preparing for Match Reapplication**

To improve their competitiveness for reapplying to the Match, the literature suggests physicians should look for opportunities to allow them to:

- Stay in touch with their medical school,
- Obtain letters of recommendation in their specialty,
- Enhance their personal statement,
- Demonstrate commitment to the specialty,
- Gain personal knowledge of faculty,
- Demonstrate leadership qualities,
- Demonstrate interest in a program,
- Gain volunteer experiences,
- Demonstrate involvement in research,
- Gain fluency in another language,
- Take USMLE Step 3/COMLEX Level 3, and
- Stay involved in a clinical environment.

There may be a need to offer financial counseling to unmatched students in cases where they are not able to defer student loans.

**Employment of Unmatched Graduates as Graduate Associate Physicians**

The original wording of Res. 205 sought TMA policy that would have required TMA to draft legislation for a state licensing program for graduate associate physicians. At least five states have such programs that authorize unmatched medical school graduates to engage in direct patient care under the supervision of a licensed physician. Two of these states extend eligibility to physicians who had some amount of residency training, and Missouri extends eligibility to certain IMGs.

Some programs are limited to certain specialties and medically underserved areas while others are not. In some states, there is a maximum number of license renewals while others are unlimited. Most programs authorize delegated prescriptive authority. After four months of practice with continuous supervision, Missouri allows “assistant physicians” to practice up to 50 miles away from their “collaborating” physician.

Assistant physicians are paid by their collaborating physicians in Missouri at a level similar to a resident’s stipend, $50-60,000 a year. The Centers for Medicare & Medicaid Services provided confirmation that patient care services by graduate associate physicians (or their equivalents with other titles) cannot be paid by Medicare as “incident-to” a physician’s services as is done for APRNs and physician assistants. Graduate associate physicians are not an “acceptable enrollment non-physician specialty type,” and there has been no request to add them and no plans to do so. Given the inability to bill for the services of graduate associate physicians, there are questions about both the affordability and sustainability of this employment model for the supervising physician as well as the graduate. Further, it is likely graduates would not be able to defer payment on their medical school-related loans, which raises a question as to how long they could remain in a position at that salary level.

TMA has policy in opposition to creation of a licensing program for assistant physicians in Texas, as follows:

**30.036 New Licensing Category for Assistant Physicians**: TMA opposes the creation of special licensing pathways for physicians who have not completed a year of residency training. Further, TMA recognizes primary care as encompassing specialties that require the completion of a full residency training process in the relevant specialties. TMA opposes lower standards of licensing for physicians and other health professions in medically underserved areas (CM-PDHCA Rep. 2-A-15).
The council also has concerns that a state initiative for a new licensing program for assistant physicians would likely hurt TMA’s advocacy efforts to maintain state support for GME expansions. Texas legislators may view assistant physicians as a less expensive alternative to funding GME positions. Further, such an initiative could undermine TMA’s efforts to advocate for appropriate staffing models that recognize the considerable differences in the education and training model for physicians in comparison to APRNs, optometrists, etc.

Opposition to Lower Standards for Medically Underserved Communities

TMA’s vision is “To Improve the Health of All Texans,” and the council has consistently held the position that establishing a lower standard for physicians or any other health care practitioner or system in medically underserved areas is not in keeping with this vision. That principle is specifically referenced in TMA Policy 30.036.

Related TMA Policy:

200.027 GME Training Positions: TMA supports the right of each graduate medical education program to select the best qualified candidates to fill available training positions (Board of Trustees, p 20, A-96; reaffirmed CME Rep. 1-A-08, and Rep. 2-A-18).

Sources:

MATCH RATES FOR INTERNATIONAL MEDICAL GRADUATES

International medical graduates (IMGs) have an important role in the U.S. physician workforce, representing 1 of 4. The numbers are likely increasing, as IMGs made up 29 percent of the newly licensed physicians in Texas in 2017.

Res. 205 expressed concerns about the ability of IMGs to secure residency training positions in the United States. IMGs do have considerably lower match rates than graduating U.S. medical school students (57.1 percent IMG compared with 94.3 percent U.S. MS4s); however, their match rates are higher than U.S. physicians who graduated before 2018 (43.8 percent).

The number of U.S.-citizen IMGs participating in the National Resident Matching Program® (NRMP®) Main Match has grown rapidly in recent years as a reflection of the greater numbers of U.S. citizens graduating from Caribbean medical schools. For 2018, there was little difference in the match rate for the two IMG groups, with U.S.-citizen IMGs matching at 57.1 percent and non-U.S. at 56.1 percent.

Findings
In the 2018 NRMP Main Match, on Match Day:

- More non-U.S.-citizen IMGs matched to an entry-level residency position than any other year in the NRMP history; and
- Match rates for both U.S.-Citizen and non-U.S. were the highest in 25 years.

Educational Commission for Foreign Medical Graduates
IMGs are required to obtain certification from the Educational Commission for Foreign Medical Graduates (ECFMG) to qualify for the NRMP Main Match. To be eligible, IMGs must pass both the USMLE Steps 1 and 2, and a test of English proficiency. This certificate is time unlimited, which raises the question about the length of time an IMG should be considered eligible for residency training following graduation from medical school or years out of medical practice, as further discussed below.

Match Resources for IMGs
IMGs have access to the same Match-related resources as U.S. medical school students, such as NRMP’s technical guidance and extensive match statistics and surveys, and the considerable array of information and self-assessment tools on the Association of American Medical Colleges’ Careers in Medicine® Online Guide. NRMP also publishes reports on Match characteristics of IMGs. Further, the American Medical Association IMG Section has online resources and webinars developed in partnership with ECFMG to assist IMGs in seeking residency positions. IMGs can participate in the NRMP post-Match process, called the Supplemental Offer and Acceptance Program (SOAP) and have access to post-Match websites that identify open residency positions, such as Association of American Medical Colleges’ FindaResident™ at https://services.aamc.org/findaresident/.

To help IMGs improve their potential competitiveness for the match, the AMA-IMG Section developed guidelines for the development of observerships. These are programs that provide an opportunity for IMGs to learn more about the U.S. health care delivery system by observing clinical practice. The AMA offers a web-based listing of observerships.

TMA’s IMG Section offers information about a variety of topics of interest to IMGs on its website at https://www.texmed.org/template.aspx?id=456, including links to the ECFMG, NRMP, and the Texas Medical Board. In addition, the section provides an opportunity for IMGs to connect with an IMG Section physician leader for mentorship on a variety of topics, through an online registration system.
Potential Challenges
U.S.-citizen and non-U.S.-citizen IMGs have different challenges in securing a match. For some IMGs, U.S. residency program directors have difficulty in assessing the prior education and training experience and overall credentials, particularly for graduates of medical schools for which accreditation or U.S. medical school/training equivalence has not been established. Further, cultural differences may influence an IMG’s interviewing skills, including use of eye contact or even customs related to handshakes.

Time Limits for Years Out-of-Training/Medical Practice for Residency Program Candidates
For any residency candidate, there is a question about continued eligibility in the years moving forward after graduation from medical school. How many years, post-graduate, should a physician maintain eligibility for residency training if he or she has not been active in medicine during those years? Should additional assessments be required to demonstrate “fit” for residency, such as Texas A&M University Health Science Center’s KSTAR (Knowledge, Skills, Training, Assessment, and Research) program, which offers assessments for physicians who have a lapse in medical licensure and/or an active practice in medicine prior to application for a Texas medical license? For an initial Texas medical license, a physician must have been engaged in active patient care for 12 months of the previous 24 months. What standard (or time limit) should be applied to physicians who are inactive in medicine for extended periods before applying for the Match?

Related TMA Policies
TMA has policies that support equitable treatment of IMGs in the residency selection process, as shown below, and the council has consistently supported awareness of these policies. Further, the council supports the retention of Policy 245.010 during the 2019 policy sunset process.

200.027 GME Training Positions: TMA supports the right of each graduate medical education program to select the best qualified candidates to fill available training positions (Board of Trustees, p 20, A-96; reaffirmed CME Rep. 1-A-08; reaffirmed CME Rep. 2-A-18).

245.010 Discrimination against IMGs: TMA supports and promotes the right of every licensed physician to be treated meritoriously without discrimination based on national origin or geographic location of medical school (Amended Res. 301-I-99; amended BOC Rep. 6-A-09).

Alternative Careers for IMGs
In cases where it is not feasible for IMGs to match to a residency position, there are resources to assist them in identifying alternative careers. As an example, the non-profit Welcome Back Initiative is described as an international health worker assistance center. There are a number of centers located throughout the United States to help IMGs find employment in health professions, particularly in medically underserved areas that are a good fit for their language skills and cultural competencies. The center assists IMGs in understanding the educational, licensing, or certificate requirements for specific professions, and services are provided at no cost.

Improving Match Outcomes for IMGs
IMGs represent the largest number that do not match to residency positions each year. Efforts should be made to ensure that IMGs are aware of the resources available to help them prepare for the Match and maximize match outcomes. It is also critically important that IMG physicians are fully aware of the options that may be available to them in the post-Match processes, including how to access listings of open positions.
119 did not match to entry-level residency positions on Match Day, the first day of the 2018 Match Week. 80 (67%) of the 119 matched in the post-Match processes. 39 (33%) of the 119 ultimately did not match to an entry-level residency position during Match Week, representing 2.2 percent of the 1,734 Texas medical school graduates for 2018.

MOST DIFFICULT SPECIALTIES TO MATCH TO IN 2018

1.  #1: Psychiatry was cited most often (by five medical schools).
2.  #2: Orthopedic Surgery was cited by four schools.
3.  #3: General Surgery was noted by three schools.

For comparison:
Specialties Most Commonly Identified as Difficult to Secure a Match, Prior Years
2017
#1 Orthopedic Surgery
#2 Psychiatry and Emergency Medicine
Follow-Up on 2017 Graduates Who Did Not Match, by Medical School

<table>
<thead>
<tr>
<th>Medical School</th>
<th>2017 graduates, as reported in 2018, who:</th>
<th>Did NOT match in 2017 but DID match in 2018</th>
</tr>
</thead>
<tbody>
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<td>Matched to a preliminary program in 2017 but NOT a PGY-2 position in 2018</td>
<td></td>
</tr>
<tr>
<td>1</td>
<td>3</td>
<td>1 (25% of 2017 unmatched)</td>
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<td>2</td>
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<td>2 (67% of 2017 unmatched)</td>
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</tr>
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</tr>
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<td>Not available</td>
<td>7 (58% of 2017 unmatched)</td>
</tr>
<tr>
<td>TOTAL</td>
<td>10</td>
<td>21* (62% of 2017 unmatched)</td>
</tr>
</tbody>
</table>

*In the 2017 medical school survey, a total of 34 fourth-year students were reported as not matched to a residency position. In 2018, the medical schools reported that 21 of the 34 did secure a match in 2018, for a second-year match rate of 62 percent for this group, with 13 unmatched in the second year after medical school graduation.

Source: Survey of student affairs deans at Texas medical schools, conducted by email April 2018. Prepared by: Texas Medical Association, Medical Education Department, May 2018.
Attachment 3

TMA COUNCIL ON MEDICAL EDUCATION’S PRINCIPLES ON MEDICAL SCHOOL AND MEDICAL STUDENT RESPONSIBILITIES WITH REGARD TO MAXIMIZING MATCH POTENTIAL

TMA’s Council on Medical Education believes medical schools can reasonably be expected to have responsibility for:

1. Ensuring every medical student is well prepared for the match process.
2. Providing guidance, counseling, and mentoring to each student to help them have a reasonable assessment and awareness of their individual skills, competencies, “fit,” and competitiveness for their preferred specialties and residency programs. Schools should ensure students are aware of the tools and resources available to assist them in selecting a residency program.
3. Making every effort to ensure students are fully informed about their training options and have a thorough understanding of the match and post-match processes.
4. Providing information on medical students to a residency program that can be considered “reasonably pertinent to a program’s decision, whether to rank an applicant, determine an applicant’s ability to satisfy program requirements, or identify circumstances that might adversely affect the applicant’s ability to satisfy program, licensure, or visa requirements or to start training on time.”
5. Informing residency programs if a student will not graduate in time to enter residency training on July 1.
6. Assisting medical students in coping with the emotional aspects of an unsuccessful match.

And, further that medical students can reasonably have responsibility:

1. For being as prepared as possible in order to maximize their opportunities in the match. This requires a student to familiarize themselves with the match process.
2. To select residency programs and specialties that are a good fit for their demonstrated competencies and aptitude.
3. To have an awareness of their “competitiveness” and “ranking” within the applicant pool with special attention to their preferred specialties and residency programs. Resources are available to students to assist them in making a reasonable assessment of their competitiveness for individual specialties.
The 84th Texas Legislature in 2015 established the Palliative Care Interdisciplinary Advisory Council to assess the availability of patient-centered and family-focused palliative care in Texas. The Council on Health Service Organizations acknowledges that supportive palliative care (SPC), a recognized specialty in the medical field, is available to people of all ages at any stage of a serious illness and offers a team-based approach to care focusing on controlling pain and improving comfort levels to provide a better quality of life for patients with life-limiting illnesses. Texas has a statutory framework regarding hospice palliative care (HPC) in Texas Health and Safety Code Chapter 142, but lacks a statutory scheme to define “supportive palliative care” as distinct from HPC.

After discussion and debate, the Council on Health Service Organizations recommends TMA adopt policy to support legislation that would enact distinct statutory language for SPC in a new chapter in the Health and Safety Code so that Texas may leverage any new statutory language through collaborative efforts with health plans and other stakeholders to develop a value-based SPC pilot focused on the most vulnerable Texans with serious, life-limiting illness.

Recommendation: That the Texas Medical Association develop policy to advocate for legislation that defines “supportive palliative care” as a distinct and different term from “hospice palliative care” under Texas Health and Safety Code Chapter 142.
Resolution 312-A-18, Identification Bracelets for Patients With Hearing Loss: That the Texas Medical Association adopt as policy a recommendation for medical care settings, especially hospitals and emergency departments, to provide identification bracelets on patients with hearing loss indicating their hearing status.

The Council on Health Service Organizations recognizes that many individuals, including physicians, nurses, and other medical staff, are not aware that hearing loss in patients can hinder effective communication, particularly in acute care facilities. The council recommends TMA adopt policy that enables acute care facilities to identify patients with hearing loss while avoiding the labeling of patients and maintaining patient dignity.

The Council on Health Service Organizations recommends the House of Delegates approve Resolution 312-A-18 as policy.

**Recommendation:** Adopt.
Subject: Sunset Policy Review

Presented by: Hattie E. Henderson, MD, Chair

Referred to: Reference Committee on Medical Education and Health Care Quality

The Texas Medical Association periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness. Following are policies the Committee on Health Services Organization reviewed, with recommendations for retention, amendment, and deletion.

The Committee on Health Services Organization recommends retention of the following policies:

20.008 Minimum Disaster Preparedness Standards for Assisted Living Action: The Texas Medical Association will request the State of Texas to enact minimum standards of operation during a disaster for licensed assisted living facilities, including provision of emergency power to operate all life-sustaining equipment and services required by current residents, and to make those standards part of the requirement to obtain a license to operate an assisted living facility in Texas (Amended Res. 206-A-09).

20.007 Behavior Evaluation in Long-Term Care Facilities Action: Behavior disorders of dementing illnesses are clinical complications that should not be classified and labeled as regulatory violations. Clinical complications are medical issues that should only be evaluated by qualified facility surveyors. Surveyors should be educated about the differences between sexual behavior as a result of mental illness or dementia and sexual abuse. Long-term care facilities should not be cited for patient sexual behavior as a result of mental illness or dementia. The Texas Medical Association in no way supports any form of sexual abuse (Amended Res. 405-I-99; reaffirmed CHSO Rep. 1-A-09).

Recommendation: Retain.
Subject: Improving Access to Care in Medically Underserved Areas Through Project ECHO and the Child Psychiatry Access Project Model

Presented by: Marco Uribe, MD, Chair

Referred to: Reference Committee on Medical Education and Health Care Quality

The committee is submitting this report in collaboration with the Committee on Medical Home and Primary Care and the Committee on Rural Health. Policy recommendations presented in this report touch on areas of responsibility for all three committees and were approved by all.

The committees learned about two innovative models that have the potential for improving access to care in medically underserved communities of the state. Project ECHO has proven to be successful in other states and other countries. The model has been implemented in Texas – only in a limited manner, however, and the committees believe there is considerable potential for broader implementation. The committees also learned about the proposed development of a Texas version of the Child Psychiatry Access Project model, which seeks to increase the availability of mental health services for children across the state. This model has the potential for improving access to care, and the committees support the development of such a program for Texas.

Project ECHO

The University of New Mexico established the Project ECHO (Extension for Community Healthcare Outcomes) model in 2003. It is an educational model that offers a unique form of continuing medical education in certain specialty services for community-based primary care physicians. It is accomplished using teleconferencing between physician specialists at academic health centers and primary care physicians who voluntarily seek the training. The goal of the program is to enable primary care physicians in physician shortage areas and medically underserved areas to manage their patients with certain complex medical conditions. Because of the void of physicians who felt qualified to treat hepatitis C, the initial program in New Mexico in 2003 offered mentorship in treating patients with this condition. Since then, the program has grown, now offering mentorships in more than 100 specialty services, including HIV-AIDS, tuberculosis, opioid use disorder, pain management, behavioral health, palliative care, and cervical cancer.

Typically, the training is provided through regularly scheduled videoconferences on a weekly or bimonthly basis for six to eight weeks. They are structured as two-part sessions: a didactic educational program, followed by virtual grand rounds where primary care clinicians from multiple sites present patient cases to the specialist teams and to each other. Patient cases and treatment options are discussed in a HIPAA-compliant way. (For example, the case presentation models use deidentified information.) Most programs offer CME credit to the community physicians, and all programs are free of charge.

Research has shown the model can improve professional satisfaction and reduce isolation among rural physicians. These benefits may help in recruiting and retaining physicians in rural areas.

To quote the Project ECHO website: “As the ECHO model expands, it is helping to address some of the health care system’s most intractable problems, including inadequate or disparities in access to care, rising costs, systemic inefficiencies, and unequal or slow diffusion of best practices. Across the United States and globally, policymakers are recognizing the potential of ECHO to exponentially expand
workforce capacity to treat more patients sooner, using existing resources. At a time when the health care system is under mounting pressure to do more without spending more, this is critical.”

Currently, 154 partners offer 402 individual programs in 45 states, including Texas, as do 80 global partners in 31 countries. The average cost of implementing an ECHO program is about $200,000 a year. Although sizeable, this is far less than most efforts to transform components of the health care delivery system.

A federal law enacted in December 2016, the Expanding Capacity for Health Outcomes (ECHO) Act, calls for research on the potential benefits of “technology-enabled collaborative learning and capacity building models,” with a report on the findings to be issued by the U.S. Department of Health and Human Services (HHS) before December 2018. The report is still unpublished.

**Project ECHO in Texas**

In Texas, eight academic health center hubs, including the five health-related institutions below, participate in Project ECHO.

1. Baylor College of Medicine and Baylor St. Luke’s Medical Center, Houston;
2. Texas Tech University Health Sciences Center, Lubbock;
3. UT Health San Antonio;
4. The University of Texas MD Anderson Cancer Center; and
5. TMF Health Quality Institute, Austin, in partnership with UT Austin Dell Medical School/Seton Healthcare.

MD Anderson Cancer Center serves as the state’s only “superhub,” which allows it to offer training on the model to physician specialists as an extension of the central program at The University of New Mexico; it offers training in multiple cancer specialties. It is one of few hubs that offers training to physicians in residency, such as a program on cancer survivorship for family medicine residents.

Project ECHO is being widely used by federally qualified health centers (FQHCs) in Texas and other states to fill the void of specialty services in the medically underserved areas where the clinics are located. Texas has more than 400 FQHCs distributed across the state.

**Relevant Grant Funding**

At the state level, the Cancer Prevention and Research Institute of Texas (CPRIT) has provided grant funding for ECHO projects at MD Anderson Cancer Center. Nationally, grants have been provided to Project ECHO projects by the General Electric Foundation, Robert Wood Johnson Foundation, and the Center for Medicare and Medicaid Innovation.

**Proposed Texas Version of Child Psychiatry Access Project in Massachusetts**

The Massachusetts Child Psychiatry Access Project has strong similarities to Project ECHO in that it is designed to fill a gap in the availability of specialty services, in this case child and adolescent psychiatry, through the training and mentoring of primary care pediatricians using telephone consultations. In Texas, child and adolescent psychiatry has one of the highest levels of physician shortages, with a ratio of 14,465 children per physician. The Massachusetts program started in 2004, and it is different from Project ECHO in the sense that it is not limited to mentoring. It serves as a statewide system of regional children’s behavioral health consultation hubs that reaches 95 percent of the children in the state. Its intent is to help pediatricians meet the needs of children with behavioral health problems.
The Texas Medical Association, the Federation of Texas Psychiatry, and the Texas Pediatric Society are all in support of establishing a similar program to expand psychiatric services for children in Texas with telemedicine. Several bills have been filed in the 2019 Texas Legislature to expand access to child/adolescent psychiatry services in Texas, and TMA is monitoring these bills.

**Potential Benefit to Texas**

In assessing the state’s physician workforce needs, the committees recognize the extensive challenges to producing adequate numbers of physician specialists to meet demands. The Texas physician workforce is growing at a rapid rate, but given the degree of physician specialty shortages, it is not expected that enough have been recruited to meet the state’s needs and to address geographic maldistribution. Neither Project ECHO nor the Child Psychiatry Access Project model have been designed to produce more physicians. Both focus on the existing primary care physician workforce by expanding their expertise in response to a defined, unmet need among their patient populations. The committees believe there is a need for such innovative models to improve access to care by maximizing the existing workforce.

Project ECHO has been established long enough to show outcomes. A prospective cohort study published in the *New England Journal of Medicine* in June 2011 found that hepatitis C patients in New Mexico treated by ECHO-trained primary care physicians had better outcomes than patients treated at a specialty clinic.

**Policy Recommendations**

Recognizing the limited implementation and awareness of Project ECHO, there is a need to promote greater awareness and voluntary participation among health-related institutions and community-based primary care physicians as a means of improving access to care in underserved areas of the state. Further, given the limited awareness of the Child Psychiatry Access Project model, as implemented in Massachusetts, the committees also support greater awareness of the potential benefits of such a program for Texas.

**Recommendation 1:** Adopt of new policy, as follows:

**Improving Access to Care Through Project ECHO and Promoting Awareness of Potential Benefits of the Child Psychiatry Access Project Model for Texas:** The Texas Medical Association should promote awareness of Project ECHO and the Child Psychiatry Access Network and encourage broad implementation and participation in the state by:

- Promoting broader participation among Texas’ health-related institutions as hubs to provide training in the specialty services most needed in rural and medically underserved areas of the state;
- Promoting awareness and voluntary participation by physicians as a method for expanding their knowledge and skills in specialty care otherwise not readily available to their patient populations;
- Ensuring stakeholders strive to identify and mitigate barriers to full implementation of physician education and mentoring models in Texas;
- Promoting awareness among state governmental agencies, such as the Texas Health and Human Services Commission as the state Medicaid authority, and the Texas Department of Agriculture’s State Office of Rural Health;
- Promoting these programs in underserved areas in partnership with state specialty societies, such as the Texas Academy of Family Physicians, Texas Pediatric Society, Texas Chapter of the American College of Physicians, Texas Association of Obstetricians and Gynecologists,
and Federation of Texas Psychiatry, and state professional organizations such as the Texas Organization of Rural and Community Hospitals;

F. Promoting awareness among physicians of the continuing medical education opportunities provided through Project ECHO;

G. Promoting awareness of national, federal, and state grant opportunities as they are identified;

H. Should state legislation pass that directs the establishment of the Child Psychiatry Access Network in Texas, monitoring the progress of implementing the network in the state and promoting awareness among physicians;

I. Monitoring whether payers offer additional payment or incentive payments for community-based physicians who engage in clinical practice improvement activities as a result of their participation in Project ECHO programs; and if confirmed, promoting awareness among physicians;

J. Evaluating the use of the Project ECHO model to provide not only clinical training to interested physicians but also training to support practice transformation for physicians seeking to adapt to new health care delivery and payment models; and

K. Enabling the implementation of these programs in rural Texas through advocacy of the availability of broadband connectivity in rural areas.

Recommendation 2: Direct the Texas Delegation to the AMA to advocate for these policies at the national level:

- Promote awareness and greater implementation of the Project ECHO and Child Psychiatry Access Project models among both academic health centers and community-based primary care physicians;
- Work with stakeholders to identify and mitigate barriers to broader implementation of the models in the United States;
- Monitor whether payers offer additional payment or incentive payments for physicians who engage in clinical practice improvement activities as a result of their participation in Project ECHO programs and if confirmed, promote awareness among physicians;
- Support broadband connectivity in all rural areas; and
- Encourage the U.S. Department of Health and Human Services to publish its findings on the potential benefits of the Project ECHO model, as required by the federal ECHO Act of December 2016 (P.L. 114-270, 114th Congress).

Sources:

3. Partnering Urban Academic Medical Centers and Rural Primary Care Clinicians to Provide Complex Chronic Disease Care, Sanjeev A., et al., *Health Affairs* (Millwood), June 2011; 30(6).
Subject: Alternative Maintenance of Certification (MOC) Pathways to Comply with Antitrust Rulings

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Medical Education and Health Care Quality

Whereas, Texas law provides some protection to physicians from maintenance of certification (MOC) by certifying boards as it requires that the physicians of each facility must vote whether to require MOC; and

Whereas, Texas law allows some institutions to require MOC; and

Whereas, History has proven that when free-market competition exists in providers of a service or product, then quality increases and price decreases; and

Whereas, Antitrust legislation and regulations prevent monopolies; therefore be it

RESOLVED, That any facility or medical staff in Texas that has complied with Texas law in requiring maintenance of certification (MOC) must accept proof of MOC from one of multiple recertifying entities.

Related TMA Policy:

175.018 Maintenance of Certification: The maintenance of certification (MOC) process should become substantially more physician friendly, offered at a reasonable cost to physicians and requiring no more than one missed day of patient care per recertification cycle. Time spent preparing for MOC should count as AMA PRA Category 1 Credit™. Use of ongoing educational processes, such as annual board certification, should be an option for practitioners in all specialties. There should be greater coordination between American Board of Medical Specialties’ boards to ensure that the demands of MOC processes are similar across all specialties (Amended Res. 305-A-07; amended CME Rep. 6-A-17).

175.021 Maintenance of Certification Requirement: The Texas Medical Association supports the American Medical Association’s Principles of Maintenance of Certification (MOC) H-275.924 to ensure physician’s choice of lifelong learning, and will pursue legislation that eliminates discrimination by the State of Texas, employers, hospitals, and payers based on the American Board of Medical Specialties’ proprietary MOC program as a requirement for licensure, employment, hospital staff membership, and payments for medical care in Texas (Res. 206-A-16).

175.023 Initial Guiding Principles on Maintenance of Certification: The Texas Medical Association believes in the following guiding principles regarding maintenance of certification:

1. Good medical practice necessitates a commitment by each physician to life-long learning.
2. Physicians have a social contract to maintain professional competency throughout their professional careers.
3. Action is needed to maintain the privilege of self-governance and decrease the potential for governmental interference.
4. Maintenance of certification (MOC) should be a meaningful process deeply rooted in best practices, responsive to participating physicians, and highly valued by physicians and the public.
Impact of MOC

5. MOC should not be a mandated requirement for licensure, credentialing, hospital privileging, payment, network participation, or employment (TMA Policy 175.021).

6. MOC should not be a revenue-generating enterprise for the specialty boards but rather a service provided to its diplomates. MOC programs should have fiduciary responsibility to their diplomates.

7. The American Medical Association should continue to monitor MOC processes to ensure they do not have a detrimental impact on the physician workforce, resulting in shortages and access barriers, due to a high loss rate of physicians unwilling or unable to participate in the MOC process (current AMA policy).

MOC Operational Characteristics

8. The MOC process should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.

9. The MOC process should use multiple options to recognize and accommodate different learning styles for physicians.

10. The MOC process should be designed with sufficient flexibility to accommodate the broad variety of physician practice characteristics, including nonclinical activities such as teaching, leadership roles, administrative, and research.

11. Physicians with lifetime board certification should not be required to seek recertification but should be afforded the opportunity for voluntary recertification.

12. High-stakes exams, including closed-book exams, should not be mandated as part of the MOC process.

13. Charges to physicians in relation to the MOC process should not be cost prohibitive but should be reasonable, not resulting in a barrier to practice.

14. Changes to the MOC process should undergo a vigorous evaluation to ensure the requirements are relevant, feasible, reasonably affordable, and accessible.

15. Individual boards should develop MOC requirements in conjunction with evaluation and feedback from its diplomates.

16. ABMS boards should make a diligent effort to inform diplomates about changes in MOC requirements, including the rationale or evidence behind the changes, and allow sufficient time for diplomates to make any changes necessary to comply with those requirements.

17. MOC requirements should be updated to reflect ongoing changes in health care delivery systems and medical practice, including the establishment of new fields of medicine.

18. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake, intent to maintain or change practice, and assess the impact on individual practices and the specialty as a whole.

19. Diplomates should have flexibility in selecting sources of MOC-related continuing medical education (CME) programming and should not be mandated or limited to participation in CME provided by American Board of Medical Specialties member boards.

20. Physicians should be exempted from MOC for no less than five years after attainment of initial board certification.

21. Patient satisfaction programs such as the Consumer Assessment of Healthcare Providers and Systems patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties and should not be part of the MOC process.

22. The MOC program should be a tool for process improvement and should not be constructed as a punitive measure to the detriment of physicians’ practices. Careful consideration should be given to the use of physician-specific data to be publicly released regarding MOC participation.

23. The MOC program should use commonly accepted practices for identifying core competencies applicable across specialties but also should provide the flexibility necessary to reasonably reflect the distinct characteristics of each specialty.

24. The MOC process should be streamlined to prevent overburdening physicians with more than one board certification by removing duplicative requirements. MOC requirements for diplomates with added qualifications should be applicable to the diplomate’s primary area of practice (CME Rep. 6-A-17).
175.024 Monitoring Maintenance of Certification Reforms: The Texas Medical Association will: (1) monitor the American Board of Medical Specialties (ABMS') Program for Maintenance of Certification (MOC), American Osteopathic Association’s Osteopathic Continuous Certification Program, and other MOC providers in direct correlation to adopted TMA Initial Guiding Principles on MOC; (2) continue to monitor the American Medical Association’s efforts as the national liaison with ABMS and other MOC providers, with particular focus on AMA’s work to address physician concerns and calls for MOC reform; (3) inform AMA and ABMS of adopted TMA Initial Guiding Principles on MOC; and (4) continue to assess physician views and experiences with MOC and Osteopathic Continuous Certification through activities by the Council on Medical Education as these programs incorporate reforms and communicate these findings to AMA, ABMS, and other appropriate MOC providers (CME Rep. 6-A-17).

175.025 Freedom from Maintenance of Certification: The Texas Medical Association will: (1) take the position in its advocacy efforts that all requirements for maintenance of board certification in medical staff bylaws for Texas health-related facilities, institutions, and programs that fall within the differentiation prohibition of Senate Bill 1148 (2017) should be considered null and void effective Jan. 1, 2018; (2) take the position in its advocacy efforts that any requirements for maintenance of board certification in medical staff bylaws for Texas health-related facilities, institutions, and programs that fall within the differentiation prohibition of Senate Bill 1148 (2017) require the vote of the medical staff (or satisfaction of another exception under the law); (3) take the position in its advocacy efforts that any vote for requiring maintenance of board certification in medical staff bylaws for Texas health-related facilities, institutions, and programs that fall within the differentiation prohibition under Senate Bill 1148 taken before the effective date of the bill should be considered null and void effective Jan. 1, 2018; and (4) be actively and immediately engaged in the rule-making process of SB 1148. (Res. 203-A-18)

Related AMA Policy:
H-275.924 Maintenance of Certification: AMA Principles on Maintenance of Certification (MOC)

1. Changes in specialty-board certification requirements for MOC programs should be longitudinally stable in structure, although flexible in content.

2. Implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures as well as to educate physician diplomates about the requirements for participation.

3. Any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for MOC.

4. Any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).

5. MOC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.

6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.

7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation.

9. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part II. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA PRA Category 1 Credit™, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)."

10. In relation to MOC Part II, our AMA continues to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.

11. MOC is but one component to promote patient safety and quality. Health care is a team effort, and changes to MOC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.

12. MOC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.

13. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.

14. MOC should be used as a tool for continuous improvement.

15. The MOC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.

16. Actively practicing physicians should be well-represented on specialty boards developing MOC.

17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.

18. MOC activities and measurement should be relevant to clinical practice.

19. The MOC process should be reflective of and consistent with the cost of development and administration of the MOC components, ensure a fair fee structure, and not present a barrier to patient care.

20. Any assessment should be used to guide physicians' self-directed study.

21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.
22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.

23. Physicians with lifetime board certification should not be required to seek recertification.

24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in MOC.

25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.

26. The initial certification status of time-limited diplomates shall be listed and publicly available on all American Board of Medical Specialties (ABMS) and ABMS Member Boards’ websites and physician certification databases. The names and initial certification status of time-limited diplomates shall not be removed from ABMS and ABMS Member Boards’ websites or physician certification databases even if the diplomate chooses not to participate in MOC.

27. Our AMA will continue to work with the national medical specialty societies to advocate for the physicians of America to receive value in the services they purchase for Maintenance of Certification from their specialty boards. Value in MOC should include cost effectiveness with full financial transparency, respect for physicians’ time and their patient care commitments, alignment of MOC requirements with other regulator and payer requirements, and adherence to an evidence basis for both MOC content and processes.
Subject: Clarification of Physician Protection From Maintenance of Certification (MOC) in Facility Bylaws

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Medical Education and Health Care Quality

Whereas, Texas law provides some protection to physicians from maintenance of certification (MOC) by certifying boards as it requires that the physicians of each facility must vote whether to require MOC; and

Whereas, Physicians of certain medical staff categories may be disenfranchised, penalized, and restricted in practice by not being allowed to vote on the question of MOC requirements in medical staff bylaws; and

Whereas, Certain institutions in Texas have disenfranchised physicians and violated Texas law by keeping or including MOC requirements in the medical staff bylaws without putting the question of such requirements to a vote of the medical staff; and

Whereas, Certain institutions in Texas have disenfranchised physicians and violated Texas law by keeping or including MOC requirements in the medical staff bylaws by ignoring a vote of the medical staff; and

Whereas, Certain institutions in Texas have disenfranchised physicians and violated Texas law by keeping or including MOC requirements in the medical staff bylaws by accepting the decision of institutional boards, such as a Medical Executive Committee, in lieu of putting the question of such requirements to a vote of the medical staff; and

Whereas, Certain institutions in Texas have disenfranchised physicians by restricting voting to a single time and place when and where physicians may be unavailable to vote; and

Whereas, Certain institutions in Texas have disenfranchised physicians by creating system-wide bylaws that can prevent or impede changes to medical staff bylaws; therefore be it

RESOLVED, That, unless statutorily exempted, every facility in Texas must conduct a vote (over a timeframe of two to four weeks) of the entire medical staff, regardless of medical staff appointment category, prior to including or allowing to remain in the medical staff bylaws any requirement of MOC; and be it further

RESOLVED, That, regardless of the existence of any system-wide medical staff bylaws, MOC requirements and voting shall be facility-specific, with each facility providing proof of receipt of a notice to each physician when the facility plans to conduct such a vote; and be it further

RESOLVED, That this vote must ignore any wishes of the facility system, administration, or medical staff representatives and under no circumstances should there be any reprisals against any physician by the facility system, administration, or medical staff representatives over any activity involving matters pertaining to MOC.
Related TMA Policy:

130.006 Hospital Medical Staff Bylaws: The Texas Medical Association supports changes in current laws to make established hospital medical staff bylaws binding upon and enforceable by the hospital medical staff and the board.

TMA policy is for Hospital Accrediting Organizations to include in its standards a provision which would require that medical staff bylaws, when formally approved by a hospital governing board, be mutually and equally binding on both the governing board and the medical staff.

TMA endorses the following principles for inclusion in future drafts of the Medical Staff Chapter of the Accreditation Manual for Healthcare Organizations:

(1) Continue the use of the term “medical staff” in the title of the chapter and throughout the manual;
(2) Provide consideration of qualified limited licensed practitioners when authorized by state laws and approved by the executive committee of the medical staff and the governing board;
(3) Require that 100 percent of the voting members of the executive committee be fully licensed physicians actively practicing; and
(4) Ensure that all hospitalized patients receive the same standard of care through appropriate language relating to admissions and the responsibility for the medical care of patients (Hospital Medical Staff Section, p 151-152, A-93; reaffirmed CHSO Rep. 1-A-03; amended CHSO Rep. 1-A-13).

130.008 Medical Staff Privileges: Rules, regulations, or bylaws of hospitals in Texas should include the following or similar phrase: “No physician may be denied staff privileges for political reasons or because of accepting or not accepting mandated assignments for payment for fee-for-service” (Hospital Medical Staff Section, p 151, A-93; reaffirmed CHSO Rep. 1-A-03; reaffirmed CHSO Rep. 1-A-13).

130.011 Medical Staffs: The need for continued community-based hospital care and the potential threat posed by the failure of governing and policymaking bodies to request, receive, and heed the advice and counsel of local medical staffs are causes for community and statewide concern. Medical staffs should foster cooperative and effective communication with their governing boards and should adopt bylaws that promote medical staff credentialing policies and procedures intended to assure a competent medical staff. Medical staffs should establish the capability to assist in resolution of conflicts between their members, hospital administration, and governing boards (Council on Socioeconomics, p 180, I-94; reaffirmed CHSO Rep. 2-A-05; reaffirmed CHSO Rep. 1-A-15).

130.015 Physician Participation in Medical Staff Affairs: The Texas Medical Association supports the principle that a hospital may not contract to limit physician participation or staff privileges or the participation or the staff privileges of a partner, associate, or employee of the physician at a different hospital or hospital system. TMA stands opposed to placing conditions on medical staff privileges to physician members by limiting their participation in medical staff matters through such conditions and limitations (Substitute Res. 29GG, p 177D, I-97; reaffirmed CHSO Rep. 1-A-08; reaffirmed CHSO Rep. 1-A-18).

130.026 Medical Staff Rights and Responsibilities Bill of Rights: The Texas Medical Association adopts the following medical staff rights and responsibilities as TMA policy:

TMA recognizes the following fundamental responsibilities of the medical staff:

- The responsibility to provide for the delivery of high-quality and safe patient care, the provision of which relies on mutual accountability and interdependence with the hospital’s governing body;
- The responsibility to provide leadership and work collaboratively with the hospital’s administration and governing body to continuously improve patient care and outcomes;
- The responsibility to participate in the hospital’s operational and strategic planning to safeguard the interest of patients, the community, the hospital, and the medical staff and its members;
• The responsibility to establish qualifications for membership and fairly evaluate all members and candidates without the use of economic criteria unrelated to quality, and to identify and manage potential conflicts that could result in unfair evaluation;
• The responsibility to establish standards and hold members individually and collectively accountable for quality, safety, and professional conduct; and
• The responsibility to make appropriate recommendations to the hospital’s governing body regarding membership, privileging, patient care, and peer review.

TMA recognizes that the following fundamental rights of the medical staff are essential to the medical staff’s ability to fulfill its responsibilities:

• The right to be self-governed, which includes but is not limited to (1) initiating, developing, and approving or disapproving of medical staff bylaws, rules, and regulations; (2) selecting and removing medical staff leaders; (3) controlling the use of medical staff funds; (4) being advised by independent legal counsel; and (5) establishing and defining, in accordance with applicable law, medical staff membership categories, including categories for nonphysician members;
• The right to advocate for its members and their patients without fear of retaliation by the hospital’s administration or governing body;
• The right to be provided with the resources necessary to continuously improve patient care and outcomes;
• The right to be well informed and share in the decisionmaking of the hospital’s operational and strategic planning, including involvement in decisions to grant exclusive contracts or close medical staff departments;
• The right to be represented and heard, regardless of the voting rights of the physician as outlined by the medical staff bylaws, at all meetings of the hospital’s governing body; and
• The right to engage the hospital’s administration and governing body on professional matters involving their own interests.

TMA recognizes the following fundamental responsibilities of individual medical staff members, regardless of contractual or independent status:

• The responsibility to work collaboratively with other members and with the hospital’s administration to improve quality and safety;
• The responsibility to provide patient care that meets the professional standards established by the medical staff;
• The responsibility to conduct all professional activities in accordance with the bylaws, rules, and regulations of the medical staff;
• The responsibility to advocate for the best interest of patients, even when such interest may conflict with the interests of other members, the medical staff, or the hospital;
• The responsibility to participate and encourage others to play an active role in the governance and other activities of the medical staff;
• The responsibility to participate in peer review activities, including submitting to review, contributing as a reviewer, and supporting member improvement.

TMA recognizes that the following fundamental rights apply to individual medical staff members, regardless of contractual or independent status, and are essential to each member’s ability to fulfill the responsibilities owed to his or her patients, the medical staff, and the hospital:

• The right to exercise fully the prerogatives of medical staff membership afforded by the medical staff bylaws, which right may not be waived as a condition of employment or medical staff privileges;
• The right to make treatment decisions, including referrals, based on the best interest of the patient, subject only to review by peers;
• The right to exercise personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care or medical staff matters, without fear of retaliation by the medical staff or the hospital’s administration or governing body;
• The right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are actively practicing physicians in the community and in the same specialty;
• The right to full due process before the medical staff or hospital takes adverse action affecting membership or privileges, including any attempt to abridge membership or privileges through the granting of exclusive contracts or closing of medical staff departments;
• The right to immunity from civil damages, injunctive or equitable relief, and criminal liability when participating in good faith peer review activities; and
• The right to be free of “sham peer reviews” and manipulation of medical staff bylaws by hospitals attempting to silence or inhibit the voicing of physician concerns regarding the advocacy of their patients. (CHSO Rep. 2-A-18).

175.018 Maintenance of Certification: The maintenance of certification (MOC) process should become substantially more physician friendly, offered at a reasonable cost to physicians and requiring no more than one missed day of patient care per recertification cycle. Time spent preparing for MOC should count as AMA PRA Category 1 Credit™. Use of ongoing educational processes, such as annual board certification, should be an option for practitioners in all specialties. There should be greater coordination between American Board of Medical Specialties’ boards to ensure that the demands of MOC processes are similar across all specialties (Amended Res. 305-A-07; amended CME Rep. 6-A-17).

175.021 Maintenance of Certification Requirement: The Texas Medical Association supports the American Medical Association’s Principles of Maintenance of Certification (MOC) H-275.924 to ensure physician’s choice of lifelong learning, and will pursue legislation that eliminates discrimination by the State of Texas, employers, hospitals, and payers based on the American Board of Medical Specialties’ proprietary MOC program as a requirement for licensure, employment, hospital staff membership, and payments for medical care in Texas (Res. 206-A-16).

175.023 Initial Guiding Principles on Maintenance of Certification: The Texas Medical Association believes in the following guiding principles regarding maintenance of certification:
1. Good medical practice necessitates a commitment by each physician to life-long learning.
2. Physicians have a social contract to maintain professional competency throughout their professional careers.
3. Action is needed to maintain the privilege of self-governance and decrease the potential for governmental interference.
4. Maintenance of certification (MOC) should be a meaningful process deeply rooted in best practices, responsive to participating physicians, and highly valued by physicians and the public.

Impact of MOC
5. MOC should not be a mandated requirement for licensure, credentialing, hospital privileging, payment, network participation, or employment (TMA Policy 175.021).
6. MOC should not be a revenue-generating enterprise for the specialty boards but rather a service provided to its diplomates. MOC programs should have fiduciary responsibility to their diplomates.
7. The American Medical Association should continue to monitor MOC processes to ensure they do not have a detrimental impact on the physician workforce, resulting in shortages and access barriers, due to a high loss rate of physicians unwilling or unable to participate in the MOC process (current AMA policy).

MOC Operational Characteristics
8. The MOC process should be based on evidence and designed to identify performance gaps and unmet
needs, providing direction and guidance for improvement in physician performance and delivery of care.

9. The MOC process should use multiple options to recognize and accommodate different learning styles for physicians.

10. The MOC process should be designed with sufficient flexibility to accommodate the broad variety of physician practice characteristics, including nonclinical activities such as teaching, leadership roles, administrative, and research.

11. Physicians with lifetime board certification should not be required to seek recertification but should be afforded the opportunity for voluntary recertification.

12. High-stakes exams, including closed-book exams, should not be mandated as part of the MOC process.

13. Charges to physicians in relation to the MOC process should not be cost prohibitive but should be reasonable, not resulting in a barrier to practice.

14. Changes to the MOC process should undergo a vigorous evaluation to ensure the requirements are relevant, feasible, reasonably affordable, and accessible.

15. Individual boards should develop MOC requirements in conjunction with evaluation and feedback from its diplomates.

16. ABMS boards should make a diligent effort to inform diplomates about changes in MOC requirements, including the rationale or evidence behind the changes, and allow sufficient time for diplomates to make any changes necessary to comply with those requirements.

17. MOC requirements should be updated to reflect ongoing changes in health care delivery systems and medical practice, including the establishment of new fields of medicine.

18. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake, intent to maintain or change practice, and assess the impact on individual practices and the specialty as a whole.

19. Diplomates should have flexibility in selecting sources of MOC-related continuing medical education (CME) programming and should not be mandated or limited to participation in CME provided by American Board of Medical Specialties member boards.

20. Physicians should be exempted from MOC for no less than five years after attainment of initial board certification.

21. Patient satisfaction programs such as the Consumer Assessment of Healthcare Providers and Systems patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties and should not be part of the MOC process.

22. The MOC program should be a tool for process improvement and should not be constructed as a punitive measure to the detriment of physicians’ practices. Careful consideration should be given to the use of physician-specific data to be publicly released regarding MOC participation.

23. The MOC program should use commonly accepted practices for identifying core competencies applicable across specialties but also should provide the flexibility necessary to reasonably reflect the distinct characteristics of each specialty.

24. The MOC process should be streamlined to prevent overburdening physicians with more than one board certification by removing duplicative requirements. MOC requirements for diplomates with added qualifications should be applicable to the diplomate’s primary area of practice (CME Rep. 6-A-17).

175.024 Monitoring Maintenance of Certification Reforms: The Texas Medical Association will: (1) monitor the American Board of Medical Specialties (ABMS’) Program for Maintenance of Certification (MOC), American Osteopathic Association’s Osteopathic Continuous Certification Program, and other MOC providers in direct correlation to adopted TMA Initial Guiding Principles on MOC; (2) continue to monitor the American Medical Association’s efforts as the national liaison with ABMS and other MOC providers, with particular focus on AMA’s work to address physician concerns and calls for MOC reform; (3) inform AMA and ABMS of adopted TMA Initial Guiding Principles on MOC; and (4) continue to assess physician views and experiences with MOC and Osteopathic Continuous Certification through activities by the Council on Medical Education as these programs incorporate reforms and communicate these findings to AMA, ABMS, and other appropriate MOC providers (CME Rep. 6-A-17).
175.025 Freedom from Maintenance of Certification: The Texas Medical Association will: (1) take the position in its advocacy efforts that all requirements for maintenance of board certification in medical staff bylaws for Texas health-related facilities, institutions, and programs that fall within the differentiation prohibition of Senate Bill 1148 (2017) should be considered null and void effective Jan. 1, 2018; (2) take the position in its advocacy efforts that any requirements for maintenance of board certification in medical staff bylaws for Texas health-related facilities, institutions, and programs that fall within the differentiation prohibition of Senate Bill 1148 (2017) require the vote of the medical staff (or satisfaction of another exception under the law); (3) take the position in its advocacy efforts that any vote for requiring maintenance of board certification in medical staff bylaws for Texas health-related facilities, institutions, and programs that fall within the differentiation prohibition under Senate Bill 1148 taken before the effective date of the bill should be considered null and void effective Jan. 1, 2018; and (4) be actively and immediately engaged in the rule-making process of SB 1148 (Res. 203-A-18).
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 203
A-19

Subject: Restrictions to Requirements of Maintenance of Certification

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Medical Education and Health Care Quality

Whereas, Texas law provides some protection to physicians from maintenance of certification (MOC) by certifying boards; and

Whereas, MOC requirements such as licensing verification can be performed easily online by any board without wasting physician resources; and

Whereas, Adequate CME requirements already exist for licensure and oversight by the Texas Medical Board; and

Whereas, Many MOC requirements have proven to be unfair; needlessly time-consuming; irrelevant to a physician’s scope of practice; costly in time away from patient care, in expenses of testing and preparation, and in personal time; and needless in data collection, possibly for the sole benefit of the certifying board; and

Whereas, MOC has never proven to improve the quality of patient care, prevent medical malpractice, provide protection to patients, nor provide value to physicians who endure the time, expense, sacrifice, and stress of the recertification process; therefore be it

RESOLVED, That the Texas Medical Association oppose mandatory maintenance of certification; and be it further

RESOLVED, That what constitutes life-long learning remain under the purview of state medical boards; and be it further

RESOLVED, That the Texas Delegation to the American Medical Association take this resolution to the AMA House of Delegates.

Related TMA Policy:

175.018 Maintenance of Certification: The maintenance of certification (MOC) process should become substantially more physician friendly, offered at a reasonable cost to physicians and requiring no more than one missed day of patient care per recertification cycle. Time spent preparing for MOC should count as AMA PRA Category 1 Credit™. Use of ongoing educational processes, such as annual board certification, should be an option for practitioners in all specialties. There should be greater coordination between American Board of Medical Specialties’ boards to ensure that the demands of MOC processes are similar across all specialties (Amended Res. 305-A-07; amended CME Rep. 6-A-17).

175.021 Maintenance of Certification Requirement: The Texas Medical Association supports the American Medical Association’s Principles of Maintenance of Certification (MOC) H-275.924 to ensure physician’s choice of lifelong learning, and will pursue legislation that eliminates discrimination by the State of Texas, employers, hospitals, and payers based on the American Board of Medical Specialties’
proprietary MOC program as a requirement for licensure, employment, hospital staff membership, and payments for medical care in Texas (Res. 206-A-16).

175.023 Initial Guiding Principles on Maintenance of Certification: The Texas Medical Association believes in the following guiding principles regarding maintenance of certification:

1. Good medical practice necessitates a commitment by each physician to life-long learning.
2. Physicians have a social contract to maintain professional competency throughout their professional careers.
3. Action is needed to maintain the privilege of self-governance and decrease the potential for governmental interference.
4. Maintenance of certification (MOC) should be a meaningful process deeply rooted in best practices, responsive to participating physicians, and highly valued by physicians and the public.

Impact of MOC

5. MOC should not be a mandated requirement for licensure, credentialing, hospital privileging, payment, network participation, or employment (TMA Policy 175.021).
6. MOC should not be a revenue-generating enterprise for the specialty boards but rather a service provided to its diplomates. MOC programs should have fiduciary responsibility to their diplomates.
7. The American Medical Association should continue to monitor MOC processes to ensure they do not have a detrimental impact on the physician workforce, resulting in shortages and access barriers, due to a high loss rate of physicians unwilling or unable to participate in the MOC process (current AMA policy).

MOC Operational Characteristics

8. The MOC process should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.
9. The MOC process should use multiple options to recognize and accommodate different learning styles for physicians.
10. The MOC process should be designed with sufficient flexibility to accommodate the broad variety of physician practice characteristics, including nonclinical activities such as teaching, leadership roles, administrative, and research.
11. Physicians with lifetime board certification should not be required to seek recertification but should be afforded the opportunity for voluntary recertification.
12. High-stakes exams, including closed-book exams, should not be mandated as part of the MOC process.
13. Charges to physicians in relation to the MOC process should not be cost prohibitive but should be reasonable, not resulting in a barrier to practice.
14. Changes to the MOC process should undergo a vigorous evaluation to ensure the requirements are relevant, feasible, reasonably affordable, and accessible.
15. Individual boards should develop MOC requirements in conjunction with evaluation and feedback from its diplomates.
16. ABMS boards should make a diligent effort to inform diplomates about changes in MOC requirements, including the rationale or evidence behind the changes, and allow sufficient time for diplomates to make any changes necessary to comply with those requirements.
17. MOC requirements should be updated to reflect ongoing changes in health care delivery systems and medical practice, including the establishment of new fields of medicine.
18. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake, intent to maintain or change practice, and assess the impact on individual practices and the specialty as a whole.
19. Diplomates should have flexibility in selecting sources of MOC-related continuing medical education (CME) programming and should not be mandated or limited to participation in CME provided by American Board of Medical Specialties member boards.
20. Physicians should be exempted from MOC for no less than five years after attainment of initial board
certification.

21. Patient satisfaction programs such as the Consumer Assessment of Healthcare Providers and Systems patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties and should not be part of the MOC process.

22. The MOC program should be a tool for process improvement and should not be constructed as a punitive measure to the detriment of physicians’ practices. Careful consideration should be given to the use of physician-specific data to be publicly released regarding MOC participation.

23. The MOC program should use commonly accepted practices for identifying core competencies applicable across specialties but also should provide the flexibility necessary to reasonably reflect the distinct characteristics of each specialty.

24. The MOC process should be streamlined to prevent overburdening physicians with more than one board certification by removing duplicative requirements. MOC requirements for diplomates with added qualifications should be applicable to the diplomate’s primary area of practice (CME Rep. 6-A-17).

175.024 Monitoring Maintenance of Certification Reforms: The Texas Medical Association will: (1) monitor the American Board of Medical Specialties (ABMS’) Program for Maintenance of Certification (MOC), American Osteopathic Association’s Osteopathic Continuous Certification Program, and other MOC providers in direct correlation to adopted TMA Initial Guiding Principles on MOC; (2) continue to monitor the American Medical Association’s efforts as the national liaison with ABMS and other MOC providers, with particular focus on AMA’s work to address physician concerns and calls for MOC reform; (3) inform AMA and ABMS of adopted TMA Initial Guiding Principles on MOC; and (4) continue to assess physician views and experiences with MOC and Osteopathic Continuous Certification through activities by the Council on Medical Education as these programs incorporate reforms and communicate these findings to AMA, ABMS, and other appropriate MOC providers (CME Rep. 6-A-17).

175.025 Freedom from Maintenance of Certification: The Texas Medical Association will: (1) take the position in its advocacy efforts that all requirements for maintenance of board certification in medical staff bylaws for Texas health-related facilities, institutions, and programs that fall within the differentiation prohibition of Senate Bill 1148 (2017) should be considered null and void effective Jan. 1, 2018; (2) take the position in its advocacy efforts that any requirements for maintenance of board certification in medical staff bylaws for Texas health-related facilities, institutions, and programs that fall within the differentiation prohibition of Senate Bill 1148 (2017) require the vote of the medical staff (or satisfaction of another exception under the law); (3) take the position in its advocacy efforts that any vote for requiring maintenance of board certification in medical staff bylaws for Texas health-related facilities, institutions, and programs that fall within the differentiation prohibition of Senate Bill 1148 (2017) taken before the effective date of the bill should be considered null and void effective Jan. 1, 2018; and (4) be actively and immediately engaged in the rule-making process of SB 1148 (Res. 203-A-18).

Related AMA Policy:

Maintenance of Certification and Osteopathic Continuous Certification D-275.954

Our AMA will:

1. Continue to monitor the evolution of Maintenance of Certification (MOC) and Osteopathic Continuous Certification (OCC), continue its active engagement in discussions regarding their implementation, encourage specialty boards to investigate and/or establish alternative approaches for MOC, and prepare a yearly report to the House of Delegates regarding the MOC and OCC process.

2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review MOC and OCC issues.

3. Continue to monitor the progress by the American Board of Medical Specialties (ABMS) and its member boards on implementation of MOC, and encourage the ABMS to report its research findings on the issues surrounding certification and MOC on a periodic basis.
4. Encourage the ABMS and its member boards to continue to explore other ways to measure the
ability of physicians to access and apply knowledge to care for patients, and to continue to examine the
evidence supporting the value of specialty board certification and MOC.
5. Work with the ABMS to streamline and improve the Cognitive Expertise (Part III)
component of MOC, including the exploration of alternative formats, in ways that effectively evaluate
acquisition of new knowledge while reducing or eliminating the burden of a high-stakes examination.
6. Work with interested parties to ensure that MOC uses more than one pathway to assess accurately the
competence of practicing physicians, to monitor for exam relevance and to ensure that MOC does not
lead to unintended economic hardship such as hospital de-credentialing of practicing physicians.
7. Recommend that the ABMS not introduce additional assessment modalities that have not been
validated to show improvement in physician performance and/or patient safety.
8. Work with the ABMS to eliminate practice performance assessment modules, as currently written,
from MOC requirements.
9. Encourage the ABMS to ensure that all ABMS member boards provide full transparency related to the
costs of preparing, administering, scoring and reporting MOC and certifying examinations.
10. Encourage the ABMS to ensure that MOC and certifying examinations do not result in substantial
financial gain to ABMS member boards, and advocate that the ABMS develop fiduciary standards for its
member boards that are consistent with this principle.
11. Work with the ABMS to lessen the burden of MOC on physicians with multiple board certifications,
particularly to ensure that MOC is specifically relevant to the physician's current practice.
12. Work with key stakeholders to (a) support ongoing ABMS member board efforts to allow multiple
and diverse physician educational and quality improvement activities to qualify for MOC; (b) support
ABMS member board activities in facilitating the use of MOC quality improvement activities to count for
other accountability requirements or programs, such as pay for quality/performance or PQRS
reimbursement; (c) encourage ABMS member boards to enhance the consistency of quality improvement
programs across all boards; and (d) work with specialty societies and ABMS member boards to develop
tools and services that help physicians meet MOC requirements.
13. Work with the ABMS and its member boards to collect data on why physicians choose to maintain or
discontinue their board certification.
14. Work with the ABMS to study whether MOC is an important factor in a physician's decision to retire
and to determine its impact on the US physician workforce.
15. Encourage the ABMS to use data from MOC to track whether physicians are
maintaining certification and share this data with the AMA.
16. Encourage AMA members to be proactive in shaping MOC and OCC by seeking leadership positions
on the ABMS member boards, American Osteopathic Association (AOA) specialty certifying boards, and
MOC Committees.
17. Continue to monitor the actions of professional societies regarding recommendations for
modification of MOC.
18. Encourage medical specialty societies' leadership to work with the ABMS, and its member boards, to
identify those specialty organizations that have developed an appropriate and relevant MOC process for
its members.
19. Continue to work with the ABMS to ensure that physicians are clearly informed of the MOC
requirements for their specific board and the timelines for accomplishing those requirements.
20. Encourage the ABMS and its member boards to develop a system to actively alert physicians of the
due dates of the multi-stage requirements of continuous professional development and performance in
practice, thereby assisting them with maintaining their board certification.
21. Recommend to the ABMS that all physician members of those boards governing the MOC process be
required to participate in MOC.
22. Continue to participate in the National Alliance for Physician Competence forums.
23. Encourage the PCPI Foundation, the ABMS, and the Council of Medical Specialty Societies to work
together toward utilizing Consortium performance measures in Part IV of MOC.
24. Continue to assist physicians in practice performance improvement.
25. Encourage all specialty societies to grant certified CME credit for activities that they offer to fulfill requirements of their respective specialty board's MOC and associated processes.

26. Support the American College of Physicians as well as other professional societies in their efforts to work with the American Board of Internal Medicine (ABIM) to improve the MOC program.

27. Oppose those maintenance of certification programs administered by the specialty boards of the ABMS, or of any other similar physician certifying organization, which do not appropriately adhere to the principles codified as AMA Policy on Maintenance of Certification.

28. Ask the ABMS to encourage its member boards to review their maintenance of certification policies regarding the requirements for maintaining underlying primary or initial specialty board certification in addition to subspecialty board certification, if they have not yet done so, to allow physicians the option to focus on maintenance of certification activities relevant to their practice.

29. Call for the immediate end of any mandatory, secured recertifying examination by the ABMS or other certifying organizations as part of the recertification process for all those specialties that still require a secure, high-stakes recertification examination.

30. Support a recertification process based on high quality, appropriate Continuing Medical Education (CME) material directed by the AMA recognized specialty societies covering the physician's practice area, in cooperation with other willing stakeholders, that would be completed on a regular basis as determined by the individual medical specialty, to ensure lifelong learning.

31. Continue to work with the ABMS to encourage the development by and the sharing between specialty boards of alternative ways to assess medical knowledge other than by a secure high stakes exam.

32. Continue to support the requirement of CME and ongoing, quality assessments of physicians, where such CME is proven to be cost-effective and shown by evidence to improve quality of care for patients.

33. Through legislative, regulatory, or collaborative efforts, will work with interested state medical societies and other interested parties by creating model state legislation and model medical staff bylaws while advocating that Maintenance of Certification not be a requirement for: (a) medical staff membership, privileging, credentialing, or recredentialing; (b) insurance panel participation; or (c) state medical licensure.

34. Increase its efforts to work with the insurance industry to ensure that maintenance of certification does not become a requirement for insurance panel participation.

35. Advocate that physicians who participate in programs related to quality improvement and/or patient safety receive credit for MOC Part IV.

36. Continue to work with the medical societies and the American Board of Medical Specialties (ABMS) member boards that have not yet moved to a process to improve the Part III secure, high-stakes examination to encourage them to do so.

37. Through its Council on Medical Education, continue to be actively engaged in following the work of the ABMS Continuing Board Certification: Vision for the Future Commission.

38. (a) Submit commentary to the American Board of Medical Specialties (ABMS) Continuing Board Certification: Vision for the Future initiative, asking that junior diplomates be given equal opportunity to serve on ABMS and its member boards; and (b) work with the ABMS and member boards to encourage the inclusion of younger physicians on the ABMS and its member boards.

39. Continue studying the certifying bodies that compete with the American Board of Medical Specialties and provide an update in the Council on Medical Education’s annual report on maintenance of certification at the 2019 Annual Meeting.

An Update on Maintenance of Licensure D-275.957

Our American Medical Association will: 1. Continue to monitor the evolution of Maintenance of Licensure (MOL), continue its active engagement in discussions regarding MOL implementation, and report back to the House of Delegates on this issue. 2. Continue to review, through its Council on Medical Education, published literature and emerging data as part of the Council's ongoing efforts to critically review MOL issues. 3. Work with the Federation of State Medical Boards (FSMB) to study whether the principles of MOL are important factors in a physician's decision to retire or have a direct impact on the U.S. physician...
workforce.

4. Work with interested state medical societies and support collaboration with state specialty medical societies and state medical boards on establishing criteria and regulations for the implementation of MOL that reflect AMA guidelines for implementation of state MOL programs and the FSMB’s Guiding Principles for MOL.

5. Explore the feasibility of developing, in collaboration with other stakeholders, AMA products and services that may help shape and support MOL for physicians.

6. Encourage the FSMB to continue to work with state medical boards to accept physician participation in the American Board of Medical Specialties maintenance of certification (MOC) and the American Osteopathic Association Bureau of Osteopathic Specialists (AOA-BOS) osteopathic continuous certification (OCC) as meeting the requirements for MOL and to develop alternatives for physicians who are not certified/recertified, and advocate that MOC or OCC not be the only pathway to MOL for physicians.

7. Continue to work with the FSMB to establish and assess MOL principles, with the AMA to assess the impact of MOL on the practicing physician and the FSMB to study its impact on state medical boards.

8. Encourage rigorous evaluation of the impact on physicians of any future proposed changes to MOL processes, including cost, staffing, and time.

An Update on Maintenance of Licensure H-275.917

AMA Principles on Maintenance of Licensure (MOL):

1. Our American Medical Association (AMA) established the following guidelines for implementation of state MOL programs:
   
   A. Any MOL activity should be able to be integrated into the existing infrastructure of the health care environment.
   
   B. Any MOL educational activity under consideration should be developed in collaboration with physicians, should be evidence-based and should be practice-specific. Accountability for physicians should be led by physicians.

   C. Any proposed MOL activity should undergo an in-depth analysis of the direct and indirect costs, including physicians’ time and the impact on patient access to care, as well as a risk/benefit analysis, with particular attention to unintended consequences.

   D. Any MOL activity should be flexible and offer a variety of compliance options for all physicians, practicing or non-practicing, which may vary depending on their roles (e.g., clinical care, research, administration, education).

   E. Any MOL activity should be designed for quality improvement and lifelong learning.

   F. Participation in quality improvement activities, such as chart review, should be an option as an MOL activity.

2. Our AMA supports the Federation of State Medical Boards Guiding Principles for MOL (current as of June 2015), which state that:

   A. Maintenance of licensure should support physicians' commitment to lifelong learning and facilitate improvement in physician practice.

   B. Maintenance of licensure systems should be administratively feasible and should be developed in collaboration with other stakeholders. The authority for establishing MOL requirements should remain within the purview of state medical boards.

   C. Maintenance of licensure should not compromise patient care or create barriers to physician practice.

   D. The infrastructure to support physician compliance with MOL requirements must be flexible and offer a choice of options for meeting requirements.

   E. Maintenance of licensure processes should balance transparency with privacy protections (e.g., should capture what most physicians are already doing, not be onerous, etc.).

3. Our AMA will:

   A. Continue to support and promote the AMA Physician's Recognition Award (PRA) Credit system as
one of the three major CME credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format, and continue to develop relationships and agreements that may lead to standards accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies, and other entities requiring evidence of physician CME as part of the process for MOL.

B. Advocate that if state medical boards move forward with a more intense or rigorous MOL program, each state medical board be required to accept evidence of successful ongoing participation in the ABMS MOC and AOA-Bureau of Osteopathic Specialists Osteopathic Continuous Certification to have fulfilled all three components of the MOL, if performed,

C. Advocate that state medical boards accept programs created by specialty societies as evidence that the physician is participating in continuous lifelong learning and allow physicians to choose which programs they participate in to fulfill their MOL criteria.

D. Oppose any MOL initiative that creates barriers to practice, is administratively unfeasible, is inflexible with regard to how physicians practice (clinically or not), does not protect physician privacy, or is used to promote policy initiatives about physician competence.

**Maintenance of Certification H-275.924**

AMERICAN MEDICAL ASSOCIATION (AMA) Principles on Maintenance of Certification (MOC)

1. Changes in specialty-board certification requirements for MOC programs should be longitudinally stable in structure, although flexible in content.
2. Implementation of changes in MOC must be reasonable and take into consideration the time needed to develop the proper MOC structures as well as to educate physician diplomates about the requirements for participation.
3. Any changes to the MOC process for a given medical specialty board should occur no more frequently than the intervals used by that specialty board for MOC.
4. Any changes in the MOC process should not result in significantly increased cost or burden to physician participants (such as systems that mandate continuous documentation or require annual milestones).
5. MOC requirements should not reduce the capacity of the overall physician workforce. It is important to retain a structure of MOC programs that permits physicians to complete modules with temporal flexibility, compatible with their practice responsibilities.
6. Patient satisfaction programs such as The Consumer Assessment of Healthcare Providers and Systems (CAHPS) patient survey are neither appropriate nor effective survey tools to assess physician competence in many specialties.
7. Careful consideration should be given to the importance of retaining flexibility in pathways for MOC for physicians with careers that combine clinical patient care with significant leadership, administrative, research and teaching responsibilities.
8. Legal ramifications must be examined, and conflicts resolved, prior to data collection and/or displaying any information collected in the process of MOC. Specifically, careful consideration must be given to the types and format of physician-specific data to be publicly released in conjunction with MOC participation.
9. Our AMA affirms the current language regarding continuing medical education (CME): "Each Member Board will document that diplomates are meeting the CME and Self-Assessment requirements for MOC Part II. The content of CME and self-assessment programs receiving credit for MOC will be relevant to advances within the diplomate's scope of practice, and free of commercial bias and direct support from pharmaceutical and device industries. Each diplomate will be required to complete CME credits (AMA PRA Category 1 Credit™, American Academy of Family Physicians Prescribed, American College of Obstetricians and Gynecologists, and/or American Osteopathic Association Category 1A)."
10. In relation to MOC Part II, our AMA continues to support and promote the AMA Physician's Recognition Award (PRA) Credit system as one of the three major credit systems that comprise the foundation for continuing medical education in the U.S., including the Performance Improvement CME (PICME) format; and continues to develop relationships and agreements that may lead to standards
accepted by all U.S. licensing boards, specialty boards, hospital credentialing bodies and other entities requiring evidence of physician CME.

11. MOC is but one component to promote patient safety and quality. Health care is a team effort, and changes to MOC should not create an unrealistic expectation that lapses in patient safety are primarily failures of individual physicians.

12. MOC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care.

13. The MOC process should be evaluated periodically to measure physician satisfaction, knowledge uptake and intent to maintain or change practice.

14. MOC should be used as a tool for continuous improvement.

15. The MOC program should not be a mandated requirement for licensure, credentialing, recredentialing, privileging, reimbursement, network participation, employment, or insurance panel participation.

16. Actively practicing physicians should be well-represented on specialty boards developing MOC.

17. Our AMA will include early career physicians when nominating individuals to the Boards of Directors for ABMS member boards.

18. MOC activities and measurement should be relevant to clinical practice.

19. The MOC process should be reflective of and consistent with the cost of development and administration of the MOC components, ensure a fair fee structure, and not present a barrier to patient care.

20. Any assessment should be used to guide physicians' self-directed study.

21. Specific content-based feedback after any assessment tests should be provided to physicians in a timely manner.

22. There should be multiple options for how an assessment could be structured to accommodate different learning styles.

23. Physicians with lifetime board certification should not be required to seek recertification.

24. No qualifiers or restrictions should be placed on diplomates with lifetime board certification recognized by the ABMS related to their participation in MOC.

25. Members of our House of Delegates are encouraged to increase their awareness of and participation in the proposed changes to physician self-regulation through their specialty organizations and other professional membership groups.

26. The initial certification status of time-limited diplomates shall be listed and publicly available on all American Board of Medical Specialties (ABMS) and ABMS Member Boards’ websites and physician certification databases. The names and initial certification status of time-limited diplomates shall not be removed from ABMS and ABMS Member Boards’ websites or physician certification databases even if the diplomate chooses not to participate in MOC.

27. Our AMA will continue to work with the national medical specialty societies to advocate for the physicians of America to receive value in the services they purchase for Maintenance of Certification from their specialty boards. Value in MOC should include cost effectiveness with full financial transparency, respect for physicians’ time and their patient care commitments, alignment of MOC requirements with other regulator and payer requirements, and adherence to an evidence basis for both MOC content and processes.
Subject: Eliminating Professional and Colloquial Use of the Term “Mental Retardation” by Physicians in a Clinical Setting

Introduced by: Medical Student Section

Referred to: Reference Committee on Medical Education and Health Care Quality

Whereas, The diagnostic and statistical manual of mental disorders (DSM-V) replaced the diagnosis of “mental retardation” with that of “intellectual disability” (intellectual developmental disorder) in 2013; and

Whereas, The updated DSM-V terminology more specifically reflects an affected individual’s condition, its impact on his or her intellectual and adaptive functioning, and encourages a more in-depth comprehension of a patient’s diagnosis; and

Whereas, In 2013, the Social Security Administration published a rule in the Federal Register to use the term “intellectual disability” in place of “mental retardation” for claims involving mental disorders; and

Whereas, In 2017, Public Law 111–256, also known as Rosa’s Law, was amended to eliminate the use of the term “mental retardation” in federal law and replace it with “intellectual disability” without changing the definition, coverage, eligibility, rights, and responsibilities of the affected individuals; and

Whereas, A 2012 study showed that while there has been an increase in the use of the terms “intellectual disability” or “developmental delay” in the past several years in primary literature, the term “mental retardation” remains the most commonly used clinical term in written publications and continues to be used regularly by physicians in clinical settings; and

Whereas, The same 2012 study surveyed parents and physicians regarding the use of the term “mental retardation” and the vast majority of both groups agreed that the term should not be utilized when talking to patients or their families about their diagnoses; and

Whereas, The campaign “Spread the Word to End the Word” is led by the Special Olympics organization and other organizations who seek to eliminate the pejorative and dehumanizing word “retarded” from public vernacular in order to promote the shift in focus from the disability to the individual and his or her accomplishments; and

Whereas, The term “mental retardation” promotes the stigma and negative treatment of people with intellectual disabilities, which also is associated with diminished access and poorer health, employment, and quality of life outcomes; and

Whereas, The World Health Organization has used diagnostic identification to update its International Classification of Diseases to expand the term “intellectual disability” to include a variety of disorders that are on the same developmental spectrum as “mental retardation,” thereby removing a core classification and implementing a more effective, parent category for developmental disorders; therefore be it
RESOLVED, That the Texas Medical Association support the elimination of the term “mental retardation” from its professional and colloquial use by physicians in a clinical setting, to be replaced with more widely accepted terminology, such as “intellectual disability” or “developmental disorder;” and be it further

RESOLVED, That the Texas Delegation carry this, or a similar resolution, to the American Medical Association that the term “mental retardation” be replaced with more widely accepted terminology by all United States physicians in a clinical setting.

Related TMA Policy:

254.014 Physicians and Substance Use Disorder: Physicians and Substance Use Disorder: The Texas Medical Association recommended that physicians adopt the term "substance use disorder" terminology instead of "addiction."

215.009 Mental Health Institutions Community Mental Health Care Centers: Community mental health and intellectual and developmental disability centers, community mental retardation centers, are providing diagnostic, therapeutic, rehabilitative, preventive, and/or educational services to a large number of persons with mental, behavioral, emotional, and/or adjustment problems, or with intellectual disabilities and/or with related disorders. Such centers are and should be classified as mental health care facilities, and the clinical director of all such centers should be required to be a licensed physician, preferably a psychiatrist, experienced in mental health care.

215.014 Texas Health and Human Services Advisory Councils: The Texas Medical Association supports representation by licensed psychiatrists on Health and Human Services Advisory Councils for services that impact the care of people with mental illness and/or developmental disabilities, including the Drug Utilization Board, the State Medicaid Advisory Committee, and the State Health Services Council.

Related AMA Policy:

H-90.968 Medical Care of Persons with Developmental Disabilities: The American Medical Association encourages: (a) clinicians to learn and appreciate variable presentations of complex functioning profiles in all persons with developmental disabilities; (b) medical schools and graduate medical education programs to acknowledge the benefits of education on how aspects in the social model of disability can impact the physical and mental health of persons with Developmental Disabilities; (c) medical schools and graduate medical education programs to acknowledge the benefits of teaching about the nuances of uneven skill sets, often found in the functioning profiles of persons with developmental disabilities, to improve quality in clinical care; (d) the education of physicians on how to provide and/or advocate for quality, developmentally appropriate medical, social and living supports for patients with developmental disabilities so as to improve health outcomes; (e) medical schools and residency programs to encourage faculty and trainees to appreciate the opportunities for exploring diagnostic and therapeutic challenges while also accruing significant personal rewards when delivering care with professionalism to persons with profound developmental disabilities and multiple co-morbid medical conditions in any setting; (f) medical schools and graduate medical education programs to establish and encourage enrollment in elective rotations for medical students and residents at health care facilities specializing in care for the developmentally disabled; and (g) cooperation among physicians, health & human services professionals, and a wide variety of adults with developmental disabilities to implement priorities and quality improvements for the care of persons with developmental disabilities.

Sources:
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 206
A-19

Subject: Considerations for Care of Individuals With Autism Spectrum Disorder (ASD)

Introduced by: Medical Student Section

Referred to: Reference Committee on Medical Education and Health Care Quality

Whereas, Autism Spectrum Disorder (ASD) is a range of neurodevelopmental disorders characterized by limited interests, social impairment, and repetitive behaviors; and

Whereas, Adults with ASD have higher rates of chronic medical illnesses, and increased exposure to violence and abuse; and

Whereas, Adults with ASD are more likely to be hospitalized or visit the emergency room due to barriers preventing them from accessing care, such as difficulty waiting in the waiting room, tolerating vital signs, and intolerance to needles or to being touched; and

Whereas, Youth with ASD are less likely to receive specific preventative services, such as vaccination; and

Whereas, Physicians have a responsibility to recognize caregiver burden; and

Whereas, Caregiver burden is prevalent in parents of children with autism, who have a greater risk for developing depression, stress, anxiety, and distress; and

Whereas, Parents of individuals with autism report that they receive “passive or decreased” reassurance about their child’s condition; and

Whereas, Staff in the health care field often lack the time and training to adapt to the communication and care needs of individuals with autism; and

Whereas, Physicians are aware of medical home deficiencies for children with autism, and acknowledge that they feel less competent providing primary care for children with autism compared to children with other neurodevelopmental conditions; and

Whereas, Applied Behavioral Analysis (ABA) therapy is the treatment approach with the best evidence to have a positive impact on child behavior, particularly in individuals with ASD; and

Whereas, Children receiving center-based ABA therapy made further gains than those receiving home-based ABA therapy; and

Whereas, The Texas Health and Human Services Commission Children’s Autism Program provides focused ABA services through local community agencies and organizations; and

Whereas, Autism Speaks is a global organization providing free autism information and resources to over 18 million people; and
Whereas, Telehealth services provide rural communities with effective and easily accessible services for ASD, such as ABA and Cognitive Behavioral Therapy (CBT); therefore be it
RESOLVED, That the Texas Medical Association support the provision of resources in the community to individuals with autism and to their families in order to provide a more comprehensive spectrum of primary and preventative care to individuals with autism; and be it further
RESOLVED, That TMA encourage Texas medical schools to educate students using a holistic and practical approach to treatment, management, and care for their patients with ASD; and be it further
RESOLVED, That TMA encourage physicians to become more aware of state and local demographics and promote existing resources in order to better accommodate patients with ASD in rural or underserved communities.

Related TMA Policy:

200.049 Advocacy Education in Medical School Curricula: The Texas Medical Association supports medical school efforts to provide advocacy education for medical students (Amended Res. 205-A-13; originally numbered 200.050).

200.054 High-Value Care in Undergraduate and Graduate Medical Education: The Texas Medical Association supports the inclusion and integration of topics of health care value in medical education (Res. 201-A-18).

55.033 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 throughout the state,
i. Coordinating with the educational system for mentally healthy schools, and

Related AMA Policy: None.

Sources:

TEXAS MEDICAL ASSOCIATION HOUSE OF DElegates

Resolution 207
A-19

Subject: Increasing Access to Service Learning Opportunities in Undergraduate Medical Education

Introduced by: Medical Student Section

Referred to: Reference Committee on Medical Education and Health Care Quality

Whereas, Service learning combines community service engagement with structured academic learning by facilitating long-term community partnerships aimed towards fulfilling the needs of community members; and

Whereas, Service learning programs are successful when there are established and studied frameworks in place to support engaged volunteers, which then cater to intrinsic motivations within students, making the time spent both worthwhile and targeted in impact; and

Whereas, There is no existing study on the current state of service learning opportunities offered within Texas medical schools and their impact; and

Whereas, Engaging in service learning allows students to reflect on their contributions, focus on their communities, contextually synthesize academic concepts, and promote a deeper level of care for patients; and

Whereas, Service learning can allow students to establish long-term relationships with patients from an underserved population in their community, exposing students to the complex medical and social conditions that contribute to the health outcomes among the underserved; and

Whereas, Studies have shown that service learning experiences can significantly improve a student’s ability to determine the health literacy status of patients and communicate with patients; and

Whereas, Qualitative interviews have shown that engaging in service learning promotes interdisciplinary work in the fields of public health and allows students and trainees to identify the health needs of their community; and

Whereas, Service learning is significantly correlated with improving students’ ability to obtain a history and perform a physical exam following volunteer experience in free clinics; and

Whereas, The Liaison Committee on Medical Education Competencies and the Association of American Medical Colleges recognize the benefits of structured service learning experiences and mandate that medical schools provide support for service learning and projects that benefit communities in competency 6.6 of the LCME’s Functions and Structure of a Medical School guide; and

Whereas, Service learning opportunities are well studied and there are multiple established frameworks for developing and implementing them into the existing framework of medical education institutions; and

Whereas, Schools who use service learning models have stronger ties to their local communities and faculty members and students alike have increased opportunities to conduct research and take action to improve health outcomes; and
Whereas, The American Medical Association supports the inclusion of service learning in medical education and the Texas Medical Association supports community-based medical education as a viable model; therefore be it

RESOLVED, That the Texas Medical Association study the impact of existing service learning programs and opportunities undergraduate medical education; and be it further

RESOLVED, That TMA collaborate with appropriate parties to identify evidence-based strategies to increase service learning opportunities for Texas undergraduate medical students.

Related TMA Policy:

115.005 Charity Care: Recognizing the problems of access to medical and health care for the indigent,
Texas physicians should voluntarily provide charity care to those who are unable to pay and to donate time to public clinics. Existing community facilities should be utilized to provide care for the medically indigent, and state agencies should augment existing community resources to provide primary care services where such assistance is necessary (Council on Medical Education, p 89, A-94; reaffirmed CME Rep. 4-A-04; reaffirmed CM-PDHCA Rep. 2-A-14).

200.036 Community Based Medical Education: The Texas Medical Association believes that community-based medical education is a viable model that should be evaluated in each community (BOT Rep. 6-I-00; reaffirmed CME Rep. 2-A-10).

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).

200.044 Community-Based Physicians as Educators and Mentors: The Texas Medical Association recognizes the important role of community physicians in educating and mentoring medical students and residents. TMA believes clerkships and other learning experiences in community-based physician practices afford medical students and residents greater exposure to different practice environments and real-world medicine. These experiences can enable medical students to be better informed when making decisions about a medical specialty as well as a preferred practice location and setting. TMA encourages the continued development and retention of partnerships between academic health centers and community-based physicians (CME Rep. 4-A-07; amended CME Rep. 7-A-17).

115.020 Supporting Community-Based Health Care Delivery Models for Vulnerable Patients: The Texas Medical Association supports the concept and implementation of community-based health care delivery models emphasizing meaningful access for vulnerable patients throughout Texas. TMA will collaborate with the county medical societies to advocate before the Texas Health and Human Services Commission, elected officials, and the Centers for Medicare & Medicaid Services for adoption of community-based health care delivery models (Res. 403-A-17).

260.037 Essential Public Health Services: The Texas Medical Association adopted the Essential Public Health Services Work Group's definition of public health and essential public health services: (1) monitor health status to identify community health problems; (2) diagnose and investigate health problems and health hazards in the community; (3) inform, educate, and empower people about health issues; (4) mobilize community partnerships to identify and solve health problems; (5) develop policies and plans that support individual and community health efforts; (6) enforce laws and regulations that protect health and ensure safety; (7) link people to needed personal health services and assure the provision of health care when
otherwise unavailable; (8) assure a competent public health and personal health care workforce; (9) evaluate
effectiveness, accessibility, and quality of personal and population-based health services; and (10) research
for new insights and innovative solutions to health problems. In addition, in accordance with stated principles,
TMA affirms that public health departments should be adequately funded in order to provide these essential
services in every Texas community deliberately and apart from indigent care. TMA supports efforts to arrive
at agreeable solutions to ensuring a stable public health system capable of adapting to health systems reform
and the challenges of addressing emerging public health issues (CPH, p 80, I-95; reaffirmed CPH Rep. 2-A-
05; amended CSPH Rep. 3-A-13).

Related AMA Policy:
H-295.916 Improving Medical School/Community Practice:
1. Medical schools should be encouraged to include community physicians who serve as volunteer faculty in
medical school activities and in committees and other decision-making bodies related to the student
educational program, such as the curriculum committee and the admission committee, and in search
committees for medical school deans and department chairs.
2. County/state medical societies should be encouraged to include medical school administrators and faculty
members in committees and other society activities, and to consider creating a seat for medical school deans
in the state society house of delegates.
3. There should be mechanisms established at local or state levels to address tensions arising between the
academic and practice communities, such as problems associated with the granting of faculty appointment or
hospital staff privileges.
4. Medical schools and other academic continuing medical education providers should work with community
physicians to develop continuing education programs that address local needs.
5. Community physician groups and schools of medicine should be encouraged to communicate during the
initial stages of discussions about the formation of patient care networks.

H-295.880 Service Learning in Medical Education: Our AMA will support the concept of service learning
as a key component in medical school and residency curricula, and that these experiences should include
student and resident collaboration with a community partner to improve the health of the population.

Sources:
1. Mackenzie, Sara L. C., Deborah M. Hinchey, and Kathryn P. Cornforth. “A Public Health Service-
2. Robison, Don, Alexandra Leader, Maryanne Gathambo, Erin Madison, and Alicia St Thomas. “Sustained
Service: A Community-Driven Framework for Longitudinal Service-Learning.” MedEdPublish 7 (June 5,
4. Lawson, Janelle E., Rebecca A. Cruz, and Gregory A. Knollman. “Increasing Positive Attitudes toward
Individuals with Disabilities through Community Service Learning.” Research in Developmental
5. Gardner, Janet, and Jan Emory. “Changing Students’ Perceptions of the Homeless: A Community Service
https://doi.org/10.1016/j.nepr.2018.01.001.
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patient.

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 208
A-19

Subject: Integration and Maintenance of Wellness Initiatives in Texas Undergraduate and Graduate Medical Education

Introduced by: Medical Student Section

Referred to: Reference Committee on Medical Education and Health Care Quality

Whereas, The current medical education system has unintended, yet significantly negative, effects on student well-being and personal development; and

Whereas, Inadequate sleep, decreased exercise frequency, and a positive depression screen are associated with burnout risk in medical students; and

Whereas, Stress, burnout, and depression are significant manifestations of distress experienced by students from the time of matriculation through the completion of residency training, and at least 24 percent of first and second year students are considered depressed or dysphoric based on the Beck Depression Inventory; and

Whereas, Assessment of students at the Albert Einstein College of Medicine indicated an increase in perceived stress and risk for depression (a Center for Epidemiologic Studies Depression Scale Score greater than 16) in third year medical students when compared to first year students, with the number of students at risk for depression increasing from 28.4 percent in the first year to 39 percent in the third year; and

Whereas, Research indicates a need for improved learning environments and systems to support physicians in training who have comparatively higher rates of suicide and depression (22 to 35 percent) compared to the general population (17 percent); and

Whereas, Regulation of duty hours alone is not sufficient to improve overall resident well-being, indicating that greater flexibility to accommodate resident training needs is required; and

Whereas, The St. Louis University School of Medicine reports a decrease in depression rates from 27 percent to 11 percent following implementation of prevention-focused wellness initiatives which identify the suboptimal aspects of the learning environment and address the source of student distress rather than viewing stress as an inevitable outcome; and

Whereas, 82 percent of students at Northwestern University’s Feinberg School of Medicine, who reported that their well-being suffered due to the rigors of medical school, were better able to recognize their limitations and were more willing to seek help without experiencing guilt after implementation of wellness courses into the curriculum; and

Whereas, Research findings suggest that students who practice positive lifestyle habits and behaviors are more confident in their ability to counsel patients on wellness and achieve better patient outcomes; and

Whereas, 75 percent of students at the Vanderbilt University School of Medicine demonstrated improved perceptions of wellness and career counseling following implementation of an Advisory College Program
which supported productivity and professional satisfaction through group-based faculty engagement with students; and

Whereas, Review of institutional wellness programs such as the trainee-specific patient-centered medical home model developed as part of The University of Texas Southwestern Housestaff Health and Wellness Initiative suggests that coordinated care and scheduling accommodations improve student health, safety, and performance; and

Whereas, Integration of wellness initiatives into medical education can be achieved through efficient changes to the existing infrastructure and includes transition to a pass/fail grading system, increased elective opportunities, and emphasis on team-based learning; and

Whereas, The University of Texas System’s Transformation in Medical Education initiative addresses resiliency and promotes student well-being by integrating wellness into medical education during the initial stages of professional identity formation; and

Whereas, Self-evaluation of wellness through an Integrative Health and Wellness Assessment (IHWA) is a potential tool for students to assess health behaviors and identify sources of distress; and

Whereas, Standardized definitions of student wellness, quality of life, and burnout in addition to assessments such as the IHWA are necessary for the establishment of evidence-based interventions to improve the welfare of medical trainees; therefore be it

RESOLVED, That the Texas Medical Association supports research on a systematic and standardized approach to wellness in order to establish common terminology and a basic framework for wellness programs in Texas undergraduate and graduate medical education; and be it further

RESOLVED, That TMA advocates for the integration of a standard multidimensional wellness model into Texas undergraduate and graduate medical education and encourages those institutions in their efforts to routinely monitor and assess student well-being.

Related TMA Policy:

**130.025 Healthy Food in Hospitals Healthy Food in Hospitals:** Texas Medical Association encourages hospitals to: (1) offer and promote healthy, reasonably priced, and easily accessible food options; and (2) work towards providing food options in accordance with Food and Drug Administration Dietary Guidelines for Americans 2015-2020, such as increased fruits and vegetables and decreased added sugar, saturated fats, and sodium consumption (Res. 310-A-17).

Related AMA Policy:

**H-405.959 Physicians and Physicians-in-Training as Examples for Their Patients to Promote Wellness and Healthy Lifestyles:** Our AMA will: (1) establish a program that recognizes physicians and physicians-in-training who model wellness and healthy lifestyles in their practice and communities or establish programs that contribute to the wellness of their patients and/or community; and (2) will aid in the development of a health and wellness component in conjunction with the Doctors Back to School Program

**9.3.1 Physician Health and Wellness:** When physician health or wellness is compromised, so may the safety and effectiveness of the medical care provided. To preserve the quality of their performance, physicians have a responsibility to maintain their health and wellness, broadly construed as preventing or treating acute or chronic diseases, including mental illness, disabilities, and occupational stress. To fulfill this responsibility individually, physicians should: (a) Maintain their own health and wellness by: (i) following healthy lifestyle
habits; (ii) ensuring that they have a personal physician whose objectivity is not compromised. (b) Take appropriate action when their health or wellness is compromised, including: (i) engaging in honest assessment of their ability to continue practicing safely; (ii) taking measures to mitigate the problem; (iii) taking appropriate measures to protect patients, including measures to minimize the risk of transmitting infectious disease commensurate with the seriousness of the disease; (iv) seeking appropriate help as needed, including help in addressing substance abuse. Physicians should not practice if their ability to do so safely is impaired by use of a controlled substance, alcohol, other chemical agent or a health condition. Collectively, physicians have an obligation to ensure that colleagues are able to provide safe and effective care, which includes promoting health and wellness among physicians.

H-295.993 Inclusion of Medical Students and Residents in Medical Society Impaired Physician Programs: Our AMA: (1) recognizes the need for appropriate mechanisms to include medical students and resident physicians in the monitoring and advocacy services of state physician health programs and wellness and other programs to prevent impairment and burnout; and (2) encourages medical school administration and students to work together to develop creative ways to inform students concerning available student assistance programs and other related services.

H-405.961 Physician Health Programs: Our AMA affirms the importance of physician health and the need for ongoing education of all physicians and medical students regarding physician health and wellness.

Sources:
10. Sastre, Elizabeth Ann, Erin E. Burke, Evan Silverstein, Asher Kupperman, Jennifer A. Rymer, Mario A. Davidson, Scott M. Rodgers, and Amy E. Fleming. "Improvements in Medical School Wellness and


WHEREAS, 17 percent of Texans lack health insurance, which is twice the state average in the United States; and

WHEREAS, By 2040, more than 6.1 million Texans will be uninsured, which translates to an estimated total loss of $178.5 billion, justifying the need to address health uninsurance in Texas by improving patient health insurance literacy; and

WHEREAS, The Centers for Disease Control and Prevention’s Healthy People 2020 identified health literacy as a priority in disease prevention and health promotion, which encompasses supporting changes to improve health professionals’ knowledge of the U.S. health care system, including the role of health insurance; and

WHEREAS, A U.S. national study reported that 29.6 percent of insured adults had delayed or foregone care because they do not understand their health insurance, in part due to a lack of patient-provider communication about their benefits and the function of insurance; and

WHEREAS, Only 41 percent of surveyed medical students at a U.S. medical school in 2012 could pass an introductory exam on the basics of health policy, including the function of health insurance within the health care system; and

WHEREAS, 96 percent of U.S. medical students surveyed believed that health policy education was important; however, 54 percent of students felt dissatisfied with their curriculum, demonstrating a student demand for improved health policy education; and

WHEREAS, The three main barriers to medical students becoming involved in health policy advocacy include a lack of knowledge about health policy (57 percent), an unawareness of opportunities available (56 percent), and a lack of time (43 percent); and

WHEREAS, 58 percent of U.S. medical school deans agree that there is not enough health policy education in medical schools; and

WHEREAS, The updated 2019-20 Liaison Committee on Medical Education accreditation standards do not mandate health insurance education in undergraduate medical curriculum; and

WHEREAS, A number of Texas medical schools have successfully included more comprehensive health insurance electives in their curriculum, but these courses have limited student capacity and are not mandatory; and
Whereas, After medical schools integrated health system education into their core curriculum, which
encompassed topics such as health insurance, health care costs, and access to health care, 96 percent of
graduating medical students reported being prepared for successful medical practice; and
Whereas, The American Medical Association has requested that undergraduate and graduate medical
education incorporate topics related to health care policy; and
Whereas, TMA currently does not have policy on undergraduate and graduate medical education on
health insurance or health policy; therefore be it
RESOLVED, That the Texas Medical Association support the availability of educational resources for
medical students on health insurance and health policy to improve readiness for understanding the role of
insurance in health care.

Related TMA Policy:
200.020 Medical Education Curriculum: Medical schools should incorporate in their curricula a broad
range of educational opportunities and perspectives, not exclusively related to the basic sciences (Council

Related AMA Policy:
H-295.864 Systems-Based Practice Education for Medical Students and Resident/Fellow
Physicians: Our AMA: (1) supports the availability of educational resources and elective rotations for
medical students and resident/fellow physicians on all aspects of systems-based practice, to improve
awareness of and responsiveness to the larger context and system of health care and to aid in developing
our next generation of physician leaders; (2) encourages development of model guidelines and curricular
goals for elective courses and rotations and fellowships in systems-based practice, to be used by state and
specialty societies, and explore developing an educational module on this topic as part of its Introduction
to the Practice of Medicine (IPM) product; and (3) will request that undergraduate and graduate medical
education accrediting bodies consider incorporation into their requirements for systems-based practice
education such topics as health care policy and patient care advocacy; insurance, especially pertaining to
policy coverage, claim processes, reimbursement, basic private insurance packages, Medicare, and
Medicaid; the physician's role in obtaining affordable care for patients; cost awareness and risk benefit
analysis in patient care; inter-professional teamwork in a physician-led team to enhance patient safety and
improve patient care quality; and identification of system errors and implementation of potential systems
solutions for enhanced patient safety and improved patient outcomes.

Sources:
1. Texas Alliance for Health Care, “The Impact of Uninsurance on Texas’ Economy,” Texas Alliance
   for Health Care (2019), http://wrgh.org/docs/TheImpactofUninsurance
2. onTexasEconomy20190108.pdf.
3. Texas Alliance for Health Care, “The Impact of Uninsurance on Texas’ Economy.”
4. “Health Literacy for Public Health Professionals," Centers for Disease Control and Prevention,
5. Renuka Tipirneni, Mary C. Politi, Jeffrey T. Kullgren, Edith C. Kieffer, Susan D. Goold, and Aaron
   M. Scherer, "Association Between Health Insurance Literacy and Avoidance of Health Care Services
   Sarah S. Nouri, and Rima E. Rudd, "Health Literacy in the “oral Exchange”: An Important Element
7. Jaya R. Agrawal, Jeffrey Huebner, Joan Hedgecock, Ashwini R. Sehgal, Paul Jung, and Steven R. Simon,
11. Liaison Committee on Medical Education, Function and Structure of a Medical School (American Medical Association, 2018).
Resolution 210
A-19

Subject: Recommendation for Hemorrhage Control Training of Health Care Professionals

Introduced by: Medical Student Section

Referred to: Reference Committee on Medical Education and Health Care Quality

Whereas, With increased attention given to mass casualty preparation, training in proper, safe, and effective use of tourniquets has been shown to be of significant benefit in reducing mortality; and

Whereas, The use of correctly placed prehospital tourniquets has shown a positive risk-benefit ratio, with the overall morbidity remaining low; and

Whereas, Collaborations between the American College of Surgeons (ACS) and the Department of Homeland Security have helped create such programs as Stop the Bleed and bleedingcontrol.org, which teach bystanders how to identify and treat life-threatening hemorrhage with direct pressure, tourniquets, and wound packing; and

Whereas, Studies have shown that a standard hemorrhage control course can improve civilian willingness to respond quickly in an emergency by as much as 31.4 percent; and

Whereas, Studies of real-world usage have shown that tourniquets in hemorrhage control situations are most effective when used prior to the onset of shock, and can increase survival rates by as much as 80 percent, so education supporting immediate prehospital response is of key importance; and

Whereas, Despite this bystander education effort, hemorrhage control is not mandatory training in the majority of medical schools or for attending physicians, but cardiopulmonary resuscitation/basic life support training is often required before matriculating or receiving hospital privileges; and

Whereas, The American Medical Association (AMA) supports state and medical societies in promoting training of both lay public and professional responders in essential techniques of bleeding control; and

Whereas, AMA and ACS support increased availability of bleeding control supplies in schools, places of employment, and public buildings; therefore be it

RESOLVED, That the Texas Medical Association support initiatives that promote the training of health care professionals in hemorrhage control, such as Stop the Bleed, at Texas medical schools; and be it further

RESOLVED, That TMA support the inclusion of hemorrhage control supplies in first aid kits in public spaces, including medical schools and hospitals.

Related TMA Policy: None.

Related AMA Policy:

H-130.935 Support for Hemorrhage Control Training:
1. Our AMA encourages state medical and specialty societies to promote the training of both lay public and professional responders in essential techniques of bleeding control.

2. Our AMA encourages, through state medical and specialty societies, the inclusion of hemorrhage control kits (including pressure bandages, hemostatic dressings, tourniquets and gloves) for all first responders.

Sources:


Subject: The Integration of LGBTQ Health Topics Into Medical Education

Introduced by: Medical Student Section

Referred to: Reference Committee on Medical Education and Health Care Quality

Whereas, LGBTQ patients experience an increased risk of physical (e.g., HIV, hepatitis, breast cancer) and mental health (e.g., anxiety, depression, suicide) problems, as well as barriers to health care (e.g., discrimination); and

Whereas, The Texas Medical Association recognizes that LGBTQ patients have unique health needs and face barriers to health care; and

Whereas, Only about five hours are allocated to LGBTQ health care topics during a physician’s training; and

Whereas, A survey asking physicians how many hours of medical school were dedicated to LGBT health care topics revealed that 61 percent received no lesbian content, 49 percent had no gay male content, 78 percent had no bisexual content, and 76 percent had no transgender content; and

Whereas, The Association of American Medical Colleges (AAMC) reported in 2014 that only 35.8 percent of medical students surveyed felt adequately trained to care for the LGBT population, and only 9.3 percent felt comfortable directing LGBT patients to LGBT health care professionals and services; and

Whereas, The American Medical Association’s Advisory Committee on LGBTQ Issues acknowledges the urgent need to provide better training to physicians to be able to deliver a higher quality of care to LGBTQ patients; and

Whereas, The AAMC concludes that understanding LGBTQ experiences and their impact on the patient-physician relationship is of the utmost importance in order to provide comprehensive, sensitive, and optimal health care; and

Whereas, the AMA supports the inclusion of LGBTQ health issues in the cultural competency curriculum for medical school and residency training; therefore be it

RESOLVED, That the Texas Medical Association support the integration of LGBTQ health care topics into undergraduate and graduate medical education; and be it further

RESOLVED, That TMA work with the appropriate parties to develop best practices for the integration of LGBTQ health care education into undergraduate and graduate medical education as well as CME.

Related TMA Policy:

265.028 Improving LGBTQ Health Care Access: The Texas Medical Association recognizes that lesbian, gay, bisexual, transgender, queer, or questioning (LGBTQ) individuals have unique health care needs and suffer significant barriers in access to care that result in health care disparities. TMA will provide educational opportunities for physicians on LGBTQ health issues to increase physician awareness of the importance of
building trust so LGBTQ patients feel comfortable voluntarily providing information on their sexual orientation and gender identity, thus improving their quality of care. TMA also will continue to study how best to reduce barriers to care and increase access to physicians and public health services to improve the health of the LGBTQ population (CSPH Rep. 8-A-18).

Related AMA Policy:
H-295.878 Eliminating Health Disparities: Promoting Awareness and Education of Lesbian, Gay, Bisexual, Transgender and Queer (LGBTQ) Health Issues in Medical Education: Our AMA: (1) supports the right of medical students and residents to form groups and meet on-site to further their medical education or enhance patient care without regard to their gender, gender identity, sexual orientation, race, religion, disability, ethnic origin, national origin or age; (2) supports students and residents who wish to conduct on-site educational seminars and workshops on health issues in Lesbian, Gay, Bisexual, Transgender and Queer communities; and (3) encourages the Liaison Committee on Medical Education (LCME), the American Osteopathic Association (AOA), and the Accreditation Council for Graduate Medical Education (ACGME) to include LGBTQ health issues in the cultural competency curriculum for both undergraduate and graduate medical education; and (4) encourages the LCME, AOA, and ACGME to assess the current status of curricula for medical student and residency education addressing the needs of pediatric and adolescent LGBTQ patients.

Sources:
Subject: Improve Physician-Hospital Relations

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Medical Education and Health Care Quality

Whereas, The number of hospital-employed and academic-employed physicians is increasing; and

Whereas, Independent physicians have unique issues that differ from their hospital or academic-employed colleagues; and

Whereas, Independent physicians have voiced that hospitals and medical executive boards are not giving their issues appropriate weight; and

Whereas, Inpatient hospital referrals and issues regarding medical staff bylaws have become two issues of greatest concern; therefore be it

RESOLVED, That the Texas Medical Association study ways to protect the relationship of physicians and their patients after inpatient hospital referrals and report back to the TMA House of Delegates at its annual 2020 meeting; and be it further

RESOLVED, That TMA study ways to improve the representation of all practice types of physicians through hospital medical staff bylaws.

Related TMA Policy:
115.008 Hospitalists and Intensivists: The Texas Medical Association opposes the mandatory utilization of hospitalists and intensivists in Texas hospitals and recommends that no hospital medical staff bylaws prohibit the patient from choosing to have his or her principal physician provide for continuity and coordination of care (Res. 407-I-98; reaffirmed CHSO Rep. 1-A-08; reaffirmed CHSO Rep. 1-A-18).

115.010 Hospitalists: The Texas Medical Association opposes the mandatory use of hospitalists proposed by health plans, institutions, or other entities, continues to support the voluntary use of hospitalists as deemed appropriate by physician-led policymaking bodies advising health plans, institutions, and other entities, and will continue to monitor hospitalist programs and assist members in dealing with the business and practice impacts associated with the use of hospitalists (Amended CSE Rep. 8-A-99; reaffirmed CSE Rep. 1-A-10).

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).

130.006 Hospital Medical Staff Bylaws: The Texas Medical Association supports changes in current laws to make established hospital medical staff bylaws binding upon and enforceable by the hospital medical staff and the board.
TMA policy is for Hospital Accrediting Organizations to include in its standards a provision which would require that medical staff bylaws, when formally approved by a hospital governing board, be mutually and equally binding on both the governing board and the medical staff.

TMA endorses the following principles for inclusion in future drafts of the Medical Staff Chapter of the Accreditation Manual for Healthcare Organizations:

1. Continue the use of the term “medical staff” in the title of the chapter and throughout the manual;
2. Provide consideration of qualified limited licensed practitioners when authorized by state laws and approved by the executive committee of the medical staff and the governing board;
3. Require that 100 percent of the voting members of the executive committee be fully licensed physicians actively practicing; and
4. Ensure that all hospitalized patients receive the same standard of care through appropriate language relating to admissions and the responsibility for the medical care of patients (Hospital Medical Staff Section, p 151-152, A-93; reaffirmed CHSO Rep. 1-A-03; amended CHSO Rep. 1-A-13).

130.008 Medical Staff Privileges: Rules, regulations, or bylaws of hospitals in Texas should include the following or similar phrase: “No physician may be denied staff privileges for political reasons or because of accepting or not accepting mandated assignments for payment for fee-for-service” (Hospital Medical Staff Section, p 151, A-93; reaffirmed CHSO Rep. 1-A-03; reaffirmed CHSO Rep. 1-A-13).

130.011 Medical Staffs: The need for continued community-based hospital care and the potential threat posed by the failure of governing and policymaking bodies to request, receive, and heed the advice and counsel of local medical staffs are causes for community and statewide concern. Medical staffs should foster cooperative and effective communication with their governing boards and should adopt bylaws that promote medical staff credentialing policies and procedures intended to assure a competent medical staff. Medical staffs should establish the capability to assist in resolution of conflicts between their members, hospital administration, and governing boards (Council on Socioeconomics, p 180, I-94; reaffirmed CHSO Rep. 2-A-05; reaffirmed CHSO Rep. 1-A-15).

130.015 Physician Participation in Medical Staff Affairs: The Texas Medical Association supports the principle that a hospital may not contract to limit physician participation or staff privileges or the participation or the staff privileges of a partner, associate, or employee of the physician at a different hospital or hospital system. TMA stands opposed to placing conditions on medical staff privileges to physician members by limiting their participation in medical staff matters through such conditions and limitations (Substitute Res. 29GG, p 177D, I-97; reaffirmed CHSO Rep. 1-A-08; reaffirmed CHSO Rep. 1-A-18).

130.021 Hospital-Based Emergency Department Referral Patterns: The Texas Medical Association work with the Texas Hospital Association (THA) and the Texas Legislature, if necessary, to (1) develop policy that requires a hospital to make a reasonable attempt to notify a patient’s own physician for direction on further care when that patient is admitted to the hospital via the emergency department; (2) work with THA and the Texas Legislature, if necessary, to develop policy to allow the referring physician, if that physician has privileges in the hospital, to have his or her patient assigned to his or her service or his or her designated proxy in the hospital, as opposed to the patient being preferentially referred to the hospital’s affiliated group; and (3) condemn the practice of steering a patient away from his or her physician to another physician because of affiliation or loyalty to the hospital (Res. 408-A-11).
130.022 Avoiding Bias in Medical Executive Committees: The Texas Medical Association strongly encourages adoption of medical staff bylaws that ensure hospital medical staff committees, particularly executive committees are composed of a majority of physician members elected by the medical staff (Amended Res. 411-A-12).

130.026 Medical Staff Rights and Responsibilities Bill of Rights: The Texas Medical Association adopts the following medical staff rights and responsibilities as TMA policy:

TMA recognizes the following fundamental responsibilities of the medical staff:

- The responsibility to provide for the delivery of high-quality and safe patient care, the provision of which relies on mutual accountability and interdependence with the hospital’s governing body;
- The responsibility to provide leadership and work collaboratively with the hospital’s administration and governing body to continuously improve patient care and outcomes;
- The responsibility to participate in the hospital’s operational and strategic planning to safeguard the interest of patients, the community, the hospital, and the medical staff and its members;
- The responsibility to establish qualifications for membership and fairly evaluate all members and candidates without the use of economic criteria unrelated to quality, and to identify and manage potential conflicts that could result in unfair evaluation;
- The responsibility to establish standards and hold members individually and collectively accountable for quality, safety, and professional conduct; and
- The responsibility to make appropriate recommendations to the hospital’s governing body regarding membership, privileging, patient care, and peer review.

TMA recognizes that the following fundamental rights of the medical staff are essential to the medical staff’s ability to fulfill its responsibilities:

- The right to be self-governed, which includes but is not limited to (1) initiating, developing, and approving or disapproving of medical staff bylaws, rules, and regulations; (2) selecting and removing medical staff leaders; (3) controlling the use of medical staff funds; (4) being advised by independent legal counsel; and (5) establishing and defining, in accordance with applicable law, medical staff membership categories, including categories for nonphysician members;
- The right to advocate for its members and their patients without fear of retaliation by the hospital’s administration or governing body;
- The right to be provided with the resources necessary to continuously improve patient care and outcomes;
- The right to be well informed and share in the decisionmaking of the hospital’s operational and strategic planning, including involvement in decisions to grant exclusive contracts or close medical staff departments;
- The right to be represented and heard, regardless of the voting rights of the physician as outlined by the medical staff bylaws, at all meetings of the hospital’s governing body; and
- The right to engage the hospital’s administration and governing body on professional matters involving their own interests.

TMA recognizes the following fundamental responsibilities of individual medical staff members, regardless of contractual or independent status:

- The responsibility to work collaboratively with other members and with the hospital’s administration to improve quality and safety;
- The responsibility to provide patient care that meets the professional standards established by the medical staff;
- The responsibility to conduct all professional activities in accordance with the bylaws, rules, and regulations of the medical staff;
- The responsibility to advocate for the best interest of patients, even when such interest may conflict with the interests of other members, the medical staff, or the hospital;
- The responsibility to participate and encourage others to play an active role in the governance and other activities of the medical staff;
The responsibility to participate in peer review activities, including submitting to review, contributing as a reviewer, and supporting member improvement.

TMA recognizes that the following fundamental rights apply to individual medical staff members, regardless of contractual or independent status, and are essential to each member’s ability to fulfill the responsibilities owed to his or her patients, the medical staff, and the hospital:

- The right to exercise fully the prerogatives of medical staff membership afforded by the medical staff bylaws, which right may not be waived as a condition of employment or medical staff privileges;
- The right to make treatment decisions, including referrals, based on the best interest of the patient, subject only to review by peers;
- The right to exercise personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care or medical staff matters, without fear of retaliation by the medical staff or the hospital’s administration or governing body;
- The right to be evaluated fairly, without the use of economic criteria, by unbiased peers who are actively practicing physicians in the community and in the same specialty;
- The right to full due process before the medical staff or hospital takes adverse action affecting membership or privileges, including any attempt to abridge membership or privileges through the granting of exclusive contracts or closing of medical staff departments;
- The right to immunity from civil damages, injunctive or equitable relief, and criminal liability when participating in good faith peer review activities; and
- The right to be free of “sham peer reviews” and manipulation of medical staff bylaws by hospitals attempting to silence or inhibit the voicing of physician concerns regarding the advocacy of their patients. (CHSO Rep. 2-A-18).
Supplement

TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 213
A-19

Subject: Complying with Value-Based Care Quality Measures for Medication Adherence

Introduced by: Elizabeth Torres, MD

Referred to: Reference Committee on Medical Education and Health Care Quality

Whereas, medication non-adherence is linked to an estimated 125,000 deaths, 10% of hospitalizations, and health care costs up to $289 billion annually; and

Whereas, Value-based care payment models are becoming more prevalent in the health care marketplace with 1,000-plus Accountable Care Organizations (ACOs) in value-based care contracts covering an estimated 32.7 million patients in the U.S. at the end of the first quarter of 2018; and

Whereas, 53 ACOs participated in Medicare’s Shared Savings Program in 2018, and an estimated additional 50 to 75 organizations participate in other value-based care contracts or pay-for-performance opportunities in Texas; and

Whereas, Many value-based care contracts offer financial incentives and shared savings opportunities to physicians and organizations based on reducing the cost of care, and most include performance on quality measures as a gating mechanism to earn the shared savings or pay-for-performance incentives; and

Whereas, More than 90% of health payers utilize the Healthcare Effectiveness Data and Information Set (HEDIS), developed and maintained by the National Committee for Quality Assurance, to assess quality performance of physicians and other providers in value-based contracts; and

Whereas, The 2019 HEDIS includes several measures addressing medication adherence such as measures for controlling high blood pressure, persistence of beta-blocker treatment after a heart attack, annual monitoring for patients on persistent medications, and medication reconciliation post-discharge; and

Whereas, Numerous blood pressure medications, such as Valsartan, Losartan, and Irbesartan, have been recalled over the past several months as federal investigators discovered potentially cancer-causing impurities in them leading to patient non-compliance and medication shortages that impede an ACO’s ability to meet quality measures regarding medication adherence and thus performance incentives; and

Whereas, Some patients access medications via pharmaceutical assistance programs, cash payments, and discounted prescription apps, such as GoodRx, which cannot be tracked via the claims submission methods used by payers to capture results for medication adherence; therefore be it

RESOLVED, That the Texas Medical Association work with payers to identify standard methodologies that address quality measure requirements for medication adherence in response to marketplace influences beyond the physician/providers control.
Sources:

   https://catalyst.nejm.org/optimize-patients-medication-adherence/

   https://www.healthaffairs.org/do/10.1377/hblog20180810.481968/full/?utm_term=Recent+Progress+In+The+Value+Journey%3A+Growth+Of+ACOs+And+Value-Based+Payment+Models+In+2018&utm

4. TMA PracticeEdge Texas Value Based Care Database (2019).

   https://www.ncqa.org/hedis/measures/.


Related TMA Policy:

95.043 Prescription Drug Value Based Contracting: In no way should value-based contracting or any other contracting method be a hindrance between the physician and the drugs the physician believes is the best treatment for his or her patient (CSE Rep. 4-A-17).

95.041 Ensuring Patient Access to Affordable Prescription Medications: TMA will: (1) support programs whose purpose is to contain the rising costs of prescription drugs provided that the following criteria are satisfied: (a) physicians must have significant input into the development and maintenance of such programs; (b) such programs must encourage optimum prescribing practices and quality of care; (c) all patients must have access to medically indicated prescription drugs necessary to treat their illnesses; (d) physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and (e) such programs should promote an environment that will give pharmaceutical manufacturers the incentive for research and development of new and innovative prescription drugs; (2) study the issue of drug pricing, including whether large price increases impact patient access to critical medications; (3) support the application of greater oversight to the establishment of closed distribution systems for prescription drugs; (4) support the mandatory provision of samples of approved out-of-patent drugs upon request to generic manufacturers seeking to perform bioequivalence assays; (5) work with interested parties to support legislation or regulatory changes that streamline and expedite the FDA approval process for generic drugs; and (6) support measures that increase price transparency for generic and brand-name prescription drugs. (Substitute Res. 405-A-16 and Res. 409-A-16).

265.017 Pay-for-Performance Principles and Guidelines: Physician pay-for-performance (PFP) programs that are designed primarily to improve the effectiveness and safety of patient care may serve as a positive force in our health care system. Fair and ethical PFP programs are patient-centered and link evidence-based performance measures to financial incentives. Such PFP programs are in alignment with the American Medical Association Principles for Pay-for-Performance Programs:
Quality of Care
Performance measures must be kept current and reflect changes in clinical practice. Except for evidence-based updates, program measures must be stable for two years.

Patient-Physician Relationship
Programs must recognize outcome limitations caused by patient nonadherence, and sponsors of PFP programs should attempt to minimize noncompliance through plan design.

Program Rewards
Programs must not penalize physicians financially based on factors outside of the physician’s control.

Related AMA Policy:
H-450.966 Quality Management: The AMA:

(1) continues to advocate for quality management provisions that are consistent with AMA policy;

(2) seeks an active role in any public or private sector efforts to develop national medical quality and performance standards and measures;

(3) continues to facilitate meetings of public and private sector organizations as a means of coordinating public and private sector efforts to develop and evaluate quality and performance standards and measures;

(4) emphasizes the importance of all organizations developing, or planning to develop, quality and performance standards and measures to include actively practicing physicians and physician organizations in the development, implementation, and evaluation of such efforts;

(5) urges national medical specialty societies and state medical associations to participate in relevant public and private sector efforts to develop, implement, and evaluate quality and performance standards and measures; and

(6) advocates that the following principles be used to guide the development and evaluation of quality and performance standards and measures under federal and state health system reform efforts: (a) Standards and measures shall have demonstrated validity and reliability. (b) Standards and measures shall reflect current professional knowledge and available medical technologies. (c) Standards and measures shall be linked to health outcomes and/or access to care. (d) Standards and measures shall be representative of the range of health care services commonly provided by those being measured. (e) Standards and measures shall be representative of episodes of care, as well as team-based care. (f) Standards and measures shall account for the range of settings and practitioners involved in health care delivery. (g) Standards and measures shall recognize the informational needs of patients and physicians. (h) Standards and measures shall recognize variations in the local and regional health care needs of different patient populations. (i) Standards and measures shall recognize the importance and implications of patient choice and preference. (j) Standards and measures shall recognize and adjust for factors that are not within the direct control of those being measured. (k) Data collection needs related to standards and measures shall not result in undue administrative burden for those being measured.
AGENDA
REFERENCE COMMITTEE ON SCIENCE AND PUBLIC HEALTH
Friday, May 17, 2019
Tower Lobby, Governor's Lecture Hall - Hilton Anatole

5. Committee on Emergency Medical Services and Trauma Report 3 – Sunset Policy Review
6. Committee on Infectious Diseases Report 1 – Sunset Policy Review
7. Council on Practice Management Services Report 2 – Improving Health Technology Products to Address the Issues of Sex and Gender
13. Resolution 301 - Distribution and Display of Human Trafficking Aid Information in Public Places
14. Resolution 302 - Statement on Personhood Measures
15. Resolution 303 - Improving Medical Clearance Policies for Traumatic Brain Injury Patients
16. Resolution 304 - Requirement for Food Allergy Posters and Employee Training in Food Establishments
17. Resolution 305 - Allow the Possession and Administration of an Epinephrine Auto-injector in Certain Entities
18. Resolution 306 - Opposition to Limiting the Physician’s Role in the End-of-Life Process
19. Resolution 307 - Regulatory Recommendations for Bed Bugs
20. Resolution 308 - Regulation of Electric Scooters
21. Resolution 309 - Factoring Adolescent Sleep Patterns into Middle and High School Start Times
22. Resolution 310 - Amending TMA Policy 315.031, Restricting the Sale of Electronic Cigarettes to Minors

23. Resolution 311 - Identifying Trauma and Mental Health Susceptibilities in Schools

24. Resolution 312 - Opposition to Increasing Work Requirements for the Supplemental Nutrition Assistance Program (SNAP)

25. Resolution 313 - Physicians Counseling Patients About the Risks of Direct-to-Consumer Genetic Testing

26. Resolution 314 - Support of Mandatory Paid Parental Leave

27. Resolution 315 - Notification of Generic Drug Manufacturing Changes

28. Resolution 316 – Determinants of Health
The Texas Medical Association periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness.

The Committee on Cancer recommends deletion of the following policy, as the Texas Department of State Health Services no longer regulates indoor tanning salons, thus rendering the policy irrelevant:

**260.062 Indoor Tanning Salon Regulation:** The Texas Medical Association supports the Texas Department of State Health Services in its regulatory and enforcement functions of indoor tanning salons (Amended CPH Rep. 5-I-99; amended CM-C Rep. 2-A-09).

**Recommendation:** Delete.
The Texas Medical Association Medical Student Section presented Resolution 306-A-18 to the House of Delegates and called for TMA to: (1) support legislation and other efforts to improve access to health care resources for children in the foster care system; (2) support legislation that protects the rights of foster care children to receive evidence-based care; and (3) oppose any legislation that allows for discrimination against adolescent patients seeking contraception.

The authors’ resolves and recommendations were developed in response to House Bill 3859 of the 85th Texas Legislature. Following testimony that clarified the bill did not apply to physicians and the practice of medicine, the author retracted the first and second resolves before the Reference Committee on Science and Public Health, but asked for consideration of the third resolve. The House of Delegates referred the third resolve to the Council on Legislation and the Committee on Child and Adolescent Health.

The committee reviewed the resolution and identified existing policy that affirms the association’s position on adolescent sexual activity and nondiscrimination policies:

- 55.004: Adolescent Sexual Activity
- 55.035: Right to Confidential Care
- 60.008: Rejection of Discrimination.
- 190.031: Texas Medicaid Reform Initiatives
- 190.033: Enhancing Children's Health Insurance Program Coverage
- 265.018: Evidence-Based Medicine.
- 330.009: Preconception and Inter-gestational Health and Care

Because of existing policy, the committee recommends that the third resolve not be adopted. The resolution’s authors agree with the committee’s recommendation.

**Recommendation:** That Resolution 306-A-18 not be adopted.
REPORT OF COMMITTEE ON CHILD AND ADOLESCENT HEALTH

Subject: Sunset Policy Review

Presented by: Maria C. Monge, MD, Chair

Referred to: Reference Committee on Science and Public Health

The Texas Medical Association periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness.

The Committee on Child and Adolescent Health recommends deletion of the following policy:

325.009 Child Abuse Prevention and Education: The Texas Medical Association supports: (1) working with legislators or congressmen to strengthen child abuse laws; (2) volunteering to teach community groups about prevention and identifying abuse; (3) providing parenting education opportunities to patients’ parents and other public audiences; (4) becoming involved in community child fatality review teams; and (5) fostering relationships with relevant government agencies and participate in community efforts and professional societies to coordinate activities that promote child abuse prevention, intervention and treatment (Council on Public Health, p 88, I-96; amended CPH Rep. 2-A-09).

Recommendation: Delete.

Presented by: Veer Vithalani, MD, Chair

Referred to: Reference Committee on Science and Public Health

At the May 2018 meeting, the House of Delegates considered Resolution 302-A-18 from the Travis County Medical Society. The resolution called on the Texas Medical Association to recommend Texas emergency medical services (EMS) systems adopt physician oversight ratios in order to support safe oversight of EMS medical practices. The resolution detailed ratios of full-time equivalent (FTE) physicians per life-support providers. The house referred the resolution to the Committee on Emergency Medical Services and Trauma for a report back in May 2019.

Last fall, the committee met with the resolution’s author as well as representatives from the Texas College of Emergency Physicians (TCEP) to discuss the resolution. While sympathetic to the author’s concerns, the committee and TCEP opposed adoption of the resolution. Many physicians were concerned that staffing requirement ratios would be costly to recreate in small EMS systems. Staffing ratios could create unfair burdens on small EMS systems in rural areas of the state. Further, the committee could not reach agreement on staffing ratios, as each EMS system is different throughout the state.

The Committee on Emergency Medical Services and Trauma recognizes the importance and challenges of physician oversight of EMS medical practices. There is evidence that errors in emergency settings such as emergency departments and emergency medical services can lead to poor outcomes for patients. One method of reducing these errors is to require physician staffing ratios per number of prehospital providers. Proponents of the resolution contend that staffing ratios would create greater oversight for EMS systems and decrease the likelihood of critical errors.

**Recommendation:** That the following new TMA policy be adopted in lieu of Resolution 302-A-18:

The Texas Medical Association will advocate for the Texas emergency medical service (EMS) systems to provide adequate funding for physicians to play an active role in the provision of Medical Direction and Oversight. This includes adequate support staff to accomplish this goal with the level of involvement necessary to perform the duties required by the Texas Medical Board (TMB) and Department of State Health Services (DSHS); thus facilitating safe oversight and management of EMS medical practices.
The Texas Medical Association periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness.

The committee recommends retaining Policy 100.013.

**100.013 Trauma Funding:** The Texas Medical Association supports the Texas Department of State Health Services’ efforts to secure a permanent funding source for state funding of emergency medical services and trauma (CM-EMS Rep. 1-I-98; reaffirmed CPH Rep. 2-A-09).

**Recommendation 1:** Retain.

The committee recommends deletion of the following policies:

**205.029 Hurricane Ike and The University of Texas Medical Branch:** The Texas Medical Association adopted the following set of principles relating to regional Hurricane Ike recovery issues and The University of Texas Medical Branch at Galveston:

Address a regional crisis regarding access to critical care, with the immediate establishment of a third Level 1 or 2 trauma center, or expansion of existing centers and supporting infrastructure (ICUs, inpatient beds, and the like) for adults and children in the Houston/Galveston/Beaumont area.

Use of emergency state appropriation to establish or expand the above-mentioned centers.

Apply existing trauma care funds, currently in the treasury, or regional tax for the sustainability of at least three Level 1 or 2 trauma centers in the region.

Adequately fund care for the uninsured patients who arrive from other counties. Use state and/or federal funding and/or mandatory uninsured compensation from the counties of residence.

The University of Texas Medical Branch (UTMB) can continue providing these services as part of its mission with state funding, or

Each county can contract with hospitals and physicians or establish hospital districts to obtain these services.

Provide adequate funding and resource capacity, either at UTMB or other facilities, for the care of:
Correctional patients (Texas Department of Criminal Justice)

Burn patients, both pediatric and adult

Mental health/substance abuse patients

Primary and preventive care patients

Chronic disease management patients

The Federal Emergency Management Agency provide 100-percent reimbursement for UTMB recovery costs, as was done for post-Katrina New Orleans.

Promote cost effective care of displaced patients and ensure reimbursement for medical schools/hospitals for costs incurred for medical students and residents transferred from UTMB (Res. 301-A-09).

Recommendation 2: Delete.
The Texas Medical Association periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness.

The Committee of Infectious Disease recommends the following policy for deletion, because the Texas Department of State Health Services is no longer pursuing efforts for uniform bar coding on vaccines, thus rendering the policy irrelevant:

260.081 Bar Coding on Vaccines: Bar Coding on Vaccines: The Texas Medical Association will work with the Texas Department of State Health Services to encourage state and national efforts to promote the use of technology, such as bar coding of vaccines, to improve patient safety and standardized reporting of immunizations (CM-ID Rep. 2-A-09).

Recommendation: Delete.
REPORT OF COUNCIL ON PRACTICE MANAGEMENT SERVICES
CPMS Report 2-A-19

Subject: Improving Health Technology Products to Address Issues of Sex and Gender

Presented by: D. Allen Schultz, MD, Chair

Referred to: Reference Committee on Science and Public Health

Background
The Council on Science and Public Health (SPH) and its LGBTQ Workgroup submitted Report 8-A-18 to the House of Delegates at its annual meeting in 2018. The report has four recommendations, two became TMA policy:

265.027 Costs to Update Health Information Technology Products to Address Issues of Sex and Gender: The Texas Medical Association believes that neither physicians nor patients should incur additional costs when electronic health records (EHRs) or health information technology (HIT) systems are updated to reflect the latest in regulatory requirements or evidence-based medical care in the area of lesbian, gay, bisexual, transgender, queer, or questioning health (CSPH Rep. 8-A-18).

265.028 Improving LGBTQ Health Care Access: The Texas Medical Association recognizes that lesbian, gay, bisexual, transgender, queer, or questioning (LGBTQ) individuals have unique health care needs and suffer significant barriers in access to care that result in health care disparities. TMA will provide educational opportunities for physicians on LGBTQ health issues to increase physician awareness of the importance of building trust so LGBTQ patients feel comfortable voluntarily providing information on their sexual orientation and gender identity, thus improving their quality of care. TMA also will continue to study how best to reduce barriers to care and increase access to physicians and public health services to improve the health of the LGBTQ population (CSPH Rep. 8-A-18).

The other two recommendations from Report 8-A-18 were referred to the Council on Practice Management Services (CPMS) and the Ad Hoc Committee on Health Information Technology (HIT):

(1) that TMA work with the American Medical Association and leaders in the field of lesbian, gay, bisexual, transgender, queer, or questioning (LGBTQ) health such as the World Professional Association for Transgender Health and the Gay and Lesbian Medical Association to develop requirements for electronic health records (EHRs), health information exchanges (HIEs), and other health information technology (HIT) products reflecting best practices that include the ability to support, capture, and provide easy use by physicians of the following information: a. Current gender identity, b. Gender assigned at birth, c. Sexual orientation, d. Name (or names) and pronoun preference, e. Indicated health screenings, f. Appropriate clinical decision support tools, and g. History of gender-affirming surgery or treatment as part of past medical or surgical history, and h. Sex assigned at birth. These products also should incorporate effective privacy attributes, particularly for adolescents, and enable physician use of a longitudinal view of changes in demographics, gender identity, sexual preference, medical and surgical history, and past interventions;

(2) that TMA and AMA continue to advocate for the rapid incorporation of best practice requirements into EHRs, HIEs, and other HIT products;
Status

Representatives from the Ad Hoc Committee on HIT had an initial conference call with representatives from AMA to discuss related AMA policy and how TMA can work with AMA on the assigned issues. AMA has an LGBTQ Advisory Committee that addresses many of the same issues as TMA’s LGBTQ Workgroup. The following is AMA’s policy on the Medical Spectrum of Gender D-295.312:

Given the medical spectrum of gender identity and sex, our AMA: (1) will work with appropriate medical organizations and community based organizations to inform and educate the medical community and the public on the medical spectrum of gender identity; (2) will educate state and federal policymakers and legislators on and advocate for policies addressing the medical spectrum of gender identity to ensure access to quality health care; and (3) affirms that an individual’s genotypic sex, phenotypic sex, sexual orientation, gender and gender identity are not always aligned or indicative of the other, and that gender for many individuals may differ from the sex assigned at birth.

On Jan. 7, 2019, TMA held a second call with representatives from the AMA LGBTQ Advisory Committee and the Gay and Lesbian Medical Association (GLMA) to discuss (1) sexual orientation and gender identity (SOGI) data management in HIT, and (2) how, working together, the three organizations and others can influence HIT companies to improve their products beyond the minimum required for designation as Certified Electronic Health Record Technology (CEHRT). Participants discussed the burdens physicians may encounter when collecting data on LGBTQ patients, such as local customization of EHRs to address SOGI issues, particularly with respect to clinical decision support, correct billing protocols, and appropriate privacy settings; ensuring such modifications are no extra cost to physicians; and more.

Recommendation: That the Texas Delegation to the AMA introduce a resolution to the American Medical Association House of Delegates asking the AMA to adopt the following:

1. Research the problems related to the handling of sex and gender within health information technology (HIT) products and how to best work with vendors so their HIT products treat patients equally and appropriately, regardless of sexual or gender identity; and

2. Advocate for the incorporation of recommended best practices into electronic health records and other HIT products at no additional cost to physicians, and investigate the use of personal health records to reduce physician burden in maintaining accurate patient information instead of having to query everyone regarding sexual orientation and gender identity at each encounter.
Subject: Extreme Risk Protection Orders and Gun Violence, Resolution 314-A-18

Presented by: Alice Gong, MD, Chair

Referred to: Reference Committee on Science and Public Health

The 2018 House of Delegates considered Resolution 314 from the Texas Pediatric Society that called for TMA to advocate for legislation permitting extreme risk protection orders in Texas. Resolution 314 identified gun violence as a public health threat – noting that mental illness, domestic violence, and substance abuse often are factors in gun violence. Testimony at the hearing of the Reference Committee on Science and Public Health revealed both support for the proposal and concerns about the consequences of such legislation. Acknowledging the complexities and challenges of firearm safety legislation and the recent mass shootings in Texas, the reference committee recommended the resolution be referred for study. The recommendation was approved, and the Board of Trustees referred Resolution 314 to the Council on Science and Public Health and the Council on Legislation. As part of the councils’ review of Resolution 314, TMA President Doug Curran, MD, appointed a TMA Workgroup on Firearms and selected 13 physician experts to review, discuss, and advise both councils with recommendations for consideration. At Dr. Curran’s request, TMA Board of Trustees member Gary Floyd, MD, chaired this workgroup. Two meetings (during 2018 TMA Fall Conference and 2018 Advocacy Retreat) were held to work up recommendations on Resolution 314 as well as Resolution 313 (Raising the Minimum Purchase Age for All Guns to 21), which also was referred for study. Additionally, the workgroup evaluated gaps in TMA firearm policy to offer a set of additional principles for consideration by both councils for a report back at 2019 TMA Winter Conference.

John Carlo, MD, member of the American Medical Association Council on Science and Public Health and TMA Council on Legislation, brought to the discussion the newly adopted 2018 AMA report, “The Physician’s Role in Firearm Safety.” The AMA council report focused on the presupposition that 38,000 U.S. deaths from firearms in 2016 is unacceptable and that firearm violence is a public health threat. Racial and ethnic disparities make nonwhites 2.5 times more likely to die from firearms than whites. The report called on the need for more scientifically based research for effective measures to address the public health issues with firearm violence.

Gun Violence and Behavioral Health

The United States has the highest violent death rates among high-income countries; this includes the highest firearm homicide rates and firearm suicide rates — both at least twice that of other high-income countries. The Centers for Disease Control and Prevention (CDC) does not use the term “gun violence,” but in its role as national surveillant of violent deaths, CDC recently identified firearm-related deaths as a public health concern. Comparing data on firearm deaths in the 50 largest U.S. metropolitan statistical areas from 2012-13 and 2015-16, CDC reports that firearm-related death rates now have risen to the high rates of more than 10 years ago (2006-07).

CDC identifies suicides as “self-directed violence” and as a top 10 leading cause of death in the United States and one of only four causes of death with significant rate increases. There were more than 44,000 suicides in the United States in 2016, and 50 percent, or more than 22,000 deaths, were suicides by firearm. The rates of suicide by firearm vary by age group, but males consistently have the highest rates.
(more than 80 percent of all firearm suicides), with the rates rising among older age groups. The U.S. suicide rate by firearm increased 21 percent from 2006 to 2016 (for people more than 10 years old).

In 2016, Louisiana, Alabama, and Alaska had the highest rates of firearm mortality in the country (21.3 to 23.3 per 100,000). With 3,353 firearm-related deaths in this period, Texas had more deaths than any other state and a firearm-death rate of 12.1 (per 100,000). Like the rest of the country, Texas’ suicide rate increased from 2000 to 2016, and Texas’ suicide-by-firearm rate of 7.3 (per 100,000) is higher than the U.S. rate of 6.5.

Contrary to news reports that associate firearm violence and mass shootings with a mental illness, most of the people who carry out a mass shooting do not have a diagnosis of a mental illness. A very small proportion of those with a severe mental illness and a history of violence may be more likely to become violent when experiencing a high-risk event. The American Psychiatric Association notes that less than 1 percent of gun-related homicides in a mass shooting each year involved a person with a serious mental illness, and about 3 percent of individuals with a serious mental illness were involved in a violent crime. A report of the Federal Bureau of Investigation (FBI) also confirms that only 25 percent of 63 active shooters in the United States (2000-13) had been diagnosed with a mental illness, and three of these were diagnosed with a psychotic disorder. The FBI reports that most of those involved in a mass shooting were known to have demonstrated concerning behaviors or to have experienced one or more severe stressors before they engaged in firearm violence. Firearm violence has been more commonly associated with compulsive, angry behavior. A recent analysis of the National Comorbidity Study Replication found that about 10 percent of U.S. residents both report pathological anger and possess firearms and/or carry firearms outside the home. In many cases, these people already have a history of misdemeanor violence (e.g., controlled substance misuse, physical altercations). These traits and access to firearms appear to increase the risk for violent behaviors.

**Red Flag Laws and Protective Orders**

Extreme risk protection orders, also known as “gun violence restraining orders” or “red flag” laws, are intended to remove firearms from individuals who are reported to be an extreme risk to themselves or to another person. While five states already have some type of red flag statute, an additional eight states recently have adopted red flag legislation. Legislation has been considered in many more states — including Texas — but has not been approved. Additionally, concerns have been raised about the complexity of these orders and their enforcement.

The United States has extensive statutory law that addresses firearm commerce, such as the Gun Control Act 1968, which limits the purchase of firearms by specific people such as those who are convicted of a felony or domestic violence, subject to a restraining order or involuntary commitment, or declared mentally incompetent. The 1968 legislation also raised the age for handgun purchase to 21 years. The Brady Handgun Violence Prevention Act established the National Instant Criminal Background Check System, and the National Crime Information Center was created for reporting required criminal justice information such as people identified under a protective restraining order.

Domestic protective orders and red flag laws are associated with federal laws on the purchase or possession of a firearm and the reporting of those not qualified to purchase or possess a firearm. While almost all states have protective orders, their scope varies by state. However, these orders generally are based on the type of risk presented — such as an association with family violence, a history of a felony conviction, or a diagnosed mental illness. The process for obtaining a protective order addresses who is at risk of harm and the mental status and history of firearm violence of the person identified as the offender. The petitioner for a protective order typically presents in court and must report direct threats or warning signs of a potential threat to family, household members, or law enforcement. The removal of firearms from the person identified as the offender is not automatic, but the petition can lead to removal if requested by the petitioner.
A protective order is not the same as a red flag law. Red flag laws do not focus on the domestic setting, nor do they relate to violence that already has occurred. Red flag laws are intended to prevent the future violent conduct of people who may have access to firearms and if there is evidence of direct threats to themselves, other individuals, or groups (e.g., in a home, school, or work setting), and/or there are other concerning behaviors. Red flag laws allow for the preemptive removal of a firearm based on potential risk.

Red Flag Law Effectiveness
Several states have had red flag laws for a few years, but red flag law requirements vary by state, and implementation of these laws still appears to be in an early stage in some states. Connecticut has the longest history, with its red flag law adopted in 1999, followed by Indiana’s red flag law authorized in 2005. No studies could be found on the impact of red flag laws in most of the states that already have implemented them. It may be that differences in these state laws and implementation status make them complex to assess.

A few studies have assessed the impact of these laws in Connecticut and Indiana. Key findings include:

- From 2005 to 2015, Indiana saw a 7.5-percent reduction in firearm-related suicides.
- Connecticut initially saw a 1.6-percent reduction in firearm-related suicides in the earliest years of implementation, but the rate of firearm-related suicides decreased most significantly after 2007. The study authors attribute this to more rigorous implementation of red flag laws following the 2007 mass shooting at the Virginia Polytechnic Institute and State University.
- Another study on Connecticut’s experience with its red flag law (1999-2012) found that while the number of suicides declined among those who had one or more firearms removed, suicides and suicide attempts that did not involve firearms increased. Suicidality was the key issue identified for almost two-thirds of the more than 760 people who were subject to a risk warrant petition. The study also found that some may seek and obtain mental health care, as 29 percent were in contact with the public mental health system in the year following their crisis. However, the removal of firearms from those at risk of suicide is viewed as a significant impact in Connecticut.

Several studies note significant inconsistencies in how red flag laws are implemented, and implementation can even vary by jurisdiction within a state. Interviews with legal counsel and judicial representatives associated with Connecticut’s red flag legislation revealed an interest in clarifying Connecticut’s process for approving risk-based warrants and also concern about the assurance of due process for people subject to firearm removal.

While there is a limited body of study on red flag laws, there is broader study on the effectiveness of domestic protective laws in reducing intimate partner violence, including reducing rates of homicide with firearms. Family and domestic protective orders are implemented in almost every state as a tool to prevent a personal assault or other violence.

Texas Statutes, Legislation, and Recent Action on Firearms
Unlike several other states, Texas does not require a permit to purchase a handgun, rifle, or shotgun, nor is registration or licensure required to possess these firearms. A permit is required to carry a handgun (open or concealed), although some facilities can restrict or prohibit the carry of a handgun. More than 1 million Texans have concealed handgun permits, and a recent national survey found that more than a third (35.7 percent) of Texas adults own a firearm. Texas’ safe storage law creates a misdemeanor if a firearm is accessible to a child, and the misdemeanor can be raised to a Class A misdemeanor if a child’s use of the firearm leads to death or serious injury to the child or another person. And while neither a municipality nor a county can adopt regulations on the possession, registration, or licensure of firearms or ammunition, municipalities can regulate the discharge of firearms within the city or the carry of a firearm at a public facility or certain events.
Texas does not have a red flag law, but like most states, Texas’ protective orders are for domestic or family violence and emergency protective orders. Texas’ protective orders statute is more expansive than most other states as it can refer not only to a spouse, family member, or other resident of the household but also to an intimate or “dating” partner and allows for a protective order against domestic or family violence or for a victim of sexual assault. Emergency protective orders also can be approved by a magistrate for a person who already has been arrested for family violence or assault — but may not allow for taking possession of a firearm. Texas’ statute also extends to the possession of ammunition. A Texas resident under a restraining order must be reported by courts to the Texas Department of Public Safety, which in turn reports to the federal National Crime Information Center.

Recent legislation (2017) filed to expand protective orders in Texas includes House Bill 866 by Rep. Joe Moody and Senate Bill 434 by Sen. José Rodriguez to allow law enforcement to remove firearms with the issuance of a lethal violence protective order if family members or law enforcement can provide evidence that the individual or others are in immediate danger. HB 866 was left pending in committee. House Bill 131 by Rep. Joe Moody on extreme risk protection orders was the first bill to be filed on red flag legislation in the 2019 legislative session.

In response to the school shooting in Santa Fe High School and the November 2017 mass shooting in Sutherland Springs, Texas Gov. Greg Abbott convened three roundtables across the state on the safety of students and teachers in Texas schools. The Governor’s School and Firearm Safety Plan made recommendations on school safety and on the reduction of firearm-related threats. One recommendation calls on Texas legislative leadership to consider the merits of red flag legislation in Texas.

The Texas Senate appointed the Select Committee on Violence in Schools and School Security, whose charge includes a review of red flag orders. Testimony at the committee’s July 2018 hearing on red flag laws provided both support and opposition to the consideration of a red flag statute in Texas. Supporters suggested allowing family members and law enforcement to initiate an order to remove a firearm from someone they perceive as presenting harm to themselves or others, and in particular, someone who is recognized as being in a crisis situation. It was also noted that current statute could be broadened to address the person who has a history of violent behavior or reckless use of a firearm or other deadly weapons, or someone who has been released from a mental health hospital who also may present a risk. Others spoke on the ability to apply Health and Safety Code Chapter 573 in the Texas Mental Health Code that allows a peace officer to take into custody and restrain a person without a warrant if the officer believes the person has a mental illness and presents a substantial risk to himself or herself or to another person.

The Senate committee’s August 2018 report made several recommendations but none in support of legislation on red flag orders. The recommendations called for legislation to clarify current statute on whether and when an individual convicted of domestic violence may possess a firearm legally and on the return of firearms to individuals who have been detained and declared no longer to be a risk to themselves or others.

**Discussion**

Gun violence often is associated with mental illness, and both matters are of significant concern to physicians. Yet studies indicate physicians are not screening routinely or counseling even high-risk patients on firearm safety. And when screening is done, it is more likely done by primary care physicians, psychiatrists, or emergency medicine physicians. This suggests there may be a need to increase physician awareness of screening tools and interventions, especially for patients who may be at risk for violence to themselves or others.
Violence is indeed a concern, and domestic and family violence is a significant problem in Texas. Texas has broad protective order procedures intended to prevent domestic and family violence, but almost 200,000 incidents of family violence were reported in 2015, with 97 percent of these categorized as involving a physical assault. Physical force was used in 80 percent of assaults, and a firearm was involved in 1.7 percent of reported family violence cases. The Texas Council on Family Violence reports that male partners killed 146 women in 2016, and there were more than 170,000 hotline calls to Texas family violence programs in this period. Yet data on current violence in Texas and firearm violence in particular could not readily be found. Active surveillance of firearm-related injuries and deaths in Texas and access to these data would help physicians better understand the circumstances contributing to injuries and deaths associated with firearms. Texas remains one of the few states that does not participate in CDC’s National Violent Death Reporting System (NVDRS). CDC notes that the NVDRS helps communities understand the “who, when, where, and how” associated with violent deaths to enable communities to take action to save lives.

But physicians have important tools to support firearm violence prevention, and this begins with the patient-physician relationship that includes confidential communications on the care and personal safety of the patient. There is substantial evidence that patients depend on and trust the free exchange of information and personal guidance they receive from their physician. Patients are more likely to act upon direction from their physician than they are from other sources. This can and should include discussions on potential risks in the home such as firearm access by the patient or family members. Texas has clear statute on the duty to ensure firearm safety in the home, and physicians can inquire and readily share information on firearm risk in their communications with patients.

The public and physicians also can readily access state and volunteer resources on family and domestic violence. The Office of the Attorney General, the Texas Council on Family Violence, and many local community organizations offer information and assistance to those at risk of domestic violence. Patients also may be unaware of current protective order laws. In addition, Texas statute allows a physician and licensed or certified mental health professionals to disclose confidential patient information if a patient appears to be at imminent risk of self-harm or harm to another. Physicians do not have a duty to share information, but this presents an important option for physicians.

Conclusion

Background checks and age-based requirements for the possession and purchase of firearms have been the mainstay of federal and state management of firearms. Keeping firearms away from people who present a risk of harm or who are unable to make sound decisions provides a strong base for managing firearm safety. But with an estimated more than 400 million firearms in the United States, clearly purchase and possession laws are not providing adequate protection to prevent firearm access by those at high risk of harm to self or to others.

About 40 percent of U.S. adults own one or more firearms or live in a home where a firearm is present. Most of these firearms were purchased or otherwise obtained legally outside the federally regulated system for licensed firearm vendors. For a large proportion of U.S. adults, gun ownership is associated with an individual’s personal freedom, and protection is a key reason why many own one or more firearms.

With dozens of significant events involving firearm violence and mortality, the country remains divided on what actions are needed to prevent firearm-related violence. But firearm violence is not a new concern for medicine. The American Medical Association, the American Academy of Pediatrics, and the American College of Physicians have taken a firm stand on the physician role in addressing gun violence as a public health issue. Other medical associations also have agreed upon the urgency for identifying public health prevention strategies to reduce firearm mortality and morbidity.
CDC defines public health as the science of protecting and improving the health of people in their communities. Historically this has focused on preventing and responding to infectious disease outbreaks, but as public health science and medicine have evolved, it has become increasingly important to direct research to better understand the factors that contribute to preventable diseases and injuries such as firearm violence. State legislation to allow extreme risk protection laws may have an impact in reducing suicide rates, but such legislation alone may not fully address other factors associated with mass shootings and domestic violence. Thus physicians must continue to advocate for and seek evidence so they can be directly engaged in identifying how to reduce firearm morbidity and mortality.

Texas has a history and culture of independence, which for about a third of Texas adults includes the freedom to possess and use firearms as permitted by the U.S. Constitution. TMA does not take a position on firearm possession or purchase, but recognizes that physicians have a role in helping identify and support their patients at risk of harm, particularly if a patient has access to firearms or lives in an unsafe environment. Further, there is an urgent need to improve Texas’ understanding of firearm violence and of the outreach and public awareness that may be needed in some communities. Therefore, in lieu of adopting Resolution 314, the council makes the following recommendations:

1. **Recommendation 1**: Amend TMA Policy 260.015, Firearms, as follows:

   - The Texas Medical Association recognizes gun violence as a public health issue requiring the promotion of evidence-based strategies in Texas. Medical professional organizations should speak out about the prevention of firearm-related injuries and deaths, and TMA calls on physicians to support:

     1. The primary prevention of firearm morbidity and mortality through educating Texans about firearm safety and the potential hazards of firearm ownership, recognizing that physicians have an unencumbered right to inquire of and inform patients and their families about the risks of firearms and in particular the risk to children;
     2. Promotion of the Texas Hunter Education and certification program developed by the Texas Department of Parks and Wildlife;
     3. Physicians in the clinical setting providing anticipatory guidance in the clinical setting on the dangers of firearm ownership in an informational, nonjudgmental manner, encouraging firearm owners to adhere to best practices for reducing the risk of accidental or intentional injuries or deaths by ensuring firearms are not accessible to children; adolescents; or people with mental, behavioral, or substance use disorders;
     4. Strict enforcement of federal and state gun control laws and mandated penalties for crimes committed with a firearm, including illegal possession;
     5. The use of trigger locks (such as can be provided by www.projectchildsafe.org) and locked gun cabinets to help prevent unintentional discharge; and
     6. Unfettered study of issues involving firearms and public health and safety, and Texas’ participation in national surveillance studies on violence in the United States, ensuring the state has timely, accurate data on firearm-related mortality and morbidity to guide Texas’ public health prevention activities (Res. 28S, p 176, A-93; Substitute CPH Rep. 3-A-08; amended CSPH Rep. 5-A-18).

2. **Recommendation 2**: That the Task Force on Behavioral Health develop information for physicians on the prevention and assessment of suicide risk and promote awareness of mental health first-aid training for physicians and office staff, and of state statute on the sharing of information on patients at risk.

3. **Recommendation 3**: That TMA advocate for a protective order process to allow for the implementation of risk-based protective orders to support those reported to be at high risk of violence to others or self-harm.
Recommendation 4: Amend TMA Policy 325.002, Family Violence, as follows:

325.002 Family Violence: The Texas Medical Association believes that physicians should learn to be aware of what resources are available in their community such as information provided by the Texas Family Violence Council and information on family protective orders developed by the Office of the Attorney General to inform and support victims of domestic violence. Physicians should make this information available in their waiting rooms or have their office staff provide it. The association should provide physicians with information on the symptoms of domestic violence and abuse, and that physicians should record information on domestic violence in the patient’s medical file (CPH, p 129, A-92; amended CPH Rep. 3-A-10).

Related TMA policy:

245.021 Patient-Doctor Privileged Communication: The Texas Medical Association (1) opposes efforts by the Texas Legislature to insert itself into the patient-physician relationship in any way that interferes with the free and full disclosure of health care information in the best interests of the patient, and (2) reaffirms its support of the free exchange of professional information in the patient-physician relationship as privileged and worthy of the highest professional protection (Amended Res. 108-A-13).

325.002 Family Violence: The Texas Medical Association believes that physicians should learn what resources are available in the community to help victims of domestic violence and make this information available in their waiting rooms or have their office staff provide it, that the association should provide physicians with information on the symptoms of domestic violence and abuse, and that physicians should record information on domestic violence in the patient's medical file (CPH, p 129, A-92; amended CPH Rep. 3-A-10).

Related AMA policy:

H-145.997 Firearms as a Public Health Problem in the United States – Injuries and Death

Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths. Therefore, the AMA:

(1) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;
(2) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;
(3) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;
(4) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns;
(5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;
(6) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;
(7) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and
(8) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.
H-145.990 Prevention of Firearm Accidents in Children

Our AMA (1) supports increasing efforts to reduce pediatric firearm morbidity and mortality by encouraging its members to (a) inquire as to the presence of household firearms as a part of childproofing the home; (b) educate patients to the dangers of firearms to children; (c) encourage patients to educate their children and neighbors as to the dangers of firearms; and (d) routinely remind patients to obtain firearm safety locks, to store firearms under lock and key, and to store ammunition separately from firearms; (2) encourages state medical societies to work with other organizations to increase public education about firearm safety; (3) encourages organized medical staffs and other physician organizations, including state and local medical societies, to recommend programs for teaching firearm safety to children; and (4) supports enactment of Child Access Prevention laws that are consistent with AMA policy.

H-145.975 Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care

1. Our AMA supports:

   a) federal and state research on firearm-related injuries and deaths;
   b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy;
   c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety;
   d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes;
   e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes;
   f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and
   g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.

2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.

3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.

H-145.972 Firearms and High-Risk Individuals

Our AMA supports:

   (1) the establishment of laws allowing family members, intimate partners, household members, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence;
   (2) prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking, from possessing or purchasing firearms;
   (3) expanding domestic violence restraining orders to include dating partners;
   (4) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons;
(5) requiring domestic violence restraining orders and gun violence restraining orders to be 
entered into the National Instant Criminal Background Check System; and 
(6) efforts to ensure the public is aware of the existence of laws that allow for the removal of 
firearms from high-risk individuals.

H-145.975 Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to 
Mental Health Care

1. Our AMA supports:

   a) federal and state research on firearm-related injuries and deaths;
   b) increased funding for and the use of state and national firearms injury databases, including the 
      expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to 
      inform state and federal health policy;
   c) encouraging physicians to access evidence-based data regarding firearm safety to educate and 
      counsel patients about firearm safety;
   d) the rights of physicians to have free and open communication with their patients regarding 
      firearm safety and the use of gun locks in their homes;
   e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes;
   f) encouraging physicians to become involved in local firearm safety classes as a means of 
      promoting injury prevention and the public health; and 
   g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the 
      prevention of gun violence in national, state, and local continuing medical education programs.

2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus 
on the diagnosis and management of mental illness and concurrent substance use disorders, and work with 
state and specialty medical societies and other interested stakeholders to identify and develop 
standardized approaches to mental health assessment for potential violent behavior.

3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula 
and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means 
safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss 
lethal means safety and work with families to reduce access to lethal means of suicide.

H-145.976 Firearm Safety Counseling in Physician-Led Health Care Teams

1. Our AMA:

   a) will oppose any restrictions on physicians' and other members of the physician-led health care 
team's ability to inquire and talk about firearm safety issues and risks with their patients;
   b) will oppose any law restricting physicians' and other members of the physician-led health care 
team's discussions with patients and their families about firearms as an intrusion into medical 
privacy; and
   c) encourages dissemination of educational materials related to firearm safety to be used in 
undergraduate medical education.

2. Our AMA will work with appropriate stakeholders to develop state-specific guidance for physicians on 
how to counsel patients to reduce their risk for firearm-related injury or death, including guidance on 
when and how to ask sensitive questions about firearm ownership, access, and use, and clarification on 
the circumstances under which physicians are permitted or may be required to disclose the content of such 
conversations to family members, law enforcement, or other third parties.
H-145.996 Firearm Availability

1. Our AMA:

(a) advocates a waiting period and background check for all firearm purchasers;
(b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and
(c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices.

2. Our AMA supports requiring the licensing/permitting of firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms.

3. Our AMA supports “gun violence restraining orders” for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as “red-flag” laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and “red-flag” laws, we also support the importance of due process so that individuals can petition for their rights to be restored.

Sources:
5. DSHS, Suicide Trends and Characteristics, Texas vs. United States.
13. Chapter 82 Subtitle B. Protective Orders, Chapter 82. Applying for Protective Order, Subchapter A. Application for Protective Order, Sec. 82.001.
center/learn-the-facts/.

19. Office of the Attorney General, Crime Victims,

20. Texas, Health and Safety Code 611.004 Authorized Disclosure of Confidential information other than
in Judicial or Administrative Proceeding; Texas Medicine, The Texas Supreme Court Speaks: Mental
Health Professionals Have No Duty to Warn or Protect Third Parties, Nov. 2002.

e1416 e1423.doi:10.1542/peds.2012-2481; Annals of Internal Medicine, Reducing Firearm Injuries
and Deaths in the United States: A Position Paper from the American College of Physicians, Oct. 30,
2018.
Subject: Support of Evidence-Based Medicine, Resolution 107-A-17

Presented by: Alice Gong, MD, Chair,

Referred to: Reference Committee on Science and Public Health

The 2017 House of Delegates considered Resolution 107-A-17 from the Resident and Fellow Section, Young Physician Section, and Medical Student Section. The House of Delegates recommended referral of the resolution. The resolution was referred to the Board of Councilors, which studied the issue and made a recommendation to the 2018 House of Delegates that Resolution 107-A-17 not be adopted. Testimony at the hearing of the Reference Committee on Financial and Organizational Affairs recommended referral to the LGBTQ Health workgroup with a report back in 2019.

Background

Resolution 107-A-17 called for Texas Medical Association to:

• Adopt policy opposing the criminalization of evidence-based medical care;
• Oppose the revocation of a medical license for the provision of evidence-based medical care; and
• Encourage TEXPAC to consider previous and planned actions to criminalize the practice of medicine when deciding endorsements and allocation of funds.

Testimony in 2017 on Resolution 107 expressed concerns with legislation proposed in the Texas Legislature associated with abortion. Testimony before the reference committee was largely supportive of the resolves although concern was expressed on the third resolve related to TEXPAC and the potential for unintended consequences. The resolution was referred to Board of Councilors, whose 2018 report to the House of Delegates did not support the resolves. Testimony at the 2018 reference committee focused on challenges to evidence-based medicine and specifically the creation of penalties for physicians for failure to comply with legislative requirements even though they were contrary to the practice of evidence-based medicine.

Penalties to the Practice of Evidence-Based Medicine

In 2011, the Florida legislature passed legislation that would restrict physician communications with their patients on firearm access. Penalties in the legislation imposed a “gag” that would include both a fine and the potential loss of the physician’s license for inquiring about firearms in the home. House Bill 155, Privacy of Firearm Owners, prohibited a licensed practitioner or a facility from recording the status of firearm ownership in a patient’s medical records or even inquiring about ownership or possession. Long a practice of pediatricians, inquiring about access to firearms and other potential hazards is a mainstay of pediatric screening and communications with children. HB 155 was finally struck down by a federal court of appeals.

Several proposals on abortion were filed during the 2017 Texas legislative session including House Bill 844 and Senate Bill 415, which called for a prohibition on the performance of “dismemberment” or partial-birth abortions. HB 844 provided penalties and created a criminal offense for physicians and others acting under the direction of a physician who performed this procedure, commonly known as dilation and evacuation (D&E), a procedure followed for abortions in the second-trimester. HB 844 was
not passed, but language from HB 844 was appended to Senate Bill 8 to prohibit D&E and other procedures. SB 8 addressed certain prohibited abortions and the treatment and disposition of a human fetus, human fetal tissue, and embryonic and fetal tissue remains. Currently, large components of the requirements in SB 8 remain under court review.

Discussion and Conclusion

A literature review of penalties on the practice of evidence-based medicine did not identify articles or studies but did turn up several reports regarding new challenges to the practice of evidence-based medicine. Public policy proposals on physician practices occasionally are developed in many states and certainly in Texas. Most recently in Texas, legislative activities have been proposed and sometimes approved, such as adding new requirements for women’s access to abortion services, for end-of-life care, for the use of marijuana as medicine, and making it easier to get an immunization exemption for a child to enroll in school.

Several recent articles note the challenges to the practice of evidence-based medicine. Among these are keeping abreast of the latest clinical research and changes in clinical guidelines necessary for effective patient care. But often the most significant challenge is managing developments and new guidelines while balancing the physician’s own judgment and expertise and the unique needs and characteristics of each patient. Patient literacy and individual preferences also will remain a challenge to the practice of evidence-based medicine.

There is little information on penalties or threats to physician licensure for the practice of evidence-based medicine. However, public policy decisions on social, clinical, and economic issues often are determined in the Texas Legislature, where stark ideological divisions are common. But the intervention of legislators and others in evidence-based medicine is not new to TMA; during legislative sessions, the association has consistently opposed obstacles to the practice of evidence-based medicine. This is why the Texas Medical Association focuses on developing effective relationships with local and state leadership to ensure physicians can serve as trusted resources for legislators on complex and divisive issues.

Resolution 107 referred to TMA Policy 265.018 on evidence-based medicine, which the Council on Science and Public Health updated significantly in 2018. Further, TMA’s policy related to abortion was updated in 2017. The council notes that while TMA has strong policy on evidence-based care, this policy does not directly address legislatively imposed penalties on physicians who are practicing evidence-based care. In lieu of Resolution 107-A-17, the council recommends amending TMA policy.

Recommendation: Amend TMA Policy 265.018 as follows:

**265.018 Evidence-Based Medicine and Practice:** The Texas Medical Association supports the use of science and well-designed, well-conducted clinical research as a foundation for good medical practice to improve the quality of patient care. Guidelines and protocols for medical care based on thorough reviews of current medical research can improve the consistency, timeliness, and efficiency of clinical care. National and international medical organizations as well as nursing and allied health continue to develop evidence-based guidelines and recommendations to improve patient care. At times, evidence is incomplete and involves expert opinion. However, popular, advertised trends are not identical to experts. The quality of the evidence to support guidance is graded on the strength of the data from which it is derived. Evidence-based guidelines are always supportive, not prescriptive, and should be adjudicated by the physician or provider with good medical judgment and experience in the best interest of the individual patient. TMA encourages continued medical research in areas where a gap in knowledge exists on which to base medical practice. TMA supports the use of
evidence-based medicine to improve approval and payment for medical services where appropriate.

TMA strongly supports the standardization of a national set of evidence-based measures that are clinically meaningful and lead to performance improvement while improving both patient outcome and patient satisfaction such as those endorsed by the National Quality Forum.

Recognizing that evidence-based medicine is continually evolving, measures should be evaluated and subject to regular review (1) at intervals in accordance with professional standards, (2) whenever there is a significant change in scientific evidence, or (3) when results from testing arise that materially affect the integrity of the measure.

TMA supports the focus of the American Medical Association policy in its efforts to (1) work with state and local medical associations, specialty societies, and other medical organizations to educate the Centers for Medicare & Medicaid Services, state legislatures, third-party payers, and state Medicaid agencies about the appropriate uses of evidence-based medicine and the dangers of cost-based medicine practices; and (2) through the Council on Legislation, work with other medical associations to develop model state legislation to protect the patient-physician relationship from cost-based medicine policies inappropriately characterized as “evidence-based medicine.”

TMA will oppose obstacles or penalties to the practice of evidence-based medicine including censure of licensure or criminal charges and calls for monitoring of local and state policy proposals that may allow for disruption to the patient-physician relationship and the practice of evidence-based care, especially in responding to vulnerable populations (CSA Rep. 3-A-08; amended CSPH Rep. 5-A-18).

Related TMA Policy:


10.003 Patient Autonomy and Accuracy of Information in Informed Consent for Abortion: The Texas Medical Association urges DSHS to distribute printed material to patients that accurately reflect current medical consensus of the potential health effects of abortion, updating the potential complications and risks of abortion so they are described in such a way that women understand the overall safety of the procedure. TMA supports the autonomy and dignity of the patient by respecting the patient’s right to decide what information she does and does not receive. TMA advocates for the Texas Legislature to relieve the penalties of refusal to admit to license exam or refusal of license issue or renewal if physicians are noncompliant with any state legislation that violates the physician’s duty to act in the best interests of his or her patients (Amended Res. 306-A-12; amended CSPH Rep. 3-A-17).

60.008 Rejection of Discrimination: The Texas Medical Association 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)

260.078 Mandated Patient Information: The Texas Medical Association opposes state mandates
dictating specific patient-physician communication without endorsement of the appropriate professional

265.018 Evidence-Based Medicine: The Texas Medical Association supports the use of science and
well-designed, well-conducted clinical research as a foundation for good medical practice to improve the
quality of patient care. Guidelines and protocols for medical care based on thorough reviews of current
medical research can improve the consistency, timeliness, and efficiency of clinical care. National and
international medical organizations as well as nursing and allied health continue to develop evidence-
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about the appropriate uses of evidence-based medicine and the dangers of cost-based medicine practices;
and (2) through the Council on Legislation, work with other medical associations to develop model state
legislation to protect the patient-physician relationship from cost-based medicine policies inappropriately

Related AMA Policy:
H-65.964. Access to Basic Human Services for Transgender Individuals: Our AMA: (1) opposes
policies preventing transgender individuals from accessing basic human services and public facilities in
line with one’s gender identity, including, but not limited to, the use of restrooms; and (2) will advocate
for the creation of policies that promote social equality and safe access to basic human services and public
facilities for transgender individuals according to one’s gender identity.

H-160.991 Health Care Needs of Lesbian, Gay, Bisexual, Transgender and Queer Populations:
1. Our AMA: (a) believes that the physician’s nonjudgmental recognition of patients’ sexual orientations,
sexual behaviors, and gender identities enhances the ability to render optimal patient care in health as well
as in illness. In the case of lesbian, gay, bisexual, transgender, queer/questioning, and other (LGBTQ)
patients, this recognition is especially important to address the specific health care needs of people who
are or may be LGBTQ; (b) is committed to taking a leadership role in: (i) educating physicians on the current state of research in and knowledge of LGBTQ Health and the need to elicit relevant gender and sexuality information from our patients; these efforts should start in medical school, but must also be a part of continuing medical education; (ii) educating physicians to recognize the physical and psychological needs of LGBTQ patients; (iii) encouraging the development of educational programs in LGBTQ Health; (iv) encouraging physicians to seek out local or national experts in the health care needs of LGBTQ people so that all physicians will achieve a better understanding of the medical needs of these populations; and (v) working with LGBTQ communities to offer physicians the opportunity to better understand the medical needs of LGBTQ patients; and (c) opposes, the use of “reparative” or “conversion” therapy for sexual orientation or gender identity.

2. Our AMA will collaborate with our partner organizations to educate physicians regarding: (i) the need for sexual and gender minority individuals to undergo regular cancer and sexually transmitted infection screenings based on anatomy due to their comparable or elevated risk for these conditions; and (ii) the need for comprehensive screening for sexually transmitted diseases in men who have sex with men; (iii) appropriate safe sex techniques to avoid the risk for sexually transmitted diseases; and (iv) that individuals who identify as a sexual and/or gender minority (lesbian, gay, bisexual, transgender, queer/questioning individuals) experience intimate partner violence, and how sexual and gender minorities present with intimate partner violence differs from their cisgender, heterosexual peers and may have unique complicating factors.

3. Our AMA will continue to work alongside our partner organizations, including GLMA, to increase physician competency on LGBTQ health issues.

4. Our AMA will continue to explore opportunities to collaborate with other organizations, focusing on issues of mutual concern in order to provide the most comprehensive and up-to-date education and information to enable the provision of high quality and culturally competent care to LGBTQ people.

Sources:
1. Texas Department of State Health Services, Table 33 Induced Terminations of Pregnancy by Type of Procedure, Texas Residents. [www.dshs.texas.gov/chs/vstat/vs15/t33.aspx](http://www.dshs.texas.gov/chs/vstat/vs15/t33.aspx); accessed Oct. 3, 2018.
Subject: Raising the Minimum Purchase Age for Guns, Resolution 313-A-18

Presented by: Alice Gong, MD, Chair

Referred to: Reference Committee on Science and Public Health

Background

The 2018 House of Delegates considered Resolution 313 submitted by the Texas Pediatric Society that called for TMA to support federal and state legislation to raise the age for the purchase of all firearms to 21 years. Testimony at the reference committee hearing was overwhelmingly in favor of the resolution, and the reference committee recommended adoption. However, there was extended discussion at the House of Delegates with members speaking in support of the resolution while others called for referral. Issues raised ranged from the association between mental illness and firearm violence, brain development and the decisionmaking capacity of adolescents, and a lack of information on the evidence that raising the age of purchase would reduce gun violence.

The House of Delegates supported the referral of the resolution, and the Board of Trustees referred Resolution 313 to the Council on Science and Public Health and the Council on Legislation. As part of the councils’ review of Resolution 313, TMA President Doug Curran, MD, appointed a TMA Workgroup on Firearms and selected 13 physician experts to review, discuss, and advise both councils with recommendations for consideration. At Dr. Curran’s request, TMA Board of Trustees member Gary Floyd, MD, chaired this workgroup. Additionally, the workgroup evaluated gaps in TMA firearm policy to offer a set of additional principles for considerations by both councils for a report back at 2019 TMA Winter Conference.

John Carlo, MD, member of the American Medical Association Council on Science and Public Health and of the TMA Council on Legislation, brought to the discussion the newly adopted 2018 AMA report, “The Physician’s Role in Firearm Safety.” The AMA council report focused on the presupposition that 38,000 U.S. deaths in 2016 from firearms is unacceptable and that firearm violence is a public health threat. Racial and ethnic disparities make nonwhites 2.5 times more likely to die from firearms than whites. The report called on the need for more scientifically based research for effective measures to address the public health issues of firearm violence.

Federal and State Laws on Firearm Purchase and Possession

Resolution 313 noted that gun violence is a threat to the health and safety of children, who are at high risk of firearm suicide, homicide, and unintentional injury, and that raising the age of purchase for long guns would align with federal and state law and would reduce child exposure to gun violence.

Federal law regulates firearm interstate commerce including purchase and possession. The 1968 federal Gun Control Act limits the purchase of firearms for certain people such as those who are convicted of a felony or domestic violence, subject to a restraining order or involuntary commitment, or declared mentally incompetent; however, federal law applies only to federally licensed firearm dealers. Federal law also sets the age of 18 years as the minimum legal age for possessing a handgun. While handguns can be purchased at the age of 21, the legal age for purchase of a rifle or a shotgun (long gun) is 18 years. There are no age prohibitions for the possession of long guns, but federal law prohibits an unlicensed private owner or firearm dealer from selling or transferring a handgun to anyone under the age of 18.
Texas does not require a permit to purchase a handgun or a rifle or shotgun, nor is registration or licensure required to possess these firearms. A permit is required to carry a handgun (open or concealed), and Texas’ safe storage law makes it unlawful to have an unsecured firearm where a child is likely to be or where the child can obtain access. A recent national survey found that more than a third (35.7 percent) of Texas adults own a firearm.

Firearm Violence and Children
Firearms are second only to motor vehicle accidents as a cause of death among minors in the United States, and about 19 children are injured or die each day because of a firearm. More than half of the 1,300 child firearm deaths each year (2012-14) are a homicide, almost 40 percent are suicides, and about 6 percent are unintentional deaths. Older children aged 13 to 17 years are more than 12 times likely to die from a firearm than are younger children. The rate of firearm suicide is about 11 times higher for those 13 to 17 years than for 10- to 12-year-olds (suicide tracking starts at age 10). The highest rates of firearm mortality are among African-American children while annual firearm suicide rates are highest in American Indian children. More than 90 percent of child firearm deaths (in children aged 0 to 14 years) in high-income countries occur in the United States.

In 2015, 609 Texas children were injured or died because of a firearm. This includes 233 deaths from suicide, assault or homicide, or accidental firearm discharge or with an undetermined intent. More than half of these child deaths were homicides, and most deaths were in children aged 15 to 19 years.

<table>
<thead>
<tr>
<th>Texas Child Firearm-Related Deaths, Age 1 to 19 years, 2015</th>
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<tr>
<td>Firearm related deaths</td>
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<tr>
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</tr>
<tr>
<td>Self-harm/suicide</td>
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<tr>
<td>Assault/homicide</td>
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<tr>
<td>Discharge of firearm, undetermined intent</td>
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<td>Accidental discharge</td>
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Source: DSHS

In a 2015 study that assessed data from 16 states participating in the Centers for Disease Control and Prevention’s (CDC’s) National Violent Death Reporting System (2005 to 2012), the authors estimate that more than 100 children aged 0 to 14 years die each year from an unintentional discharge of a firearm. For those children under the age of 10 years, almost 40 percent died from a self-inflicted discharge, while in most other cases a family member was the shooter. Hunting was a factor in some cases, but most unintentional firearm deaths took place in the child’s home or in the home of a friend. Of the children aged 11 to 14 years, 39 percent were killed in the home of a friend. And while some surveys indicate parents believe their children do not know how to access the firearms in the home, it appears that a lack of supervision for older children may be a factor in unintentional fatalities.
Age Restrictions in Texas

One of the issues raised during the House of Delegates’ discussion on raising the age for the purchase of firearms was on understanding the rationale for a specific age. A comprehensive study could not be found that described or explained the relevance of age for some federal and state laws. Both the federal and state governments have designated a minimum age for a range of activities of importance to government and as allowed under their constitutional powers. Setting an age in a statute establishes a minimum age when a person becomes legally responsible for a right or activity regulated by the government. Almost all states including Texas have designated 18 years as the age of majority. A minor in Texas is a person under the age of 18 years who has not been married and not sought emancipation. But there are many well-recognized laws in Texas with varying age limits. These either directly or generally address health and/or personal or public safety:

- Minors are directly prohibited from buying tobacco products, and it is illegal to sell tobacco products to a person under the age of 18, including e-cigarettes. A minor in violation of state law can be fined, and both the minor and his or her parents may be required to participate in community service or attend a tobacco awareness program. The City of San Antonio recently raised the age for legal purchase of tobacco to 21 years.
- Minors cannot consent to their own health care, but they have limited ability to consent for care in certain circumstances such as for a pregnancy, for treatment of a reportable infectious disease, or if seeking diagnosis or treatment for a mental health condition. Minor parents can consent to the health care of their child.
- Texas’ Alcoholic Beverage Code identifies a minor as someone who is under the age of 21 years. A person under the age of 21 is prohibited from buying, attempting to buy, or consuming alcohol, although a person aged 18 or older can serve alcohol. All state liquor age laws align with the federal minimum age as it appears that only states that observe the minimum age of 21 years can qualify for federal transportation funding.
- A minor can obtain a driver’s license at the age of 16 with graduated driving restrictions until the age of 18.
- A person under the age of 18 can be employed with the minimum age of work set at 14 years, although there are exceptions for even younger ages for certain types of work (e.g., working for a parent, agriculture). Employed minors aged 14 to 15 years are limited in the number of hours and the time of day they can work, and minors may not perform work hazardous to their safety or health.
- Minors cannot marry nor can they enlist in the United States military without the consent of a parent.
- A minor cannot get a tattoo.

Finally, 18-year-olds can vote and hold almost any local public office (e.g., sheriff, constable, county commissioner, justice of the peace, tax assessor). They cannot be elected to serve as a U.S. senator or a member of Congress until the age of 25, although a Texas state senator must be at least 26 years and a Texas state representative must be at least 21 years of age.

While several states have adopted the age of 21 for the purchase of all firearms, the majority of states including Texas, have not done so.

Child Decisionmaking

TMA members offered testimony that some of those who are 18 years old still lack the executive function abilities needed to make reasoned, adult decisions such as the purchase of a firearm. There is a growing body of research on child brain development including the development of executive function.

Executive function of the brain refers to the brain’s organization of information from different parts of the brain needed for decisionmaking. The genes in our brains are continually expressed in the development of
millions of neural connections in different areas of the brain. Brain development starts while we are still in utero, and early neural development supports key sensory abilities such as vision and hearing, which allow an infant to build other abilities. The frontal lobe is where the integration of information occurs for executive function; the last stages of pruning or myelination in the brain occur in the frontal lobe, where these rapid developments will continue well into the mid- to late 20s for most.

By the time children are teenagers, many already have physically developed so that they appear to be an adult. But parents and educators may note that some – at the age of 18 or older – are not yet making informed adult decisions and often are receptive to activities that raise the risk of harm to themselves or others. Brain development and executive function capacity do not follow a regular schedule or pattern. There is evidence that adolescent and teenage brain development may be harmed or less developed based on a child’s experiences. For some, adverse experiences can hamper a child’s ability to access or process critical information from some parts of the brain. Unable to rapidly process memory or other information on a potentially harmful activity, a teenager may defer to his or her immediate emotional response. Poor decisionmaking can be exacerbated when a teen is regularly exposed to stress from school and peer pressure, financial concerns, family adversity, or even a lack of sleep or hormonal developments. Thus, while a teenager may be able to drive a car or understand the details of every new technology product, the brain of every 18-year-old is still in a process of maturation that will continue for several years. And while this process varies for every child, growing up in a stable, safe environment appears to contribute to improved ability to prioritize information and to manage emotions. This is particularly important for early brain development when daily, ongoing “serve and return” or back-and-forth interaction with parents and other adult caregivers supports neural development that connects different parts of a child’s brain.

Discussion and Conclusion

The United States and most states have an inconsistent method for determining the age at which a person can be held responsible for an activity that can have an impact on personal or public health, such as firearm purchase. In most cases, decisions on age-related public policy appear to be based on tradition rather than on evidence of an ability to manage a regulated activity.

In a November 2018 CDC, the nation’s public health agency identified firearm-related deaths as a public health concern and a leading cause of death in the United States. Firearm mortality is the second most common cause of death among U.S. children. Firearm homicide, suicide, and unintentional discharge are the major factors in both child injury and fatality. From 1994 to 2014, there were more than 180 million applications through the federal system for permits to purchase a firearm or to transfer firearms. The United States has a robust process for managing the sale of firearms by licensed vendors, but unlicensed firearm vendors can legally sell firearms at hundreds of gun show events held each year in Texas alone. Family members also can legally transfer firearms to other family members.

CDC has developed a framework for addressing child maltreatment and nurturing children that calls for bringing together those with shared interests in developing and supporting environments where children can grow healthy and be productive. This includes children being continually in an environment where they are secure and free of harm. As reported by the American Academy of Pediatrics, many parents believe their children will not touch a firearm or do not know where firearms are kept or can be accessed in the home. Most parents with firearms will talk to their children about firearm safety, but in homes where children are not taught, there is an increased risk, especially with children who are prone to make an impulsive decision. And the public health data tell us that children who are with untrained or otherwise careless adults or a friend that has access to a firearm are most likely to be injured or killed in an unintentional discharge.

There is extensive study on the development and role of executive function in teenagers, but it is not yet determined if brain imaging studies fully explain how we make decisions, particularly as we all are
continually exposed to different environments and experiences that can affect behavior and on the
decisions an adult makes on a daily basis. Neuroscience and behavioral science are helping us better
understand child maturation and development, but it does not appear the research is being applied for
public policy development such as setting an age for the purchase of a firearm or other regulated
activities. However, the rates of child injury and death from firearms indicate a need to reinforce and
promote awareness of evidence-based harm reduction strategies for reducing firearm morbidity and
mortality. Therefore, in recognition of the physician role in promoting evidence-based prevention, the
council makes the following recommendations:


Recommendation 2: Adopt language from AMA policy H-145.990 as new TMA policy as follows:

Parental Education on Prevention of Firearm Accidents in Children: Texas Medical Association
supports physician efforts to reduce pediatric firearm morbidity and mortality by encouraging its
members to: (1) inquire as to the presence of household firearms as a routine part of childproofing the
home; and (2) share information materials to educate parents on the dangers of firearms to children; (3)
encourage patients to educate their children and neighbors as to the dangers of child access to firearms;
and (4) routinely remind patients to obtain firearm safety locks, store firearms under lock and key, and
store ammunition separately from firearms.

Recommendation 3: Reaffirm TMA Policy 245.021, Patient-Doctor Privileged Communication:

245.021 Patient-Doctor Privileged Communication: The Texas Medical Association (1)
opposes efforts by the Texas Legislature to insert itself into the patient-physician
relationship in any way that interferes with the free and full disclosure of health care
information in the best interests of the patient, and (2) reaffirms its support of the free
exchange of professional information in the patient-physician relationship as privileged
and worthy of the highest professional protection (Amended Res. 108-A-13).

Related TMA policy:

260.015 Firearms: The Texas Medical Association supports: 1. The primary prevention of firearm
morbidity and mortality through educating Texans about firearm safety and the potential hazards of
firearm ownership; 2. The Texas Hunter Education and certification program developed by the Texas
Department of Parks and Wildlife; 3. Physicians in the clinical setting providing anticipatory guidance on
the dangers of firearm ownership in an informational, nonjudgmental manner; 4. Strict enforcement of
federal and state gun control laws and mandated penalties for crimes committed with a firearm, including
illegal possession; 5. The use of trigger locks (such as can be provided by www.projectchildsafe.org) and
locked gun cabinets to help prevent unintentional discharge; and 6. Unfettered study of issues involving
firearms and public health and safety (Res. 28S, p 176, A-93; Substitute CPH Rep. 3-A-08; amended

55.033 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 throughout the state,

i. Coordinating with the educational system for mentally healthy schools, and


Related AMA policy: (Partial)

H-145.990 Prevention of Firearm Accidents in Children: Our AMA (1) supports increasing efforts to reduce pediatric firearm morbidity and mortality by encouraging its members to (a) inquire as to the presence of household firearms as a part of childproofing the home; (b) educate patients to the dangers of firearms to children; (c) encourage patients to educate their children and neighbors as to the dangers of firearms; and (d) routinely remind patients to obtain firearm safety locks, to store firearms under lock and key, and to store ammunition separately from firearms; (2) encourages state medical societies to work
with other organizations to increase public education about firearm safety; (3) encourages organized medical staffs and other physician organizations, including state and local medical societies, to recommend programs for teaching firearm safety to children; and (4) supports enactment of Child Access Prevention laws that are consistent with AMA policy.

H-145.975 Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care

1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.

2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.

3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.

H-145.997 Firearms as a Public Health Problem in the United States – Injuries and Death:

Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths. Therefore, the AMA:

1. encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;
2. urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;
3. urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;
4. urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;
5. encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;
6. urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and
7. strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.

H-145.972 Firearms and High-Risk Individuals:

Our AMA supports: (1) the establishment of laws allowing family members, intimate partners, household members, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence; (2) prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor
domestic violence crimes or stalking, from possessing or purchasing firearms; (3) expanding domestic violence restraining orders to include dating partners; (4) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons; (5) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and (6) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals.

**H-145.976 Firearm Safety Counseling in Physician-Led Health Care Teams:** 1. Our AMA: (a) will oppose any restrictions on physicians’ and other members of the physician-led health care team’s ability to inquire and talk about firearm safety issues and risks with their patients; (b) will oppose any law restricting physicians' and other members of the physician-led health care team's discussions with patients and their families about firearms as an intrusion into medical privacy; and (c) encourages dissemination of educational materials related to firearm safety to be used in undergraduate medical education. 2. Our AMA will work with appropriate stakeholders to develop state-specific guidance for physicians on how to counsel patients to reduce their risk for firearm-related injury or death, including guidance on when and how to ask sensitive questions about firearm ownership, access, and use, and clarification on the circumstances under which physicians are permitted or may be required to disclose the content of such conversations to family members, law enforcement, or other third parties.

**H-145.984 Data on Firearm Deaths and Injuries:** The AMA supports legislation or regulatory action that: (1) requires questions in the National Health Interview Survey about firearm related injury as was done prior to 1972; (2) mandates that the Centers for Disease Control and Prevention develop a national firearm fatality reporting system; and (3) expands activities to begin tracking by the National Electronic Injury Surveillance System.

**Sources:**

The Task Force on Behavioral Health began its study on the relationship between childhood adversity, disease, and illness to address its charge from the Council on Science and Public Health to promote prevention and develop resources for physicians on behavioral health.

Significant recent advances in neuroscience and genomics have enhanced our understanding of the relationship between childhood adversity and health. Traumatic experiences in early childhood such as abuse, household dysfunction, or neglect can alter brain architecture and the functioning of the neurobiological systems that coordinate a person’s response to stress. For example, experiencing abuse in childhood has been associated with low baseline cortisol and increased stress-induced cortisol response. Smaller hippocampal volume has been observed among adults with a history of childhood abuse and with depression. In turn, adverse childhood experiences (ACEs) can predispose children to problems with development, behavior, and health throughout the lifespan. ACEs also have been linked to negative social and economic outcomes, including low educational attainment, financial stress, and incarceration. A parent’s experience of childhood adversity also can be associated with negative social, emotional, and physical health outcomes in their children, indicating there can be intergenerational transmission of ACEs.

Effect of ACEs on Health and Well-Being

The first major research on the health impact of childhood adversity occurred among Kaiser Permanente health system beneficiaries in southern California. In an effort to explain high dropout rates among patients in an obesity clinic who successfully lost weight, Vincent Felitti, MD, and Robert F. Anda, MD, surveyed more than 17,000 Kaiser Permanente patients on their general health and exposure to childhood abuse and household dysfunction. The results showed a strong, graded relationship between the number and intensity of adverse childhood experiences and the presence of health risk behaviors and chronic disease. Commonly known as the “ACE study,” Felitti and Anda’s work initiated further research on childhood adversity and health outcomes. The Centers for Disease Control and Prevention (CDC) continues to monitor the health of the original 17,000-plus ACE study participants. CDC’s longitudinal ACE surveys of the 17,000-plus participants (waves 1 and 2) identified physical abuse and household substance use as the most prevalent ACEs.
Measuring ACEs

While definitions vary in the literature, CDC and others generally recognize three categories of ACEs:

1. **Abuse.** Verbal, emotional, physical, or sexual abuse by or of a household member or other adult
2. **Household dysfunction.** Substance abuse, mental illness, or suicidality in the household; parental divorce or separation; a household member who is incarcerated; or physical violence in the family
3. **Neglect.** Physical or emotional neglect of a child

In research and clinical practice, a person’s ACE exposure typically is assessed via a questionnaire. The ACEs a person reports often are summed into an overall ACE “score,” with higher ACE scores reflecting more severe ACE exposure and risk. Studies have repeatedly shown a strong dose-response relationship between ACE scores and likelihood of subsequent negative health outcomes, including depression, anxiety, alcohol misuse, smoking, lung disease, heart disease, liver disease, and miscarriage. While the risk for health problems increases as ACEs accumulate, the research is clear that even one ACE is sufficient to predispose some people to poor health outcomes.

Several state and national public health surveillance systems measure ACEs in the general population, the most statistically powerful of which is CDC’s Behavioral Risk Factor Surveillance System (BRFSS). Each year, BRFSS is administered to adults aged 18 and over in all 50 states. In Texas, BRFSS is managed by the Texas Department of State Health Services (DSHS) and is the state’s largest ongoing population-based health survey, with a sample size of approximately 11,000 Texas adults per year. BRFSS collects standardized data on health risk factors and chronic conditions, and states may choose to collect optional data on health topics of interest, including ACEs. In 2015, DSHS included BRFSS’ optional ACE questionnaire and is scheduled to include the ACE questionnaire again in 2019.

Prevalence of ACEs in Texas

The 2015 Texas BRFSS measured the statewide prevalence of 11 different ACEs among Texas adults. Given the large and representative annual sample of Texas BRFSS, prevalence estimates are backed by considerable statistical power and can be presumed to represent the state population at large.

The most common ACE in Texas is parental separation or divorce, affecting 27 percent of Texas adults. Nearly one quarter of Texas adults were exposed to repeated verbal or emotional abuse by a parent or another adult in the household, and 20 percent lived with someone who was a problem drinker or an alcoholic. Roughly one in six Texas adults experienced physical abuse or family violence. Between 4 and 9 percent of Texans experienced various forms of sexual abuse.

Texas BRFSS did not report ACE scores, or an average cumulative number of ACEs per person. However, a large, multistate study of responses to BRFSS’ 2010 ACEs questionnaire – using identical questions to those asked in Texas in 2015 – found more than a third (36 percent) of adults in the sample experienced two or more ACEs.

More recent data indicates that childhood adversity and traumatic experiences remain prevalent among Texas youth today. According to the 2016-17 National Survey of Children’s Health (NSCH), approximately 20 percent of Texas children aged 0 to 17 years have experienced at least two ACEs. In 2017, the Texas Department of Family and Protective Services (TDFPS) confirmed 71,308 cases of child abuse statewide and removed 19,864 children from their homes, a 16-percent increase in removals since 2015. Neglectful supervision (which includes substance use in the home), physical abuse, and sexual abuse accounted for the majority of confirmed abuse reports. TDFPS’ Healthy Outcomes through Prevention and Early Support (HOPES) program provides support to caregivers in families identified as at risk for child maltreatment. In a 2018 evaluation of HOPES, 32 percent of caregivers surveyed had four or more ACEs.
**Texans aged 18-plus who experienced the following events before age 18**

<table>
<thead>
<tr>
<th>Adverse Childhood Experience</th>
<th>Prevalence</th>
</tr>
</thead>
<tbody>
<tr>
<td>Parents were separated or divorced</td>
<td>27.40%</td>
</tr>
<tr>
<td>Parent or adult in home swore at, insulted, or put you down more than once</td>
<td>23.50%</td>
</tr>
<tr>
<td>Lived with anyone who was a problem drinker or alcoholic</td>
<td>20.20%</td>
</tr>
<tr>
<td>Parent or adult in home ever hit, kick, or physically hurt you, not including spankings</td>
<td>17.50%</td>
</tr>
<tr>
<td>Parents or adults in home ever slapped, hit, kicked, punched, or beat each other up</td>
<td>16.50%</td>
</tr>
<tr>
<td>Lived with anyone who was depressed, mentally ill, or suicidal</td>
<td>13.90%</td>
</tr>
<tr>
<td>Lived with anyone who used illegal street drugs or abused prescription medications</td>
<td>9.20%</td>
</tr>
<tr>
<td>Anyone at least 5 years older or an adult touched you sexually</td>
<td>8.50%</td>
</tr>
<tr>
<td>Anyone at least 5 years older or an adult tried to make you touch them sexually</td>
<td>7.10%</td>
</tr>
<tr>
<td>Lived with anyone who served time or was sentenced to serve time in a prison, jail, or other correctional facility</td>
<td>6.90%</td>
</tr>
<tr>
<td>Anyone at least 5 years older than you or an adult forced you to have sex</td>
<td>3.80%</td>
</tr>
</tbody>
</table>

*Source: Texas Behavioral Risk Factor Surveillance System, 2015. Adverse Childhood Experiences. Texas Department of State Health Services, Center for Health Statistics.*

Validation studies have confirmed BRFSS and NSCH ACE questionnaires as empirically sound measures of ACEs in a population, though some limitations must be considered. Data are based on self-report of sensitive events that some respondents may not wish to disclose or may not disclose accurately due to recall bias. ACE scoring is subject to limitations; it treats all trauma types as equally severe and does not convey trauma duration, frequency, or intensity.

**Statewide Efforts on ACEs and Trauma-Informed Care in Texas**

Physicians and health care providers may have seen an increase in references to adverse childhood experiences and trauma-informed care models in health and human services systems in Texas. Some state agency programs directed by the Texas Legislature, along with nonprofit organizations, have taken steps to identify adverse childhood experiences and provide treatment because of their influence on health and wellness. Texas public agencies and private organizations have implemented a range of activities to improve and ensure supportive care for children.

**Health Care System Efforts.** The Texas Health and Human Services Commission (HHSC) promotes awareness and offers training to physicians and other health care professionals through the module Addressing Adverse Childhood Experiences through Trauma-Informed Care. The module aims to
promote ACE recognition, awareness of health effects of trauma and toxic stress, and culturally sensitive 
trauma-informed care. HHSC’s community mental health services for children incorporate an evaluation 
of the child and family’s trauma history using the Child and Adolescent Needs and Strengths (CANS) 
assessment.

With support from Episcopal Health Foundation and St. David’s Foundation, TDFPS, DSHS, and The 
University of Texas System Population Health recently convened a pediatric brain health summit to 
explore how current science on brain development in children from birth to age 3 can promote resilience 
to adverse childhood experiences. In greater Austin, the Trauma-Informed Care Consortium of Central 
Texas regularly brings together local health care and professional organizations and agencies to address 
community-specific needs. The St. David’s Foundation and Texas Pediatric Society have established a 
learning collaborative serving central Texas physicians interested in tools and practices that address social 
determinants of health, ACEs, and childhood trauma.

**Child Welfare, Juvenile Justice, and Education System Efforts.** Like HHSC, TDFPS also uses CANS 
to screen for trauma among all children placed in the state’s conservatorship as required by state law. 
TDFPS manages community-based programs, such as the evidence-based Nurse Family Partnership, to 
prevent juvenile delinquency and child abuse and neglect among at-risk pregnant women and caregivers 
of children from birth to age 5. TDFPS also requires staff, contractors, caregivers, and foster and adoptive 
parents to be trained on trauma-informed care and child traumatic stress.

TDFPS and DSHS are jointly reviewing data associated with maternal and child health and prevention 
and early intervention programs to assess statewide needs and develop effective plans to use federal funds 
allocated to Texas in the future. As now required by law, TDFPS, the Texas Juvenile Justice Department, 
the Texas Education Agency, and the Texas Military Department are coordinating services and progress 
reporting, and have identified a shared goal of ACE prevention. TDFPS also participates in the Texas 
Supreme Court’s Children’s Commission, an interagency, multidisciplinary group addressing trauma- 
informed care for children and families involved in the child welfare, mental health, and juvenile justice 
programs of the state.

**Discussion**

The council and the Task Force on Behavioral Health are working to promote awareness of ACEs and 
health. This includes a CME presentation at 2017 TMA Fall Conference, several CME offerings on ACEs 
in other settings, an article in *Texas Medicine*, and other TMA communications. Locally, physicians 
across Texas have come together to study and implement screening and support services for children and 
adults affected by adverse experiences. We recognize that evidence-based primary and secondary 
prevention activities can have an impact on child development. These activities include:

- **Primary Prevention.** Accurate identification of children and adults at risk of childhood 
adversity is the first step in providing intervention. Standardized tools that identify risk 
factors are available, and their use is funded by medical insurance. Patients may benefit from 
education on the purpose of ACE screening and the relationship between ACEs and their 
health.

- **Secondary Prevention.** Given the limited number of evidence-based interventions, primary 
care screeners need access to information on resources and strong referral networks for 
interventions and supports available in their communities. Early childhood intervention 
programs, community child and adolescent mental health services, and medicolegal 
partnerships to address social determinants all have a role in treatment but may not be 
known, available, or easily accessed by primary care physicians.
Texas data and assessment are critical for physicians to work with others to identify and implement initiatives for the prevention and treatment of ACEs in Texas. Such efforts should include consideration of the following strategies:

- Advocating for the use in primary care (including obstetrics) of routine screening for ACEs as part of the medical history, and especially advocacy for pediatricians screening parents;
- Improving education of physicians on the resources available for referral when risks are discovered;
- Advocating for education of people with a history of trauma, parents, child care providers, teachers, policymakers, civic leaders, and the general public about the long-term consequences of adverse childhood experiences, including physical, sexual, and verbal abuse; physical and emotional neglect; and family dysfunction. Tailored messaging to these populations should emphasize the widespread nature of ACEs, promote resilience, and convey availability of resources and supports; and
- Advocating at the national and state levels for adequate payment for the time needed for universal screening and for proportionate funding of evidence-based prevention through parenting classes, sexual abuse prevention training for teachers, respite care, home visits to new parents, and community capacity building.

Conclusion and Recommendations

Significant efforts to address ACEs are underway at both the state and local levels in Texas, but physicians must be more widely informed in order to support initiatives to prevent and respond to ACEs. Some types of early childhood trauma are not captured in the CDC’s definition of ACEs, such as fleeing war and armed conflict, surviving a natural disaster, or witnessing community violence. In Texas, these exclusions likely are not trivial given the state’s sizeable immigrant and refugee populations; our history of major natural disasters such as hurricanes Katrina, Rita, and Harvey; and non-negligible rates of violent crime. And while some degree of childhood adversity may be inevitable, promoting resilience and mitigating the severe effects of toxic stress are other important components of a public health approach. Strategies might include community collaborations to strengthen family social supports; encouraging positive parenting; and facilitating optimal childhood social, emotional, and academic development.

TMA will continue to promote the role of primary care physicians in screening and caring for patients exposed to ACEs, but TMA also can recognize early childhood adversity as a public health issue that must be widely recognized in order to improve the health and well-being of many of our individual patients. Because of the profound effects ACEs have on the health of children and adults, TMA must commit to leadership in addressing ACEs. Therefore, the council and the Task Force on Behavioral Health make the following recommendations:

**Recommendation 1:** Identify adverse childhood experiences (ACEs) as a public health issue and advance TMA activities to increase awareness and understanding of ACEs among TMA members and the public, and ensure physicians have information on resources for screening patients, payment for care, and local resources and services for their patients.

**Recommendation 2:** That TMA convene a summit with physicians and other health professionals, community leaders, and representatives of public health and high risk populations to identify priorities for addressing ACEs. This includes identifying barriers physicians face in screening and caring for children and adults, gaps in services and resources in public programs and communities, evidence-based programming, access to data for assessment, and understanding the unique needs of specific populations.

**Recommendation 3:** That TMA advocate for public health initiatives and activities that provide effective support and care for children and adults exposed to trauma.
Sources
Subject: Sunset Policy Review

Presented by: Alice Gong, MD, Chair

Referred to: Reference Committee on Science and Public Health

The Texas Medical Association periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness. Following are policies reviewed by the Council on Science and Public Health with recommendations for retention, amendment, and deletion.

The following policies are recommended for retention:

260.019 Protective Headgear for Equestrian Sports: The Texas Medical Association believes that educational programs should be given to parents, riding instructors, show organizers, and managers emphasizing the risks in horseback riding and methods to minimize them. A satisfactory, protective hat must be developed for each type of riding activity and worn when riding or preparing to ride. All riding schools, horse shows, rodeos, and other events at which young persons participate with horses should require that a protective hat be worn during the activity (Council on Public Health, p 98, A-93; reaffirmed CPH Rep. 2-A-09).


Recommendation 1: Retain.

Council review of the following policies revealed these are no longer relevant and are being recommended for deletion:

95.031 Controlled Substance Registrations: The Texas Medical Association will seek relief in the form of legislation or rule making that would allow for three-year renewal terms for Texas Department of Public Safety (DPS) controlled substance registrations (Amended Res. 204-A-09).

95.032 Minimum Pharmacy Disaster Standards: The Texas Medical Association will urge state and local officials to develop a plan to ensure a sufficient supply of medications that are critical to the population in times of disaster (Amended Res. 207-A-09).

100.017 Emergency Preparedness Re Chemical and Bio-Terrorism, Physician Education: Physician members should acknowledge the need for emergency preparedness to include chemical and biologic terrorism tactics. The Texas Medical Association will work with the Texas Department of State Health Services and others to make physicians aware of bio-terrorist possibilities and provide education and information to those likely to provide front-
line treatment during a crisis situation (i.e., emergency medicine, internal medicine, pediatrics, family practice); explore the establishment of an informal network of experts willing to participate in emergency response studies; and work with the Texas Department of State Health Services to provide for coordination in the event of a bio-chemical attack in Texas (CM-ID Rep. 1-A-99; reaffirmed CPH Rep. 2-A-09).

260.051 **Helmet Requirement for Motorcycle Riders:** All who operate a motorcycle should be required to wear an approved helmet whenever they operate a motorcycle (Amended Committee on Rehabilitation, p 118, A-98; amended CPH Rep. 2-A-09).

260.041 **Ephedrine:** The Texas Medical Association, recognizing that many health care professionals may not be aware of the widespread availability and use of ephedrine and large number of adverse reactions which occur, supports including information on this drug in its communications on a regular basis (Amended Council on Public Health, p 150, A-96; reaffirmed by CPH Rep. 4-I-98; reaffirmed CPH Rep. 2-A-09).

260.059 **Texas Poison Center Network:** The Texas Medical Association supports the Texas Poison Center Network (TPCN) and encourages TPCN to seek system certification by the American Association of Poison Control Centers to assure that Texas physicians and the general public have access to comprehensive resources and information on emergency treatment, poison prevention, and other potential exposures (Amended Res. 303-A-99; amended CM-ID Rep. 1-A-09).

260.082 **Reducing the Health Burden of Air Pollution in Texas:** The Texas Medical Association will urge our local, state, and federal government leaders and legislators to act promptly and aggressively to reduce the health burden of pollution from vehicular, diesel, National Ambient Air Quality Standards criteria pollutants, and air toxics emissions (Amended Res. 205-A-09).

**Recommendation 2:** Delete.

Upon review of the following policies, council consensus was to update the language to read as follows:

95.023 **Direct-to-Consumer (DTC) Advertising of Prescription Drugs and Implantable Devices:**

The Texas Medical Association advocates that direct-to-consumer (DTC) prescription drug and medical device advertisements should contain the disclaimer, “Your physician may recommend other appropriate treatments.” TMA strongly supports AMA Policy H-105.988, which clearly disapproves of misleading advertising for prescription drugs to the general public and supports research into the effects of DTC marketing, including physician and patient behavior and the impact of DTC ads on the cost of medical services. TMA further opposes product-specific DTC advertisements and supports a ban on DTC advertising for prescription drugs and implantable medical devices, and until such a ban is in place, opposes product-claim DTC advertising that does not comply with the following AMA guidelines:

(a) The advertisement should be indication-specific and enhance consumer education about the drug or implantable medical device and the disease, disorder, or condition for which the drug or device is used.

(b) In addition to creating awareness about a drug or implantable medical device for the treatment or prevention of a disease, disorder, or condition, the advertisement should
convey a clear, accurate, and responsible health education message by providing objective information about the benefits and risks of the drug or implantable medical device for a given indication. Information about benefits should reflect the true efficacy of the drug or implantable medical device as determined by clinical trials that resulted in the drug’s or device’s approval for marketing.

(c) The advertisement should clearly indicate that the product is a prescription drug or implantable medical device to distinguish such advertising from other advertising for non-prescription products.

(d) The advertisement should not encourage self-diagnosis and self-treatment, but should refer patients to their physicians for more information. A statement, such as “Your physician may recommend other appropriate treatments,” is recommended.

(e) The advertisement should exhibit fair balance between benefit and risk information when discussing the use of the drug or implantable medical device product for the disease, disorder, or condition. The amount of time or space devoted to benefit and risk information, as well as its cognitive accessibility, should be comparable.

(f) The advertisement should present information about warnings, precautions, and potential adverse reactions associated with the drug or implantable medical device product in a manner (e.g., at a reading grade level) such that it will be understood by a majority of consumers, without distraction of content, and will help facilitate communication between physician and patient.

(g) The advertisement should not make comparative claims for the product versus other prescription drug or implantable medical device products; however, the advertisement should include information about the availability of alternative non-drug or non-operative management options, such as diet and lifestyle changes, where appropriate, for the disease, disorder, or condition.

(h) In general, product-specific DTC advertisements should not use an actor to portray a health care professional who promotes the drug or implantable medical device product, because this portrayal may be misleading and deceptive. If actors portray health care professionals in DTC advertisements, a disclaimer should be prominently displayed.

(i) The use of actual health care professionals, either practicing or retired, in DTC to endorse a specific drug or implantable medical device product is discouraged but, if utilized, the advertisement must include a clearly visible disclaimer that the health care professional is compensated for the endorsement.

(j) The advertisement should be targeted for placement in print, broadcast, or other electronic media so as to avoid audiences that are not age appropriate for the messages involved.

(k) In addition to the above, the advertisement must comply with all other applicable Food and Drug Administration (FDA) regulations, policies, and guidelines. (CSA Rep. 2-I-01; substituted CSA Rep. 3-A-09).

260.003 Poison Control Center Enhancements: The Texas Medical Association supports the continued operation of the state’s six regional poison control centers, and their membership in the American Association of Poison Control Centers, and supports ensuring sufficient funding so that the centers can be able to timely respond to calls by physicians and the public and collaborate with centers across the country (Res. 27BB, p 181-I, I-90; reaffirmed CM-EMS Rep. 2-I-00; amended CPH Rep. 3-A-10).

260.080 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 in order to determine if they are covering the true costs of these preventive services; and
(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 providing 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 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).

260.083 Promotion of Healthy Lifestyles – Reducing the Population Burden of Cardiovascular Disease by Reducing the Intake of Sodium-Intake, Saturated Fats, and Added Sugars: The Texas Medical Association supports the AMA’s efforts to:

(1) Call for a stepwise, minimum 50-percent reduction in sodium in processed foods, fast food products, and restaurant meals to be achieved over the next decade. Food manufacturers and restaurants should review their product lines and reduce sodium levels to the greatest extent possible (without increasing levels of other unhealthy ingredients). Gradual but steady reductions over several years may be the most effective way to minimize sodium levels.
(2) Urge the Food and Drug Administration (FDA) to revoke the "generally recognized as safe" (GRAS) status of salt, and to develop regulatory measures to limit sodium in processed and restaurant foods.
(3) Recommend that the FDA consider all options to promote reductions in the sodium content of processed foods.
TMA supports the AMA’s efforts to urge FDA regulation of sodium. TMA further supports recommendations of the Texas Public Health Coalition, including measures to label foods and post nutrition information.

To assist in achieving the Healthy People 2020 goals for sodium, saturated fat, and added sugar consumption, TMA will work with the FDA, the National Heart Lung Blood Institute, the Centers for Disease Control and Prevention, the American Heart Association, and other interested partners to educate consumers and members about the benefits of long-term, moderate reductions in the sodium intake of sodium, saturated fats, and added sugars. (4) Discuss with the FDA ways to improve labeling to assist consumers in understanding the amount of sodium contained in processed food products, and to develop labels and warnings for foods high in sodium. (5) Recommend that the FDA consider all options to promote reductions in the sodium content of processed foods.

TMA supports educating and motivating consumers to adopt more healthful lifestyles (1) through targeted public communication, (2) by encouraging consumers in appropriate risk groups to use professional preventive health care services that would permit the early detection and treatment or the prevention of illness, and (3) by physicians demonstrating personal examples of healthy lifestyles (CSA Rep. 2-A-09).

280.035 ST-Elevation Acute Myocardial Infarction (STEMI): The Texas Medical Association supports AMA efforts to (1) work with relevant societies to conduct a thorough analysis of the geographic, economic, and political barriers to optimal care for the ST-Elevation myocardial infarction (STEMI) patient, e.g., the current environment, existing literature, the costs of ambulance ECG hardware, training and transmission, political issues of reimbursing one county for care provided to patients from another county or state, and the financial issues of shifting patients to centers that can perform preferred treatment algorithms, and (2) develop model legislation that would draw upon the successes of existing programs and the data garnered from a comprehensive environmental analysis, to identify workable solutions to breaking down the current geographic, economic, and political barriers to optimal care for the STEMI patient that currently exist.

Recognizing the importance of strengthening and standardizing STEMI protocol throughout Texas, TMA strongly supports the American Heart Association and American College of Cardiology STEMI-related statewide initiatives, including STEMI-related initiatives in Texas that reflect the most up-to-date guidelines and science.

TMA will promote ongoing educational initiatives for the general public, emergency medical personnel, physicians, and hospital administration on the benefits of early symptom recognition in ST wave myocardial infarction as well as development of an efficient and collaborative treatment algorithm (CSA Rep. 1-A-09).
260.103  **Disaster Preparedness Planning and Response:** The Texas Medical Association recognizes the challenges and issues in all-hazards disaster planning and the need to promote ongoing physician participation in state and local planning and response to ensure local readiness and protection of each community and our patients. To that end, TMA will:

1. Work with the Texas Department of State Health Services (DSHS) in statewide disaster planning and advocate for a strong role for county medical societies (CMSs) in local planning, drills, and other related activities;
2. Identify a member of the TMA’s Board of Trustees or the member’s designee to serve as a liaison to the commissioner of health and the state’s emergency coordinator to ensure consideration of medical needs during terrorism, public health emergencies, and natural disasters, and to identify specific needs and special services to support the medical needs of high-risk populations including bariatric patients and shelter evacuees during a disaster;
3. Work with DSHS state and regional officials to establish state-level communications and assist local health departments or other appropriate agencies in expanding the mechanism for apprising physicians of essential information on newly recognized outbreaks and potential emergencies;
4. Work with DSHS in the event of a pandemic or other infectious disease disaster to ensure that plans minimize the negative impact on the health care community and ensure a sufficient supply of medications critical to the population; and
5. Monitor state laws governing practice and liability under these various disaster declarations and advocate for any needed legislative changes to address these issues.

**Recommendation 3:** Retain as amended.
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 301
A-19

Subject: Distribution and Display of Human Trafficking Aid Information in Public Places

Introduced by: Lone Star Caucus
               Lubbock County Medical Society

Referred to: Reference Committee on Science and Public Health

Whereas, Human trafficking is slavery, including both labor and sex trafficking and involving people of any age, gender, race/ethnicity, nationality, immigration status, or sexual orientation; and

Whereas, Human trafficking represents one of the most insidious and seemingly invisible public health challenges; and

Whereas, The National Human Trafficking Hotline has reported more than 4,000 cases of human trafficking in Texas since 2007; and

Whereas, The National Human Trafficking Hotline recently reported 455 cases of human trafficking in Texas in 2018; and

Whereas, The reports presented by the National Human Trafficking Hotline are not a comprehensive report on the scale or scope of human trafficking within Texas, and the actual number of victims is likely much higher; and

Whereas, The reports from the National Human Trafficking Hotline indicate a persistent need for community response in order to serve victims and survivors, respond to human trafficking cases, and share information and resources; and

Whereas, Physicians have a unique and critical role to play in preventing human trafficking, and identifying and treating its victims; and

Whereas, Victims and survivors of human trafficking may be seen at local clinics, emergency departments, or other medical settings, and the health care team’s actions at that moment can make a lifesaving difference; therefore be it

RESOLVED, That the Texas Medical Association adopt as policy that readily visible signs, notices, posters, placards, or other readily available educational materials providing information about reporting human trafficking activities or providing assistance to victims and survivors be permitted in local clinics, emergency departments, or other medical settings; and be it further

RESOLVED, That the Texas Medical Association, through its website or internet presence, provide downloadable materials displaying the National Human Trafficking Hotline number to aid in displaying such information in local clinics, emergency departments, or other medical settings and advocate that other recognized medical professional organizations do the same; and be it further

RESOLVED, That the Texas Medical Association urge both state and federal governments to make changes in laws to advocate the broad posting of the National Human Trafficking Hotline number in areas such as local clinics, emergency departments, and other medical settings; and be it further
RESOLVED, That our Texas Delegation to the American Medical Association take this resolution to the
AMA House of Delegates for consideration.

Related TMA Policy:

260.101 Increasing Identification, Support, and Reporting of Human Trafficking Victims: Increasing
Identification, Support, and Reporting of Human Trafficking Victims: The Texas Medical Association will
work with (1) physician member experts on human trafficking and ensure continued participation in the
activities of the Texas Human Trafficking Prevention Task Force to help: (a) identify and advocate public
policy measures that strengthen infrastructure which will improve response to human trafficking victims;
(b) aid physicians in promoting the use of effective screening tools so they can identify potential victims of
human trafficking; (c) provide information to physicians on the availability of local resources in their
communities, including information on treatment and recovery for victims of human trafficking, including
trauma-informed interventions; and (d) with requirements related to reporting suspected abuse of children
and of potential victims of violence and/or sexual abuse and exploitation; and (2) county medical societies
to encourage training at local health facilities on identifying human trafficking victims or request training
from nationally recognized human trafficking support entities (CSHP Rep. 3-A-16).

Related AMA Policy:

H-65.966 Physicians Response to Victims of Human Trafficking:

1. Our AMA encourages its Member Groups and Sections, as well as the Federation of Medicine, to raise
awareness about human trafficking and inform physicians about the resources available to aid them in
identifying and serving victims of human trafficking.

Physicians should be aware of the definition of human trafficking and of resources available to help them
identify and address the needs of victims.

The US Department of State defines human trafficking as an activity in which someone obtains or holds a
person in compelled service. The term covers forced labor and forced child labor, sex trafficking, including
child sex trafficking, debt bondage, and child soldiers, among other forms of enslavement. Although it's
difficult to know just how extensive the problem of human trafficking is, it's estimated that hundreds of
thousands of individuals may be trafficked every year worldwide, the majority of whom are women and/or
children.

The Polaris Project -
In addition to offering services directly to victims of trafficking through offices in Washington, DC and
New Jersey and advocating for state and federal policy, the Polaris Project:
- Operates a 24-hour National Human Trafficking Hotline
- Maintains the National Human Trafficking Resource Center, which provides
  a. An assessment tool for health care professionals
  b. Online training in recognizing and responding to human trafficking in a health care context
  c. Speakers and materials for in-person training
  d. Links to local resources across the country

The Rescue & Restore Campaign -
The Department of Health and Human Services is designated under the Trafficking Victims Protection Act
to assist victims of trafficking. Administered through the Office of Refugee Settlement, the Department's
Rescue & Restore campaign provides tools for law enforcement personnel, social service organizations, and
health care professionals.

2. Our AMA will help encourage the education of physicians about human trafficking and how to report
cases of suspected human trafficking to appropriate authorities to provide a conduit to resources to address
the victim's medical, legal and social needs.
Subject: Statement on Personhood Measures

Introduced by: Dallas County Medical Society

Referred to: Reference Committee on Science and Public Health

Whereas, In a growing number of states, vaguely worded and often misleading measures appear in legislation or as proposed constitutional amendments that define when life begins and grant legal “personhood” status to embryos at varying stages of development; and

Whereas, If approved, these measures would have profound consequences for women and their families; and

Whereas, If the goal of these measures is to make abortion illegal, that policy outcome should be addressed directly. Broadly worded or poorly worded measures could significantly affect medical treatments available to women of reproductive age, for example by:

- Making some common birth control measures illegal;
- Making illegal a physician’s ability to provide medically appropriate care to women experiencing life-threatening complications from a tubal pregnancy;
- Consigning infertility patients to less-effective, less-safe treatments for their disease; and
- Unduly restricting infertile patients’ right to make decisions about their medical treatments, including determining the fate of embryos created as part of in vitro fertilization; and

Whereas, A personhood measure would severely complicate the management of storage and disposition of human embryos; and

Whereas, An American Society of Reproductive Medicine position statement opposes ambiguously worded measures that would restrict the practice of reproductive medicine and the success of assisted reproductive technology; and

Whereas, The American Medical Association has a relevant policy, Code of Medical Ethics 4.2.5 Storage and Use of Human Embryos:

Embryos created during cycles of in vitro fertilization (IVF) that are not intended for immediate transfer are often frozen for future use. The primary goal is to minimize risk and burden by minimizing the number of cycles of ovarian stimulation and egg retrieval that an IVF patient undergoes.

While embryos usually are frozen with the expectation that they will be used for reproductive purposes by the prospective parents for whom they were created, frozen embryos also may offer hope to other prospective parents who otherwise would not be able to have a child. Frozen embryos also offer the prospect of advancing scientific knowledge when made available for research purposes. In all these scenarios, ethical concerns arise regarding who has authority to
make decisions about stored embryos and what kinds of choices they may ethically make. Decision-making authority with respect to stored embryos varies depending on the relationships between the prospective rearing parents and individuals who provide gametes. At stake are the individuals’ interests in procreating.

When gametes are provided by the prospective rearing parents or a known donor, physicians who provide clinical services that include creation and storage of embryos have an ethical responsibility to proactively discuss with the parties whether, when and under what circumstances stored embryos may be: (a) Used by a surviving party for purposes of reproduction in the event of the death of a partner or gamete donor. (b) Made available to other patients for purposes of reproduction. (c) Made available to investigators for research purposes, in keeping with ethics guidance and on the understanding that embryos used for research will not be subsequently used for reproduction. (d) Allowed to thaw and deteriorate. (e) Otherwise disposed of; therefore be it

RESOLVED, That the Texas Medical Association oppose any personhood measure that is unclear, confusing, ambiguous, or not based on sound scientific or medical knowledge, which threatens the safety and effective treatment of patients, and which threatens access to assisted reproductive services.

Related TMA Policy:

265.018 Evidence-Based Medicine: The Texas Medical Association supports the use of science and well-designed, well-conducted clinical research as a foundation for good medical practice to improve the quality of patient care. Guidelines and protocols for medical care based on thorough reviews of current medical research can improve the consistency, timeliness, and efficiency of clinical care. National and international medical organizations as well as nursing and allied health continue to develop evidence-based guidelines and recommendations to improve patient care. At times, evidence is incomplete and involves expert opinion. However, popular, advertised trends are not identical to experts. The quality of the evidence to support guidance is graded on the strength of the data from which it is derived. Evidence-based guidelines are always supportive, not prescriptive, and should be adjudicated by the physician or provider with good medical judgment and experience in the best interest of the individual patient. TMA encourages continued medical research in areas where a gap in knowledge exists on which to base medical practice. TMA supports the use of evidence-based medicine to improve approval and payment for medical services where appropriate.

TMA strongly supports the standardization of a national set of evidence-based measures that are clinically meaningful and lead to performance improvement while improving both patient outcome and patient satisfaction such as those endorsed by the National Quality Forum.

Recognizing that evidence-based medicine is continually evolving, measures should be evaluated and subject to regular review (1) at intervals in accordance with professional standards, (2) whenever there is a significant change in scientific evidence, or (3) when results from testing arise that materially affect the integrity of the measure.

TMA supports the focus of the American Medical Association policy in its efforts to (1) work with state and local medical associations, specialty societies, and other medical organizations to educate the Centers for Medicare & Medicaid Services, state legislatures, third-party payers, and state Medicaid agencies about the appropriate uses of evidence-based medicine and the dangers of cost-based medicine practices; and (2) through the Council on Legislation, work with other medical associations to develop model state legislation to protect the patient-physician relationship from cost-based medicine policies inappropriately characterized as “evidence-based medicine” (CSA Rep. 3-A-08; amended CSPH Rep. 5-A-18).

Related AMA Policy:

H-5.990 Policy on Abortion: The issue of support of or opposition to abortion is a matter for members of the AMA to decide individually, based on personal values or beliefs. The AMA will take no action which may be construed as an attempt to alter or influence the personal views of individual physicians regarding abortion procedures.

H-5.995 Abortion: Our AMA reaffirms that: (1) abortion is a medical procedure and should be performed only by a duly licensed physician and surgeon in conformance with standards of good medical practice and the Medical Practice Act of his state; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment. Neither physician, hospital, nor hospital personnel shall be required to perform any act violative of personally held moral principles. In these circumstances, good medical practice requires only that the physician or other professional withdraw from the case, so long as the withdrawal is consistent with good medical practice.

4.2.5 Storage & Use of Human Embryos (Stated in the sixth Whereas above.)
Subject: Improving Medical Clearance Policies for Traumatic Brain Injury Patients

Introduced by: Dallas County Medical Society

Referred to: Reference Committee on Science and Public Health

Whereas, About 6,000 people per day sustain a traumatic brain injury (TBI) in the United States; and

Whereas, People with TBI are twice as likely to commit suicide; veterans, a large population of whom have a TBI, are also twice as likely to commit suicide; a systematic review found that 18 percent of people affected by brain injury have attempted suicide and were successful three to four times more often than the general population; individuals with TBI are at significantly increased risk of committing violent crimes; and

Whereas, During the first year after moderate-to-severe TBI, psychiatric disorders were diagnosed in 61 percent of participants, which excludes the larger majority of mild TBI patients; and

Whereas, At-risk TBI patients obtain medical clearance before the Texas Department of Public Safety begins return-to-driving testing for individuals; and

Whereas, U.S. law prohibits anyone “who has been adjudicated as a mental defective or has been committed to any mental institution” from possessing or purchasing a firearm; and

Whereas, U.S. law 49 USC 31113(a)(8), 49 CFR 391.41-49 states that medical clearance is required for interstate commercial travel, and numerous states have laws promoting or requiring physicians to report to specific agencies (in Texas, the Medical Advisory Board [MAB]) patients with medical issues that would impair driving; and

Whereas, Texas Government Code, Title 4, Sec. 411.172, states that in order to carry a handgun, a person must be capable of exercising sound judgment with respect to the proper use and storage of the handgun; is not chemically dependent; does not suffer from a psychiatric disorder or condition that causes or is likely to cause substantial impairment in judgment, mood, perception, impulse control, or intellectual ability, or is in remission but reasonably likely to redevelop; cannot require continuous medical treatment for any of these issues; must not have been diagnosed by a licensed physician or declared by a court to be incompetent to manage his or her affairs; is not in default of a loan, or delinquent in tax payments or child support; and

Whereas, Pursuant to Health and Safety Code, Title 2, Sec. 12.095, the Texas Department of Public Safety (DPS) may request an opinion or recommendation from the Medical Advisory Board on the ability of an applicant or license holder to operate a motor vehicle safely or to exercise sound judgment on the proper use and storage of a handgun; in addition, DPS requests physicians to self-report, when they deem appropriate, a patient to the Texas MAB when he or she may pose a risk to self and others due to a medical condition or does not exercise sound judgment; and

Whereas, According to the Texas Health and Safety Code, Title 2, Sec. 12.092, MEDICAL ADVISORY BOARD; BOARD MEMBERS, The Texas MAB consists of “persons licensed to practice medicine in
Texas, including physicians who are board certified in medicine, psychiatry, neurology, physical medicine, or ophthalmology and who are jointly recommended by the department and the Texas Medical Association” as acutely attuned to conditions affecting sound judgment and impairment that could harm when related to driving and gun use; and

Whereas, the Texas Medical Association’s single gun policy is limited to supporting gun safety, advocating support of current gun laws, and supporting the study and education of gun safety, and this gun policy is directed at people with no cognitive or mental deficits; and

Whereas, TMA has policy for brain-injured patients only in regard to prevention and for student sports-related injuries and all-terrain-vehicle accidents; and

Whereas, Recently, TMA has supported and prioritized programs aimed at identifying abuse/violence and mental health disparities; and

Whereas, American Medical Association policies pertaining to TBI are boxing safety and sports-related injury/concussion safety; and

Whereas, AMA has policy focused on decreasing gun-related violence and deaths through public campaigning, generalized advocacy, and requests to the U.S. surgeon general; and

Whereas, AMA policy supports people with no cognitive deficits having to wait to purchase firearms and opposes people with no cognitive deficits who have committed domestic violence from purchasing or owning firearms; and

Whereas, AMA policy supports laws aimed at removing firearms from households that are at higher risk of violence and directs banning realistic toy guns due to safety concerns; and

Whereas, AMA supports physician reporting of impaired or possibly impaired patients to state agencies in regard to their driving abilities; therefore be it

RESOLVED, That Texas Medical Association reaffirm its policy stating that it strongly supports current national and Texas gun law and regulations relating to medical need and public safety, and advocates for legislation that more strongly implements these laws due to public health concerns; and be it further

RESOLVED, That TMA advocate for amending Texas law to clearly include prohibiting symptomatic TBI patients from obtaining or retaining a license to carry a firearm until medical clearance; and be it further

RESOLVED, That TMA create policy, advocates for, and supports legislation that expands to all people the medical clearance requirements and firearm purchasing restrictions in Texas’ license-to-carry law; and be it further

RESOLVED, That TMA advocate for legislation that would promote and emphasize the need and importance of physician reporting of all patients who have prohibitive conditions, including symptomatic TBI patients, to the Texas Medical Advisory Board; and be it further

RESOLVED, That TMA advocate for expansion of and investment into the Medical Advisory Board so it is better known by physicians, easier to use, and explicit regarding the medical conditions that may require reporting to it; and be it further
RESOLVED, That TMA advocate for legislation that expands the Medical Advisory Board’s oversight of possibly impaired individuals with gun licenses to all possibly impaired gun owners; and be it further

RESOLVED, That the Texas Delegation to the AMA carry any newly adopted policy related to TBI and access to firearms to AMA.

Related TMA Policy:

260.015 Firearms: The Texas Medical Association supports:

1. The primary prevention of firearm morbidity and mortality through educating Texans about firearm safety and the potential hazards of firearm ownership;
2. The Texas Hunter Education and certification program developed by the Texas Department of Parks and Wildlife;
3. Physicians in the clinical setting providing anticipatory guidance on the dangers of firearm ownership in an informational, nonjudgmental manner;
4. Strict enforcement of federal and state gun control laws and mandated penalties for crimes committed with a firearm, including illegal possession;
5. The use of trigger locks (such as can be provided by www.projectchildsafe.org) and locked gun cabinets to help prevent unintentional discharge; and

Related AMA Policy:

H-470.963 Boxing Safety: While the AMA recognizes that boxing is a violent sport associated with brain and eye injuries, we recommend the following preventive strategies to reduce such injuries in boxers: (1) Relevant regulatory bodies are encouraged to: (a) require the use of objective brain injury risk assessment tools to exclude individual at-risk boxers from sparring or fighting. (b) develop and enforce standard criteria for referees, ringside officials, and ringside physicians to halt sparring or boxing bouts when a boxer has experienced concussive or subconcussive blows that place him or her at imminent risk of more serious injury. (c) encourage implementation of measures advocated by the World Medical Boxing Congress designed to reduce the incidence of brain and eye injuries. (d) require initial and repeat eye examinations for amateur and professional boxers and mandate suspensions from sparring or boxing for specific ocular pathology according to recommendations of the American Academy of Ophthalmology. (2) Our AMA promotes the concept that the professional responsibility of the physician who serves in a medical capacity at a boxing contest is to protect the health and safety of the contestants. The desire of spectators, promoters of the event, or even injured athletes that they not be removed from the contest should not be controlling. The physician's judgment should be governed only by medical considerations.

H-470.954 Reduction of Sports-Related Injury and Concussion: 1. Our AMA will: (a) work with appropriate agencies and organizations to promote awareness of programs to reduce concussion and other sports-related injuries across the lifespan; and (b) promote awareness that even mild cases of traumatic brain injury may have serious and prolonged consequences.

2. Our AMA supports the adoption of evidence-based, age-specific guidelines on the evaluation and management of concussion in all athletes for use by physicians, other health professionals, and athletic organizations.

3. Our AMA will work with appropriate state and specialty medical societies to enhance opportunities for continuing education regarding professional guidelines and other clinical resources to enhance the ability of physicians to prevent, diagnose, and manage concussions and other sports-related injuries.

4. Our AMA urges appropriate agencies and organizations to support research to: (a) assess the short- and long-term cognitive, emotional, behavioral, neurobiological, and neuropathological consequences of
concussions and repetitive head impacts over the life span; (b) identify determinants of concussion and other sports-related injuries in pediatric and adult athletes, including how injury thresholds are modified by the number of and time interval between head impacts and concussions; (c) develop and evaluate effective risk reduction measures to prevent or reduce sports-related injuries and concussions and their sequelae across the lifespan; and (d) develop objective biomarkers to improve the identification, management, and prognosis of athletes suffering from concussion to reduce the dependence on self-reporting and inform evidence-based, age-specific guidelines for these patients.

5. Our AMA supports research into the detection, causes, and prevention of injuries along the continuum from subconcussive head impacts to conditions such as chronic traumatic encephalopathy (CTE).

H-470.984 Brain Injury in Boxing: The AMA supports the following series of steps designed to protect amateur and professional boxers from injuries:

1. Encourage the establishment of a “National Registry of Boxers” for all amateur and professional boxers, including “sparring mates,” in the country. The proposed functions of a computer-based central registry would be to record the results of all licensed bouts, including technical knockouts, knockouts, and other boxing injuries, and to compile injury and win/loss records for individual boxers.

2. Recommend to all boxing jurisdictions that the ring physician should be authorized to stop any bout in progress, at any time, to examine a contestant and, when indicated, to terminate a bout that might, in his opinion, result in serious injury for either contestant.

3. Urge state and local commissions to conduct frequent medical training seminars for all ring personnel.

4. Recommend to all boxing jurisdictions that no amateur or professional boxing bout should be permitted unless: (a) the contest is held in an area where adequate neurosurgical facilities are immediately available for skilled emergency treatment of an injured boxer; (b) a portable resuscitator with oxygen equipment and appropriate endotracheal tubes are available at ringside; and (c) a comprehensive evacuation plan for the removal of any seriously injured boxer to hospital facilities is ready.

5. Inform state legislatures that unsupervised boxing competition between unlicensed boxers in “tough man” contests is a most dangerous practice that may result in serious injury or death to contestants, and should be condemned.

6. Urge state and local boxing commissions to mandate the use of safety equipment, such as plastic safety mats and padded cornerposts, and to encourage continued development of safety equipment.

7. Urge state and local boxing commissions to extend all safety measures to sparring partners.

8. Urge state and local boxing commissions to upgrade, standardize and strictly enforce medical evaluations for boxers.

H-145.974 Increasing Toy Gun Safety: Our American Medical Association (1) encourages toy gun manufacturers to take further steps beyond the addition of an orange tip on the gun to reduce the similarity of toy guns with real guns, and (2) encourages parents to increase their awareness of toy gun ownership risks.

H-145.979 Prevention of Unintentional Shooting Deaths Among Children: Our AMA supports legislation at the federal and state levels making gun owners legally responsible for injury or death caused by a child gaining unsupervised access to a gun, unless it can be shown that reasonable measures to prevent child access to the gun were taken by the gun owner, and that the specifics,
including the nature of “reasonable measures,” be determined by the individual constituencies affected by the law.

**H-145.997 Firearms as a Public Health Problem in the United States - Injuries and Death:** Our AMA recognizes that uncontrolled ownership and use of firearms, especially handguns, is a serious threat to the public's health inasmuch as the weapons are one of the main causes of intentional and unintentional injuries and deaths. Therefore, the AMA: (1) encourages and endorses the development and presentation of safety education programs that will engender more responsible use and storage of firearms;

(2) urges that government agencies, the CDC in particular, enlarge their efforts in the study of firearm-related injuries and in the development of ways and means of reducing such injuries and deaths;

(3) urges Congress to enact needed legislation to regulate more effectively the importation and interstate traffic of all handguns;

(4) urges the Congress to support recent legislative efforts to ban the manufacture and importation of nonmetallic, not readily detectable weapons, which also resemble toy guns; (5) encourages the improvement or modification of firearms so as to make them as safe as humanly possible;

(6) encourages nongovernmental organizations to develop and test new, less hazardous designs for firearms;

(7) urges that a significant portion of any funds recovered from firearms manufacturers and dealers through legal proceedings be used for gun safety education and gun-violence prevention; and

(8) strongly urges US legislators to fund further research into the epidemiology of risks related to gun violence on a national level.

**H-145.978 Gun Safety:** Our AMA: (1) recommends and promotes the use of trigger locks and locked gun cabinets as safety precautions; and (2) endorses standards for firearm construction reducing the likelihood of accidental discharge when a gun is dropped and that standardized drop tests be developed.

**H-145.975 Firearm Safety and Research, Reduction in Firearm Violence, and Enhancing Access to Mental Health Care:**

1. Our AMA supports: a) federal and state research on firearm-related injuries and deaths; b) increased funding for and the use of state and national firearms injury databases, including the expansion of the National Violent Death Reporting System to all 50 states and U.S. territories, to inform state and federal health policy; c) encouraging physicians to access evidence-based data regarding firearm safety to educate and counsel patients about firearm safety; d) the rights of physicians to have free and open communication with their patients regarding firearm safety and the use of gun locks in their homes; e) encouraging local projects to facilitate the low-cost distribution of gun locks in homes; f) encouraging physicians to become involved in local firearm safety classes as a means of promoting injury prevention and the public health; and g) encouraging CME providers to consider, as appropriate, inclusion of presentations about the prevention of gun violence in national, state, and local continuing medical education programs.

2. Our AMA supports initiatives to enhance access to mental and cognitive health care, with greater focus on the diagnosis and management of mental illness and concurrent substance use disorders, and work with state and specialty medical societies and other interested stakeholders to identify and develop standardized approaches to mental health assessment for potential violent behavior.

3. Our AMA (a) recognizes the role of firearms in suicides, (b) encourages the development of curricula and training for physicians with a focus on suicide risk assessment and prevention as well as lethal means safety counseling, and (c) encourages physicians, as a part of their suicide prevention strategy, to discuss lethal means safety and work with families to reduce access to lethal means of suicide.
D-145.995 Gun Violence as a Public Health Crisis: Our AMA: (1) will immediately make a public statement that gun violence represents a public health crisis which requires a comprehensive public health response and solution; and (2) will actively lobby Congress to lift the gun violence research ban.

H-145.996 Firearm Availability: 1. Our AMA: (a) advocates a waiting period and background check for all firearm purchasers; (b) encourages legislation that enforces a waiting period and background check for all firearm purchasers; and (c) urges legislation to prohibit the manufacture, sale or import of lethal and non-lethal guns made of plastic, ceramics, or other non-metallic materials that cannot be detected by airport and weapon detection devices. 2. Our AMA supports requiring the licensing/permitting of firearms-owners and purchasers, including the completion of a required safety course, and registration of all firearms. 3. Our AMA supports “gun violence restraining orders” for individuals arrested or convicted of domestic violence or stalking, and supports extreme risk protection orders, commonly known as “red-flag” laws, for individuals who have demonstrated significant signs of potential violence. In supporting restraining orders and “red-flag” laws, we also support the importance of due process so that individuals can petition for their rights to be restored.

D-145.997 Physicians and the Public Health Issues of Gun Safety: Our AMA will request that the US Surgeon General develop a report and campaign aimed at reducing gun-related injuries and deaths.

H-145.985 Ban on Handguns and Automatic Repeating Weapons: It is the policy of the AMA to: (1) Support interventions pertaining to firearm control, especially those that occur early in the life of the weapon (e.g., at the time of manufacture or importation, as opposed to those involving possession or use). Such interventions should include but not be limited to: (a) mandatory inclusion of safety devices on all firearms, whether manufactured or imported into the United States, including built-in locks, loading indicators, safety locks on triggers, and increases in the minimum pressure required to pull triggers; (b) bans on the possession and use of firearms and ammunition by unsupervised youths under the age of 21; (c) bans of sales of firearms and ammunition from licensed and unlicensed dealers to those under the age of 21 (excluding certain categories of individuals, such as military and law enforcement personnel); (d) the imposition of significant licensing fees for firearms dealers; (e) the imposition of federal and state surtaxes on manufacturers, dealers and purchasers of handguns and semiautomatic repeating weapons along with the ammunition used in such firearms, with the attending revenue earmarked as additional revenue for health and law enforcement activities that are directly related to the prevention and control of violence in U.S. society; and (f) mandatory destruction of any weapons obtained in local buy-back programs. (2) Support legislation outlawing the Black Talon and other similarly constructed bullets. (3) Support the right of local jurisdictions to enact firearm regulations that are stricter than those that exist in state statutes and encourage state and local medical societies to evaluate and support local efforts to enact useful controls. (4) Oppose “concealed carry reciprocity” federal legislation that would require all states to recognize concealed carry firearm permits granted by other states and that would allow citizens with concealed gun carry permits in one state to carry guns across state lines into states that have stricter laws. (5) Support the concept of gun buyback programs as well as research to determine the effectiveness of the programs in reducing firearm injuries and deaths.
H-145.989 Safety of Nonpowder (Gas-Loaded/Spring-Loaded) Guns: It is the policy of the AMA to encourage the development of appropriate educational materials designed to enhance physician and general public awareness of the safe use of as well as the dangers inherent in the unsafe use of nonpowder (gas-loaded/spring-loaded) guns.

H-60.947 Guns in School Settings: Our AMA recommends: (1) all children who take guns or other weapons to school should receive an evaluation by a psychiatrist or an appropriately trained mental health professional; and (2) that children who are determined by such evaluation to have a mental illness should receive appropriate treatment.

H-215.977 Guns in Hospitals: 1. The policy of the AMA is to encourage hospitals to incorporate, within their security policies, specific provisions on the presence of firearms in the hospital. The AMA believes the following points merit attention:

A. Given that security needs stem from local conditions, firearm policies must be developed with the cooperation and collaboration of the medical staff, the hospital security staff, the hospital administration, other hospital staff representatives, legal counsel, and local law enforcement officials. Consultation with outside experts, including state and federal law enforcement agencies, or patient advocates may be warranted.

B. The development of these policies should begin with a careful needs assessment that addresses past issues as well as future needs.

C. Policies should, at minimum, address the following issues: a means of identification for all staff and visitors; restrictions on access to the hospital or units within the hospital, including the means of ingress and egress; changes in the physical layout of the facility that would improve security; the possible use of metal detectors; the use of monitoring equipment such as closed circuit television; the development of an emergency signaling system; signage for the facility regarding the possession of weapons; procedures to be followed when a weapon is discovered; and the means for securing or controlling weapons that may be brought into the facility, particularly those considered contraband but also those carried in by law enforcement personnel.

D. Once policies are developed, training should be provided to all members of the staff, with the level and type of training being related to the perceived risks of various units within the facility. Training to recognize and defuse potentially violent situations should be included.

E. Policies should undergo periodic reassessment and evaluation.

F. Firearm policies should incorporate a clear protocol for situations in which weapons are brought into the hospital.

2. Our AMA will advocate that hospitals and other healthcare delivery settings limit guns and conducted electrical weapons in units where patients suffering from mental illness are present.

H-145.999 Gun Regulation: Our AMA supports stricter enforcement of present federal and state gun legislation and the imposition of mandated penalties by the judiciary for crimes committed with the use of a firearm, including the illegal possession of a firearm.

H-145.988 AMA Campaign to Reduce Firearm Deaths: The AMA supports educating the public regarding methods to reduce death and injury due to keeping guns, ammunition and other explosives in the home.
H-145.972 Firearms and High-Risk Individuals: Our AMA supports: (1) the establishment of laws allowing family members, intimate partners, household members, and law enforcement personnel to petition a court for the removal of a firearm when there is a high or imminent risk for violence; (2) prohibiting persons who are under domestic violence restraining orders, convicted of misdemeanor domestic violence crimes or stalking, from possessing or purchasing firearms; (3) expanding domestic violence restraining orders to include dating partners; (4) requiring states to have protocols or processes in place for requiring the removal of firearms by prohibited persons; (5) requiring domestic violence restraining orders and gun violence restraining orders to be entered into the National Instant Criminal Background Check System; and (6) efforts to ensure the public is aware of the existence of laws that allow for the removal of firearms from high-risk individuals.

H-145.992 Waiting Period Before Gun Purchase: The AMA supports legislation calling for a waiting period of at least one week before purchasing any form of firearm in the U.S.

Sources:
5. Texas Department of State Health Services. Medical Advisory Board.
A person is eligible for a license to carry a handgun if the person: is not a chemically dependent person; and is not incapable of exercising sound judgment with respect to the proper use and storage of a handgun. A person is incapable of exercising sound judgment with respect to the proper use and storage of a handgun if the person: has been diagnosed by a licensed physician as suffering from a psychiatric disorder or condition that causes or is likely to cause substantial impairment in judgment, mood, perception, impulse control, or intellectual ability; suffers from a psychiatric disorder or condition that is in remission but is reasonably likely to redevelop at a future time or requires continuous medical treatment to avoid redevelopment; has been diagnosed by a licensed physician, determined by a review board or similar authority, or declared by a court to be incompetent to manage the person’s affairs; or has entered in a criminal proceeding a plea of not guilty by reason of insanity.
Subject: Requirement for Food Allergy Posters and Employee Training in Food Establishments

Introduced by: Harris County Medical Society
Louise H. Bethea, MD, Texas Allergy, Asthma & Immunology Society

Referred to: Reference Committee on Science and Public Health

Whereas, Anaphylaxis is a potentially fatal systemic allergic reaction, and foods are a common cause; and

Whereas, Many food service employees are unaware of the frequency and severity of food allergies in their clientele; and

Whereas, Many food service employees are unaware of the top eight food allergies: milk, eggs, wheat, soy, shellfish, fish, peanuts, and tree nuts; and

Whereas, Many food service employees are unaware of the ingredients in the foods they serve; and

Whereas, Every three minutes, a food allergy reaction sends someone to the emergency department. These reactions result in approximately 200,000 emergency department visits per year. The reaction is often so severe that a potentially life-threatening reaction (anaphylaxis) occurs roughly every six minutes; and

Whereas, Even a tiny amount of an allergen can cause a severe and potentially life-threatening allergic reaction; and

Whereas, Proper cooking does not reduce or eliminate the chances of a food allergy reaction; and

Whereas, Proper food allergy cooking and handling procedures are available for use by food establishments; and

Whereas, The Food Allergy Research and Education Organization and the Food Allergy Awareness Organization have free downloadable posters with the needed information available to post on the food establishment’s employee information board; and

RESOLVED, That the Texas Medical Association provide advocacy support to the Texas Allergy, Asthma & Immunology Society’s efforts as the society seeks the passage of legislation mandating, not just recommending, that all food service establishments display a poster related to food allergen awareness in an area of the establishment accessible primarily to its employees. This poster must include the risk of an allergic reaction, a list of the major food allergens, methods to prevent cross-contamination in food preparation, and signs and symptoms associated with anaphylaxis with instructions to call 911; and be it further

RESOLVED, That TMA advocate for a mandate that food service employees be required, on a biennial basis, to be trained in food allergy awareness with information on which foods – milk, eggs, wheat, soy, shellfish, fish, peanuts, and tree nuts – cause the most reactions; trained in the prevention of cross-contamination in food preparation; and trained in the signs and symptoms associated with anaphylaxis with instructions to call 911. The training programs can be completed online or in class form and should
be certified by a nationally recognized organization and approved by the Texas Department of Health and Human Services.

**Related TMA Policy:**

**55.053 Childhood Medical Emergencies and Anaphylactic Reactions in Schools:** The Texas Medical Association urges all schools, from preschool through 12th grade, to:

1. Develop Medical Emergency Response Plans (MERPs);
2. Practice these plans to identify potential barriers and strategies for improvement;
3. Ensure that school campuses have a direct communication link with an emergency medical service (EMS);
4. Identify students at risk for life-threatening emergencies, and ensure these children have an individual emergency care plan that is formulated with input from a physician;
5. Designate roles and responsibilities among school staff for handling potential life-threatening emergencies, including administering medications, working with EMS and local emergency departments, and contacting families;
6. Train school personnel in cardiopulmonary resuscitation in addition to information on district emergency policies, signs and symptoms of anaphylaxis, and strategies to reduce the risk of exposure;
7. Adopt the School Guidelines for Managing Students with Food Allergies distributed by the Food Allergy Research and Education; and
8. Ensure that appropriate emergency equipment to deal with anaphylaxis and acute asthmatic reactions is available and that assigned staff know how to use this equipment.

TMA will work to expand to all state laws permitting students to carry prescribed epinephrine or other medications prescribed by their physician for asthma or anaphylaxis.

TMA supports increased research to better understand the causes, epidemiology, and effective treatment of anaphylaxis.

TMA urges the Centers for Disease Control and Prevention to study the adequacy of school personnel and services to address asthma and anaphylactic emergencies.

TMA urges physicians to work with parents and schools to ensure that all their patients with a food allergy have an individualized emergency plan.

TMA urges physicians to work with school health advisory councils to ensure districts have comprehensive emergency management plans that address prevention and recognition of anaphylaxis, and medication administration. Plans should include procedures for students without a previously diagnosed allergy.

TMA will work to allow all appropriately trained clinical first responders to carry and administer epinephrine in suspected cases of anaphylaxis (CM-CAH Rep. 4-A-08; amended CM-CAH Rep. 1-A-13).

**100.008 Statewide Emergency Communication Network System:** Texas should maintain a robust and adequately funded statewide 911 communications system and, as part of that effort, county medical societies should assist in advocating needed resources to support their local 9-1-1 emergency systems and
local expansion of the emergency service infrastructure to include next generation 9-1-1 features (CPH, p 91, A-95, amended CPH Rep. 3-A-10; amended Res. 308-A-17).

100.016 Texas Department of State Health Services Emergency Medical Services Local Projects Grant Program: The Texas Medical Association supports the DSHS EMS Local Projects Grant program which provides emergency medical services education, training and equipment to rural and frontier areas of Texas (CM-EMS Rep. 2-A-99; reaffirmed CPH Rep. 2-A-09).

100.018 Emergency Medical Resources: The Texas Medical Association will work to pass legislation that removes limits of emergency medical resources to the acutely sick and injured and provides resources necessary to meet the needs of patient trauma care (Amended Res. 17-I-02; reaffirmed CSPH Rep. 1-A-13).

100.025 Access to Emergency Care in Texas: The Texas Medical Association will seek to establish a Texas bipartisan commission to examine, address, and support issues related to access to emergency care in Texas, or a coalition of organizations to address the current crisis (Res. 205-A-08; reaffirmed CM-EMST Rep. 2-A-18).

100.029 Requirement for Epinephrine Auto-Injectors in Texas Schools: The Texas Medical Association supports legislation that (1) requires all Texas schools, pre-Kindergarten through 12th grade, to have epinephrine auto-injectors available on their campuses and at school activities to treat acute life-threatening allergic emergencies; (2) includes a mandate for school personnel to be trained to recognize and treat allergic emergencies; and (3) would amend Section 74.151(a) of the Civil Practice and Remedies Code to state that physicians prescribing unassigned epinephrine auto-injectors for use in schools and athletic settings, and nurses and trained school personnel administering epinephrine auto-injectors during medical emergencies, not be liable for civil damages unless the act was willfully or wantonly negligent (Res. 301-A-14).

170.001 Good Samaritan and Charitable Immunity Laws: The Texas Medical Association continues to support the Good Samaritan Law, that allows persons including physicians, to render aid in an emergency free from liability when it is not provided for or in expectation of compensation. The Texas Medical Association continues to support the Charitable Immunity Law which allows any health care provider who voluntarily provides medical or health care to the needy free of charge to be free of liability risks. These laws 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 road blocks to access to medical care by the needy (Res. 27DD, p 181K, I-90; reaffirmed CSE Rep. 5-I-01; amended CSE Rep. 8-A-11).

170.002 Charitable Immunity: The Texas Medical Association favors extending liability protections of the Texas Charitable Immunity and Liability Act of 1987 to physicians acting as direct-service volunteers on behalf of city, county, and state health departments, as well as those who volunteer services in local, state, or federally owned health care facilities, and voted to seek amendment of that law (Res. 28HH, p 207, A-92; reaffirmed CSE Rep. 3-A-04; reaffirmed CSE Rep. 2-A-14).

260.037 Essential Public Health Services: The Texas Medical Association adopted the Essential Public Health Services Work Group's definition of public health and essential public health services: (1) monitor health status to identify community health problems; (2) diagnose and investigate health problems and health hazards in the community; (3) inform, educate, and empower people about health issues; (4) mobilize community partnerships to identify and solve health problems; (5) develop policies and plans that support individual and community health efforts; (6) enforce laws and regulations that protect health and ensure safety; (7) link people to needed personal health services and assure the provision of health care when otherwise unavailable; (8) assure a competent public health and personal health care
workforce; (9) evaluate effectiveness, accessibility, and quality of personal and population-based health services; and (10) research for new insights and innovative solutions to health problems. In addition, in accordance with stated principles, TMA affirms that public health departments should be adequately funded in order to provide these essential services in every Texas community deliberately and apart from indigent care. TMA supports efforts to arrive at agreeable solutions to ensuring a stable public health system capable of adapting to health systems reform and the challenges of addressing emerging public health issues (CPH, p 80, I-95; reaffirmed CPH Rep. 2-A-05; amended CSPH Rep. 3-A-13).

260.042 Core Public Health Functions: The Texas Medical Association affirms the need for the practice of the core public health functions of assessment, assurance, and policy development as distinct, inherently governmental, complementary, and necessary to support population health in each Texas community. TMA recognizes the need for objectivity and the potential for conflict of interest in community health and opposes the delegation of responsibility entirely to non-governmental entities. In addition, TMA supports legislation that would more clearly assign responsibility for performing core public health functions which would ensure necessary resources to maintain and further improve the public health infrastructure in Texas. TMA supports efforts to educate the public, legislators, and other elected and appointed officials about the mission and role of public health in order to ensure continued and adequate funding. TMA supports efforts to amend the Local Public Health Reorganization Act as a means to simplify and improve the efficiency of local public health by facilitating and removing barriers to city and county collaborations for the provision of public health services (CPH, p 125A, I-96; amended CPH Rep. 2-A-09; amended CSPH Rep. 3-A-13).

260.049 Local Public Health Authorities and Training: The Texas Medical Association recognizes that there is an interdependence between medicine and public health and supports the preservation of the local health authority role as the bridge between both. TMA supports increased public health training in medical schools, residencies, and continuing medical education to improve physician understanding of public health and to help bridge the gap between private medicine and public health. TMA also urges the Department of State Health Services to encourage the local public health entities that they fund to collaborate with county medical societies to strengthen the bond between medicine and public health (Council on Public Health, p 76, A-97; amended CPH Rep. 2-A-07; amended CSPH Rep. 3-A-13).

Subject: Allow the Possession and Administration of an Epinephrine Auto-Injector in Certain Entities

Introduced by: Harris County Medical Society
Louise H. Bethea, MD, Texas Allergy, Asthma & Immunology Society

Referred to: Reference Committee on Science and Public Health

Whereas, Anaphylaxis is a potentially fatal systemic allergic reaction. Primary treatment consists of administration of epinephrine as soon as the reaction is identified. Prompt administration (e.g., within minutes of symptoms of anaphylaxis) of epinephrine (adrenaline) is crucial to treating anaphylactic reactions successfully. Any delay in administration of epinephrine has been shown to be the major risk factor for death from anaphylaxis; and

Whereas, Food allergies affect approximately 15 million Americans, including one in 13 children in the United States; and

Whereas, Every three minutes, a food allergy reaction sends someone to the emergency department. These reactions result in approximately 200,000 emergency department visits per year. The reaction is often so severe that a potentially life-threatening reaction (anaphylaxis) occurs roughly every six minutes; and

Whereas, Symptoms of anaphylaxis can develop rapidly after exposure to an allergen, often within minutes and usually within 30 minutes. However, symptoms can take up to two hours after exposure to a food allergen to become apparent; and

Whereas, Teenagers and young adults with food allergies are at the highest risk of fatal food-induced anaphylaxis; and

Whereas, Food is the most common cause of anaphylaxis, and eight foods cause 90 percent of the reactions. These foods are milk, egg, wheat, soy, shellfish, fish, peanuts, and tree nuts; and

Whereas, Past reactions to a food allergy do not predict future reactions. A person can have a life-threatening reaction to a food to which they are allergic even if they have never had a prior serious reaction; and

Whereas, Other causes of anaphylaxis are latex, medications, and bites from insects, such as fire ants; and

Whereas, Anaphylaxis must be treated immediately with epinephrine (adrenaline), which is crucial for the individual to survive a potentially life-threatening reaction; therefore be it

RESOLVED, That epinephrine auto-injectors be allowed to be placed in public places in areas accessible as determined by the entity. Those entities include amusement parks, camps, institutions of higher education, food service establishments, sports venues, concerts, state government entities, retail facilities, churches, synagogues, youth centers, and any other entity the Texas Executive Commissioner, by rule, designates as an entity that would benefit from the possession and administration of epinephrine auto-injectors; and be it further
RESOLVED, That an employee or volunteer with these entities be trained on an annual basis by an approved source to administer an epinephrine auto-injector to a person reasonably believed to be experiencing anaphylaxis on the premises of the entity; and be it further

RESOLVED, That policies relating to epinephrine auto-injectors be established by the Texas Executive Commission; and be it further

RESOLVED, That a trained person who in good faith initiates treatment using an epinephrine auto-injector under the rules established by the state be immune from civil or criminal liability, as will the entity or business and those associated with the prescribing, dispensing, and administration of the epinephrine auto-injectors.

Related TMA Policy:

**55.002 Comprehensive School Health Education in All School Districts:** The Texas Medical Association believes the Texas Education Agency should have statutory authority to require comprehensive school health education in all school districts of the state, and that the process should begin with implementation of the TEA-developed modules on physical education, nutrition, substance use, and sexuality (Council on Public Health, p 104-107, I-90; amended CM-CAH Rep. 2-A-01; reaffirmed CM-CAH Rep. 4-A-10).


**55.053 Childhood Medical Emergencies and Anaphylactic Reactions in Schools:** The Texas Medical Association urges all schools, from preschool through 12th grade, to:

- Develop Medical Emergency Response Plans (MERPs);
- Practice these plans to identify potential barriers and strategies for improvement;
- Ensure that school campuses have a direct communication link with an emergency medical service (EMS);
- Identify students at risk for life-threatening emergencies, and ensure these children have an individual emergency care plan that is formulated with input from a physician;
- Designate roles and responsibilities among school staff for handling potential life-threatening emergencies, including administering medications, working with EMS and local emergency departments, and contacting families;
- Train school personnel in cardiopulmonary resuscitation in addition to information on district emergency policies, signs and symptoms of anaphylaxis, and strategies to reduce the risk of exposure;
- Adopt the School Guidelines for Managing Students with Food Allergies distributed by the Food Allergy Research and Education; and
- Ensure that appropriate emergency equipment to deal with anaphylaxis and acute asthmatic reactions is available and that assigned staff know how to use this equipment.
TMA will work to expand to all state laws permitting students to carry prescribed epinephrine or other medications prescribed by their physician for asthma or anaphylaxis.

TMA supports increased research to better understand the causes, epidemiology, and effective treatment of anaphylaxis.

TMA urges the Centers for Disease Control and Prevention to study the adequacy of school personnel and services to address asthma and anaphylactic emergencies.

TMA urges physicians to work with parents and schools to ensure that all their patients with a food allergy have an individualized emergency plan.

TMA urges physicians to work with school health advisory councils to ensure districts have comprehensive emergency management plans that address prevention and recognition of anaphylaxis, and medication administration. Plans should include procedures for students without a previously diagnosed allergy.

TMA will work to allow all appropriately trained clinical first responders to carry and administer epinephrine in suspected cases of anaphylaxis (CM-CAH Rep. 4-A-08; amended CM-CAH Rep. 1-A-13).

100.008 *Statewide Emergency Communication Network System*: Texas should maintain a robust and adequately funded statewide 911 communications system and, as part of that effort, county medical societies should assist in advocating needed resources to support their local 9-1-1 emergency systems and local expansion of the emergency service infrastructure to include next generation 9-1-1 features (CPH, p 91, A-95, amended CPH Rep. 3-A-10; amended Res. 308-A-17).

100.016 *Texas Department of State Health Services Emergency Medical Services Local Projects Grant Program*: The Texas Medical Association supports the DSHS EMS Local Projects Grant program which provides emergency medical services education, training and equipment to rural and frontier areas of Texas (CM-EMS Rep. 2-A-99; reaffirmed CPH Rep. 2-A-09).

100.018 *Emergency Medical Resources*: The Texas Medical Association will work to pass legislation that removes limits of emergency medical resources to the acutely sick and injured and provides resources necessary to meet the needs of patient trauma care (Amended Res. 17-I-02; reaffirmed CSPH Rep. 1-A-13).

100.025 *Access to Emergency Care in Texas*: The Texas Medical Association will seek to establish a Texas bipartisan commission to examine, address, and support issues related to access to emergency care in Texas, or a coalition of organizations to address the current crisis (Res. 205-A-08; reaffirmed CM-EMST Rep. 2-A-18).

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115.004 Indemnification of Physicians: The Texas Medical Association supports state and federal legislative mechanisms whereby the state and/or federal governments will indemnify physicians who provide medical services for Medicaid, Medicare, and indigent patients (Res. 28JJ, p 209, A-92; reaffirmed CSE Rep. 3-A-04; amended CSE Rep. 2-A-14).

170.001 Good Samaritan and Charitable Immunity Laws: The Texas Medical Association continues to support the Good Samaritan Law, that allows persons including physicians, to render aid in an emergency free from liability when it is not provided for or in expectation of compensation. The Texas Medical Association continues to support the Charitable Immunity Law which allows any health care provider who voluntarily provides medical or health care to the needy free of charge to be free of liability risks. These laws 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 road blocks to access to medical care by the needy (Res. 27DD, p 181K, I-90; reaffirmed CSE Rep. 5-I-01; amended CSE Rep. 8-A-11).

170.002 Charitable Immunity: The Texas Medical Association favors extending liability protections of the Texas Charitable Immunity and Liability Act of 1987 to physicians acting as direct-service volunteers on behalf of city, county, and state health departments, as well as those who volunteer services in local, state, or federally owned health care facilities, and voted to seek amendment of that law (Res. 28HH, p 207, A-92; reaffirmed CSE Rep. 3-A-04; reaffirmed CSE Rep. 2-A-14).

260.037 Essential Public Health Services: The Texas Medical Association adopted the Essential Public Health Services Work Group's definition of public health and essential public health services: (1) monitor health status to identify community health problems; (2) diagnose and investigate health problems and health hazards in the community; (3) inform, educate, and empower people about health issues; (4) mobilize community partnerships to identify and solve health problems; (5) develop policies and plans that support individual and community health efforts; (6) enforce laws and regulations that protect health and ensure safety; (7) link people to needed personal health services and assure the provision of health care when otherwise unavailable; (8) assure a competent public health and personal health care workforce; (9) evaluate effectiveness, accessibility, and quality of personal and population-based health services; and (10) research for new insights and innovative solutions to health problems. In addition, in accordance with stated principles, TMA affirms that public health departments should be adequately funded in order to provide these essential services in every Texas community deliberately and apart from indigent care. TMA supports efforts to arrive at agreeable solutions to ensuring a stable public health system capable of adapting to health systems reform and the challenges of addressing emerging public health issues (CPH, p 80, I-95; reaffirmed CPH Rep. 2-A-05; amended CSPH Rep. 3-A-13).

260.042 Core Public Health Functions: The Texas Medical Association affirms the need for the practice of the core public health functions of assessment, assurance, and policy development as distinct, inherently governmental, complementary, and necessary to support population health in each Texas community. TMA recognizes the need for objectivity and the potential for conflict of interest in community health and opposes the delegation of responsibility entirely to non-governmental entities. In addition, TMA supports legislation that would more clearly assign responsibility for performing core public health functions which would ensure necessary resources to maintain and further improve the public health infrastructure in Texas. TMA supports efforts to educate the public, legislators, and other elected and appointed officials about the mission and role of public health in order to ensure continued and adequate funding. TMA supports efforts to amend the Local Public Health Reorganization Act as a means to simplify and improve the efficiency of local public health by facilitating and removing barriers to city and county collaborations for the provision of public health services (CPH, p 125A, I-96; amended CPH Rep. 2-A-09; amended CSPH Rep. 3-A-13).
260.049 **Local Public Health Authorities and Training:** The Texas Medical Association recognizes that there is an interdependence between medicine and public health and supports the preservation of the local health authority role as the bridge between both. TMA supports increased public health training in medical schools, residencies, and continuing medical education to improve physician understanding of public health and to help bridge the gap between private medicine and public health. TMA also urges the Department of State Health Services to encourage the local public health entities that they fund to collaborate with county medical societies to strengthen the bond between medicine and public health (Council on Public Health, p 76, A-97; amended CPH Rep. 2-A-07; amended CSPH Rep. 3-A-13).

265.003 **Medicine and Business Coalitions:** The Texas Medical Association supports medicine/business coalitions and encourages local dialogue between industry, business, labor, insurance carriers, hospitals, and physicians for the purpose of quality health care delivery (Hospital Medical Staff Section, p 160, A-92; reaffirmed CSE Rep. 3-A-04; reaffirmed CSE Rep. 2-A-14).
Subject: Opposition to Limiting the Physician’s Role in the End-of-Life Process

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Science and Public Health

Whereas, The role of a physician in providing health care to a patient should include honest discussions about important end-of-life decisions; and

Whereas, Recent efforts in the Texas Legislature by right-to-life organizations have centered on limiting physicians’ ability to participate in executing the wishes of a patient at the end of life; and

Whereas, Legislation passed by the 2017 Texas Legislature has the effect of allowing a surrogate to override the wishes of a patient; and

Whereas, The physician may be the last person to hear a patient’s end-of-life wishes; and

Whereas, The physician may be in the best position to help patients and family make these very difficult decisions; therefore be it

RESOLVED, That the Texas Medical Association oppose any efforts to limit the physician’s appropriate and ethical role in the end-of-life process.

Related TMA Policy:

**20.006 Alzheimer’s Disease and Other Dementia:** The Texas Medical Association:

1. Encourages physicians to make appropriate use of guidelines for clinical decisionmaking in the diagnosis and treatment of Alzheimer’s disease and other dementias;
2. Encourages physicians to make available information about community resources to facilitate appropriate and timely referral to supportive caregiver services;
3. Encourages studies to determine the comparative cost-effectiveness/cost-benefit of assisted in-home care versus nursing home care for patients with Alzheimer’s disease and related disorders;
4. Encourages studies to determine how best to provide stable funding for the long-term care of patients with Alzheimer’s disease and other dementing disorders;
5. Supports the use of evidence-based, cost-effective technologies with prior consent of patients or designated health care power of attorney, as a solution to prevent, identify, and rescue missing patients with Alzheimer’s disease and other related dementias with the help of appropriate allied specialty organizations;
6. Supports increased awareness of the sex and gender differences in incidence and etiology of Alzheimer’s disease and related dementias;
7. Encourages increased enrollment in clinical trials of appropriate patients with Alzheimer’s disease and related dementias, and their families, to better identify sex-differences in incidence and progression and to advance a treatment and cure of Alzheimer’s disease and related dementias;
8. Encourages physicians to promote regular physical activity, healthy eating, and management of cardiovascular risk factors (diabetes, obesity, smoking, and hypertension) to reduce the risk of cognitive decline and of dementia; and
9. Encourages physicians to discuss living wills, medical power of attorney, directive to physicians, and other end-of-life planning decisions with all appropriate patients (Extracted CSA Rep. 4-I-98; reaffirmed CSA Rep. 4-A-08; amended CSPH Rep. 5-A-18).

85.003 Education of Advance Directives: The Texas Medical Association encourages its members to educate patients, families, caregivers, and significant others in the necessity to have an appropriate, properly executed advance directive to protect the patient’s wishes in a pre-hospital environment and in the appropriate use of emergency medical services in terminal situations (Amended Res. 28BB, p 201, A-92; reaffirmed by Sub. MSS 3-I98; reaffirmed CM-EMS Rep. 1-A-03; reaffirmed BOC Rep. 6-A-13).


85.006 Life-Prolonging Measures: Medical staffs should develop general guidelines for the care of critically ill and/or terminally ill patients and should refer to the Current Opinions of the Board of Councilors and other Texas Medical Association policy for guidance and implementation of these guidelines (Board of Councilors, p 59, A-94; amended CHSO Rep. 2-A-05; reaffirmed CHSO Rep. 1-A-15).

85.007 Treatment of Terminally Ill: Treatment of the terminally ill patient should be handled on an individual basis. The physician, in consultation with the family and the patient, should determine in what setting the treatment can be most appropriately delivered (Council on Health Facilities, p 83, A-94; reaffirmed CHSO Rep. 2-A-05; reaffirmed CHSO Rep. 1-A-15).

85.008 Physician Assisted Suicide: The Texas Medical Association strongly opposes any bill to legalize physician-assisted suicide or euthanasia, as these practices are fundamentally inconsistent with the physician’s role as healer (Res. 29J, p 198, I-96; amended BOC Rep. 5-A-07; amended BOC Rep. 6-A-17).

85.009 Do Not Resuscitate Orders: The Texas Medical Association supports the right of terminally and chronically ill patients to utilize DNR orders in non-hospital settings (Medical Student Section, p 139, A-97; reaffirmed BOC Rep. 5-A-07; reaffirmed BOC Rep. 6-A-17).

85.010 Terminally Ill: Only one physician should be required to certify that a patient is terminally ill under the Texas Advance Directives Act rather than certification by two physicians (BOC Rep. 8-I-98; amended BOC Rep. 7-A-08; reaffirmed BOC Rep. 7-A-18).

85.011 Palliative Care: The Texas Medical Association (1) urges Texas medical schools to periodically assess the adequacy of their curricular content in preparing medical students and residents to respond to the special needs of patients requiring palliative care with the goals of maintaining the highest quality of life possible during the final stages of life and preparing physicians for clinical and ethical issues related to end-of-life care; and (2) encourages availability of continuing medical education courses on the clinical and ethical issues related to end-of-life care (Amended CME Rep. 2-I-98 and Sub. Res. 201-I-98; amended CME Rep. 1-A-08; reaffirmed CME Rep. 2-A-18).

85.012 Advance Directives: The Texas Medical Association encourages physicians who staff hospitals to attempt to obtain appropriate advance directives before discharging a patient (CM-EMS Rep. 4-A-00; reaffirmed CHSO Rep. 1-A-10).
85.013 Absence of Advance Directives: When patients have not executed advance directives, facility staff should be permitted to follow physician orders for patient care (CHSO Rep. 3-A-02; reaffirmed CHSO Rep. 2-A-12).

85.014 Physician Responsibility with End-of-Life Care: Physicians should educate themselves on the opportunities and responsibilities provided by state law governing advance directives and medical power of attorney and use all appropriate opportunities to educate their patients on the subject (Amended CHSO Rep. 1-A-05; reaffirmed CHSO Rep. 1-A-15).


85.016 Medical Orders for Scope of Treatment in Texas: The Texas Medical Association will work with other health care and community organizations to promote adoption of a statewide medical orders for scope of treatment (MOST) document, thus better promoting patient-centered care and enhancing communication about patient wishes between sites of care. TMA will encourage the development of education programs for physicians and patients about the appropriate use of MOST (Amended Res. 419-A-12; reaffirmed Res. 411-A-14; originally numbered 200.049; amended CHSO Rep. 2-A-15).

85.017 Medical Orders for Scope of Treatment Coalition Recommendations: The Texas Medical Association supports the use of a Medical Orders for Scope of Treatment (MOST) document that is: (a) a written expression of the unique values and goals of a patient in relation to medical care, expressed by a patient or a surrogate decisionmaker; (b) produced as a product of a conversation with a physician, a midlevel provider under appropriate supervision and delegation, or another person who is properly trained to conduct the conversation; (c) signed by the patient or, if the patient lacks capacity, by the patient’s surrogate decisionmaker(s); (d) verified and signed by a physician (or midlevel provider under proper delegation) who has established that the patient or surrogate understands and agrees with the form contents; (e) reevaluated periodically AND when there is a change in the patient’s status; (f) a guide concerning patient wishes for medical care to be used by any medical caregiver, but does not override any physician’s independent clinical decisionmaking; and (g) not legislatively mandated or modified in any way. TMA will work with the MOST Coalition to develop an education program for Texas physicians regarding the Medicare advance planning payments and the use of the MOST document (CHSO Rep. 2-A-16).

105.001 Consent for Medical and Surgical Treatment: The Texas Medical Association supports provision for consent for medical and surgical treatment by appropriate surrogate decision makers on behalf of incompetent or comatose patients (Res. 28M, p 148, I-91; reaffirmed BOC Rep. 3-A-03; reaffirmed BOC Rep. 6-A-13).

105.009 Informed Consent: An informed patient is the best patient, ethically and legally. Disclosure techniques and information recommended by the Texas Medical Disclosure Panel, in addition to other information which physicians may provide, enable patients to give an informed consent for proposed procedures (Board of Councilors, p 58, A-94; reaffirmed BOC Rep.3-A-04; reaffirmed BOC Rep. 6-A-14).

195.029 Registry for Advance Directives: The Texas Medical Association supports a Centers for Medicare & Medicaid Services requirement for all Medicare patients to register the advance directive of their choice to facilitate their end-of-life preferences being respected (Res. 307-A-09).
Related AMA Policy:

H-140.949 Physician-Assisted Suicide: The AMA will (1) initiate an educational campaign to make palliative treatment and care directions based on values-based advance care planning the standard of care for meeting the needs of patients at the end of life; and (2) will work with local, state, and specialty medical societies to develop programs to: facilitate referrals to physicians qualified to provide necessary palliative and other care for patients seeking help in meeting their physiological and psychological needs at the end of life; and establish a faculty of physicians with expertise in end-of-life care who can provide consultations for other physicians in caring for patients at the end of life.

5.7 Physician-Assisted Suicide: Physician-assisted suicide occurs when a physician facilitates a patient’s death by providing the necessary means and/or information to enable the patient to perform the life-ending act (e.g., the physician provides sleeping pills and information about the lethal dose, while aware that the patient may commit suicide).

It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life. However, permitting physicians to engage in assisted suicide would ultimately cause more harm than good.

Physician-assisted suicide is fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks.

Instead of engaging in assisted suicide, physicians must aggressively respond to the needs of patients at the end of life. Physicians:

(a) Should not abandon a patient once it is determined that cure is impossible.

(b) Must respect patient autonomy.

(c) Must provide good communication and emotional support.

(d) Must provide appropriate comfort care and adequate pain control.

AMA Principles of Medical Ethics: I,IV

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.

5.8 Euthanasia: Euthanasia is the administration of a lethal agent by another person to a patient for the purpose of relieving the patient’s intolerable and incurable suffering.

It is understandable, though tragic, that some patients in extreme duress—such as those suffering from a terminal, painful, debilitating illness—may come to decide that death is preferable to life.

However, permitting physicians to engage in euthanasia would ultimately cause more harm than good.

Euthanasia is fundamentally incompatible with the physician’s role as healer, would be difficult or impossible to control, and would pose serious societal risks. Euthanasia could readily be extended to incompetent patients and other vulnerable populations.

The involvement of physicians in euthanasia heightens the significance of its ethical prohibition. The physician who performs euthanasia assumes unique responsibility for the act of ending the patient’s life.
Instead of engaging in euthanasia, physicians must aggressively respond to the needs of patients at the end of life. Physicians:

(a) Should not abandon a patient once it is determined that a cure is impossible.
(b) Must respect patient autonomy.
(c) Must provide good communication and emotional support.
(d) Must provide appropriate comfort care and adequate pain control.

*AMA Principles of Medical Ethics: I,IV*

The Opinions in this chapter are offered as ethics guidance for physicians and are not intended to establish standards of clinical practice or rules of law.
Whereas, The incidence of bed bug (Cimex lectularius) infestations in Texas has been increasing at an alarming rate, with several cities routinely considered among the worst according to private industry; and

Whereas, Bed bugs are an important public health issue according to the Centers for Disease Control and Prevention, able to cause potentially serious physical, mental, and financial harm to individuals; and

Whereas, Bed bug infestations are insidious and refractory to treatment, often requiring multiple visits, and associated with significant material loss to individuals; and

Whereas, Children, the elderly, and those disabled by physical or psychiatric comorbidities are particularly vulnerable to bed bug infestations; and

Whereas, Multifamily dwelling units can function as a central location of dissemination to the overall population as infestations become even more refractory and insidious, spreading to adjacent units often without the knowledge of the building community; and

Whereas, The lack of a mechanism for the collection, analysis, and dissemination of data regarding bed bug infestations in Texas makes it difficult to evaluate its effect on public health; and

Whereas, Outside of Texas, many state and local municipalities have taken proactive legislative and regulatory steps to improve public awareness, and encourage the prompt reporting and complete treatment of bed bug infestations; and

Whereas, Despite the existing mandates in sections 341.011 and 341.012 of the Texas Health and Safety Code, the Texas Association of City and County Health Officials recognizes that current enforcement is difficult and that laws should be strengthened to further promote pest-free environments; and

Whereas, Bed bugs (Cimex lectularius) can cause potentially serious physical and mental harm to individuals and therefore are to be considered a public health issue; therefore be it

RESOLVED, That the Texas Medical Association consider bed bugs as a public health issue; and be it further

RESOLVED, That this resolution be referred to the appropriate Texas Medical Association council, committee, or body to seek a mechanism for the collection, study, and public reporting of data on the impact of bed bugs on the public health of Texans; and be it further

RESOLVED, That this resolution be referred to the appropriate TMA council, committee, or body to collaborate with the Texas Association of City and County Health Officials to develop guidelines for local health authorities using an Integrated Pest Management approach to bed bugs; and be it further
RESOLVED, That TMA in collaboration with the Texas Department of State Health Services support regulatory changes that encourage the reporting, treatment, and study of bed bugs in state-supported living centers; and be it further

RESOLVED, That TMA seek legislation to address the public health issue of bed bugs in Texas, most especially when affecting vulnerable populations or inhabitants of multifamily dwelling units (MDUs); and be it further

RESOLVED, That the Texas Delegation carry this resolution, or a similar one, to the American Medical Association to develop public health recommendations and seek regulatory or legislative action for this growing national public health issue, especially in regard to the collection, study, and public reporting of data on the impact of bed bugs; the effect of bed bug infestations on MDUs; and the U.S. Department of Housing and Urban Development’s role in bed bug management.

Related TMA Policy: None found.

Related AMA Policy: None found.

Sources:

Texas State Law

1. Sec. 341.011. NUISANCE. Each of the following is a public health nuisance:

   (1) a condition or place that is a breeding place for flies and that is in a populous area;
   (2) spoiled or diseased meats intended for human consumption;
   (3) a restaurant, food market, bakery, other place of business, or vehicle in which food is prepared, packed, stored, transported, sold, or served to the public and that is not constantly maintained in a sanitary condition;
   (4) a place, condition, or building controlled or operated by a state or local government agency that is not maintained in a sanitary condition;
   (5) sewage, human excreta, wastewater, garbage, or other organic wastes deposited, stored, discharged, or exposed in such a way as to be a potential instrument or medium in disease transmission to a person or between persons;
   (6) a vehicle or container that is used to transport garbage, human excreta, or other organic material and that is defective and allows leakage or spilling of contents;
   (7) a collection of water in which mosquitoes are breeding in the limits of a municipality or a collection of water that is a breeding area for mosquitoes that can transmit diseases regardless of the collection's location other than a location or property where activities meeting the definition of Section 11.002(12)(A), Water Code, occur;
   (8) a condition that may be proven to injuriously affect the public health and that may directly or indirectly result from the operations of a bone boiling or fat rendering plant, tallow or soap works, or other similar establishment;
   (9) a place or condition harboring rats in a populous area;
   (10)the presence of ectoparasites, including bedbugs, lice, and mites, suspected to be disease carriers in a place in which sleeping accommodations are offered to the public;
   (11)the maintenance of an open surface privy or an overflowing septic tank so that the contents may be accessible to flies; and
   (12)an object, place, or condition that is a possible and probable medium of disease transmission to or between humans.

2. Sec. 341.012. ABATEMENT OF NUISANCE.
   (a) A person shall abate a public health nuisance existing in or on a place the person possesses as soon as the person knows that the nuisance exists.
(b) A local health authority who receives information and proof that a public health nuisance exists in the local health authority's jurisdiction shall issue a written notice ordering the abatement of the nuisance to any person responsible for the nuisance. The local health authority shall at the same time send a copy of the notice to the local municipal, county, or district attorney.

c) The notice must specify the nature of the public health nuisance and designate a reasonable time within which the nuisance must be abated.

d) If the public health nuisance is not abated within the time specified by the notice, the local health authority shall notify the prosecuting attorney who received the copy of the original notice. The prosecuting attorney:

(1) shall immediately institute proceedings to abate the public health nuisance; or

(2) request the attorney general to institute the proceedings or provide assistance in the prosecution of the proceedings, including participation as an assistant prosecutor when appointed by the prosecuting attorney.

Subject: Regulation of Electric Scooters

Presented by: Bexar County Medical Society

Referred to: Reference Committee on Science and Public Health

Whereas, There has been an increase in safety issues concerning electric scooters; and

Whereas, Electric scooters are unregulated and cause unintentional hazards and/or injuries with operators leaving scooters laying on the ground and operating at high speeds on sidewalks and streets; and

Whereas, A recent *Journal of the American Medical Association* Network report mentions that a high percentage of scooter operators do not wear helmets, including children; therefore be it

RESOLVED, That the Texas Medical Association work with the Texas Department of Public Safety (DPS) to have electric scooters regulated as bicycles and require operators to follow traffic laws as bicycle operators; and be it further

RESOLVED, That TMA work with DPS to place an age restriction on electric scooter operators to limit the use of these scooters by children too young to understand traffic laws and to allow only one operator per scooter; and be it further

RESOLVED, That TMA work with DPS to require the use of helmets when operating electric scooters and to add safety features so that car drivers can see them.

Related 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 (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).

Related AMA Policy:

**H-10.964 Helmets for Riders of Motorized and Non-motorized Cycles:** General Helmet Use: Our AMA: (1) encourages physicians to counsel their patients who ride motorized and non-motorized cycles to use approved helmets and appropriate protective clothing while cycling; (2) encourages patients and families to inform and train children about safe cycle-riding procedures, especially on roads and at intersections, the need to obey traffic laws, and the need for responsible behavior; (3) encourages community agencies, such as those involving law enforcement, schools, and parent-teacher organizations, to promote training programs for the responsible use of cycles; (4) urges manufacturers to improve the safety and reliability of the vehicles they produce and to support measures to improve cycling safety; (5) advocates further research on the effectiveness of helmets and on the health outcomes of community programs that mandate their use; (6) encourages efforts to investigate the impact of helmet use by riders of motorcycles and all bicycles, in order to establish the risk of major medical trauma from not wearing helmets, the costs added to the health care system by such behavior, and the payers of these added costs
(i.e., private insurance, uncompensated care, Medicare, Medicaid, etc.); (7) supports the exploration of ways to ensure the wearing of helmets through the use of disincentives or incentives such as licensing fees, insurance premium adjustments and other payment possibilities.

Bicycles: Our AMA: (1) actively supports bicycle helmet use and encourages physicians to educate their patients about the importance of bicycle helmet use; (2) encourages the manufacture, distribution, and utilization of safe, effective, and reasonably priced bicycle helmets; and (3) encourages the availability of helmets at the point of bicycle purchase.

Scooters: Our AMA: (1) recommends the use of protective gear (certified helmets, elbow and knee pads, closed-toe shoes) for riders of scooters, especially children and adolescents; (2) encourages physicians to counsel patients, and their parents when appropriate, that full protective equipment should be worn and appropriate safety measures should be taken to prevent scooter injuries (e.g., riding away from traffic, and close supervision of riders under the age of eight); and (3) urges companies that manufacture or sell scooters to include appropriate information about the safe use of scooters on the scooters themselves, on or inside scooter packaging, on their web sites, and at the point of sale.

Motorcycles: Our AMA: (1) encourages physicians to be aware of motorcycle risks and safety measures and to counsel their patients who ride motorcycles to wear appropriate protective gear and helmets that meet federal safety standards, receive appropriate training in the safe operation of their motorcycle, comply with state licensing laws, and avoid riding a motorcycle while under the influence of alcohol and other drugs; (2) endorses the concept of legislative measures to require the use of helmets when riding or driving a motorcycle; (3) supports federal regulatory rules to make the receipt of federal highway funds by a state dependent on passage of mandatory motorcycle helmet laws by that state; (4) urges constituent societies to support the enactment or preservation of state motorcycle helmet laws; and (5) supports rider education legislation, which is more easily implemented and more effective than legislation requiring manufacturers to emphasize the dangers of operating motorcycles.
Resolution 309
A-19

Subject: Factoring Adolescent Sleep Patterns into Middle and High School Start Times

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, 72.7 percent of high school students sleep less than the consensus recommendation by the American Academy of Sleep Medicine (AASM) of eight to 10 hours; and

Whereas, 57.8 percent of middle school students sleep less than the consensus recommendation by AASM of nine to 12 hours; and

Whereas, Adolescents who get less than the recommended amount of sleep have double the risk of being overweight or obese, which is associated with an increased risk for metabolic syndrome; and

Whereas, Partial sleep restriction for even one week in healthy individuals increases risk of atherosclerosis and cardiovascular disease; and

Whereas, Sleep deprivation decreases memory consolidation, recall, cognitive function, and learning outcomes in adolescents; and

Whereas, Sleep deprivation in adolescents has negative impacts on mental health, including increased depression, anxiety, and suicidal ideation; and

Whereas, Chronic sleep loss increases impulsivity and risky behaviors such as substance use; and

Whereas, Adolescents experience a natural delay in sleep onset, with teenagers struggling to fall asleep before 11 pm, leading to late-morning awakening; and

Whereas, Only 12 percent of school districts in Texas and fewer than 20 percent of middle and high schools in the United States have a start time of 8:30 am or later as recommended by the American Academy of Pediatrics (AAP) and the American Medical Association; and

Whereas, Opening schools later substantially increases the amount of sleep adolescents receive; and

Whereas, Starting school later improves student well-being, mood, and depressive symptoms; and

Whereas, Delaying high school start times leads to increased attendance, graduation rates, and academic performance outcomes in core subjects on state and national exams; and

Whereas, The majority of parents and principals in Texas’ largest school district, Houston Independent School District, voted for start times of 8:30 am or later for middle and high school students; and

Whereas, AAP and AMA support middle and high school start times of 8:30 am or later; therefore be it
RESOLVED, That the Texas Medical Association encourage physicians to be informed on the biologic sleep needs of adolescents, promote awareness of this need to the community, and communicate with local school health advisory committees to share evidence-based, best practices regarding health promotion, including the benefits of later school start times for adolescents.

Related TMA 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).

Related AMA Policy:

H-60.930 Insufficient Sleep in Adolescents:
1. Our AMA identifies adolescent insufficient sleep and sleepiness as a public health issue and supports education about sleep health as a standard component of care for adolescent patients.
2. Our AMA: (a) encourages school districts to aim for the start of middle schools and high schools to be no earlier than 8:30 a.m., in order to allow adolescents time for adequate sleep; (b) encourages physicians, especially those who work closely with school districts, to become actively involved in the education of parents, school administrators, teachers, and other members of the community to stress the importance of sleep and consequences of sleep deprivation among adolescents, and to encourage school districts to structure school start times to accommodate the biologic sleep needs of adolescents; and (c) encourages continued research on the impact of sleep on adolescent health and academic performance.

Sources:


Subject: Amending TMA Policy 315.031, Restricting the Sale of Electronic Cigarettes to Minors

Resolved, That the Texas Medical Association amend Policy 315.031, Restricting the Sale of Electronic Cigarettes to Minors as follows:

1. Whereas, People between 18 and 21 years of age have the highest rate of JUUL use, the most common electronic cigarette, occupying 70 percent of the electronic cigarette market in 2019; and
2. Whereas, Electronic cigarettes can deliver the addictive substance nicotine to the body, including some electronic cigarettes that deliver nicotine at levels higher than combustible cigarettes; and
3. Whereas, Adolescents who use electronic cigarettes are 6.17 times more likely to smoke cigarettes as they transition to adulthood; and
4. Whereas, Texans pay $8.85 billion annually in smoking-caused health bills, while 28,000 Texans die each year from smoking-related illness; and
5. Whereas, The aerosol that users inhale and exhale from e-cigarettes potentially exposes both themselves and bystanders to harmful substances, including heavy metals, volatile organic compounds, and ultrafine particles that can be inhaled deeply into the lung; and
6. Whereas, The cytotoxic profile of electronic cigarettes adversely impacts the pulmonary, cardiovascular, immune, and central nervous systems; and
7. Whereas, Nicotine exposure to people under 21 years of age can cause damage to the brain, which continues to develop until 25 years of age; and
8. Whereas, Nicotine use in people under 21 years of age can adversely impact memory, attention, and learning; and
9. Whereas, Electronic cigarette usage grew by 78 percent (approximately 1.3 million people) from December 2017 to December 2018 among high school students nationwide; and
10. Whereas, The most common reason cited for using JUUL is seeing a person in a social circle using it; and
11. Whereas, More than half the people aged 18 years or younger who use JUUL receive it from a social source; and
12. Whereas, Increasing the purchase age of electronic cigarettes to 21 years or older will make electronic cigarettes less likely to be in the same social networks as high school students; therefore be it
13. RESOLVED, That the Texas Medical Association amend Policy 315.031, Restricting the Sale of Electronic Cigarettes to Minors as follows:
The Texas Medical Association supports (1) limiting the sale of electronic cigarettes (e-cigarettes) and associated products only to those people who are 18 to 21 years of age or older; (2) regulation of e-cigarettes in Texas in a similar manner as tobacco products; (3) increased clinical research on the effects of e-cigarettes; and (4) education in schools for children and adolescents about the effects of e-cigarettes, nicotine, tobacco, and other addictive substances (Res. 305-A-14).

Related TMA Policy:

315.030 Physicians and Regulation of Electronic Cigarettes: The Texas Medical Association will (1) work with the Texas Department of State Health Services to develop communications for physicians to share with patients on e-cigarettes and associated products and to encourage the Texas Quit line to identify the use of e-cigarettes by callers; (2) encourage physicians to work with their county medical societies and local public officials to ensure that current smoke-free ordinances include e-cigarettes and associated products; and (3) work with the Texas Legislature to restrict the purchase of e-cigarettes and associated products by minors (CSPH Rep. 4-A-14).

Related AMA Policy:

H-495.986 Sales and Distribution of Tobacco Products and Electronic Nicotine Delivery Systems (ENDS) and E-cigarettes: Our AMA: (1) recognizes the use of e-cigarettes and vaping as an urgent public health epidemic and will actively work with the Food and Drug Administration and other relevant stakeholders to counteract the marketing and use of addictive e-cigarette and vaping devices, including but not limited to bans and strict restrictions on marketing to minors under the age of 21; (2) encourages the passage of laws, ordinances and regulations that would set the minimum age for purchasing tobacco products, including electronic nicotine delivery systems (ENDS) and e-cigarettes, at 21 years, and urges strict enforcement of laws prohibiting the sale of tobacco products to minors; (3) supports the development of model legislation regarding enforcement of laws restricting children's access to tobacco, including but not limited to attention to the following issues: (a) provision for licensure to sell tobacco and for the revocation thereof; (b) appropriate civil or criminal penalties (e.g., fines, prison terms, license revocation) to deter violation of laws restricting children's access to and possession of tobacco; (c) requirements for merchants to post notices warning minors against attempting to purchase tobacco and to produce proof of age for would-be purchasers; (d) measures to facilitate enforcement; (e) banning out-of-package cigarette sales ("loosies"); and (f) requiring tobacco purchasers and vendors to be of legal smoking age; (4) requests that states adequately fund the enforcement of the laws related to tobacco sales to minors; (5) opposes the use of vending machines to distribute tobacco products and supports ordinances and legislation to ban the use of vending machines for distribution of tobacco products; (6) seeks a ban on the production, distribution, and sale of candy products that depict or resemble tobacco products; (7) opposes the distribution of free tobacco products by any means and supports the enactment of legislation prohibiting the disbursement of samples of tobacco and tobacco products by mail; (8) (a) publicly commends (and so urges local medical societies) pharmacies and pharmacy owners who have chosen not to sell tobacco products, and asks its members to encourage patients to seek out and patronize pharmacies that do not sell tobacco products; (b) encourages other pharmacists and pharmacy owners individually and through their professional associations to remove such products from their stores; (c) urges the American Pharmacists Association, the National Association of Retail Druggists, and other pharmaceutical associations to adopt a position calling for their members to remove tobacco products from their stores; and (d) encourages state medical associations to develop lists of pharmacies that have voluntarily banned the sale of tobacco for distribution to their members; and
(9) opposes the sale of tobacco at any facility where health services are provided; and (10) supports that the sale of tobacco products be restricted to tobacco specialty stores.

H-495.973 FDA to Extend Regulatory Jurisdiction Over All Non-Pharmaceutical Nicotine and Tobacco Products: Our AMA:

(1) supports the U.S. Food and Drug Administration's (FDA) proposed rule that would implement its deeming authority allowing the agency to extend FDA regulation of tobacco products to pipes, cigars, hookahs, e-cigarettes and all other non-pharmaceutical tobacco/nicotine products not currently covered by the Federal Food, Drug, and Cosmetic Act, as amended by the Family Smoking Prevention and Tobacco Control Act;

(2) supports legislation and/or regulation of electronic cigarettes and all other non-pharmaceutical tobacco/nicotine products that: (a) establishes a minimum legal purchasing age of 21; (b) prohibits use in all places that tobacco cigarette use is prohibited, including in hospitals and other places in which health care is delivered; (c) applies the same marketing and sales restrictions that are applied to tobacco cigarettes, including prohibitions on television advertising, product placement in television and films, and the use of celebrity spokespeople; (d) prohibits product claims of reduced risk or effectiveness as tobacco cessation tools, until such time that credible evidence is available, evaluated, and supported by the FDA; (e) requires the use of secure, child- and tamper-proof packaging and design, and safety labeling on containers of replacement fluids (e-liquids) used in e-cigarettes; (f) establishes manufacturing and product (including e-liquids) standards for identity, strength, purity, packaging, and labeling with instructions and contraindications for use; (g) requires transparency and disclosure concerning product design, contents, and emissions; and (h) prohibits the use of characterizing flavors that may enhance the appeal of such products to youth; and

(3) urges federal officials, including but not limited to the U.S. Food and Drug Administration to: (a) prohibit the sale of any e-cigarette cartridges and e-liquid refills that do not include a complete list of ingredients on its packaging, in the order of prevalence (similar to food labeling); and (b) require that an accurate nicotine content of e-cigarettes, e-cigarette cartridges, and e-liquid refills be prominently displayed on the product alongside a warning of the addictive quality of nicotine.

Sources:


TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 311
A-19

Subject: Identifying Trauma and Mental Health Susceptibilities in Schools

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, Student mental health concerns have been brought to the forefront by recent traumatic events such as the Santa Fe shooting and Hurricane Harvey; and

Whereas, Environmental sources of mental stress can induce depression, post-traumatic stress disorder, substance use, other mental disorders, learning difficulties, behavioral issues, and poor developmental and health outcomes that persist long into adulthood; and

Whereas, Community epidemiological studies have found that approximately 20 percent of American children and adolescents are currently experiencing symptoms that would qualify them for a psychiatric diagnosis, yet only a very small percentage of these youth are typically identified; and

Whereas, Key environmental protective factors, which include attachment to nurturing caregivers, a sense of belonging, and a protective community, have been associated with the development of “resilience” in a child that can buffer him or her from the negative health outcomes associated with adverse childhood events; and

Whereas, Because children spend a significant portion of their time in school, educators can play a key role in fostering protective environments for children and identifying children who may need additional support; and

Whereas, It has been shown that school-based mental health identification efforts, including teacher identification efforts, have been successful in promoting the identification of those in need of mental health services, and the improvement of academic and mental health functioning; and

Whereas, The National Alliance on Mental Illness and Mental Health of America, nationally recognized advocacy groups for the advancement of mental illness treatment, as well as the American Academy of Pediatrics support mental health services being provided in a school-based format; and

Whereas, Although Texas law mandates that teachers be trained in recognizing trauma, it requires only one training for new teachers when they are hired, with no requirement for refresher trainings; and

Whereas, Texas Medical Association Policy 215.019, Public Mental Health Care already 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; and (4) innovative and evidence-based approaches for the early detection and prevention of mental illness (Res. 201-A-07; amended CSPH Rep. 3-A-17); therefore be it

RESOLVED, That the Texas Medical Association advocate for school-based systems of mental health care that provide an integrated system of educator training, referral to treatment, and clear access to providers.
Related TMA Policy:

55.033 Children's Mental and Behavioral Health: 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:

   h. Adequate numbers and quality of mental health professionals throughout the state,
   i. Coordinating with the educational system for mentally healthy schools, and

Related AMA Policy:

H-345.977 Improving Pediatric Mental Health Screening: Our AMA: (1) recognizes the importance of, and supports the inclusion of, mental health (including substance use, abuse, and addiction) screening in routine pediatric physicals; (2) will work with mental health organizations and relevant primary care organizations to disseminate recommended and validated tools for eliciting and addressing mental health (including substance use, abuse, and addiction) concerns in primary care settings; and (3) recognizes the importance of developing and implementing school-based mental health programs that ensure at-risk children/adolescents access to appropriate mental health screening and treatment services and supports efforts to accomplish these objectives.

D-345.994 Increasing Detection of Mental Illness and Encouraging Education: 1. Our AMA will work with: (A) mental health organizations, state, specialty, and local medical societies and public health groups to encourage patients to discuss mental health concerns with their physicians; and (B) the Department of Education and state education boards and encourage them to adopt basic mental health education designed specifically for preschool through high school students, as well as for their parents, caregivers and teachers.

2. Our AMA will encourage the National Institute of Mental Health and local health departments to examine national and regional variations in psychiatric illnesses among immigrant, minority, and refugee populations in order to increase access to care and appropriate treatment.

H-60.929 National Child Traumatic Stress Network: Our AMA: 1) recognizes the importance of and support the widespread integration of evidence-based pediatric trauma services with appropriate post-traumatic mental and physical care, such as those developed and implemented by the National Child Traumatic Stress Initiative; and 2) will work with mental health organizations and relevant healthcare organizations to support full funding of the National Child Traumatic Stress Initiative at FY 2011 levels at minimum and to maintain the full mission of the National Child Traumatic Stress Network.

H-130.946 AMA Leadership in the Medical Response to Terrorism and Other Disasters: Our AMA: (1) Condemns terrorism in all its forms and provide leadership in coordinating efforts to improve the medical and public health response to terrorism and other disasters.

   (2) Will work collaboratively with the Federation in the development, dissemination, and evaluation of a national education and training initiative, called the National Disaster Life Support Program, to provide physicians, medical students, other health professionals, and other emergency responders with a fundamental understanding and working knowledge of their integrated roles and responsibilities in disaster management and response efforts.

   (3) Will join in working with the Department of Homeland Security, the Department of Health and Human Services, the Department of Defense, the Federal Emergency Management Agency, and other appropriate
federal agencies; state, local, and medical specialty societies; other health care associations; and private
foundations to (a) ensure adequate resources, supplies, and training to enhance the medical and public health
response to terrorism and other disasters; (b) develop a comprehensive strategy to assure surge capacity to
address mass casualty care; (c) implement communications strategies to inform health care professionals and
the public about a terrorist attack or other major disaster, including local information on available medical and
mental health services; (d) convene local and regional workshops to share "best practices" and "lessons
learned" from disaster planning and response activities; (e) organize annual symposia to share new scientific
knowledge and information for enhancing the medical and public health response to terrorism and other
disasters; and (f) develop joint educational programs to enhance clinical collaboration and increase physician
knowledge of the diagnosis and treatment of depression, anxiety, and post-traumatic stress disorders
associated with exposure to disaster, tragedy, and trauma.

(4) Believes all physicians should (a) be alert to the occurrence of unexplained illness and death in the
community; (b) be knowledgeable of disease surveillance and control capabilities for responding to unusual
clusters of diseases, symptoms, or presentations; (c) be knowledgeable of procedures used to collect patient
information for surveillance as well as the rationale and procedures for reporting patients and patient
information; (d) be familiar with the clinical manifestations, diagnostic techniques, isolation precautions,
decontamination protocols, and chemotherapy/prophylaxis of chemical, biological, and radioactive agents
likely to be used in a terrorist attack; (e) utilize appropriate procedures to prevent exposure to themselves and
others; (f) prescribe treatment plans that may include management of psychological and physical trauma; (g)
understand the essentials of risk communication so that they can communicate clearly and nonthreateningly
with patients, their families, and the media about issues such as exposure risks and potential preventive
measures (e.g., smallpox vaccination); and (h) understand the role of the public health, emergency medical
services, emergency management, and incident management systems in disaster response and the individual
health professional's role in these systems.

(5) Believes that physicians and other health professionals who have direct involvement in a mass casualty
event should be knowledgeable of public health interventions that must be considered following the onset of a
disaster including: (a) quarantine and other movement restriction options; (b) mass
immunization/chemoprophylaxis; (c) mass triage; (d) public education about preventing or reducing
exposures; (e) environmental decontamination and sanitation; (f) public health laws; and (g) state and federal
resources that contribute to emergency management and response at the local level.

(6) Believes that physicians and other health professionals should be knowledgeable of ethical and legal
issues and disaster response. These include: (a) their professional responsibility to treat victims (including
those with potentially contagious conditions); (b) their rights and responsibilities to protect themselves from
harm; (c) issues surrounding their responsibilities and rights as volunteers, and (d) associated liability issues.

(7) Believes physicians and medical societies should participate directly with state, local, and national public
health, law enforcement, and emergency management authorities in developing and implementing disaster
preparedness and response protocols in their communities, hospitals, and practices in preparation for terrorism
and other disasters.

(8) Urges Congress to appropriate funds to support research and development (a) to improve understanding of
the epidemiology, pathogenesis, and treatment of diseases caused by potential bioweapon agents and the
immune response to such agents; (b) for new and more effective vaccines, pharmaceuticals, and antidotes
against biological and chemical weapons; (c) for enhancing the shelf life of existing vaccines,
pharmaceuticals, and antidotes; and (d) for improving biological chemical, and radioactive agent detection
and defense capabilities.
**Sources:**

Whereas, The Supplemental Nutrition Assistance Program (SNAP), commonly known as “food stamps,” provides financial assistance to low-income individuals and families to address domestic hunger; and

Whereas, SNAP is a federal-state partnership, with the federal government funding 100 percent of recipients’ food expenditures and up to 50 percent of administrative costs for the program, with states funding the remaining administrative costs; and

Whereas, SNAP serves 38 million people in the United States and 3.5 million individuals in Texas alone; and

Whereas, In Texas, SNAP prevents more than 900,000 recipients, including 479,000 children, from falling below the poverty line annually due to family expenditures on food; and

Whereas, SNAP usage is associated with improved nutrition, better health outcomes, and lower cost of health care among recipients; and

Whereas, In order for individuals to qualify for SNAP, federal law requires work or participation in employment and training programs for certain adults aged 18 to 59; and

Whereas, Efforts to increase work requirements for recipients of welfare programs can have negative effects on recipients’ health outcomes and limit their ability to find stable employment; and

Whereas, Many recipients register for SNAP only after losing employment, and more than 80 percent report securing employment within a year after starting to receive SNAP benefits; and

Whereas, Many able-bodied SNAP recipients who are unemployed are forced to report health issues as their reason for not working enough to qualify for benefits; and

Whereas, Increased work requirements to qualify for SNAP have the potential to create administrative barriers that prevent even working recipients from receiving benefits; and

Whereas, Both federal and state governments share authority over SNAP work requirements, and states can exempt recipients from federal work requirements at their discretion to allow more individuals to benefit from SNAP; and

Whereas, The Agriculture Improvement Act of 2018, commonly known as the “farm bill,” continues funding for SNAP through September 2023; and
Whereas, The U.S. House of Representatives’ original version of the 2018 farm bill would have extended work requirements to all adults capable of work and increased states’ administrative duties to implement these requirements, leading to opposition in Congress and the removal of this provision; and

Whereas, In a recent letter to the U.S. Senate, the American Medical Association expressed its support for the preservation of SNAP and opposed increasing work requirements that would reduce benefits for recipients, as proposed by the U.S. House of Representatives; and

Whereas, The Food and Nutrition Service proposed a new rule on Feb. 1, 2019, that would limit states’ authority to exempt recipients from work requirements; therefore be it

RESOLVED, That the Texas Medical Association oppose any governmental efforts to increase work requirements for the Supplemental Nutrition Assistance Program (SNAP) beyond the level detailed in the Agriculture Improvement Act of 2018; and be it further

RESOLVED, That TMA oppose any governmental efforts to limit the Texas government’s ability to exempt SNAP recipients from work requirements.

Related TMA Policy:

190.037 Medicaid Work Requirements: The Texas Medical Association opposes: (1) any federal Medicaid waiver seeking to impose mandatory work requirements, but instead collaborate with lawmakers, the Texas Health and Human Services Commission, and the Centers for Medicare & Medicaid Services to support constructive measures to help Medicaid enrolled and eligible patients overcome barriers that prevent them from working or engaging in other meaningful community activities; (2) efforts to impose lifetime limits on adult Medicaid enrollees; and (3) any policy or regulation that punitively limits access to affordable health care for Medicaid-eligible patients (CSE Rep. 6-A-18).

190.038 Opposition to Medicaid Work Requirements: The Texas Medical Association will apply all appropriate resources to oppose Medicaid work requirements to ensure that vulnerable, low-income adults with children and other covered populations continue to receive necessary medical services and that Texas does not increase uncompensated care for physicians (Res. 402-A-18).

260.095 Eligibility of Sugar-Sweetened Beverages for SNAP and Counseling: The Texas Medical Association 1) will develop educational materials for physicians to support their efforts to inform and counsel parents and their children about the effects of sugar-sweetened beverages (SSBs) and high-fat, -salt, or -carbohydrate foods on obesity and overall health; and 2) encourages the Texas Health and Human Services Commission (HHSC) to include educational materials about nutrition and healthy food and beverage choices in routine materials that are currently sent to Supplemental Nutrition Assistance Program (SNAP) recipients along with the revised eligible foods and beverages guidelines and to extend local programs that multiply value for the purchase of fresh fruits and vegetables under SNAP; and 3) will work with both the Texas Legislature and the HHSC to remove SSBs from SNAP (Amended Res. 302-A-13; amended CSPH Rep. 4-A-18).

Related AMA Policy:

H-150.937 Improvements to Supplemental Nutrition Programs: Our AMA will actively lobby Congress to preserve and protect the Supplemental Nutrition Assistance Program through the reauthorization of the 2018 Farm Bill in order for Americans to live healthy and productive lives.
Sources:


Subject: Physicians Counseling Patients About the Risks of Direct-to-Consumer Genetic Testing

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, Direct-to-consumer genetic tests are genetic tests marketed directly to consumers and can be bought online or in stores; and

Whereas, Personal genome services (PGSs) such as 23andMe and Ancestry.com sell direct-to-consumer genetic tests to the public; and

Whereas, Texas Medical Association Policy 155.008 addresses the issue that genetic testing and interpretation should be done by a physician, and “appropriate informed consent should occur prior to testing”; and

Whereas, Direct-to-consumer genetic tests may be unreliable because they rely on invalidated algorithms, single nucleotide polymorphisms that may underpredict or overpredict the risk of disease, and they fail to take into consideration the multi-factorial nature of health; and

Whereas, The Federal Drug Administration recognizes direct-to-consumer genetic tests can be unreliable and may persuade patients to undergo unnecessary health procedures; and

Whereas, Patients use the information from direct-to-consumer genetic tests to make their health decisions; and

Whereas, Collection of genetic information creates the risk of privacy violation because genetic information cannot be de-identified, and large-scale data breaches are common; and

Whereas, Unauthorized access to personal genetic information can result in unintended consequences, including but not limited to employers discriminating against employees, genetic information being used for state surveillance, and genetic information being used to influence decisions; and

Whereas, Genetic information can be used to target advertising; and

Whereas, Collected genetic information has been and can be distributed to pharmaceutical companies; and

Whereas, Pharmaceutical companies do not have to obtain informed consent before using genetic information for research; and

Whereas, PGSs that do obtain informed consent may not obtain it for all uses of genetic material or may change their policies; and

Whereas, Failure to gain informed consent is a violation of biomedical research ethics; therefore be it
RESOLVED, That the Texas Medical Association support establishing policies that promote educating the public about potential risks created by direct-to-consumer genetic testing; and be it further

RESOLVED, That TMA support encouraging physicians to caution patients on risks that direct-to-consumer genetic testing can pose, including but not limited to unreliable test results and privacy violations.

Related TMA Policy:

105.009 Informed Consent: An informed patient is the best patient, ethically and legally. Disclosure techniques and information recommended by the Texas Medical Disclosure Panel, in addition to other information which physicians may provide, enable patients to give an informed consent for proposed procedures (Board of Councilors, p 58, A-94; reaffirmed BOC Rep.3-A-04; reaffirmed BOC Rep. 6-A-14).

155.008 Direct Access Laboratory Testing: Patients are best served when laboratory tests are ordered by qualified physicians, a physician directs the course of a patient’s diagnostic and therapeutic care, and a physician determines which clinical and anatomic laboratory services are appropriate. Individual pathologists, pathology groups, or laboratories should decide for themselves whether to accept requests for diagnostic laboratory studies directly from patients and should retain the right to refuse direct access laboratory testing requests. More information about risks and benefits of direct access laboratory testing is needed, such as data on whether direct access laboratory testing improves health and wellness or reduces morbidity or mortality rates. To ensure maximum safety and quality, direct access laboratory testing should occur with the following stipulations: (a) It should be confidential (not anonymous) with contact information provided by the patient. Anonymous testing should occur only with built-in assurances of patient follow up for counseling; (b) It must be performed by a laboratory certified by the Clinical Laboratory Improvement Amendments. The results should be provided to the patient, and the laboratory physician should review the results with the patient. The responsibility for subsequent actions are solely that of the patient; (c) Appropriate informed consent should occur prior to testing; (d) Only tests licensed in the United States for diagnostic testing should be performed (e.g., no research tests); and (e) Appropriate reflex/confirmatory testing should be performed. Repeat testing should be done if appropriate, with the patient contacted if additional blood specimens are needed (Amended BOT Rep. 15-A-06; amended CHCQ Rep. 2-A-16).

Related AMA Policy:

4.1.1 Genetic Testing & Counseling: Genetic testing can provide valuable information to support informed decision making about personal health risks and care options as well as reproductive choices. The fact that genetic information carries implications for others to whom the individual is biologically related raises ethical challenges of balancing confidentiality against the well-being of others. Because genetic contribution to disease can be complex and highly variable, interpreting findings and helping patients understand the implications for their health and health care requires special skill and attention. Genetic testing is most appropriate when the results of testing will have meaningful impact on the patient’s care. Physicians should not encourage testing unless there is effective therapy available to prevent or ameliorate the condition tested for. Whether a genetic test is performed to help diagnose an existing health condition, or to predict future health risks, or to provide information for managing a disease, it is important that the patient receives appropriate counseling. Physicians who order genetic tests (individually or as part of a multi-test panel or large-scale sequencing) or who offer clinical genetic services should: (a) Have appropriate knowledge and expertise to counsel patients about heritable conditions, risks for disease, and implications for health management, and to interpret findings of individual genetic tests or collaborate with other health care professionals who can provide these services, such as licensed genetic counselors. (b) Adhere to standards of nondirective counseling and avoid imposing their personal moral values or judgment on the patient. (c) Discuss with the patient: (i) what can and cannot be learned from the proposed genetic test(s) and reasons for and against testing, including the possibility of incidental findings. Physicians should ascertain whether the patient wishes to be informed about findings unrelated to the goal of testing; (ii) medical and psychological
implications for the individual’s biological relatives; (iii) circumstances under which the physician will expect
the patient to notify biological relatives of test findings; and (iv) that the physician will be available to assist in
communicating with relatives. (d) Obtain the individual’s informed consent for the specific test or tests to be
performed. (e) Ensure that appropriate measures are taken to protect the confidentiality of the patient’s and
their biological relatives’ genetic information.

4.1.2 Genetic Testing for Reproductive Decision Making: Genetic testing can provide information to help
prospective parents make informed decisions about childbearing. Genetic testing to inform reproductive
decisions was once recommended only for women/couples whose family history or medical record indicated
an elevated risk for a limited set of genetically mediated conditions. As procreation among individuals of diverse
ancestries becomes more common and tests for more conditions become more accurate and less costly, the
relevance of broad preconception, pre-implantation, or prenatal genetic screening grows stronger. Physicians
may ethically provide genetic testing to inform reproductive decision making when the patient requests, but
may also wish to offer broad screening to all persons who are considering having a child. Physicians who
provide reproductive health care that includes genetic testing should: (a) Adhere to standards of non-directive
counseling and avoid imposing their personal moral values or judgment on the patient. (b) Discuss reasons for
and against genetic testing and ethically inappropriate uses of genetic testing, such as to identify non-disease-
related characteristics or traits. (c) Obtain the individual’s informed consent to the specific test or tests to be
performed. Physicians should ascertain whether the person wishes to be informed about incidental findings.
(d) Inform the individual about any abnormal findings for the tests ordered and discuss the severity of the
associated health condition, likelihood of clinical manifestation (penetrance), age at onset, and other factors
relevant to a decision about childbearing. (e) Respect an individual’s decision to terminate or continue a
pregnancy when testing reveals a genetic abnormality in the fetus, in accordance with applicable law. (f)
Refer the individual to another qualified physician when personal moral values prohibit the physician from
providing lawful abortion services when this is a service that the person desires, in keeping with ethics
guidance.

H480.944 Improving Genetic Testing and Counseling Services: Our AMA supports: (1) appropriate
utilization of genetic testing, pre- and post-test counseling for patients undergoing genetic testing, and
physician preparedness in counseling patients or referring them to qualified genetics specialists; (2) the
development and dissemination of guidelines for best practice standards concerning pre- and post-test genetic
counseling; and (3) research and open discourse concerning issues in medical genetics, including genetic
specialist workforce levels, physician preparedness in the provision of genetic testing and counseling services,
and impact of genetic testing and counseling on patient care and outcomes.

D-480.987 Direct-to-Consumer Marketing and Availability of Genetic Testing: (1) recommends that
genetic testing be carried out under the personal supervision of a qualified health care professional; (2)
encourages individuals interested in obtaining genetic testing to contact a qualified healthcare professional for
further information; (3) will work with relevant organizations to develop criteria on what constitutes an
acceptable advertisement for a direct-to-consumer genetic test; (4) encourages the U.S. Federal Trade
Commission, with input from the U.S. Food and Drug Administration and the Centers for Medicare and
Medicaid Services, to require that direct-to-consumer advertisements for genetic testing are truthful and not
misleading; such advertisements should include all relevant information regarding capabilities and limitations
of the tests, and contain a statement referring patients to physicians to obtain further information; (5) will
work to educate and inform physicians regarding the types of genetic tests that are available directly to
consumers, including information about the lack of scientific validity associated with some direct-to-
consumer genetic tests, so that patients can be appropriately counseled on the potential harms.

4.1.3 Third-Party Access to Genetic Information: The rapid pace of development and dissemination of
genetic testing has made it possible to generate information about individuals across a wide and growing
spectrum of genetic variations associated with disease risk. The prospect of access to and use of such information by third parties who have a stake in an individual’s health raises ethical concerns about confidentiality and potentially inappropriate use of genetic information. Patients who undergo genetic testing have a right to have their information kept in confidence, and a variety of state and federal laws prohibit discrimination by employers, insurers, and other third parties based on genetic information they obtain about an individual. Physicians who provide and interpret genetic tests, or who maintain patient records that include the findings of genetic tests, have professional ethical obligations to: (a) Maintain the confidentiality of the patient’s health information, including genetic information. (b) Release a patient’s genetic information to third parties only with the patient’s informed consent. (c) Decline to participate in genetic testing at the request of third parties (for example, for purposes of establishing health care or other benefits or coverage for the individual) except when at the patient’s request and with their informed consent.

**H-55.979 Genetic Susceptibility Testing for Hereditary Cancers:** (1) That physicians who feel unprepared to provide comprehensive genetic test counseling should refer candidates for genetic susceptibility testing to specialized care centers with experience and expertise in hereditary cancers or to investigators for relevant research, where family history can be confirmed and they can be tested if they so choose. (2) That genetic susceptibility testing, including that marketed directly to consumers, should be provided only in the context of fully informed consent and comprehensive pre- and post-test counseling by a qualified health care professional.

**H-460.908 Genomic-Based Personalized Medicine:** (1) acknowledges the increasingly important role of genomic-based personalized medicine applications in the delivery of care, and will continue to assist in informing physicians about relevant personalized medicine issues; (2) will continue to develop educational resources and point-of-care tools to assist in the clinical implementation of genomic-based personalized medicine applications, and will continue to explore external collaborations and additional funding sources for such projects; and (3) will continue to represent physicians' voices and interests in national policy discussions of issues pertaining to the clinical implementation of genomic-based personalized medicine, such as genetic test regulation, clinical validity and utility evidence development, insurance coverage of genetic services, direct-to-consumer genetic testing, and privacy of genetic information.

**H-460.931 Genetics Testing Legislation:** The AMA opposes legislative initiatives on genetic testing that would unduly restrict the ability to use stored tissue for medical research; and will continue to support existing federal and private accreditation and quality assurance programs designed to ensure the accuracy and reliability of tests, but oppose legislation that could establish redundant or duplicative federal programs of quality assurance in genetic testing.

**H-315.983 Patient Privacy and Confidentiality:** 1. Our AMA affirms the following key principles that should be consistently implemented to evaluate any proposal regarding patient privacy and the confidentiality of medical information: (a) That there exists a basic right of patients to privacy of their medical information and records, and that this right should be explicitly acknowledged; (b) That patients' privacy should be honored unless waived by the patient in a meaningful way or in rare instances when strong countervailing interests in public health or safety justify invasions of patient privacy or breaches of confidentiality, and then only when such invasions or breaches are subject to stringent safeguards enforced by appropriate standards of accountability; (c) That patients' privacy should be honored in the context of gathering and disclosing information for clinical research and quality improvement activities, and that any necessary departures from the preferred practices of obtaining patients' informed consent and of de-identifying all data be strictly controlled; (d) That any information disclosed should be limited to that information, portion of the medical record, or abstract necessary to fulfill the immediate and specific purpose of disclosure; and (e) That the Health Insurance Portability and Accountability Act of 1996 (HIPAA) be the minimal standard for protecting clinician-patient privilege, regardless of where care is received. 2. Our AMA affirms: (a) that physicians and
medical students who are patients are entitled to the same right to privacy and confidentiality of personal
medical information and medical records as other patients, (b) that when patients exercise their right to keep
their personal medical histories confidential, such action should not be regarded as fraudulent or inappropriate
concealment, and (c) that physicians and medical students should not be required to report any aspects of their
patients' medical history to governmental agencies or other entities, beyond that which would be required by
law. 3. Employers and insurers should be barred from unconsented access to identifiable medical information
lest knowledge of sensitive facts form the basis of adverse decisions against individuals. (a) Release forms
that authorize access should be explicit about to whom access is being granted and for what purpose, and
should be as narrowly tailored as possible. (b) Patients, physicians, and medical students should be educated
about the consequences of signing overly-broad consent forms. (c) Employers and insurers should adopt
explicit and public policies to assure the security and confidentiality of patients' medical information. (d) A
patient's ability to join or a physician's participation in an insurance plan should not be contingent on signing
a broad and indefinite consent for release and disclosure. 4. Whenever possible, medical records should be de-
identified for purposes of use in connection with utilization review, panel credentialing, quality assurance, and
peer review. 5. The fundamental values and duties that guide the safekeeping of medical information should
remain constant in this era of computerization. Whether they are in computerized or paper form, it is critical
that medical information be accurate, secure, and free from unauthorized access and improper use. 6. Our
AMA recommends that the confidentiality of data collected by race and ethnicity as part of the medical
record, be maintained. 7. Genetic information should be kept confidential and should not be disclosed to third
parties without the explicit informed consent of the tested individual. 8. When breaches of confidentiality are
compelled by concerns for public health and safety, those breaches must be as narrow in scope and content as
possible, must contain the least identifiable and sensitive information possible, and must be disclosed to the
fewest possible to achieve the necessary end. 9. Law enforcement agencies requesting private medical
information should be given access to such information only through a court order. This court order for
disclosure should be granted only if the law enforcement entity has shown, by clear and convincing evidence,
that the information sought is necessary to a legitimate law enforcement inquiry; that the needs of the law
enforcement authority cannot be satisfied by non-identifiable health information or by any other information;
and that the law enforcement need for the information outweighs the privacy interest of the individual to
whom the information pertains. These records should be subject to stringent security measures.10. Our AMA
must guard against the imposition of unduly restrictive barriers to patient records that would impede or
prevent access to data needed for medical or public health research or quality improvement and accreditation
activities. Whenever possible, de-identified data should be used for these purposes. In those contexts where
personal identification is essential for the collation of data, review of identifiable data should not take place
without an institutional review board (IRB) approved justification for the retention of identifiers and the
consent of the patient. In those cases where obtaining patient consent for disclosure is impracticable, our
AMA endorses the oversight and accountability provided by an IRB. 11. Marketing and commercial uses of
identifiable patients' medical information may violate principles of informed consent and patient
confidentiality. Patients divulge information to their physicians only for purposes of diagnosis and treatment.
If other uses are to be made of the information, patients must first give their uncoerced permission after being
fully informed about the purpose of such disclosures. 12. Our AMA, in collaboration with other professional
organizations, patient advocacy groups and the public health community, should continue its advocacy for
privacy and confidentiality regulations, including: (a) The establishment of rules allocating liability for
disclosure of identifiable patient medical information between physicians and the health plans of which they
are a part, and securing appropriate physicians' control over the disposition of information from their patients'
medical records. (b) The establishment of rules to prevent disclosure of identifiable patient medical
information for commercial and marketing purposes; and (c) The establishment of penalties for negligent or
deliberate breach of confidentiality or violation of patient privacy rights. 13. Our AMA will pursue an
aggressive agenda to educate patients, the public, physicians and policymakers at all levels of government
about concerns and complexities of patient privacy and confidentiality in the variety of contexts mentioned.
14. Disclosure of personally identifiable patient information to public health physicians and departments is
appropriate for the purpose of addressing public health emergencies or to comply with laws regarding public health reporting for the purpose of disease surveillance. 15. In the event of the sale or discontinuation of a medical practice, patients should be notified whenever possible and asked for authorization to transfer the medical record to a new physician or care provider. Only de-identified and/or aggregate data should be used for "business decisions," including sales, mergers, and similar business transactions when ownership or control of medical records changes hands. 16. The most appropriate jurisdiction for considering physician breaches of patient confidentiality is the relevant state medical practice act. Knowing and intentional breaches of patient confidentiality, particularly under false pretenses, for malicious harm, or for monetary gain, represents a violation of the professional practice of medicine. 17. Our AMA Board of Trustees will actively monitor and support legislation at the federal level that will afford patients protection against discrimination on the basis of genetic testing. 18. Our AMA supports privacy standards that would require pharmacies to obtain a prior written and signed consent from patients to use their personal data for marketing purposes. 19. Our AMA supports privacy standards that require pharmacies and drug store chains to disclose the source of financial support for drug mailings or phone calls. 20. Our AMA supports privacy standards that would prohibit pharmacies from using prescription refill reminders or disease management programs as an opportunity for marketing purposes. 21. Our AMA will draft model state legislation requiring consent of all parties to the recording of a physician-patient conversation.

D-460.976 Genomic and Molecular-based Personalized Health Care: (1) continue to recognize the need for possible adaptation of the US health care system to prospectively prevent the development of disease by ethically using genomics, proteomics, metabolomics, imaging and other advanced diagnostics, along with standardized informatics tools to develop individual risk assessments and personal health plans; (2) support studies aimed at determining the viability of prospective care models and measures that will assist in creating a stronger focus on prospective care in the US health care system; (3) support research and discussion regarding the multidimensional ethical issues related to prospective care models, such as genetic testing; (4) maintain a visible presence in genetics and molecular medicine, including web-based resources and the development of educational materials, to assist in educating physicians about relevant clinical practice issues related to genomics as they develop; and (5) promote the appropriate use of pharmacogenomics in drug development and clinical trials.

9.6.7 Direct-to-Consumer Advertisement of Prescription Drugs: Direct-to-consumer advertising may raise awareness about diseases and treatment and may help inform patients about the availability of new diagnostic tests, drugs, treatments, and devices. However, direct-to-consumer advertising also carries the risk of creating unrealistic expectations for patients and conflicts of interest for physicians, adversely affecting patients’ health and safety, and compromising patient physician relationships. In the context of direct-to-consumer advertising of prescription drugs, physicians individually should: (a) Remain objective about advertised tests, drugs, treatments, and devices, avoiding bias for or against advertised products. (b) Engage in dialogue with patients who request tests, drugs, treatments, or devices they have seen advertised to: (i) assess and enhance the patient’s understanding of the test, drug or device; (ii) educate patients about why an advertised test, drug, or device may not be suitable for them, including providing cost-effectiveness information about different options. (c) Resist commercially induced pressure to prescribe tests, drugs, or devices that may not be indicated. (d) Obtain informed consent before prescribing an advertised test, drug, or device, in keeping with professional standards. (e) Deny requests for an inappropriate test, drug, or device. (f) Consider reporting to the sponsoring manufacturer or appropriate authorities direct-to-consumer advertising that: (i) promotes false expectations; (ii) does not enhance consumer education; (iii) conveys unclear, inaccurate, or misleading health education messages; (iv) fails to refer patients to their physicians for additional information; (v) does not identify the target population at risk; (vi) encourages consumer self-diagnosis and treatment. Collectively, physicians should: (g) Encourage and engage in studies that examine the impact of direct-to-consumer advertising on patient health and medical care. (h) Whenever possible, assist authorities to enforce existing law by reporting advertisements that do not: (i) provide a fair and balanced discussion of the use of the drug
product for the disease, disorder, or condition; (ii) clearly explain warnings, precautions, and potential adverse reactions associated with the drug product; (iii) present summary information in language that can be understood by the consumer (iv) comply with applicable regulations; (v) provide collateral materials to educate both physicians and consumers.

**H-480.941 Direct-to-Consumer Laboratory Testing:** Our AMA will: (1) advocate for vigilant oversight of direct-to-consumer (DTC) laboratory testing by relevant state and federal agencies; and (2) encourage physicians to educate their patients about the risks and benefits of DTC laboratory tests, as well as the risks associated with interpreting DTC test results without input from a physician or other qualified health care professional.

**7.1.2 Informed Consent in Research:** Informed consent is an essential safeguard in research. The obligation to obtain informed consent arises out of respect for persons and a desire to respect the autonomy of the individual deciding whether to volunteer to participate in biomedical or health research. For these reasons, no person may be used as a subject in research against his or her will. Physicians must ensure that the participant (or legally authorized representative) has given voluntary, informed consent before enrolling a prospective participant in a research protocol. With certain exceptions, to be valid, informed consent requires that the individual have the capacity to provide consent and have sufficient understanding of the subject matter involved to form a decision. The individual’s consent must also be voluntary.

A valid consent process includes: (a) Ascertaining that the individual has decision-making capacity. (b) Reviewing the process and any materials to ensure that it is understandable to the study population. (c) Disclosing: (i) the nature of the experimental drug(s), device(s), or procedure(s) to be used in the research; (ii) any conflicts of interest relating to the research, in keeping with ethics guidance; (iii) any known risks or foreseeable hazards, including pain or discomfort that the participant might experience; (iv) the likelihood of therapeutic or other direct benefit for the participant; (v) that there are alternative courses of action open to the participant, including choosing standard or no treatment instead of participating in the study; (vi) the nature of the research plan and implications for the participant; (vii) the differences between the physician’s responsibilities as a researcher and as the patient’s treating physician. (d) Answering questions the prospective participant has. (e) Refraining from persuading the individual to enroll. (f) Avoiding encouraging unrealistic expectations. (g) Documenting the individual’s voluntary consent to participate. Participation in research by minors or other individuals who lack decision-making capacity is permissible in limited circumstances when: (h) Consent is given by the individual’s legally authorized representative, under circumstances in which informed and prudent adults would reasonably be expected to volunteer themselves or their children in research. (i) The participant gives his or her assent to participation, where possible. Physicians should respect the refusal of an individual who lacks decision-making capacity. (j) There is potential for the individual to benefit from the study. In certain situations, with special safeguards in keeping with ethics guidance, the obligation to obtain informed consent may be waived in research on emergency interventions.

**Sources:**


Subject: Support of Mandatory Paid Parental Leave

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, While 193 countries offer paid parental leave, the United States is the only developed country to not mandate paid parental leave; and

Whereas, The 1993 Family and Medical Leave Act was pivotal in providing job-protected access to leave for parents, but this law does not require the leave to be paid and does not apply to employers that have fewer than 50 employees; and

Whereas, As of 2019, Rhode Island, California, and New Jersey, followed by other states in 2020, have state-financed programs that allow for partial compensation when on leave; and

Whereas, The Texas Workforce Commission does not stipulate parental leave unless it would be under reasonable disability- or pregnancy-related accommodations, and, even if granted, such leave can be paid or unpaid; and

Whereas, A study from McGill University delineates that little evidence exists correlating paid leave with negative employment or economic consequences; and

Whereas, A longitudinal study conducted by Rutgers University found that women who took paid parental leave reported to work within nine to 12 months compared to those who did not take parental leave, and women who returned to work after paid leave have a 39-percent lower likelihood of utilizing federal aid and a 40-percent lower likelihood of needing food stamps; and

Whereas, Medical checkups; diphtheria, pertussis, and tetanus/oral polio immunizations; and breastfeeding in the first year of life are likely to be less frequent for children whose mothers return to work early; specifically, there is a stronger concern for children whose mothers return to work full-time within the first three months of delivery; and

Whereas, The maternal mortality rate in Texas has risen exponentially from 18.6 per 100,000 live births in 2010 to 38.7 in 2013, in comparison to national rates rising from 19.3 in 2011 to 21.5 in 2014; and

Whereas, Studies from the Texas Department of State Health Services’ Maternal Mortality and Morbidity Task Force reveal that most deaths occur between 42 and 365 days after delivery, and most causes of maternal deaths are stress-related, including preeclampsia, cardiac complications, and overdoses; and

Whereas, The American College of Obstetricians and Gynecologists supports providing at least six weeks of paid parental leave, noting benefits such as decreased infant mortality, improved health of child and mother, and improved worker morale and retention; and
Whereas, A Pew Research Center poll from March 2018 shows that 82 percent of Americans believed mothers should get paid time off for the birth or adoption of a child, and 69 percent believed fathers should as well; therefore be it

RESOLVED, That the Texas Medical Association support the expansion of existing legislation regarding job-secured parental leave of at least 12 weeks, to include monetary compensation; and be it further

RESOLVED, That TMA advocate for mandatory paid parental leave.

Related TMA Policy:
260.104 Parental Leave: The Texas Medical Association will promote awareness and education for physicians, legislators, and the public on the importance of paid parental leave in ensuring good maternal and infant health outcomes and promoting the health and well-being of the family. TMA will work with the Department of State Health Services, Health and Human Services Commission, and state higher education institutions to support study on the barriers to expanding paid parental leave in Texas, particularly for the Texas workforce who does not have access to paid leave (CSPH Rep. 2-A-17).

Related AMA Policy:
H-405.954 Parental Leave: 1. Our AMA encourages the study of the health implications among patients if the United States were to modify one or more of the following aspects of the Family and Medical Leave Act (FMLA): a reduction in the number of employees from 50 employees; an increase in the number of covered weeks from 12 weeks; and creating a new benefit of paid parental leave.
2. Our AMA will study the effects of FMLA expansion on physicians in varied practice environments.

H-405.960 Policies for Parental, Family and Medical Necessity Leave: AMA adopts as policy the following guidelines for, and encourages the implementation of, Parental, Family and Medical Necessity Leave for Medical Students and Physicians:
1. Our AMA urges medical schools, residency training programs, medical specialty boards, the Accreditation Council for Graduate Medical Education, and medical group practices to incorporate and/or encourage development of leave policies, including parental, family, and medical leave policies, as part of the physician's standard benefit agreement.
2. Recommended components of parental leave policies for medical students and physicians include: (a) duration of leave allowed before and after delivery; (b) category of leave credited; (c) whether leave is paid or unpaid; (d) whether provision is made for continuation of insurance benefits during leave, and who pays the premium; (e) whether sick leave and vacation time may be accrued from year to year or used in advance; (f) how much time must be made up in order to be considered board eligible; (g) whether make-up time will be paid; (h) whether schedule accommodations are allowed; and (i) leave policy for adoption.
3. AMA policy is expanded to include physicians in practice, reading as follows: (a) residency program directors and group practice administrators should review federal law concerning maternity leave for guidance in developing policies to assure that pregnant physicians are allowed the same sick leave or disability benefits as those physicians who are ill or disabled; (b) staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in other physicians' workloads, particularly in residency programs; and (c) physicians should be able to return to their practices or training programs after taking parental leave without the loss of status.
4. Our AMA encourages residency programs, specialty boards, and medical group practices to incorporate into their parental leave policies a six-week minimum leave allowance, with the understanding that no parent should be required to take a minimum leave.
5. Residency program directors should review federal and state law for guidance in developing policies for parental, family, and medical leave.
6. Medical students and physicians who are unable to work because of pregnancy, childbirth, and other related medical conditions should be entitled to such leave and other benefits on the same basis as other physicians who are temporarily unable to work for other medical reasons.

7. Residency programs should develop written policies on parental leave, family leave, and medical leave for physicians. Such written policies should include the following elements: (a) leave policy for birth or adoption; (b) duration of leave allowed before and after delivery; (c) category of leave credited (e.g., sick, vacation, parental, unpaid leave, short term disability); (d) whether leave is paid or unpaid; (e) whether provision is made for continuation of insurance benefits during leave and who pays for premiums; (f) whether sick leave and vacation time may be accrued from year to year or used in advance; (g) extended leave for resident physicians with extraordinary and long-term personal or family medical tragedies for periods of up to one year, without loss of previously accepted residency positions, for devastating conditions such as terminal illness, permanent disability, or complications of pregnancy that threaten maternal or fetal life; (h) how time can be made up in order for a resident physician to be considered board eligible; (i) what period of leave would result in a resident physician being required to complete an extra or delayed year of training; (j) whether time spent in making up a leave will be paid; and (k) whether schedule accommodations are allowed, such as reduced hours, no night call, modified rotation schedules, and permanent part-time scheduling.

8. Our AMA endorses the concept of equal parental leave for birth and adoption as a benefit for resident physicians, medical students, and physicians in practice regardless of gender or gender identity.

9. Staffing levels and scheduling are encouraged to be flexible enough to allow for coverage without creating intolerable increases in the workloads of other physicians, particularly those in residency programs.

10. Physicians should be able to return to their practices or training programs after taking parental leave, family leave, or medical leave without the loss of status.

11. Residency program directors must assist residents in identifying their specific requirements (for example, the number of months to be made up) because of leave for eligibility for board certification and must notify residents on leave if they are in danger of falling below minimal requirements for board eligibility. Program directors must give these residents a complete list of requirements to be completed in order to retain board eligibility.

12. Our AMA encourages flexibility in residency training programs, incorporating parental leave and alternative schedules for pregnant house staff.

13. In order to accommodate leave protected by the federal Family and Medical Leave Act, our AMA encourages all specialties within the American Board of Medical Specialties to allow graduating residents to extend training up to 12 weeks after the traditional residency completion date while still maintaining board eligibility in that year.

14. These policies as above should be freely available online and in writing to all applicants to medical school, residency or fellowship.

Sources:


Subject: Notification of Generic Drug Manufacturing Changes

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Science and Public Health

Whereas, Generic drug use is prevalent across the medical spectrum, with multiple manufacturers producing the same base drug; and

Whereas, Pharmacies and pharmacy benefit managers may change a generic manufacturer from one prescription to another; and

Whereas, Generic drugs are not required to replicate the extensive clinical trials used in the development of brand drugs; and

Whereas, Bioequivalence only needs 24 to 36 healthy, normal volunteers to demonstrate the time it takes a generic to reach the bloodstream and its concentration in the bloodstream; and

Whereas, Two versions of a drug are said to be bioequivalent if the 90-percent confidence intervals for the ratios of the geometric means of the area under the curve and chemical makeup fall within 80 percent and 125 percent; and

Whereas, Generic drugs are not required to contain the same non-medicinal ingredients as the brand or another manufacturer’s generic drug; and

Whereas, Most patients are unaware of a change from one manufacturer to another of their generic drug prescription; and

Whereas, The unknown change in generic manufacturers has caused harm to patients; therefore be it

RESOLVED, That the Texas Medical Association work with Texas legislators to ensure that each patient is expressly notified by the pharmacy or pharmacy benefit manager of a change in the manufacturer of his or her generic medication; and be it further

RESOLVED, That the Texas Delegation to the American Medical Association present a similar resolution to the AMA House of Delegates for congressional approval and implementation.

Related TMA Policy:

95.004 Drugs Labeling of Generic Substitutions: Drugs Labeling of Generic Substitutions: When generic substitutions are made, the prescription label on the container should show the brand name of the generic substitution, the generic chemical and the generic name. Texas Medical Association voted to ask the pharmaceutical community to cooperate in this endeavor (Resolution 28C, p 138, I-91; reaffirmed CSA Rep. 2-A-02; reaffirmed CSPH Rep. 3-A-12).

95.012 Drug Antisubstitution Laws and Generic Prescriptions: Compulsory generic prescribing should be opposed because generic equivalency in drugs does not necessarily mean therapeutic equivalence. The patient’s right to receive the drugs and medications best suited for his or her individual
needs should be protected by preserving the current system of brand name prescribing. Legislation and regulations which prohibit generic drug substitution without prior agreement between the pharmacist and the physician should be supported (Council on Socioeconomics, p 177, 1-94; reaffirmed CSE Rep. 3-A-04; reaffirmed CSE Rep. 2-A-14).

**180.031 Pharmacy Benefit Managers:** The Texas Medical Association will (1) gather evidence of the administrative burden placed on physicians and patients by the policies and operating practices of Pharmacy Benefit Managers (PBMs) in order to document the impact on medical practices and determine whether the business practices of PBMs comply with state laws and regulations; (2) explore the possibility of legislative action should no state laws or regulations apply to the preauthorization process required by PBMs; and (3) promote cooperation by Texas pharmacists to provide physicians with up-to-date information about prescriptive drugs covered by pharmacy benefit managers and appropriate alternative medications in pharmacy benefit managers' formularies (Amended Res. 401-A-06; reaffirmed CSE Rep. 6-A-16).

**Related AMA Policy:**

**H-115.974 Prescription Labeling:** Our AMA recommends (1) That when a physician desires to prescribe a brand name drug product, he or she do so by designating the brand name drug product and the phrase "Do Not Substitute" (or comparable phrase or designation, as required by state law or regulation) on the prescription; and when a physician desires to prescribe a generic drug product, he or she do so by designating the USAN-assigned generic name of the drug on the prescription.

(2) That, except where the prescribing physician has indicated otherwise, the pharmacist should include the following information on the label affixed to the container in which a prescription drug is dispensed: in the absence of product substitution, (a) the brand and generic name of the drug dispensed; (b) the strength, if more than one strength of drug is marketed; (c) the quantity dispensed; and (d) the name of the manufacturer or distributor.

(3) When generic substitution occurs: (a) the generic name (or, when applicable, the brand name of the generic substitute ["branded" generic name]) of the drug dispensed; (b) the strength, if more than one strength of drug is marketed; (c) the quantity dispensed; (d) the manufacturer or distributor; and (e) either the phrase "generic for [brand name prescribed]" or the phrase "substituted for [brand name prescribed]."

(4) When a prescription for a generic drug product is refilled (e.g., for a patient with a chronic disease), changing the manufacturer or distributor should be discouraged to avoid confusion for the patient; when this is not possible, the dispensing pharmacist should satisfy the following conditions: (a) orally explain to the patient that the generic drug product being dispensed is from a different manufacturer or distributor and, if possible (e.g., for solid oral dosage forms), visually show the product being dispensed to the patient; (b) replace the name of the prior generic drug manufacturer or distributor on the label affixed to the prescription drug container with the name of the new generic drug manufacturer or distributor and, show this to the patient; (c) affix to the primary label an auxiliary (sticker) label that states, "This is the same medication you have been getting. Color, size, or shape may appear different;" and (d) place a notation on the prescription record that contains the name of the new generic drug manufacturer or distributor and the date the product was dispensed.

**H-115.988 Qualitative Labeling of All Drugs:** The AMA supports efforts to promote the qualitative labeling of all drugs and dietary supplements, requiring both active and inactive ingredients of over-the-counter and prescription drugs and dietary supplements to be listed on the manufacturer's label or package insert.

**D-120.933 Pharmacy Benefit Managers Impact on Patients:** Our AMA will: (1) gather more data on the erosion of physician-led medication therapy management in order to assess the impact pharmacy
benefit manager (PBM) tactics may have on patient’s timely access to medications, patient outcomes, and
the physician-patient relationship; (2) examine issues with PBM-related clawbacks and direct and indirect
remuneration (DIR) fees to better inform existing advocacy efforts; and (3) request from PBMs, and
 compile, data on the top twenty-five medication precertification requests and the percent of such requests
approved after physician challenge.

H-125.986 Pharmaceutical Benefits Management Companies: Our AMA:
(1) encourages physicians to report to the Food and Drug Administration’s (FDA) MedWatch reporting
program any instances of adverse consequences (including therapeutic failures and adverse drug
reactions) that have resulted from the switching of therapeutic alternates;
(2) encourages the Federal Trade Commission (FTC) and the FDA to continue monitoring the
relationships between pharmaceutical manufacturers and PBMs, especially with regard to manufacturers’
influences on PBM drug formularies and drug product switching programs, and to take enforcement
actions as appropriate;
(3) pursues congressional action to end the inappropriate and unethical use of confidential patient
information by pharmacy benefits management companies;
(4) states that certain actions/activities by pharmacy benefit managers and others constitute the practice of
medicine without a license and interfere with appropriate medical care to our patients;
(5) encourages physicians to routinely review their patient's treatment regimens for appropriateness to
ensure that they are based on sound science and represent safe and cost-effective medical care;
(6) supports efforts to ensure that reimbursement policies established by PBMs are based on medical
need; these policies include, but are not limited to, prior authorization, formularies, and tiers for
compounded medications; and
(7) encourages the FTC and FDA to monitor PBMs’ policies for potential conflicts of interests and anti-
trust violations, and to take appropriate enforcement actions should those policies advantage pharmacies
in which the PBM holds an economic interest.
Subject: Determinants of Health

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Science and Public Health

Whereas, Determinants of health are conditions in the environment that affect a wide range of health, functioning, and quality-of-life outcomes and risks. Examples include stress and burnout, economic conditions, housing, food insecurity, public safety, culture, levels of education including health education, access to health care services, access to job/economic opportunities, among many others; and

Whereas, Determinants of health are an important component of overall health care quality and a driver in health care costs; and

Whereas, The phrase “social determinants of health” has garnered renewed attention in academia and in the discussion of the move from fee-for-service to value-based care; and

Whereas, Physician performance is now being judged by governmental and commercial payors using a set of quality standards and cost metrics that do not account for determinants of health that are outside of a physician’s control, such as patient noncompliance and lifestyle choices; and

Whereas, Physicians can be financially disadvantaged and/or rated inaccurately due to poor health outcomes and lack of adequate risk adjustment methodology by governmental and commercial payors; and

Whereas, Physicians are not systematically given both adequate and accurate clinical and financial information on their performance in real time including quality and cost data, cost of care options, emergency department utilization, and risk attribution; therefore be it

RESOLVED, That the Texas Medical Association study the social determinants of health for the purpose of better understanding its impact on medicine; and be it further

RESOLVED, That TMA advocate to governmental and commercial payors the power of determinants of health on overall health care quality and health care costs; and be it further

RESOLVED, That TMA advocate that governmental and commercial payors modify existing performance and quality programs to include determinants of health in the total compensation for the provision of medical services.

Related TMA Policy:

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).


180.029 Economic Profiling: The Texas Medical Association opposes all forms of economic profiling schemes that do not accurately assess quality cost effective health care. TMA will work with insurers, health plans, and HMOs to advise on the development of credible, reliable, and understandable clinical measurements of medical practice that contribute to improving quality of care in a cost effective manner (Res. 409-A-04; reaffirmed CSE Rep. 2-A-14).

195.033 Medicare Payment Incentives and Penalties: The Texas Medical Association advocates that any Medicare penalty or incentive program including the Value-Based Payment Modifier program and the Merit-Based Incentive Payment System be designed so that: (1) the measures and standards used do not result in financial penalties for physicians when their patients do not comply with orders or recommendations for testing and treatment; (2) physicians are not penalized for providing services to disadvantaged patients; (3) physicians are not penalized for noncompliance with obsolete or superseded guidelines and standards; and (4) both cost and quality measures are adequately risk adjusted to eliminate the effects of poverty, poor educational attainment, and cultural differences from the measures used to adjust payment. Until all of the above are implemented, Medicare payments should not be adjusted using these measures (CSE Rep. 2-A-12; amended CSE Rep. 6-A-17).

265.017 Pay-for-Performance Principles and Guidelines. Physician pay-for-performance (PFP) programs that are designed primarily to improve the effectiveness and safety of patient care may serve as a positive force in our health care system. Fair and ethical PFP programs are patient-centered and link evidence-based performance measures to financial incentives. Such PFP programs are in alignment with the American Medical Association Guidelines for Pay-for-Performance Programs and the following five American Medical Association Principles for Pay-for-Performance Programs:

1. **Ensure quality of care.** Fair and ethical PFP programs are committed to improved patient care as their most important mission. Evidence-based quality-of-care measures, created by physicians across appropriate specialties, are the measures used in the programs. Variations in an individual patient care regimen are permitted based on a physician’s sound clinical judgment and should not adversely affect PFP program rewards.

2. **Foster the patient-physician relationship.** Fair and ethical PFP programs support the patient-physician relationship and overcome obstacles to physicians treating patients, regardless of patients’ health conditions, ethnicity, economic circumstances, demographics, or treatment compliance patterns.

3. **Offer voluntary physician participation.** Fair and ethical PFP programs offer voluntary physician participation, and do not undermine the economic viability of nonparticipating physician practices. These programs support participation by physicians in all practice settings by minimizing potential financial and technological barriers including costs of start-up.

4. **Use accurate data and fair reporting.** Fair and ethical PFP programs use accurate data and scientifically valid analytical methods. Physicians are allowed to review, comment, and appeal results prior to the use of the results for programmatic reasons and any type of reporting.

5. **Provide fair and equitable program incentives.** Fair and ethical PFP programs provide new funds for positive incentives to physicians for their participation, progressive quality improvement, or attainment of goals within the program. The eligibility criteria for the incentives are fully explained to participating physicians. These programs support the goal of quality improvement across all participating physicians.
Guidelines for Pay-for-Performance Programs

Safe, effective, and affordable health care for all Americans is the American Medical Association’s goal for our health care delivery system. AMA presents the following guidelines regarding the formation and implementation of fair and ethical pay-for-performance (PFP) programs. These guidelines augment AMA’s Principles for Pay-for-Performance Programs and provide AMA leaders, staff, and members operational boundaries that can be used in an assessment of specific PFP programs.

Quality of Care

- The primary goal of any PFP program must be to promote quality patient care that is safe and effective across the health care delivery system, rather than to achieve monetary savings.
- Evidence-based quality-of-care measures must be the primary measures used in any program.
  1. All performance measures used in the program must be defined prospectively and developed collaboratively across physician specialties.
  2. Practicing physicians with expertise in the area of care in question must be integrally involved in the design, implementation, and evaluation of any program.
  3. All performance measures must be developed and maintained by appropriate professional organizations that periodically review and update these measures with evidence-based information in a process open to the medical profession.
  4. Performance measures should be scored against both absolute values and relative improvement in those values.
  5. Performance measures must be subject to the best available risk adjustment for patient demographics, severity of illness, and comorbidities.
  6. Performance measures must be kept current and reflect changes in clinical practice. Except for evidence-based updates, program measures must be stable for two years.
  7. Performance measures must be selected for clinical areas that have significant promise for improvement.
- Physician adherence to PFP program requirements must conform with improved patient care, quality, and safety.
- Programs should allow for variance from specific performance measures that are in conflict with sound clinical judgment and, in so doing, require minimal, but appropriate, documentation.
- PFP programs must be able to demonstrate improved quality patient care that is safer and more effective as the result of program implementation.
- PFP programs help to ensure quality by encouraging collaborative efforts across all members of the health care team.
- Prior to implementation, pay-for-performance programs must be successfully pilot-tested for a sufficient duration to obtain valid data in a variety of practice settings and across all affected medical specialties. Pilot testing also should analyze for patient deselection. If implemented, the program must be phased in over an appropriate period of time to enable participation by any willing physician in affected specialties.
- Plans that sponsor PFP programs must explain these programs prospectively to the patients and communities covered by them.

Patient-Physician Relationship

- Programs must be designed to support the patient-physician relationship and recognize that physicians are ethically required to use sound medical judgment, holding the best interests of the patient as paramount.
- Programs must not cause conditions that limit access to improved care.
  1. Programs must not directly or indirectly disadvantage patients from ethnic, cultural, and socioeconomic groups, as well as those with specific medical conditions, or the physicians who serve these patients.
  2. Programs must neither directly nor indirectly disadvantage patients and their physicians, based on the setting where care is delivered or the location of populations served (such as inner city or rural areas).
- Programs must neither directly nor indirectly encourage patient deselection.
- Programs must recognize outcome limitations caused by patient nonadherence, and sponsors of
  PFP programs should attempt to minimize noncompliance through plan design.

**Physician Participation**
- Physician participation in any PFP program must be completely voluntary.
- Sponsors of PFP programs must notify physicians of PFP program implementation and offer
  physicians the opportunity to opt in or out of the PFP program without affecting the existing or
  offered contract provisions from the sponsoring health plan or employer.
- Programs must be designed so that physician nonparticipation does not threaten the economic
  viability of physician practices.
- Programs should be available to any physicians and specialties wishing to participate and must
  not favor one specialty over another. Programs must be designed to encourage broad physician
  participation across all modes of practice.
- Programs must not favor physician practices by size (large, small, or solo) or by capabilities in
  information technology (IT).
  1. Programs should provide physicians tools to facilitate participation.
  2. Programs should be designed to minimize financial and technological barriers to
     physician participation.
- Although some IT systems and software may facilitate improved patient management, programs
  must avoid implementation plans that require physician practices to purchase health-plan specific
  IT capabilities.
- Physician participation in a particular PFP program must not be linked to participation in other
  health plan or government programs.
- Programs must educate physicians about the potential risks and rewards inherent in program
  participation, and immediately notify participating physicians of newly identified risks and
  rewards.
- Physician participants must be notified in writing about any changes in program requirements and
  evaluation methods. Such changes must occur at most on an annual basis.

**Physician Data and Reporting**
- Patient privacy must be protected in all data collection, analysis, and reporting. Data collection
  must be administratively simple and consistent with the Health Insurance Portability and
  Accountability Act.
- The quality of data collection and analysis must be scientifically valid. Collecting and reporting
  of data must be reliable and easy for physicians and should not cause financial or other burdens
  on physicians and/or their practices. Audit systems should be designed to ensure the accuracy of
  data in a nonpunitive manner.
  1. Programs should use accurate administrative data and data abstracted from medical
     records.
  2. Medical record data should be collected in a manner that is not burdensome and
     disruptive to physician practices.
  3. Program results must be based on data collected over a significant period of time and
     relate care delivered (numerator) to a statistically valid population of patients in the
     denominator.
- Physicians must be reimbursed for any added administrative costs incurred as a result of
  collecting and reporting data to the program.
- Physicians should be assessed in groups and/or across health care systems, rather than
  individually when feasible.
- Physicians must have the ability to review and comment on data and analysis used to construct
  any performance ratings prior to the use of such ratings to determine physician payment or for
  public reporting.
  1. Physicians must be able to see preliminary ratings and be given the opportunity to adjust
     practice patterns over a reasonable period of time to more closely meet quality
     objectives.
2. Prior to release of any physician ratings, programs must have a mechanism for physicians to see and appeal their ratings in writing. If requested by the physician, physician comments must be included adjacent to any ratings.

- If PFP programs identify physicians with exceptional performance in providing effective and safe patient care, the reasons for such performance should be shared with physician program participants and widely promulgated.
- The results of PFP programs must not be used against physicians in health plan credentialing, licensure, and certification. Individual physician quality performance information and data must remain confidential and not subject to discovery in legal or other proceedings.
- PFP programs must have defined security measures to prevent the unauthorized release of physician ratings.

**Program Rewards**

- Programs must be based on rewards and not on penalties.
- Program incentives must be sufficient in scope to cover any additional work and practice expense incurred by physicians as a result of program participation.
- Programs must offer financial support to physician practices that implement IT systems or software that interacts with aspects of the PFP program.
- Programs must finance bonus payments based on specified performance measures with supplemental funds.
- Programs must reward all physicians who actively participate in the program and who achieve prespecified absolute program goals or demonstrate prespecified relative improvement toward program goals.
- Programs must not reward physicians based on ranking compared with other physicians in the program.
- Programs must provide to all eligible physicians and practices a complete explanation of all program facets, to include the methods and performance measures used to determine incentive eligibility and incentive amounts, prior to program implementation.
- Programs must not penalize physicians financially based on factors outside of the physician’s control.
- Programs utilizing bonus payments must be designed to protect patient access and must not financially disadvantage physicians who serve minority or uninsured patients.
- Programs must not penalize physicians financially when they follow current, accepted clinical guidelines that are different from measures adopted by payers, especially when measures have not been updated to meet currently accepted guidelines.


**265.018 Evidence-Based Medicine.** The Texas Medical Association supports the use of science and well-designed, well-conducted clinical research as a foundation for good medical practice to improve the quality of patient care. Guidelines and protocols for medical care based on thorough reviews of current medical research can improve the consistency, timeliness, and efficiency of clinical care. National and international medical organizations as well as nursing and allied health continue to develop evidence-based guidelines and recommendations to improve patient care. At times, evidence is incomplete and involves expert opinion. However, popular, advertised trends are not identical to experts. The quality of the evidence to support guidance is graded on the strength of the data from which it is derived. Evidence-based guidelines are always supportive, not prescriptive, and should be adjudicated by the physician or provider with good medical judgment and experience in the best interest of the individual patient. TMA encourages continued medical research in areas where a gap in knowledge exists on which to base medical practice. TMA supports the use of evidence-based medicine to improve approval and payment for medical services where appropriate.
TMA strongly supports the standardization of a national set of evidence-based measures that are clinically meaningful and lead to performance improvement while improving both patient outcome and patient satisfaction such as those endorsed by the National Quality Forum.

Recognizing that evidence-based medicine is continually evolving, measures should be evaluated and subject to regular review (1) at intervals in accordance with professional standards, (2) whenever there is a significant change in scientific evidence, or (3) when results from testing arise that materially affect the integrity of the measure.

TMA supports the focus of the American Medical Association policy in its efforts to (1) work with state and local medical associations, specialty societies, and other medical organizations to educate the Centers for Medicare & Medicaid Services, state legislatures, third-party payers, and state Medicaid agencies about the appropriate uses of evidence-based medicine and the dangers of cost-based medicine practices; and (2) through the Council on Legislation, work with other medical associations to develop model state legislation to protect the patient-physician relationship from cost-based medicine policies inappropriately characterized as “evidence-based medicine” (CSA Rep. 3-A-08; amended CSPH Rep. 5-A-18).

265.024 Bridges to Excellence as Best Practice Model: The Texas Medical Association supports Bridges to Excellence (BTE) modules for asthma, cardiac care, and diabetes as best practice models, and will investigate risk stratification models and patient compliance assessment tools as modifiers in measuring quality of care (Amended CHCQ Rep. 2-A-13).
AGENDA
REFERENCE COMMITTEE ON SOCIOECONOMICS
Friday, May 17, 2019
Tower Lobby, Sapphire Room - Hilton Anatole

1. Committee on Rural Health Report 1 – Expand Availability of Broadband Internet Access to Rural Texas
2. Committee on Rural Health Report 3 – Sunset Policy Review
3. Council on Socioeconomics Report 1 – Health Plan Claim Auditing Programs
5. Resolution 401 - Participation in Government Programs when Receiving Payment for Uncompensated Care
6. Resolution 402 - Prescription Monitoring Program Integration Into Electronic Medical Records
7. Resolution 403 - Prior Authorization Approval
8. Resolution 404 - Medicare Part B Coverage of Vaccines
9. Resolution 405 – Lower Drug Costs
10. Resolution 407 - Compensation to Physicians for Activities Other Than Direct Patient Care
11. Resolution 408 - Managing Patient-Physician Relations Within Medicare Advantage Plans
12. Resolution 409 - Update Practice Expense Component of Relative Value Units
13. Resolution 410 – Laboratory Benefit Managers
14. Resolution 411 - Data Migration Responsibilities of Electronic Health Record Vendors in Client Contract Termination
15. Resolution 412 - Medical Necessity Tax Exemption for Feminine Hygiene Products
16. Resolution 413 - The Benefits of Importation of International Pharmaceutical Medications
17. Resolution 414 - Studying Financial Barriers of Rural Hospitals
18. Resolution 415 - Improving Buprenorphine Access for Opioid Substance Use Disorder Treatment
19. Resolution 416 – Revising the Texas Department of Insurance Division of Worker’s Compensation Designated Doctor Training and Education Process

*Resolution 406 was moved to the Reference Committee on Financial and Organizational Affairs and renamed Resolution 112
At its fall 2018 meeting, the committee discussed the issues surrounding unreliable broadband internet access in rural areas. Reliable broadband internet access is essential to a modern health care delivery system that increasingly uses electronic means to communicate shared health information and to improve availability of services, such as by incorporating telemedicine and telehealth initiatives into practices or sharing information via health information exchanges or interoperable electronic health records.

Texas has expansive rural areas accounting for 85 percent of the state’s land, with 4 million residents living in rural areas. One out of every four rural Texans (1.25 million) lacks access to broadband infrastructure. Estimates show that more than $5.1 billion in potential economic benefit is left unrealized among disconnected households. Broadband can offer residents access to health care, jobs, education, government services, and other modern amenities.

For physicians practicing in rural Texas, lack of reliable broadband services forces physicians to use outdated and slower communications systems, including faxes, to communicate with other physicians, hospitals, pharmacies and patients. It also means rural patients will be deprived of the benefits new telemedicine and telehealth services can bring, including increased access to care.

The committee supports TMA strongly pursuing legislative initiatives to support the expeditious expansion of broadband to rural communities.

**Recommendation:** That the Texas Medical Association advocate for the expeditious expansion of broadband connectivity to all rural areas of Texas.

**Sources:**
The Texas Medical Association periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness.

The committee recommends retaining Policy 100.016.

**100.016 Texas Department of State Health Services Emergency Medical Services Local Projects Grant Program:** The Texas Medical Association supports the DSHS EMS Local Projects Grant program which provides emergency medical services education, training and equipment to rural and frontier areas of Texas (CM-EMS Rep. 2-A-99; reaffirmed CPH Rep. 2-A-09).

**Recommendation:** Retain.
Subject: Health Plan Claim Auditing Programs

Presented by: John Flores, MD, Chair

Referred to: Reference Committee on Socioeconomics

In recent years, there has been an observable increase in health plans using third-party software to analyze and audit claims for payment based solely on the diagnosis code(s), Current Procedural Terminology (CPT) code(s) and modifier(s) on the claim. The patient’s previous claims history with the health plan is sometimes used as part of the software “equation” to determine if the claim should be paid. The physician’s billing patterns compared with his or her peers is another possible part of the software equation.

Software programs currently in use by some health plans include Coding Advisor from Change Healthcare that UnitedHealthcare (UHC) plans on piloting in Texas and ConVeregence Point from Verscend Technologies by Blue Cross and Blue Shield of Texas (BCBSTX). Coding Advisor looks at a physician’s past use of high-level evaluation and management (E&M) codes and compares their use with that of physicians of the same specialty. ConVeregence Point flags claims that contain one or more modifiers appended to a CPT code(s). The E/M codes under review are typically level 4 and 5 codes. The modifiers under review include -25 (unrelated evaluation and management service by the same physician or other qualified health care professional on the same day of the procedure or other service) and -59 (distinct procedural service).

No nationally recognized guidelines on billing, coding, and payment support the use of these software programs as the sole determinant of claim payment or denial. A review of the patient’s medical record is necessary to determine if it clearly documents the necessity of the modifier or supports the billing of a high-level E&M code.

These software programs are applied at different times during the claim submission process. The UHC product stops the claim on the front end and sends it back to the practice. This means the claim never made it past submission to the clearinghouse. The practice has the option to change information on the claim and resubmit it or reject the suggested change and resubmit the claim. The BCBSTX product is applied at the back end. The claim is processed like other claims except that the system may deny payment on the line item(s) containing the modifiers in question. The portion of the claim not associated with the modifier proceeds as usual leading to the practice possibly receiving a partial payment of the claim. Any portion of the claim that is denied must be appealed following BCBSTX appeals procedures including submission of the medical record that supports the modifier(s) on the claim. After reviewing the medical record, BCBSTX will either send the claim back for payment or continue to deny the claim.

The Texas Department of Insurance (TDI) is aware of these programs. TMA staff continue to have discussions with TDI about its role in monitoring the software use during claims auditing.

Current TMA policy addresses general downcoding of claims and the E/M documentation guidelines. Current AMA policy addresses the appropriate use of modifiers.

Recommendation 1: Amend TMA Policy 65.008 as follows:

65.008 Downcoding and Bundling of Claims: The Texas Medical Association opposes:

(1) The practices of insurance companies and their agents unilaterally downcoding evaluation and management services and bundling Current Procedural Terminology (CPT) codes that were correctly reported with a modifier by insurance companies and their agents.
(2) the use of software or other methodologies to determine payment and/or denial of a claim based solely on the CPT codes, ICD-10 codes, and modifiers submitted on a claim;

(3) the use of billing, coding, and payment methods that do not adhere to CPT guidelines, rules, and conventions; and

(4) the patient’s past medical claim history being used as a tool to deny or pay a claim. A patient’s medical claim history is not an accurate or complete reflection of the patient’s overall health and should not be used as a substitute for a medical record.

TMA and will take all necessary and appropriate steps to stop these unreasonable business practices (Amended Res. 404-I-98; reaffirmed CSE Rep. 1-A-08; reaffirmed CSE Rep. 1-A-18).

Recommendation 2: That the Texas Delegation take a resolution to the AMA House of Delegates at its 2019 Annual Meeting asking for adoption of this policy and advocacy.
The Texas Medical Association periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness.

The Council on Socioeconomics recommends retention of the following policies:

40.005 **AMA Private Sector Advocacy:** The Texas Medical Association supports the actions of the AMA Division of Private Sector Advocacy in its coordination of advocacy activities and, with county medical society and specialty society partners, pledges to support the efforts of the division.

55.055 **Increase Enrollment of Children in Health Insurance Plans:** The Texas Medical Association, as a high priority in conjunction with the Texas Medical Association Alliance and other groups, will work to increase the number of children enrolled in available health insurance programs with the goal of ensuring that all Texas children are provided a medical home for comprehensive basic medical care in the very near future. Reimbursement for services in the medical home should be adequate to keep the medical home a viable institution for Texas children (Res. 415-A-09).

130.019 **Emergency Medical Treatment and Active Labor Act:** The Texas Medical Association supports requirements for health care payment plans to provide fair payment for services rendered under the Emergency Medical Treatment and Active Labor Act mandate and opposes efforts to limit or restrict balance billing of patients for out-of-network physician services (Amended Res. 402-A-09).

145.025 **Out-of-Network Payments:** The Texas Medical Association supports legislation for clear and transparent health insurance company language so that prudent lay persons would know their financial responsibility when receiving care out of network (Res. 401-A-09).

145.026 **Expanding Coverage to Children:** The Texas Medical Association endorses multiple options for expanding coverage to children, such as government contributions to commercial premiums or payment to out-of-pocket, high-deductible insurance plans (Res. 411-A-09).

145.027 **Transparency of Preventive Care Services:** The Texas Medical Association will seek legislation requiring insurance companies to adopt standardized, readily accessible, and understandable terminology spelling out coverage for preventive care services, including adequate payment for recommended vaccine products and services (Amended Res. 413-A-09).

160.017 **Utilization Review:** The Texas Medical Association will pursue legislation to ensure that adverse utilization review determinations be made only by physicians who are fully licensed by the Texas Medical Board and monitor proposed legislation to maintain the Texas Medical Board’s current authority to enforce the Medical Practice Act in regard to utilization review decisions (CL/CSE Rep. 2-A-09).

190.029 **Health Care Coverage Legislative Initiatives:** The Texas Medical Association continues to strongly support legislation to establish a buy-in option under the Children’s Health Insurance Program (CHIP) for families with uninsured children who do not currently qualify for CHIP. Any
CHIP buy-in program must include policies to deter families or employers from dropping private
coverage in favor of public coverage, including graduated premium payments based on family
income, a limited open-enrollment period, and a waiting period.

TMA support for any CHIP buy-in legislation will be contingent on continued, aggressive, and
simultaneous efforts to (1) increase Medicaid and CHIP payment rates to Medicare parity or
better; (2) enact 12-months’ continuous coverage for children in Medicaid; (3) ensure sufficient
funding for the state’s eligibility system so that applications for Medicaid or CHIP are timely
adjudicated; and (4) expand availability of affordable private health insurance for small businesses

235.029 Franchise Tax Issues: The Texas Medical Association opposes all negative impacts of the
franchise tax on a physician’s practice, and supports the features that favor patients and physicians
(CSE Rep. 3-A-09).

325.008 Insurance Discrimination Against Victims of Family Violence: The Texas Medical Association
supports insurance coverage of victims of family violence and abuse and recommends pursuit of
legislation to prevent the discriminatory denial of coverage or reduction of reimbursement

335.014 Workers’ Compensation Delivery System: Texas Medical Association supports the following in
pursuit of a fair, efficient, and accountable workers’ compensation delivery system in Texas:
(1) Continue dialogue with legislative and executive branch policymakers to maintain the out-of-
network medical fee reimbursement formula based on an annual MEI adjustment that may result
in fair and reasonable physician payments;
(2) Continue to educate policymakers and regulators on the need for employer accountability
when dealing with injured workers and encouraging return to work initiatives;
(3) Consider all appropriate strategies to help correct injustices within the system for doctors,
specifically reducing inappropriate carrier gaming and reducing administrative hassles and
burdens;
(4) Diligently work with Texas Department of Insurance in the regulatory arena to improve
physician input and physician stakeholder involvement to produce much needed reforms to the

Recommendation 1: Retain.

The Council on Socioeconomics recommends amending these policies as follows:

120.010 Principles for Evaluating Health System Reform: The Texas Medical Association will use the
following principles as evaluation criteria in examining all national health system reform
proposals. These principles are not ranked in order of importance; all are viewed as high priorities.

Promote portable and continuous health care coverage for all Americans using an affordable mix
of public and private payer systems.

Promote patient safety as a top priority for reform, recognizing an effective mix of initiatives that
combine evidence-based accountability standards, committed financial resources, and rewards for
performance that incentivize and ensure patient safety.
Adopt physician-developed, evidence-based tools for use in scientifically valid quality/patient safety initiatives that incentivize the physician-led health care delivery team, and include comparative effectiveness research used only to help those in patient-physician relationships choose the best care for patients.

Preserve patient and physician choice and the integrity of the patient-physician relationship. Incorporate physician-developed, evidence-based measures and preventive health and wellness initiatives into any new or expanded health benefits package as a means to promote healthier citizens.

Recognize and support the role of safety-net and public health systems in delivering essential health care services within our communities, to include essential prevention and health promotion public health services.

Support the development of a well-funded, nationwide emergency and trauma care system that provides appropriate emergency and trauma care for all Americans.

Support public policy that fosters ethical and effective end-of-life care decisions, to include requiring all Medicare patients to have an advance directive that a Medicare enrollee can discuss as part of a covered Medicare visit with a physician.

Provide sustainable financing mechanisms that ensure the aforementioned affordable mix of services, and create personal responsibility among all stakeholders for financing and appropriate utilization of the system.

Invest needed resources to expand the physician-led workforce to meet the health care needs of a growing and increasingly diverse and aging population.

Provide financial and technological support to implement physician-led, patient-centered medical homes for all Americans, including increased funding and compensation for services provided by primary care physicians and the services provided by non-primary care, specialist physicians as part of the patient-centered medical home continuum.

Through public policy enactments, require accountability and transparency among health insurers to disclose how their premium dollars are spent, eliminate preexisting condition exclusions, simplify administrative processes, and observe fair and competitive market practices.

Reform the national tort system to prevent non-meritorious lawsuits, keeping Texas reforms in place as enacted by the Texas Legislature and constitutionally affirmed by Texas voters.

Abolish the Medicare Sustainable Growth Rate annual update system and initiate a true cost of practice methodology that provides for annual updates in the Medicare Fee Schedule as determined by a credible, practice expense-based, medical economic index.

Provide incentives that support the universal adoption of interoperable health information technology that supports physician workflow, increases practice efficiency, is safe for patients, and enhances quality of care, implementation of an interoperable National Electronic Medical Records System, financed and implemented through federal funding.
1 Require payers to have a standard, transparent contract with physicians that cannot be
2 sold or leased for any other payer purposes without the express, written consent of the contracted
3 physician.
4
5 Support efforts to make health care financing and delivery decisionmaking more
6 of a professionally advised function, with appropriate standard setting, payment policy, and
7 delivery system decisions fashioned by physician-led deliberative bodies as authorized
8 legislatively (SC-HSR Rep. 1-A-09)
9
10 **180.033 Payment for After-Hours Non-Emergent Care:** The Texas Medical Association proposes that
11 the Texas Health and Human Services Commission standardize its contracts with Texas health
12 care payment plan Medicaid managed care organizations to allow and instruct each organization to
13 cover and offer payment for after-hours non-emergency care provided by
14 physicians at a fair payment rate (Amended Res. 408-A-09).
15
16 **Recommendation 2:** Retain as amended.
RESOLUTION 401
A-19

Subject: Participation in Government Programs When Receiving Payment for Uncompensated Care

Introduced by: Lone Star Caucus

Referred to: Reference Committee on Socioeconomics

 Whereas, Texas hospitals receive more than $1 billion in funds each year for uncompensated care, and there is a shortfall under the Texas Medicaid program; and

Whereas, Physicians who participate in Texas Medicaid receive payment at such a low rate for their services that there is a serious limitation on the number of Texas physicians caring for the Medicaid population both in primary care and subspecialty care; and

Whereas, Uncompensated care costs continue to increase in Texas, with uncompensated care costs in 2016 exceeding $6.85 billion; and

Whereas, 4.5 million Texans are uninsured, the highest number in the nation for any individual state; and

Whereas, Texas counties are required to care for the uninsured if they are at or below 21 percent of the federal poverty level; and

Whereas, The majority of Medicaid payments go to the hospitals in Texas, not to the physicians who provide the care; therefore be it

RESOLVED, That all Texas health care facilities receiving federal or state funds for uncompensated care must also accept Medicare, Medicaid, TRICARE, CHIP, and federally subsidized health insurance via the Affordable Care Act from patients covered by these forms of insurance; and be it further

RESOLVED, That some of the funds for uncompensated care now going to the hospitals in Texas be transferred to another part of the Texas Medicaid program and used to increase the payment rate for physicians who provide Medicaid services.

Related TMA Policy:

235.023 Reimbursement for Uncompensated Services to the Uninsured or Underinsured:
Reimbursement 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).

Related AMA Policy:

H-160.923 Offsetting the Costs of Providing Uncompensated Care:
Our AMA: (1) supports the transitional redistribution of disproportionate share hospital (DSH) payments for use in subsidizing private health insurance coverage for the uninsured; (2) supports the use of innovative federal- or state-based projects that are not budget neutral for the purpose of supporting physicians that treat large numbers of uninsured patients, as well as EMTALA-directed care; and (3) encourages public and private sector researchers to utilize data collection methodologies that accurately
reflect the amount of uncompensated care (including both bad debt and charity care) provided by physicians.

**H-160.971 Uncompensated Care:**
Our AMA supports (1) communicating to the public the problem of uncompensated care and the ever increasing regulations involving such care as well as the detrimental effect that uncompensated care has on the availability of necessary health care services to many citizens; and (2) publicizing the programs currently instituted to address uncompensated care and pursuing additional solutions for dealing with the problem of uncompensated care.

**H-290.965 Affordable Care Act Medicaid Expansion:**
1. Our AMA encourages state medical associations to participate in the development of their state's Medicaid access monitoring review plan and provide ongoing feedback regarding barriers to access.
2. Our AMA will continue to advocate that Medicaid access monitoring review plans be required for services provided by managed care organizations and state waiver programs, as well as by state Medicaid fee-for-service models.
3. Our AMA supports efforts to monitor the progress of the Centers for Medicare and Medicaid Services (CMS) on implementing the 2014 Office of Inspector General's recommendations to improve access to care for Medicaid beneficiaries.
4. Our AMA will advocate that CMS ensure that mechanisms are in place to provide robust access to specialty care for all Medicaid beneficiaries, including children and adolescents.
5. Our AMA supports independent researchers performing longitudinal and risk-adjusted research to assess the impact of Medicaid expansion programs on quality of care.
6. Our AMA supports adequate physician payment as an explicit objective of state Medicaid expansion programs.
7. Our AMA supports increasing physician payment rates in any redistribution of funds in Medicaid expansion states experiencing budget savings to encourage physician participation and increase patient access to care.
8. Our AMA will continue to advocate that CMS provide strict oversight to ensure that states are setting and maintaining their Medicaid rate structures at levels to ensure there is sufficient physician participation so that Medicaid patients can have equal access to necessary services.
9. Our AMA will continue to advocate that CMS develop a mechanism for physicians to challenge payment rates directly to CMS.
10. Our AMA supports extending to states the three years of 100 percent federal funding for Medicaid expansions that are implemented beyond 2016.
11. Our AMA supports maintenance of federal funding for Medicaid expansion populations at 90 percent beyond 2020 as long as the Affordable Care Act's Medicaid expansion exists.
12. Our AMA supports improved communication among states to share successes and challenges of their respective Medicaid expansion approaches.
13. Our AMA supports the use of emergency department (ED) best practices that are evidenced-based to reduce avoidable ED visits.
Subject: Prescription Monitoring Program Integration Into Electronic Medical Records

Introduced by: Lone Star Caucus

Referred to: Reference Committee on Socioeconomics

Whereas, Prescription monitoring programs (PMPs) should be a resource for physicians in the safe
treatment of patients; and

Whereas, Physicians have been incentivized to install electronic medical records as a resource to try to
improve patient care; and

Whereas, New laws attempting to decrease the opioid epidemic will require physicians to query these
databases prior to prescribing controlled substances; and

Whereas, Monitoring on the PMP side will allow law enforcement to automatically target physicians for
compliance; and

Whereas, Electronic medical records can be integrated with PMPs, allowing physicians to have patient-
specific information delivered within the physician’s workflow; and

Whereas, Physicians should not have to pay extra for PMP integration into electronic medical records;
and

Whereas, PMPs should be in the business of assisting physicians in the care of patients rather than an
entrapment type of enforcement; therefore be it

RESOLVED, That the Texas Medical Association advocate for prescription monitoring program
integration into electronic medical records, at no cost to the physician, providing patient-specific
information whenever a physician attempts to prescribe a controlled substance.

Related TMA Policy:
95.008 National All Schedules Prescription Electronic Reporting System: National All Schedules
Prescription Electronic Reporting System: The Texas Medical Association supports legislative and
regulatory efforts to sunset the official prescription program and implement a real-time electronic
prescription monitoring system based on the National All Schedules Prescription Electronic
Reporting System with appropriate access by physicians, and clinical staff with delegated permission
from physicians, pharmacists and practitioners with Drug Enforcement Administration permits

Related AMA Policy:
H-95.947 Prescription Drug Monitoring to Prevent Abuse of Controlled Substances:
Our AMA:
(1) supports the refinement of state-based prescription drug monitoring programs and development and implementation of appropriate technology to allow for Health Insurance Portability and Accountability Act (HIPAA)-compliant sharing of information on prescriptions for controlled substances among states;
(2) policy is that the sharing of information on prescriptions for controlled substance with out-of-state entities should be subject to same criteria and penalties for unauthorized use as in-state entities;
(3) actively supports the funding of the National All Schedules Prescription Electronic Reporting Act of 2005 which would allow federally funded, interoperative, state based prescription drug monitoring programs as a tool for addressing patient misuse and diversion of controlled substances;
(4) encourages and supports the prompt development of, with appropriate privacy safeguards, treating physician's real time access to their patient's controlled substances prescriptions;
(5) advocates that any information obtained through these programs be used first for education of the specific physicians involved prior to any civil action against these physicians;
(6) will conduct a literature review of available data showing the outcomes of prescription drug monitoring programs (PDMP) on opioid-related mortality and other harms; improved pain care; and other measures to be determined in consultation with the AMA Task Force to Reduce Opioid Abuse;
(7) will advocate that U.S. Department of Veterans Affairs pharmacies report prescription information required by the state into the state PDMP;
(8) will advocate for physicians and other health care professionals employed by the VA to be eligible to register for and use the state PDMP in which they are practicing even if the physician or other health care professional is not licensed in the state; and
(9) will seek clarification from SAMHSA on whether opioid treatment programs and other substance use disorder treatment programs may share dispensing information with state-based PDMPs.

**H-95.929 Support for Prescription Drug Monitoring Programs:**

Our AMA will: (1) continue to encourage Congress to assure that the National All Schedules Prescription Electronic Reporting Act (NASPER) and/or similar programs be fully funded to allow state prescription drug monitoring programs (PDMPs) to remain viable and active; and (2) work to assure that interstate operability of PDMPs in a manner that allows data to be easily accessed by physicians and does not place an onerous burden on their practices.

**D-95.980 Opioid Treatment and Prescription Drug Monitoring Programs:**

Our AMA will seek changes to allow states the flexibility to require opioid treatment programs to report to prescription monitoring programs.

**H-95.990 Drug Abuse Related to Prescribing Practices:**

1. Our AMA recommends the following series of actions for implementation by state medical societies concerning drug abuse related to prescribing practices:

A. Institution of comprehensive statewide programs to curtail prescription drug abuse and to promote appropriate prescribing practices, a program that reflects drug abuse problems currently within the state, and takes into account the fact that practices, laws and regulations differ from state to state. The program should incorporate these elements: (1) Determination of the nature and extent of the prescription drug abuse problem; (2) Cooperative relationships with law enforcement, regulatory agencies, pharmacists and other professional groups to identify "script doctors" and bring them to justice, and to prevent forgeries, thefts and other unlawful activities related to prescription drugs; (3) Cooperative relationships with such bodies to provide education to "duped doctors" and "dated doctors" so their prescribing practices can be improved in the future; (4) Educational materials on appropriate prescribing of controlled substances for all physicians and for medical students.
B. Placement of the prescription drug abuse programs within the context of other drug abuse control efforts by law enforcement, regulating agencies and the health professions, in recognition of the fact that even optimal prescribing practices will not eliminate the availability of drugs for abuse purposes, nor appreciably affect the root causes of drug abuse. State medical societies should, in this regard, emphasize in particular: (1) Education of patients and the public on the appropriate medical uses of controlled drugs, and the deleterious effects of the abuse of these substances; (2) Instruction and consultation to practicing physicians on the treatment of drug abuse and drug dependence in its various forms.

2. Our AMA:

A. promotes physician training and competence on the proper use of controlled substances;
B. encourages physicians to use screening tools (such as NIDAMED) for drug use in their patients;
C. will provide references and resources for physicians so they identify and promote treatment for unhealthy behaviors before they become life-threatening; and
D. encourages physicians to query a state's controlled substances databases for information on their patients on controlled substances.

3. Our AMA opposes any federal legislation that would require physicians to check a prescription drug monitoring program (PDMP) prior to prescribing controlled substances.
Subject: Prior Authorization Approval

Introduced by: Lone Star Caucus

Referred to: Reference Committee on Socioeconomics

Whereas, The prior authorization process is becoming one of the major sources of frustration for physicians who want to devote their time to providing medical care to their patients rather than completing onerous administrative tasks; and

Whereas, The prior authorization process can be required for a variety of reasons, such as referrals to another health care professional, laboratory tests, radiology tests, medical or surgical procedures, and medications; and

Whereas, At times, the physician has no idea what criteria must be met to justify the referral, test, surgery, procedure, or medication; and

Whereas, The process for authorizations can be very time-consuming and require additional staff, thus increasing the cost of health care, already above 18 percent of the U.S. GDP, nearly 50 percent more than most other industrial countries; and

Whereas, Many prior authorizations are not needed due to the fact that the referral, test, surgery, procedure, or medication is considered to be standard medical care; and

Whereas, The physician often has no idea of the criteria that must be met to get approval from the insurance carrier; and

Whereas, There are circumstances in which it is understandable that the insurance carrier requests certain information to ensure that expensive tests, therapies, or procedures are truly indicated, but this should be the exception, not the rule; therefore be it

RESOLVED, That the criteria for prior approval for patient referrals, tests, surgeries, procedures, and medications be available to all physicians at the time of the request for such action; and be it further

RESOLVED, That the types of patient referrals, tests, surgeries, procedures, and medications that typically require prior authorization be kept to a minimum, and such criteria be available to the physician and staff in a transparent manner; and be it further

RESOLVED, That prior approval for patient referrals, tests, surgeries, procedures, and medications be handled in a rapid enough manner that patient care is not delayed.

Related TMA Policy:

235.038 Standardized Electronic Prior Authorization Transactions: The Texas Medical Association supports policy and legislation that third-party payers, benefit managers, and any other party conducting utilization management be required to accept and respond to (1) standard electronic prior authorization
(ePA) transactions for pharmacy benefits that use a nationally recognized format, such as the National Council for Prescription Drug Programs (NCPDP) SCRIPT Standard; and (2) standard electronic transactions for review and response to prior authorization requests for medical service benefits that use a nationally recognized format, such as the ASC X12N 278 Health Care Service Review Request. (CSE Report 3-A-18)

**235.034 Authorizations Initiated by Third-Party Payers:**
The Texas Medical Association supports policy and legislation that (1) third-party payers, benefit managers, and utilization review entities may not implement prior authorization mechanisms unless these payers compensate physician practices for work required independent of any payment for patient care; specifically, medical practices must be compensated for the burden of added staff and resources required to navigate payer-initiated prior authorizations for medications, studies, or procedures; (2) third-party payers, benefit managers, and utilization review entities should disclose all prior authorization requirements and restrictions on their websites in both the subscriber section and the physician section with neither location requiring a log-in or password; (3) third-party payers, benefit managers and utilization review entities should confirm patient eligibility, payment determinations, medical policies and subscriber specific exclusions as part of the prior authorization process; and (4) third-party payers, benefit managers, and utilization review entities should make detailed statistics regarding prior authorization approval and denial rates available on their website (Res. 401-A-11) (CSE Rep. 3-A-18).

**Related AMA Policy:**

**H-320.939 Prior Authorization and Utilization Management Reform:**
1. Our AMA will continue its widespread prior authorization (PA) advocacy and outreach, including promotion and/or adoption of the Prior Authorization and Utilization Management Reform Principles, AMA model legislation, Prior Authorization Physician Survey and other PA research, and the AMA Prior Authorization Toolkit, which is aimed at reducing PA administrative burdens and improving patient access to care.
2. Our AMA will oppose health plan determinations on physician appeals based solely on medical coding and advocate for such decisions to be based on the direct review of a physician of the same medical specialty/subspecialty as the prescribing/ordering physician.
3. Our AMA supports efforts to track and quantify the impact of health plans’ prior authorization and utilization management processes on patient access to necessary care and patient clinical outcomes, including the extent to which these processes contribute to patient harm.
Subject: Medicare Part B Coverage of Vaccines

Introduced by: El Paso County Medical Society

Referred to: Reference Committee on Socioeconomics

Whereas, Medicare Part B has a fee schedule for influenza vaccine, hepatitis B vaccine, tetanus-diphtheria-pertussis vaccine, pneumonia vaccine, and tetanus-diphtheria vaccine, and for administration of these vaccines; and

Whereas, Medicare Part B does not have a fee schedule for herpes zoster vaccine, hepatitis A vaccine, or meningitis vaccine, or for the administration of these vaccines; and

Whereas, The Centers for Disease Control and Prevention (CDC) Recommended Adult Immunization Schedule for the United States 2019 recommends either one dose of the live zoster virus be administered in the Medicare age group or two doses of the recombinant zoster (preferred) in those aged 50 and older; and

Whereas, The CDC Recommended Adult Immunization Schedule by Medical Condition and Other Indications for the United States 2019 version recommends the hepatitis A vaccine for patients with chronic liver disease; and

Whereas, The CDC Recommended Adult Immunization Schedule by Medical Condition and Other Indications for the United States 2019 version recommends the meningitis vaccine in patients with asplenia, complement deficiencies, and HIV infection; and

Whereas, The CDC Recommended Immunizations for Travel recommends the hepatitis A and B vaccines prior to travel to countries with high or intermediate endemic status for these illnesses; therefore be it

RESOLVED, That the Texas Medical Association advocate for Centers for Medicare & Medicaid Services to include the zoster virus vaccine, hepatitis A vaccine, and meningitis vaccine, and administration of these vaccines in its fee schedule.

Related TMA Policy:
135.009 Immunization in Adults: The Texas Medical Association supports physician and public awareness on the importance of adult immunizations and endorses the adult schedule recommended by the Centers for Disease Control and Prevention Advisory Committee on Infectious Diseases.

Related AMA Policy:
H-440.875 Assuring Access to ACIP/AAFP/AAP-Recommended Vaccines: 1. It is AMA policy that all persons, regardless of economic and insurance status, receive all Advisory Committee on Immunization Practices (ACIP)-recommended vaccines as soon as possible following publication of these recommendations in the Centers for Disease Control and Prevention's (CDC) Morbidity and Mortality Weekly Report (MMWR).
2. Our AMA will continue to work with the federal government, Congress, and other stakeholders to improve liability protection for vaccine manufacturers and health care professionals who provide immunization services and to examine and improve compensation mechanisms for patients who were legitimately injured by a vaccine.

3. Our AMA will continue to work with the federal government, Congress, and other appropriate stakeholders to enhance public opinion of vaccines and to monitor and ensure the continued safety of existing and newly approved vaccines (including providing adequate resources for post-approval surveillance) so as to maintain and improve public confidence in the safety of vaccines.

4. Our AMA will work with appropriate stakeholders, including vaccine manufacturers, vaccine distributors, the federal government, medical specialty societies, and third party payers, to guarantee a robust vaccine delivery infrastructure (including but not limited to, the research and development of new vaccines, the ability to track the real-time supply status of ACIP-recommended vaccines, and the timely distribution of ACIP-recommended vaccines to providers).

5. Our AMA will work with appropriate federal and state agencies and private sector entities to ensure that state Medicaid agencies and private insurance plans pay health care professionals at least the approved Relative Value Unit (RVU) administration Medicare rates for payment when they administer ACIP-recommended vaccines.

6. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) to address barriers associated with Medicare recipients receiving live zoster vaccine and the routine boosters Td and Tdap in physicians' offices.

7. Our AMA will work through appropriate state entities to ensure all health insurance plans rapidly include newly ACIP-recommended vaccines in their list of covered benefits, and to pay health care professionals fairly for the purchase and administration of ACIP-recommended vaccines.

8. Our AMA will urge Medicare to include Tdap (Tetanus, Diphtheria, Acellular Pertussis) under Medicare Part B as a national public health measure to help prevent the spread of Pertussis.

9. Until compliance of AMA Policy H-440.875(6) is actualized to the AMA's satisfaction regarding the tetanus vaccine, our AMA will aggressively petition CMS to include tetanus and Tdap at both the "Welcome to Medicare" and Annual Medicare Wellness visits, and other clinically appropriate encounters, as additional "triggering event codes" (using the AT or another modifier) that allow for coverage and payment of vaccines to Medicare recipients.

10. Our AMA will aggressively petition CMS to include coverage and payment for any vaccinations administered to Medicare patients that are recommended by the ACIP, the US Preventive Services Task Force (USPSTF), or based on prevailing preventive clinical health guidelines.
Whereas, Medical care, especially drug prices, have accelerated significantly faster than the rate of inflation; and

Whereas, The original Medicare bill had a restriction negotiating prices with physicians, and it only took three years until Medicare not only negotiated prices, but set prices for physician services; and

Whereas, Drug companies and hospitals point out that there is a restriction on negotiation of prices in present Medicare law, and that it is somehow unchangeable; and

Whereas, Price increases by drug manufacturers cannot be construed as capitalism; and

Whereas, Pricing structures include intangible sources such as reduction of lawsuits and noneconomic conditions; and

Whereas, Patients in the United States must pay prices that are multiple times the cost of drugs in other countries; and

Whereas, Attempts are being made to completely upend all medical systems with a single-payer system, under the promise of reducing cost, and any cost reductions will certainly include negotiation of drug prices; therefore be it

RESOLVED, That the Texas Medical Association advocate reducing the higher cost of medications by supporting negotiation of drug prices for Medicare and Medicaid.

Related TMA Policy:

195.037 Prescription Drug Negotiation in the Medicare Program: The Texas Medical Association supports congressional authorization of Medicare to negotiate the prices of drugs paid for by Medicare Part D plans, as it does for other goods and services (CSE Rep. 3-A-17).

95.041 Ensuring Patient Access to Affordable Prescription Medications: The Texas Medical Association will: (1) support programs whose purpose is to contain the rising costs of prescription drugs provided that the following criteria are satisfied: (a) physicians must have significant input into the development and maintenance of such programs; (b) such programs must encourage optimum prescribing practices and quality of care; (c) all patients must have access to medically indicated prescription drugs necessary to treat their illnesses; (d) physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and (e) such programs should promote an environment that will give pharmaceutical manufacturers the incentive for research and development of new and innovative prescription drugs; (2) study the issue of drug pricing, including whether large price increases impact patient access to critical medications; (3) support the application of greater oversight to
the establishment of closed distribution systems for prescription drugs; (4) support the mandatory
provision of samples of approved out-of-patent drugs upon request to generic manufacturers seeking to
perform bioequivalence assays; (5) work with interested parties to support legislation or regulatory
changes that streamline and expedite the FDA approval process for generic drugs; and (6) support
measures that increase price transparency for generic and brand-name prescription drugs. (Substitute Res.

Related AMA Policy:

H-110.997 Cost of Prescription Drugs: Our AMA:
(1) supports programs whose purpose is to contain the rising costs of prescription drugs, provided that the
following criteria are satisfied: (a) physicians must have significant input into the development and
maintenance of such programs; (b) such programs must encourage optimum prescribing practices and
quality of care; (c) all patients must have access to all prescription drugs necessary to treat their illnesses;
(d) physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for
the individual patient; and (e) such programs should promote an environment that will give
pharmaceutical manufacturers the incentive for research and development of new and innovative
prescription drugs;
(2) reaffirms the freedom of physicians to use either generic or brand name pharmaceuticals in
prescribing drugs for their patients and encourages physicians to supplement medical judgments with cost
considerations in making these choices;
(3) encourages physicians to stay informed about the availability and therapeutic efficacy of generic drugs
and will assist physicians in this regard by regularly publishing a summary list of the patient expiration
dates of widely used brand name (innovator) drugs and a list of the availability of generic drug products;
(4) encourages expanded third party coverage of prescription pharmaceuticals as cost effective and
necessary medical therapies;
(5) will monitor the ongoing study by Tufts University of the cost of drug development and its
relationship to drug pricing as well as other major research efforts in this area and keep the AMA House
of Delegates informed about the findings of these studies;
(6) encourages physicians to consider prescribing the least expensive drug product (brand name or FDA
A-rated generic); and
(7) encourages all physicians to become familiar with the price in their community of the medications
they prescribe and to consider this along with the therapeutic benefits of the medications they select for
their patients.

H-125.990 Medicaid Payment for Over-The-Counter Drugs When They are the Drug of Choice:
The AMA supports over-the-counter drug benefits under Medicaid that provide physician-prescribed
medications to enrollees. Cost-conscious OTC drug programs should satisfy the criteria contained in
Policy 110.997 for AMA support of programs designed to contain the rising costs of prescription drugs
and follow AMA Policy 125.991 on development and implementation of drug formularies.
Subject: Compensation to Physicians for Activities Other Than Direct Patient Care

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Socioeconomics

Whereas, Traditionally, physicians get paid for direct patient care, such as evaluation and management and procedures; and

Whereas, Insurance and managed care companies (“payers”) demand and require physicians and their staff to perform services outside of direct patient care (“non-care services’) without any payment. Examples of such “non-care services” include authorization and preauthorization for coverage and payment for prescriptions, laboratory tests, radiology tests, procedures, surgeries, hospitalizations, and physician visits. Other examples of “non-care services” include the gathering, compilation, and submission of 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 utilize actuarial data for their pricing and profitability. “Non-care services” (1) have greatly increased expenses for physicians; (2) have endangered the ability of physician practices to survive economically; and (3) have caused the demise of independent physician practices; and

Whereas, The purpose of such “non-care services” is to delay and deny care, thus allowing payers to save, keep, and invest money that otherwise would pay for patient care, thus increasing their profits; and

Whereas, The overwhelming majority of authorization and preauthorization requests eventually are authorized by payers; and

Whereas, Such “non-care services” harm patients by delaying diagnosis and treatment, thus causing pain, suffering, morbidity, and mortality. The time spent by physicians and their staff in performing “non-care services” decreases their availability to provide direct patient care for other patients, thus exacerbating physician shortages; and

Whereas, Other professionals, such as attorneys, accountants, and their staff bill and get paid for all services they provide to their clients. The payers’ demands and requirements for physicians and their staff to provide “non-care services” without compensation is theft, extortion, and indentured servitude; and

Whereas, Despite existing Texas Medical Association policy, such “non-care services” and their direct and indirect costs have continued to increase and are endangering the viability of the private practice of medicine. As payers continue to disregard existing TMA policy, physicians are currently not compensated for such “non-care services” that benefit only payers, to the detriment of patients and physicians. The dire need for relief from payers’ demands and requirements for physicians to provide “non-care services” necessitates the reiteration and strengthening of existing TMA policy; therefore be it

RESOLVED, That insurance companies and managed care companies, including companies managing governmental insurance plans (“payers”), compensate physicians for the time that physicians and their staff spend on “non-care services,” including, but not limited to, authorization and preauthorization for coverage and payment for prescriptions, laboratory tests, radiology tests, procedures, surgeries, hospitalizations, and physician visits; as well as the gathering, compilation, and submission of 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. Payment should be at a rate comparable to the most highly trained professionals. The physician shall bill the payers for time spent by the physician and his or her staff in performing “non-care services.” Billable time for “non-care services” includes, 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, including telemedicine in all its forms, 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. Since “non-care services” benefit the insurance companies, compensation owed to physicians for “non-care services” should not be billable to patients.

Related TMA Policy:

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).

120.003 Health System Reform Managed Care: To provide a basic framework for association policies and activities in health system reform, the Texas Medical Association: (1) supports the concept of universal access to appropriate health care; (2) supports freedom of patients to select their own physicians; (3) supports meaningful professional liability reform for physicians as a key element of health system reform; (4) supports genuine relief from red-tape hassles and excessive administrative costs of health care; (5) supports freedom from unreasonable restrictions, including antitrust prohibitions, that prevent physicians from conducting peer review of quality and fees; (6) continues to support a health care system that includes a multiplicity of funding sources and payment mechanisms; (7) supports the right of a physician organization to negotiate at the federal or state level for payment of physician services, quality and utilization review, professional liability reform, and to reduce the hassle and cost of regulation; (8) continues to support sufficient autonomy for physicians to be advocates for patients and to make decisions in the best interests of their patients; (9) supports efforts to control costs in an efficient and effective manner that considers the needs of patients and allows the exercise of good medical judgment; (10) supports the funding of research and medical education in any health system reform proposal and believes that all corporate payers of health care share in the costs of graduate medical education; (11) supports quality assurance through practice parameters and outcomes research; (12) supports patient responsibility for first dollar coverage to allow patients to make individual decisions regarding their own health care spending with consideration given to patients’ ability to pay.

In addition, TMA offers the following principles for managed care for adoption as AMA policy: (1) physician participation in any managed care organization he or she chooses, (2) patient freedom to select his or her own physician, (3) physician autonomy and freedom to be patient advocates (Second Supplemental BOT, p 36P-36S, A-93; amended CSE Rep. 6-A-03; reaffirmed CSE Rep. 1-A-13).

180.026 Health Insurance Plans: The Texas Medical Association approves continued aggressive advocacy for members in dealing with health insurance plan issues and will expand where appropriate its cooperative, collaborative initiatives with health insurers to address issues and problems of mutual concern (BOT Rep. 22-A-99; amended CSE Rep. 1-A-10).

180.031 Pharmacy Benefit Managers: The Texas Medical Association will (1) gather evidence of the administrative burden placed on physicians and patients by the policies and operating practices of Pharmacy Benefit Managers (PBMs) in order to document the impact on medical practices and determine whether the business practices of PBMs comply with state laws and regulations; (2) explore the
possibility of legislative action should no state laws or regulations apply to the preauthorization process required by PBMs; and (3) promote cooperation by Texas pharmacists to provide physicians with up-to-date information about prescriptive drugs covered by pharmacy benefit managers and appropriate alternative medications in pharmacy benefit managers' formularies (Amended Res. 401-A-06; reaffirmed CSE Rep. 6-A-16).

235.027 Payment for Physician Work Product: A physician's time is not "free;" a physician's work product and time is justly compensable in accordance with standard business practices of learned professionals (Res. 409-A-07; reaffirmed CSE Rep. 7-A-17).

235.034 Authorizations Initiated by Third-Party Payers, Benefit Managers, and Utilization Review Entities: The Texas Medical Association supports policy and legislation that (1) third-party payers, benefit managers, and utilization review entities may not implement prior authorization mechanisms unless these payers compensate physician practices for work required independent of any payment for patient care; specifically, medical practices must be compensated for the burden of added staff and resources required to navigate payer-initiated prior authorizations for medications, studies, or procedures; (2) third-party payers, benefit managers, and utilization review entities should disclose all prior authorization requirements and restrictions on their websites in both the subscriber section and the physician section with neither location requiring a log-in or password; (3) third-party payers, benefit managers and utilization review entities should confirm patient eligibility, payment determinations, medical policies and subscriber specific exclusions as part of the prior authorization process; and (4) third-party payers, benefit managers, and utilization review entities should make detailed statistics regarding prior authorization approval and denial rates available on their website (Res. 401-A-11) (CSE Rep. 3-A-18).
Subject: Managing Patient-Physician Relations Within Medicare Advantage Plans

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Socioeconomics

Whereas, Medicare Advantage plans are usually Health Maintenance Organization (HMO) plans, and, therefore, patients must be assigned to a primary care physician’s (PCP) patient panel; and

Whereas, Most patients will choose a physician they wish to serve as their PCP. However, those patients who do not choose for themselves will be assigned by the plan to a PCP’s patient panel, usually based on geographic area or zip code; and

Whereas, PCPs are responsible for these assigned patients for completing Healthcare Effectiveness Data and Information Set (HEDIS) measures, such as an annual preventive visit, breast cancer screening, colorectal screening, diabetic eye examination, body mass index, hospital discharge follow up, medication adherence, etc.; and

Whereas, PCPs are given bonuses/incentives or are penalized based on their HEDIS star rating score. Star rating scores range from one to five, with five stars being the best rating score; and

Whereas, PCPs must endure time consuming and costly measures to remove from their patient panel those patients who will not establish a patient-physician relationship. In many instances, a relationship is not established because the PCP has not been provided the patient’s correct contact information (address, telephone number) or because the patient refuses to make or show for an appointment. These time consuming and costly measures may even include the requirement to send certified letters to the patient; therefore be it

RESOLVED, That the Texas Medical Association adopt a policy that Medicare Advantage plans allow a primary care physician (PCP) to remove patients from his or her patient panel if the PCP has proven that he or she has been unable to establish a patient-physician relationship, despite repeated attempts; and be it further

RESOLVED, That the physician’s Healthcare Effectiveness Data and Information Set (HEDIS) and other quality scores and ratings not be affected by those patients with whom the physician has been unable to establish a relationship; and be it further

RESOLVED, That the Texas Delegation to the American Medical Association take this resolution to the AMA House of Delegates.

Related TMA Policy:

265.017 Pay-for-Performance Principles and Guidelines. Physician pay-for-performance (PFP) programs that are designed primarily to improve the effectiveness and safety of patient care may serve as a positive force in our health care system. Fair and ethical PFP programs are patient-centered and link evidence-based performance measures to financial incentives. Such PFP programs are in alignment with the American Medical Association Guidelines for Pay-for-Performance Programs and the following five American Medical Association Principles for Pay-for-Performance Programs:
1. **Ensure quality of care.** Fair and ethical PFP programs are committed to improved patient care as their most important mission. Evidence-based quality-of-care measures, created by physicians across appropriate specialties, are the measures used in the programs. Variations in an individual patient care regimen are permitted based on a physician’s sound clinical judgment and should not adversely affect PFP program rewards.

2. **Foster the patient-physician relationship.** Fair and ethical PFP programs support the patient-physician relationship and overcome obstacles to physicians treating patients, regardless of patients’ health conditions, ethnicity, economic circumstances, demographics, or treatment compliance patterns.

3. **Offer voluntary physician participation.** Fair and ethical PFP programs offer voluntary physician participation, and do not undermine the economic viability of nonparticipating physician practices. These programs support participation by physicians in all practice settings by minimizing potential financial and technological barriers including costs of start-up.

4. **Use accurate data and fair reporting.** Fair and ethical PFP programs use accurate data and scientifically valid analytical methods. Physicians are allowed to review, comment, and appeal results prior to the use of the results for programmatic reasons and any type of reporting.

5. **Provide fair and equitable program incentives.** Fair and ethical PFP programs provide new funds for positive incentives to physicians for their participation, progressive quality improvement, or attainment of goals within the program. The eligibility criteria for the incentives are fully explained to participating physicians. These programs support the goal of quality improvement across all participating physicians.

**Guidelines for Pay-for-Performance Programs**

Safe, effective, and affordable health care for all Americans is the American Medical Association’s goal for our health care delivery system. AMA presents the following guidelines regarding the formation and implementation of fair and ethical pay-for-performance (PFP) programs. These guidelines augment AMA’s Principles for Pay-for-Performance Programs and provide AMA leaders, staff, and members operational boundaries that can be used in an assessment of specific PFP programs.

**Quality of Care**

- The primary goal of any PFP program must be to promote quality patient care that is safe and effective across the health care delivery system, rather than to achieve monetary savings.
- Evidence-based quality-of-care measures must be the primary measures used in any program.
  1. All performance measures used in the program must be defined prospectively and developed collaboratively across physician specialties.
  2. Practicing physicians with expertise in the area of care in question must be integrally involved in the design, implementation, and evaluation of any program.
  3. All performance measures must be developed and maintained by appropriate professional organizations that periodically review and update these measures with evidence-based information in a process open to the medical profession.
  4. Performance measures should be scored against both absolute values and relative improvement in those values.
  5. Performance measures must be subject to the best available risk adjustment for patient demographics, severity of illness, and comorbidities.
  6. Performance measures must be kept current and reflect changes in clinical practice. Except for evidence-based updates, program measures must be stable for two years.
  7. Performance measures must be selected for clinical areas that have significant promise for improvement.
- Physician adherence to PFP program requirements must conform with improved patient care, quality, and safety.
- Programs should allow for variance from specific performance measures that are in conflict with sound clinical judgment and, in so doing, require minimal, but appropriate, documentation.
- PFP programs must be able to demonstrate improved quality patient care that is safer and more effective as the result of program implementation.
• PFP programs help to ensure quality by encouraging collaborative efforts across all members of the health care team.

• Prior to implementation, pay-for-performance programs must be successfully pilot-tested for a sufficient duration to obtain valid data in a variety of practice settings and across all affected medical specialties. Pilot testing also should analyze for patient deselection. If implemented, the program must be phased in over an appropriate period of time to enable participation by any willing physician in affected specialties.

• Plans that sponsor PFP programs must explain these programs prospectively to the patients and communities covered by them.

Patient-Physician Relationship

• Programs must be designed to support the patient-physician relationship and recognize that physicians are ethically required to use sound medical judgment, holding the best interests of the patient as paramount.

• Programs must not cause conditions that limit access to improved care.
  1. Programs must not directly or indirectly disadvantage patients from ethnic, cultural, and socioeconomic groups, as well as those with specific medical conditions, or the physicians who serve these patients.
  2. Programs must neither directly nor indirectly disadvantage patients and their physicians, based on the setting where care is delivered or the location of populations served (such as inner city or rural areas).

• Programs must neither directly nor indirectly encourage patient deselection.

• Programs must recognize outcome limitations caused by patient nonadherence, and sponsors of PFP programs should attempt to minimize noncompliance through plan design.

Physician Participation

• Physician participation in any PFP program must be completely voluntary.

• Sponsors of PFP programs must notify physicians of PFP program implementation and offer physicians the opportunity to opt in or out of the PFP program without affecting the existing or offered contract provisions from the sponsoring health plan or employer.

• Programs must be designed so that physician nonparticipation does not threaten the economic viability of physician practices.

• Programs should be available to any physicians and specialties wishing to participate and must not favor one specialty over another. Programs must be designed to encourage broad physician participation across all modes of practice.

• Programs must not favor physician practices by size (large, small, or solo) or by capabilities in information technology (IT).
  1. Programs should provide physicians tools to facilitate participation.
  2. Programs should be designed to minimize financial and technological barriers to physician participation.

• Although some IT systems and software may facilitate improved patient management, programs must avoid implementation plans that require physician practices to purchase health-plan specific IT capabilities.

• Physician participation in a particular PFP program must not be linked to participation in other health plan or government programs.

• Programs must educate physicians about the potential risks and rewards inherent in program participation, and immediately notify participating physicians of newly identified risks and rewards.

• Physician participants must be notified in writing about any changes in program requirements and evaluation methods. Such changes must occur at most on an annual basis.

Physician Data and Reporting

• Patient privacy must be protected in all data collection, analysis, and reporting. Data collection must be administratively simple and consistent with the Health Insurance Portability and Accountability Act.
The quality of data collection and analysis must be scientifically valid. Collecting and reporting of data must be reliable and easy for physicians and should not cause financial or other burdens on physicians and/or their practices. Audit systems should be designed to ensure the accuracy of data in a nonpunitive manner.

1. Programs should use accurate administrative data and data abstracted from medical records.
2. Medical record data should be collected in a manner that is not burdensome and disruptive to physician practices.
3. Program results must be based on data collected over a significant period of time and relate care delivered (numerator) to a statistically valid population of patients in the denominator.

Physicians must be reimbursed for any added administrative costs incurred as a result of collecting and reporting data to the program.

Physicians should be assessed in groups and/or across health care systems, rather than individually when feasible.

Physicians must have the ability to review and comment on data and analysis used to construct any performance ratings prior to the use of such ratings to determine physician payment or for public reporting.

1. Physicians must be able to see preliminary ratings and be given the opportunity to adjust practice patterns over a reasonable period of time to more closely meet quality objectives.
2. Prior to release of any physician ratings, programs must have a mechanism for physicians to see and appeal their ratings in writing. If requested by the physician, physician comments must be included adjacent to any ratings.

If PFP programs identify physicians with exceptional performance in providing effective and safe patient care, the reasons for such performance should be shared with physician program participants and widely promulgated.

The results of PFP programs must not be used against physicians in health plan credentialing, licensure, and certification. Individual physician quality performance information and data must remain confidential and not subject to discovery in legal or other proceedings.

PFP programs must have defined security measures to prevent the unauthorized release of physician ratings.

Program Rewards

• Programs must be based on rewards and not on penalties.
• Program incentives must be sufficient in scope to cover any additional work and practice expense incurred by physicians as a result of program participation.
• Programs must offer financial support to physician practices that implement IT systems or software that interacts with aspects of the PFP program.
• Programs must finance bonus payments based on specified performance measures with supplemental funds.
• Programs must reward all physicians who actively participate in the program and who achieve prespecified absolute program goals or demonstrate prespecified relative improvement toward program goals.
• Programs must not reward physicians based on ranking compared with other physicians in the program.
• Programs must provide to all eligible physicians and practices a complete explanation of all program facets, to include the methods and performance measures used to determine incentive eligibility and incentive amounts, prior to program implementation.
• Programs must not penalize physicians financially based on factors outside of the physician’s control.
• Programs utilizing bonus payments must be designed to protect patient access and must not financially disadvantage physicians who serve minority or uninsured patients.
• Programs must not penalize physicians financially when they follow current, accepted clinical
guidelines that are different from measures adopted by payers, especially when measures have not
been updated to meet currently accepted guidelines.
TMA opposes private payer, congressional, or Centers for Medicare & Medicaid Services pay-for-
performance initiatives if they do not meet the AMA’s Principles and Guidelines for Pay for Performance

Related AMA Policy:
H-285.947 Retroactive Assignment of Patients by Managed Care Entities: Our AMA opposes the
practice of "retroactive or late assignment" of patients by managed care entities, noting that "retroactive or
last assignment" includes: (a) the practice of failing to require enrollees in a capitated plan to select a
responsible physician(s) at the time of enrollment; (b) the practice of failing to inform the responsible
physician(s) of the enrollment of the patient and the assignment of responsibility until the patient has
sought care; and (c) the practice of failing to pay the responsible physician the capitated rate until after the
patient has sought care.

H-450.947 Pay-for-Performance Principles and Guidelines: 1. The following Principles for Pay-for-
Performance and Guidelines for Pay-for-Performance are the official policy of our AMA.

PRINCIPLES FOR PAY-FOR-PERFORMANCE PROGRAMS

Physician pay-for-performance (PFP) programs that are designed primarily to improve the effectiveness
and safety of patient care may serve as a positive force in our health care system. Fair and ethical PFP
programs are patient-centered and link evidence-based performance measures to financial incentives.
Such PFP programs are in alignment with the following five AMA principles:

1. Ensure quality of care - Fair and ethical PFP programs are committed to improved patient care as
their most important mission. Evidence-based quality of care measures, created by physicians across
appropriate specialties, are the measures used in the programs. Variations in an individual patient care
regimen are permitted based on a physician's sound clinical judgment and should not adversely affect PFP
program rewards.

2. Foster the patient/physician relationship - Fair and ethical PFP programs support the
patient/physician relationship and overcome obstacles to physicians treating patients, regardless of
patients' health conditions, ethnicity, economic circumstances, demographics, or treatment compliance
patterns.

3. Offer voluntary physician participation - Fair and ethical PFP programs offer voluntary physician
participation, and do not undermine the economic viability of non-participating physician practices. These
programs support participation by physicians in all practice settings by minimizing potential financial and
technological barriers including costs of start-up.

4. Use accurate data and fair reporting - Fair and ethical PFP programs use accurate data and
scientifically valid analytical methods. Physicians are allowed to review, comment and appeal results
prior to the use of the results for programmatic reasons and any type of reporting.

5. Provide fair and equitable program incentives - Fair and ethical PFP programs provide new funds
for positive incentives to physicians for their participation, progressive quality improvement, or
attainment of goals within the program. The eligibility criteria for the incentives are fully explained to
participating physicians. These programs support the goal of quality improvement across all participating
physicians.

GUIDELINES FOR PAY-FOR-PERFORMANCE PROGRAMS

Safe, effective, and affordable health care for all Americans is the AMA's goal for our health care
delivery system. The AMA presents the following guidelines regarding the formation and implementation
of fair and ethical pay-for-performance (PFP) programs. These guidelines augment the AMA's "Principles for Pay-for-Performance Programs" and provide AMA leaders, staff and members with operational boundaries that can be used in an assessment of specific PFP programs.

Quality of Care

- The primary goal of any PFP program must be to promote quality patient care that is safe and effective across the health care delivery system, rather than to achieve monetary savings.

- Evidence-based quality of care measures must be the primary measures used in any program.
  1. All performance measures used in the program must be prospectively defined and developed collaboratively across physician specialties.
  2. Practicing physicians with expertise in the area of care in question must be integrally involved in the design, implementation, and evaluation of any program.
  3. All performance measures must be developed and maintained by appropriate professional organizations that periodically review and update these measures with evidence-based information in a process open to the medical profession.
  4. Performance measures should be scored against both absolute values and relative improvement in those values.
  5. Performance measures must be subject to the best-available risk-adjustment for patient demographics, severity of illness, and co-morbidities.
  6. Performance measures must be kept current and reflect changes in clinical practice. Except for evidence-based updates, program measures must be stable for two years.
  7. Performance measures must be selected for clinical areas that have significant promise for improvement.

- Physician adherence to PFP program requirements must conform with improved patient care quality and safety.

- Programs should allow for variance from specific performance measures that are in conflict with sound clinical judgment and, in so doing, require minimal, but appropriate, documentation.

- PFP programs must be able to demonstrate improved quality patient care that is safer and more effective as the result of program implementation.

- PFP programs help to ensure quality by encouraging collaborative efforts across all members of the health care team.

- Prior to implementation, pay-for-performance programs must be successfully pilot-tested for a sufficient duration to obtain valid data in a variety of practice settings and across all affected medical specialties. Pilot testing should also analyze for patient de-selection. If implemented, the program must be phased-in over an appropriate period of time to enable participation by any willing physician in affected specialties.

- Plans that sponsor PFP programs must prospectively explain these programs to the patients and communities covered by them.

Patient/Physician Relationship

- Programs must be designed to support the patient/physician relationship and recognize that physicians are ethically required to use sound medical judgment, holding the best interests of the patient as paramount.
- Programs must not create conditions that limit access to improved care.
  1. Programs must not directly or indirectly disadvantage patients from ethnic, cultural, and socio-economic groups, as well as those with specific medical conditions, or the physicians who serve these patients.
  2. Programs must neither directly nor indirectly disadvantage patients and their physicians, based on the setting where care is delivered or the location of populations served (such as inner city or rural areas).

- Programs must neither directly nor indirectly encourage patient de-selection.

- Programs must recognize outcome limitations caused by patient non-adherence, and sponsors of PFP programs should attempt to minimize non-adherence through plan design.

**Physician Participation**

- Physician participation in any PFP program must be completely voluntary.

- Sponsors of PFP programs must notify physicians of PFP program implementation and offer physicians the opportunity to opt in or out of the PFP program without affecting the existing or offered contract provisions from the sponsoring health plan or employer.

- Programs must be designed so that physician nonparticipation does not threaten the economic viability of physician practices.

- Programs should be available to any physicians and specialties who wish to participate and must not favor one specialty over another. Programs must be designed to encourage broad physician participation across all modes of practice.

- Programs must not favor physician practices by size (large, small, or solo) or by capabilities in information technology (IT).

  1. Programs should provide physicians with tools to facilitate participation.
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- Although some IT systems and software may facilitate improved patient management, programs must avoid implementation plans that require physician practices to purchase health-plan specific IT capabilities.

- Physician participation in a particular PFP program must not be linked to participation in other health plan or government programs.

- Programs must educate physicians about the potential risks and rewards inherent in program participation, and immediately notify participating physicians of newly identified risks and rewards.

- Physician participants must be notified in writing about any changes in program requirements and evaluation methods. Such changes must occur at most on an annual basis.

**Physician Data and Reporting**

- Patient privacy must be protected in all data collection, analysis, and reporting. Data collection must be administratively simple and consistent with the Health Insurance Portability and Accountability Act (HIPAA).
- The quality of data collection and analysis must be scientifically valid. Collecting and reporting of data must be reliable and easy for physicians and should not create financial or other burdens on physicians and/or their practices. Audit systems should be designed to ensure the accuracy of data in a non-punitive manner.
  1. Programs should use accurate administrative data and data abstracted from medical records.
  2. Medical record data should be collected in a manner that is not burdensome and disruptive to physician practices.
  3. Program results must be based on data collected over a significant period of time and relate care delivered (numerator) to a statistically valid population of patients in the denominator.

- Physicians must be reimbursed for any added administrative costs incurred as a result of collecting and reporting data to the program.

- Physicians should be assessed in groups and/or across health care systems, rather than individually, when feasible.

- Physicians must have the ability to review and comment on data and analysis used to construct any performance ratings prior to the use of such ratings to determine physician payment or for public reporting.
  1. Physicians must be able to see preliminary ratings and be given the opportunity to adjust practice patterns over a reasonable period of time to more closely meet quality objectives.
  2. Prior to release of any physician ratings, programs must have a mechanism for physicians to see and appeal their ratings in writing. If requested by the physician, physician comments must be included adjacent to any ratings.

- If PFP programs identify physicians with exceptional performance in providing effective and safe patient care, the reasons for such performance should be shared with physician program participants and widely promulgated.

- The results of PFP programs must not be used against physicians in health plan credentialing, licensure, and certification. Individual physician quality performance information and data must remain confidential and not subject to discovery in legal or other proceedings.

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- Programs must be based on rewards and not on penalties.

- Program incentives must be sufficient in scope to cover any additional work and practice expense incurred by physicians as a result of program participation.

- Programs must offer financial support to physician practices that implement IT systems or software that interact with aspects of the PFP program.

- Programs must finance bonus payments based on specified performance measures with supplemental funds.

- Programs must reward all physicians who actively participate in the program and who achieve pre-specified absolute program goals or demonstrate pre-specified relative improvement toward program goals.
- Programs must not reward physicians based on ranking compared with other physicians in the program.

- Programs must provide to all eligible physicians and practices a complete explanation of all program facets, to include the methods and performance measures used to determine incentive eligibility and incentive amounts, prior to program implementation.

- Programs must not financially penalize physicians based on factors outside of the physician's control.

- Programs utilizing bonus payments must be designed to protect patient access and must not financially disadvantage physicians who serve minority or uninsured patients.

- Programs must not financially penalize physicians when they follow current, accepted clinical guidelines that are different from measures adopted by payers, especially when measures have not been updated to meet currently accepted guidelines.

2. Our AMA opposes private payer, Congressional, or Centers for Medicare and Medicaid Services pay-for-performance initiatives if they do not meet the AMA's "Principles and Guidelines for Pay-for-Performance."
Whereas, In 1992, Medicare established a standardized physician payment schedule based on a resource-based relative value scale (RBRVS), where payments for services are determined by the resource costs needed to provide them; and

Whereas, The American Medical Association created the RVS Update Committee (RUC) to recommend payment schedules to the Centers for Medicare & Medicaid Services (CMS), and 90 percent of RUC recommendations are accepted by CMS; and

Whereas, RBRVS costs are composed of three components: physician work, practice expense, and professional liability insurance; and

Whereas, The AMA Practice Expense Advisory Committee, a subcommittee of the RUC, was charged to review direct practice expenses (clinical labor activities, medical supplies, and equipment) to calculate practice expense relative values and to make code-specific recommendations to the RUC; and

Whereas, Physician practice expenses have not been comprehensively reviewed since 2004, nor updated since 2007, including new practice costs related to electronic health records; quality documentation and reporting; population health registries; prior authorizations; pharmacy benefit manager reviews; prescription drug monitoring programs; interval increases in other federal, state, and local documentation requirements; additional staff required to comply with these new reporting requirements; as well as rent, equipment, supplies, salaries, and inflation; and

Whereas, Physicians require the resources to practice 21st-century medicine and implement the value-based payment requirements established by the 2015 Medicare Access and CHIP Reauthorization Act; and

Whereas, Current TMA policy supports AMA development of an RBRVS free of the distortions imposed by the federal government, reform of the Medicare payment system to provide adequate and equitable funding to all physicians providing services to patients who are Medicare beneficiaries, as well as requesting Congress to act to set Medicare fees at an adequate rate and enact requirements for future updates that are adequate to accommodate increasing practice costs; and

Whereas, The 2018 Rand Practice Expense Analysis concluded, “the PPIS [Physician Practice Information Survey] survey inputs that are used for indirect cost allocation are outdated and likely to become increasingly inaccurate over time. … We recommend establishing a new PE survey that can be repeated on an ongoing basis;” therefore be it

RESOLVED, That the Texas Delegation to the American Medical Association submit a resolution to the AMA House of Delegates at the 2019 Annual Meeting requesting that the AMA pursue efforts to update
resource-based relative value unit practice expense methodology so that it accurately reflects current
physician practice costs, with report back at the AMA House of Delegates 2019 Interim Meeting.

Related TMA Policy:

230.005 Fee Schedules Mandated by Federal Government: Amounts listed in fee schedules for
medical services mandated by the federal government (e.g., Medicare, Medicaid, and TRICARE fee
schedules) are unrelated to “usual and customary,” “customary and reasonable,” “prevailing,” or any
other characterization implying a market-based determination (Res. 413-A-08; amended CSE Rep. 1-A-
18).

240.13 RBRVS -- AMA Development: The Texas Medical Association strongly supports AMA
development of an RBRVS free of the distortions imposed by the federal government on the RBRVS
currently in use by Medicare. The AMA should continue to work through the Relative Value System
Update Committee (RUC) to remove any distortions from the RBRVS currently in use by Medicare

240.016 Medicare Reimbursement Rates: The Texas Medical Association will work to reform the
Medicare payment system to provide adequate and equitable funding to all physicians providing services
to patients who are Medicare beneficiaries (Substitute Res. 401-A-03 reaffirmed CSE Rep. 1-A-13).

240.018 Medicare Fees: Inadequate fee updates since 2001 have caused Medicare physician payments to
fall well below the average cost to provide services, so that physician practices are unable to survive at
Medicare payment rates. Inadequate fees lead to a shift of care to costly hospital-based settings. Adequate
fees and update factors are necessary to maintain beneficiary access to outpatient care and to accomplish
improvements in medical care quality. Congress should act now to set Medicare fees at an adequate rate
and enact requirements for future updates that are adequate to accommodate increasing practice costs

235.026 Medical Care and Fair Compensation: Medical care should not be an unfunded mandate from
the government. If a governmental body provides access to health care, fair compensation to the physician
must be provided (Amended Res.104-A-07; amended CSE Rep. 7-A-17).

235.027 Payment for Physician Work Product: A physician's time is not "free;" a physician's work
product and time is justly compensable in accordance with standard business practices of learned

Related AMA Policy:

D-400.986 The RUC: Recent Activities to Improve the Valuation of Primary Care Services:
Our AMA continues to advocate for the adoption of AMA/Specialty Society RVS Update Committee
(RUC) recommendations, and separate payment for physician services that do not necessarily require
face-to-face interaction with a patient.

D-400.988 PLI-RVU Component of RBRVS Medicare Fee Schedule: Our AMA will: (1) continue its
current activities to seek correction of the inadequate professional liability insurance component in the
Resource-Based Relative Value Scale Formula; (2) continue its current activities to seek action from the
Centers for Medicare & Medicaid Services to update the Professional Liability Insurance Relative Value
Units (PLI-RVU) component of the RBRVS to correctly account for the current relative cost of
professional liability insurance and its funding; and (3) support federal legislation to provide additional
funds for this correction and update of the PLI-RVU component of the RBRVS, rather than simply
making adjustments in a budget-neutral fashion.
D-400.99 CPT Modifiers: (1) Our AMA will continue to actively collect information, through existing processes, including the semi-annual study of non-Medicare use of the Medicare RBRVS conducted by the AMA Department of Physician Payment Policy and Systems and the recently unveiled AMA Private Sector Advocacy (PSA) Health Plan Complaint Form, and solicit input and assistance in this data collection from other interested members of the Federation on the acceptance of CPT modifiers by third party payers.

(2) Pertinent information collected by our AMA through existing methods and collected through the AMA PSA Health Plan Complaint Form about acceptance of CPT modifiers by third party payers be shared with applicable state, county and national medical specialty societies in order to promote a greater understanding of third party payer payment policies related to CPT modifiers.

(3) Our AMA use the available information to engage in discussions with payers.

(4) Aggregate information collected through existing methods and collected through the AMA PSA Health Plan Complaint Form on acceptance for payment of CPT modifiers by third party payers be disseminated to state and federal regulators and legislators.

D-400.999 Non-Medicare Use of the RBRVS: Our AMA will: (1) reaffirm Policy H-400.960 which advocates that annually updated and rigorously validated Resource Based Relative Value Scale (RBRVS) relative values could provide a basis for non-Medicare physician payment schedules, and that the AMA help to ensure that any potential non-Medicare use of an RBRVS reflects the most current and accurate data and implementation methods; (2) reaffirm Policy H-400.969 which supports the use of the AMA/Specialty Society process as the principal method of refining and maintaining the Medicare relative value scale; (3) continue to identify the extent to which third party payers and other public programs modify, adopt, and implement Medicare RBRVS payment policies; (4) strongly oppose and protests the Centers for Medicare & Medicaid Services’ Medicare multiple surgery reduction policy which reduces payment for additional surgical procedures after the first procedure by more than 50%; and (5) encourage third party payers and other public programs to utilize the most current CPT codes updated by the first quarter of the calendar year, modifiers, and relative values to ensure an accurate implementation of the RBRVS.

H-400.955 Establishing Capitation Rates:

1. Our AMA believes Geographic variations in capitation rates from public programs (e.g., Medicare or Medicaid) should reflect only demonstrable variations in practice costs and correctly validated variations in utilization that reflect legitimate and demonstrable differences in health care need. In particular, areas that have relatively low utilization rates due to cost containment efforts should not be penalized with unrealistically low reimbursement rates. In addition, these payments should be adjusted at the individual level with improved risk adjustors that include demographic factors, health status, and other useful and cost-effective predictors of health care use.

2. Our AMA will work to assure that any current or proposed Medicare or Medicaid (including waivers) capitated payments should be set at levels that would establish and maintain access to quality care.

3. Our AMA seeks modifications as appropriate to the regulations and/or statues affecting Medicare HMOs and other Medicare managed care arrangements to incorporate the revised Patient Protection Act and to ensure equal access to Medicare managed care contracts for physician-sponsored managed care organizations.

4. Our AMA supports development of a Medicare risk payment methodology that would set payment levels that are fair and equitable across geographic regions; in particular, such methodology should allow
for equitable payment rates in those localities with relatively low utilization rates due to cost containment efforts.

H-400.956 RBRVS Development:
(1) That the AMA strongly advocate CMS adoption and implementation of all the RUC's recommendations for the five-year review;
(2) That the AMA closely monitor all phases in the development of resource-based practice expense relative values to ensure that studies are methodologically sound and produce valid data, that practicing physicians and organized medicine have meaningful opportunities to participate, and that any implementation plans are consistent with AMA policies;
(3) That the AMA work to ensure that the integrity of the physician work relative values is not compromised by annual budget neutrality or other adjustments that are unrelated to physician work;
(4) That the AMA encourage payers using the relative work values of the Medicare RBRVS to also incorporate the key assumptions underlying these values, such as the Medicare global periods; and
(5) That the AMA continue to pursue a favorable advisory opinion from the Federal Trade Commission regarding AMA provision of a valid RBRVS as developed by the RUC process to private payers and physicians.

H-400.957 Medicare Reimbursement of Office-Based Procedures: Our AMA will: (1) encourage CMS to expand the extent and amount of reimbursement for procedures performed in the physician's office, to shift more procedures from the hospital to the office setting, which is more cost effective; (2) seek to have the RBRVS practice expense RVUs reflect the true cost of performing office procedures; and (3) work with CMS to develop consistent regulations to be followed by carriers that include reimbursement for the costs of disposable supplies and surgical tray fees incurred with office-based procedures and surgery.

H-400.959 Refining and Updating the Physician Work Component of the RBRVS: The AMA: (1) supports the efforts of the CPT Editorial Panel and the AMA/Specialty Society RVS Update Committee's (RUC's) work with the American Academy of Pediatrics and other specialty societies to develop pediatric-specific CPT codes and physician work relative value units to incorporate children's services into the RBRVS; (2) supports the RUC's efforts to improve the validity of the RBRVS through development of methodologies for assessing the relative work of new technologies and for assisting CMS in a more comprehensive review and refinement of the work component of the RBRVS; and (3) continues to object to use of the relative values as a mechanism to preserve budget neutrality.

H-400.962 The AMA/Specialty Society RVS Update Process: Our AMA will strengthen its efforts to secure CMS adoption of the AMA/Specialty Society RVS Update Committee's (RUC) recommendations.

H-400.969 RVS Updating: Status Report and Future Plans: The AMA/Specialty Society RVS Update Committee (RUC) represents an important opportunity for the medical profession to maintain professional control of the clinical practice of medicine. The AMA urges each and every organization represented in its House of Delegates to become an advocate for the RUC process in its interactions with the federal government and with its physician members. The AMA (1) will continue to urge CMS to adopt the recommendations of the AMA/Specialty Society RVS Update Committee for physician work relative values for new and revised CPT codes; (2) supports strongly use of this AMA/Specialty Society process as the principal method of refining and maintaining the Medicare RVS; (3) encourages CMS to rely upon this process as it considers new methodologies for addressing the practice expense components of the Medicare RVS and other RBRVS issues; and (4) opposes changes in Relative Value Units that are in excess of those recommended by the AMA/Specialty Society Relative Value Scale Update Committee (RUC).
H-400.972 Physician Payment Reform: It is the policy of the AMA to (1) take all necessary legal, legislative, and other action to redress the inequities in the implementation of the RBRVS, including, but not limited to, (a) reduction of allowances for new physicians; (b) the non-payment of EKG interpretations; (c) defects in the Geographic Practice Cost Indices and area designations; (d) inappropriate Resource-Based Relative Value Units; (e) the deteriorating economic condition of physicians' practices disproportionately affected by the Medicare payment system; (f) the need for restoration of the RBRVS conversion factor to levels consistent with the statutory requirement for budget neutrality; (g) the inadequacy of payment for services of assistant surgeons; and (h) the loss of surgical-tray benefit for many outpatient procedures (Reaffirmed by Rules & Credentials Cmt., A-96); (2) seek an evaluation of (a) stress factors (i.e., intensity values) as they affect the calculation of the Medicare Payment Schedule, seeking appropriate, reasonable, and equitable adjustments; and (b) descriptors (i.e., vignettes) and other examples of services used to determine RBRVS values and payment levels and to seek adjustments so that the resulting values and payment levels appropriately pertain to the elderly and often infirm patients; (3) evaluate the use of the RBRVS on the calculation of the work component of the Medicare Payment Schedule and to ascertain that the concept for the work component continues to be an appropriate part of a resource-based relative value system; (4) seek to assure that all modifiers, including global descriptors, are well publicized and include adequate descriptors; (5) seek the establishment of a reasonable and consistent interpretation of global fees, dealing specifically with preoperative office visits, concomitant office procedures, and/or future procedures; (6) seek from CMS and/or Congress an additional comment period beginning in the Fall of 1992; (7) seek the elimination of regulations directing patients to points of service; (8) support further study of refinements in the practice cost component of the RBRVS to ensure better reflection of both absolute and relative costs associated with individual services, physician practices, and medical specialties, considering such issues as data adequacy, equity, and the degree of disruption likely to be associated with any policy change; (9) take steps to assure that relative value units in the Medicare payment schedule, such as nursing home visits, are adjusted to account for increased resources needed to deliver care and comply with federal and state regulatory programs that disproportionately affect these services and that the Medicare conversion factor be adjusted and updated to reflect these increased overall costs; (10) support the concepts of HR 4393 (the Medicare Geographic Data Accuracy Act of 1992), S 2680 (the Medicare Geographic Data Accuracy Act of 1992), and S 2683 (Medicare Geographic Data Accuracy Act) for improving the accuracy of the Medicare geographic practice costs indices (GPCIs) and work with CMS and the Congress to assure that GPCIs are updated in as timely a manner as feasible and reflect actual physician costs, including gross receipt taxes; (11) request that CMS refine relative values for particular services on the basis of valid and reliable data and that CMS rely upon the work of the AMA/Specialty Society RVS Updating Committee (RUC) for assignment of relative work values to new or revised CPT codes and any other tasks for which the RUC can provide credible recommendations;
(12) pursue aggressively recognition and CMS adoption for Medicare payment schedule conversion factor updates of an index providing the best assurance of increases in the monetary conversion factor reflective of changes in physician practice costs, and to this end, to consider seriously the development of a "shadow" Medicare Economic Index;

(13) continue to implement and refine the Payment Reform Education Project to provide member physicians with accurate and timely information on developments in Medicare physician payment reform; and

(14) take steps to assure all relative value units contained in the Medicare Fee Schedule are adjusted as needed to comply with ever-increasing federal and state regulatory requirements.

H-400.973 Limited Licensed Practitioners and RBRVS: It is the policy of the AMA to advocate that Medicare expenditure data clearly differentiate between the services of fully licensed physicians and those of limited licensed practitioners and of other Part B services.

H-400.980 Behavioral Adjustments on Physician Payments: It is the policy of the AMA to do whatever it deems necessary to make certain that the RBRVS fee schedule does not include behavioral adjustments.

H-400.988 Medicare Reimbursement, Geographical Differences: The AMA reaffirms its policy that geographic variations under a Medicare payment schedule should reflect only valid and demonstrable differences in physician practice costs, especially liability premiums, with other non-geographic practice cost index (GPCI) -based adjustments as needed to remedy demonstrable access problems in specific geographic areas.

H-400.990 Refinement of Medicare Physician Payment System: The AMA: (1) reaffirms its support for development and implementation of a Medicare indemnity payment schedule according to the policies established in Policy 400.991; (2) supports reasonable attempts to remedy geographic Medicare physician payment inequities that do not substantially interfere with the AMA's support for an RBRVS-based indemnity payment system; (3) supports continued efforts to ensure that implementation of an RBRVS-based Medicare payment schedule occurs upon the expansion, correction, and refinement of the Harvard RBRVS study and data as called for in Board Report AA (I-88), and upon AMA review and approval of the relevant proposed enabling legislation; and (4) continues to oppose any effort to link the acceptance of an RBRVS with any proposal that is counter to AMA policy, such as expenditure targets or mandatory assignment.

H-400.991 Guidelines for the Resource-Based Relative Value Scale: (1) The AMA reaffirms its current policy in support of adoption of a fair and equitable Medicare indemnity payment schedule under which physicians would determine their own fees and Medicare would establish its payments for physician services using: (a) an appropriate RVS based on the resource costs of providing physician services; (b) an appropriate monetary conversion factor; and (c) an appropriate set of conversion factor multipliers.

(2) The AMA supports the position that the current Harvard RBRVS study and data, when sufficiently expanded, corrected and refined, would provide an acceptable basis for a Medicare indemnity payment system.

(3) The AMA reaffirms its strong support for physicians' right to decide on a claim-by-claim basis whether or not to accept Medicare assignment and its opposition to elimination of balance billing (Reaffirmed: Sub. Res. 132, A-94).
(4) The AMA reaffirms its opposition to the continuation of the Medicare maximum allowable actual charge (MAAC) limits.

(5) The AMA promotes enhanced physician discussion of fees with patients as an explicit objective of a Medicare indemnity payment system.

(6) The AMA supports expanding its activities in support of state and county medical society-initiated voluntary assignment programs for low-income Medicare beneficiaries.

(7) The AMA reaffirms its current policy that payments under a Medicare indemnity payment system should reflect valid and demonstrable geographic differences in practice costs, including professional liability insurance premiums. In addition, as warranted and feasible, the costs of such premiums should be reflected in the payment system in a manner distinct from the treatment of other practice costs.

(8) The AMA believes that payment localities should be determined based on principles of reasonableness, flexibility and common sense (e.g., localities could consist of a combination of regions, states, and metropolitan and nonmetropolitan areas within states) based on the availability of high quality data.

(9) The AMA believes that, in addition to adjusting indemnity payments based on geographic practice cost differentials, a method of adjusting payments to effectively remedy demonstrable access problems in specific geographic areas should be developed and implemented.

(10) Where specialty differentials exist, criteria for specialty designation should avoid sole dependence on rigid criteria, such as board certification or completion of residency training. Instead, a variety of general national criteria should be utilized, with carriers having sufficient flexibility to respond to local conditions. In addition to board certification or completion of a residency, such criteria could include, but not be limited to: (a) partial completion of a residency plus time in practice; (b) local peer recognition; and (c) carrier analysis of practice patterns. A provision should also be implemented to protect the patients of physicians who have practiced as specialists for a number of years.

(11) The AMA strongly opposes any attempt to use the initial implementation or subsequent use of any new Medicare payment system to freeze or cut Medicare expenditures for physician services in order to produce federal budget savings.

(12) The AMA believes that whatever process is selected to update the RVS and conversion factor, only the AMA has the resources, experience and umbrella structure necessary to represent the collective interests of medicine, and that it seek to do so with appropriate mechanisms for full participation from all of organized medicine, especially taking advantage of the unique contributions of national medical specialty societies.

Sources:

Subject: Laboratory Benefit Managers

Introduced by: Texas Society of Pathologists and Travis County Medical Society

Referred to: Reference Committee on Socioeconomics

Whereas, Health insurance payers’ use of laboratory benefit management has the potential to impinge upon the practice of medicine if not properly administered and structured; and

Whereas, Laboratory benefit management programs used by health insurance payers should be based upon transparent, verifiable, and published medical and scientific evidence, and should not be influenced by improper financial conflicts of interests in the administration of such programs arising from the health insurance payer or program administrator; and

Whereas, More than nine in 10 physicians (92 percent) say that prior authorization programs have a negative impact on patient clinical outcomes, according to a physician survey released in March 2018 by the American Medical Association; and

Whereas, The Texas Medical Association currently has policy on pharmaceutical benefits management companies (180.031); however, no policy specifically addresses laboratory benefit management; and

Whereas, The use of laboratory benefit management programs by health insurance payers should not adversely curtail physician medical judgment nor adversely impact patient diagnosis and treatment, especially for life-threatening medical conditions; and

Whereas, Ordering physician referrals to in-network laboratories should not be dictated nor constrained by laboratory benefit management; and

Whereas, No adverse claims impact should accrue to any laboratory or physician who performs a pathology or laboratory service pursuant to a lawful order for such services by a health care professional; therefore be it

RESOLVED, That the Texas Medical Association support efforts to reduce laboratory benefit management policies that result in delays in patient care, reduced patient access, or increased patient costs without clinical justification; and be it further

RESOLVED, That TMA support any policies regarding laboratory benefit management arrangements that preclude any potential conflict of interest in programs adopted by health insurance payers to provide laboratory benefit management, including prohibition on the use of any laboratory benefit management entity financially affiliated with a clinical laboratory.

Related TMA Policy:

180.031 Pharmacy Benefit Managers: The Texas Medical Association will (1) gather evidence of the administrative burden placed on physicians and patients by the policies and operating practices of
Pharmacy Benefit Managers (PBMs) in order to document the impact on medical practices and determine whether the business practices of PBMs comply with state laws and regulations; (2) explore the possibility of legislative action should no state laws or regulations apply to the preauthorization process required by PBMs; and (3) promote cooperation by Texas pharmacists to provide physicians with up-to-date information about prescriptive drugs covered by pharmacy benefit managers and appropriate alternative medications in pharmacy benefit managers' formularies (Amended Res. 401-A-06; reaffirmed CSE Rep. 6-A-16).

Related AMA Policy:

H-260.962 Laboratory Benefit Managers: Our AMA will: (1) support efforts to reduce laboratory benefit management policies that result in delays in patient care, reduced patient access, or increased patient costs without clinical justification; and (2) support... that any policies regarding laboratory benefit management arrangements preclude any potential conflict of interest in programs adopted by health insurance payors to provide laboratory benefit management, including prohibition on the use of any laboratory benefit management...
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 411
A-19

Subject: Data Migration Responsibilities of Electronic Health Record Vendors in Client Contract Termination

Introduced by: Medical Student Section

Referred to: Reference Committee on Socioeconomics

Whereas, 22.Tex.Admin Code §165.1 confers medical record ownership to a physician’s employer, including group practices, professional associations, and nonprofit health organizations, but does not delegate a physician’s ownership of data as it applies to electronic health record (EHR) vendors; and

Whereas, the Texas Medical Association supports efforts to hold health information technology (HIT) vendors accountable for developing processes, systems, and customer support that are responsive to patient safety concerns and proactively work to prevent and resolve patient safety concerns, but does not specify an EHR vendor’s role upon contract termination; and

Whereas, The Health Insurance Portability and Accountability Act of 1996 (HIPAA) specifies that business associates, including EHR vendors, must return or destroy patient health information upon termination of their agreement, but does not specify timeliness, transfer format, or the longevity of data access granted to a physician; and

Whereas, Physician dissatisfaction with EHRs is at an all-time high, and many physicians are looking to change systems; and

Whereas, EHR vendors are reconsolidating through acquisitions and mergers, and vendors are going out of business, resulting in physician practices and health care systems seeking to replace their EHRs; and

Whereas, The transition between EHR systems already may lead to unintended negative patient safety consequences and pose important safety threats, particularly in early post-transition; and

Whereas, Incomplete or barred physician access to patient records poses a threat to patient safety and continuity of care; and

Whereas, EHR vendor contract terms may not specify EHR data rights and may limit a physician’s ability to migrate data easily and inexpensively to a new EHR system in the event of a future transition; and

Whereas, Migrating data between different EHR systems is often incompatible, rendering an incomplete transfer of data between EHRs, compromising data integrity migration and patient safety; and

Whereas, 83 percent of individuals went to a health care professional at least once in the past year, with 32 percent reporting they experienced a gap in information exchange, had to redo a test or procedure because their prior data was unavailable, or had to provide medical history again because their chart could not be found; and
Whereas, Access to the old EHR is often revoked or granted for a limited time following termination, and an EHR company may not migrate patient data (progress notes, consults, radiology reports, laboratory results) in a timely manner or in a format that is useful to a physician or at all; therefore be it

RESOLVED, That the Texas Medical Association support policy that electronic health record (EHR) vendors assist in completing a data transfer and that all data be given to the physician in an industry-recognized, nonproprietary format immediately upon termination of the contract or when the EHR vendor goes out of business; and be it further

RESOLVED, That our TMA seek legislative and/or regulatory relief to require that physicians have access to their former EHR data while transitioning EHRs to ensure continuity of patient care, limit gaps in information exchange, and ensure physician ownership of data.

Related TMA Policy:

118.004 Health Information Technology – Health Information Exchange:

1. Patient safety, privacy, and quality of care are the guiding principles of all HIE efforts; cost reduction and efficiency are expected byproducts.

2. TMA is a professional organization for physicians and as such recognizes that some parts of patients’ medical records should be considered the intellectual property of the physician. HIE efforts should recognize that the physician’s work product has value for which he or she, along with the patient, has intrinsic ownership, and therefore both should control its use. Patient records are the documentation of interactions between physicians and patients. Patient privacy protections that traditionally exist in the patient-physician relationship continue to apply where HIT is used. Physicians must uphold their responsibility to protect and secure all information related to the sacred patient-physician relationship.

3. Patients have the right to withhold information. Physicians may provide a notice to users that the record is incomplete when a patient withholds information.

4. Patient privacy and confidentiality shall be maintained in all HIE efforts by using secure systems and transmission methods.

5. Patients must have complete control over all uses of individually identified medical data. Except for emergencies, or otherwise as required by law, their medical data must not be disclosed or disseminated to third parties without patient consent.

6. Open standards for the interoperable electronic transmission of clinical data should be mutually acceptable to the medical community and compatible with national and regional standards.

Foundational Principles for HIE Participation

7. Participation in HIE, beyond that required by law or in emergencies, should be determined at the local level. Regardless, participants should be able to withdraw upon reasonable notice.

8. HIE should strive to provide, at the point of care as part of the physician’s workflow, complete, timely, and relevant patient-focused information in a fully enabled electronic information environment designed to engage patients, transform care delivery, and improve population health. Patients and physicians will have confidence that personal health information is reliable; private; secure; and used with patient consent in appropriate, beneficial ways for patient and public good.

9. Any costs of supporting systems should be borne by all stakeholders, clearly defined, fair, simple to understand, and accountable, and should support the financial viability of the considered practice.

10. To ensure HIE activity remains focused on the patient interest, HIE governance should be representative of and responsive to the needs and concerns of stakeholders, with particular attention to the concerns of physicians and patients.

11. To protect the interest of patients, an HIE provider or entity must define whether and how it will share information for public health research, and surveillance and evaluation of health care quality. When
participants choose to allow these uses, patient information must be deidentified unless informed consent has been obtained and can be documented.

12. An HIE provider or entity must be designed and function to enable and enhance coordinated collaboration for improving health and patient safety. Participants should give consideration to special populations who are otherwise incapable of representing themselves (e.g., children; the aged; people who are disabled, uninsured, or homeless).

13. The patient’s Social Security number should not be used as the de facto unique patient identifier.

14. Patient data should be transmitted over a secure network, with provisions for authentication and encryption in accordance with HIPAA and other appropriate guidelines. Standard email services do not meet these guidelines. HIE participants need to be aware of potential security risks, including unauthorized physical access and security of computer hardware, and guard against them with technologies such as automatic logout and password protection.

15. HIE operations will not modify original patient data in any way.

16. The HIE entity or provider must have a means to audit, track, and use reasonable efforts to ensure the integrity of all entities or individuals engaged in receiving and converting transaction data.

17. Dissemination of information identifiable with a specific patient is permissible only when the patient provides express permission to do so.

18. The HIE entity or provider should maintain and enforce strict conflict of interest policies that require members to disclose all possible conflicts of interest, to recuse themselves from deliberations on matters in which they have a conflict of interest, and to abstain from voting on such matters. The HIE must further maintain financial transparency in its operations, acknowledging all material sources and uses of funds.

19. State support for HIE is important. However, state government’s primary role should be to foster coordination of HIE efforts, including providing access to funding or other financial incentives that promote the adoption of health information technologies. TMA opposes a governmental entity owning or primarily controlling an HIE entity or provider.

20. TMA physicians should cooperate with nongovernmental entities developing HIE solutions with minimal mandates, but only where it leads to physicians’ stewardship of the data they produce, and patients’ control over data that may identify them.

21. TMA supports national health information standards such as Nationwide Health Information Network, HL7, Continuity of Care Record (CCR)/Continuity of Care Document (CCD), and other standards adopted by the Centers for Medicare & Medicaid Services. In addition to the CCR/CCD contents, HIE participants’ data also should include labs, radiology results (text), history and physical, discharge summaries, and progress and other notes.

22. TMA supports HIE participation of the U.S. Department of Veterans Affairs, U.S. Department of Defense, the uninsured, and other populations that may have medical records inadequately integrated into the health care system.

23. TMA supports a legislative safe harbor that limits a physician’s liability exposure if patient data provided to an HIE by the physician are breached due to the actions or inactions of the HIE, another HIE participant, or any other person. Each participating individual or entity should be responsible only for their own actions or inactions as these relate to a possible breach of protected health information provided to an HIE.

Data Warehouses — Principles for the Collection, Use, and Warehousing of EHRs and Claims Data
TMA supports policy that any payer, clearinghouse, vendor, or other entity that collects, warehouses, and uses EHRs and claims data adhere to the following principles. For purposes of this policy, the compilation of electronic records in a physician’s office does not constitute a data warehouse.

1. EHRs and claims data transmitted for any purpose to a third party must contain the minimum necessary needed to accomplish the intended purpose. TMA supports the development of simple and efficient tools to facilitate extraction and submission of such data sets.
2. The physician and his or her patients must be informed of and provide permission for third-party analyses undertaken with the physician’s EHR and claims data, including the data being studied and how the results will be used.

3. The physician must be compensated by the requesting entity for any additional work required to collect data.

4. Criteria developed for the analysis of physician claims or medical record data must be open for review and input.

5. Methods and criteria for analyzing the EHR and claims data must be provided to the physician or an independent third party so that reanalysis of the data can be performed.

6. An appeals process must be in place for a physician to appeal, prior to public release, any adverse decision derived from an analysis of his or her EHR and claims data.

7. Clinical data collected by a data exchange network and searchable by a record locator service must be accessible only for payment and health care processes.

8. The warehouse vendor must take the necessary steps to ensure the confidentiality and integrity of patient records and claims data.

9. Organizations that store, transmit, or use patient records or claims data must have internal policies and procedures in place that adequately protect the integrity, security, and confidentiality of such data.

10. EHR data must remain accessible to authorized users for purposes of treatment, public health, patient safety, quality improvement, medical liability defense, and research.

11. Following the request from a physician to transfer his or her data to another data warehouse, the current warehouse vendor must transfer the EHR and claims data and must delete or destroy the data from its data warehouse once the transfer has been completed and confirmed, at the request of the physician or patient. (Previously 265.029; CPMS; Rep. 2-A-18).

118.002 Health Information Technology – Electronic Health Records and Personal Health Records: The Texas Medical Association supports voluntary universal adoption of health information technology (HIT) that supports physician workflow, increases practice efficiency, is safe for patients, and enhances quality of care. TMA believes HIT vendors should adhere to these principles.

Electronic Health Record Adoption

The Texas Medical Association:

1. Supports legislation and other appropriate initiatives that provide positive incentives for physicians to acquire and maintain health information technology.

2. Supports the ability of the physician and patients to change HIT programs or vendors with minimal workflow and financial impact. Systems must have interoperability that allows movement of data between databases without the need for data conversion to ensure compatibility among all HIT systems.

3. Supports appropriate financial, operational, and technical assistance from an inpatient facility and other entities for physicians who need help converting to and maintaining electronic health records (EHRs) when it does not unreasonably constrain the physician’s choice of which ambulatory EHR systems to purchase.

4. Promotes voluntary rather than mandatory sharing of protected health information (PHI) consistent with the patient’s wishes, as well as applicable legal, ethical, and public good considerations.

5. Supports the use of clinical checklists contained in EHRs to increase patient safety and decrease errors of omission. These checklists should allow for data entry by any member of the care team under the physician’s supervision, and be developed with appropriate quality guidelines as endorsed by nationally recognized medical specialty societies and quality improvement organizations.
6. TMA, where possible, will provide its members with up-to-date, accurate information enabling them to select HIT that improves the quality of their patients’ care, interoperates seamlessly with other automated clinical information sources, and enhances the efficiency and viability of their practices.

Personal Health Records
1. TMA supports the use of personal health records (PHRs) by individuals and families.
2. TMA supports the concept that patients should be able to use their PHR as a source of information regarding their medical status.
3. PHRs need standardized formats that contain at minimum core medical information necessary to treat the patient.
4. TMA supports legislative efforts directed at providing incentives to facilitate PHR use and maintenance.
5. Physicians should be able to access PHR-released information free of charge.
6. TMA supports interoperability of PHRs allowing access to patient health information in patient care settings.
7. TMA supports ensuring that the source of information in PHRs is clearly identifiable.

Access to Cost of Treatment Information
1. Physicians should have simple and efficient access to cost information associated with potential treatments ordered.
2. Physicians should have simple and efficient access to costs of treatments ordered that the patient will pay.

Patient Safety, Risk Management, and Liability
1. Physicians’ current standards of practice should not be compromised by their use of EHRs. There is a degree of precision with EHRs that does not exist with the use of paper records. Physicians should not be held liable for innocent inconsistencies that occur within the EHR environment, for example a computer stamp versus a manual time entry by the physician.
2. TMA supports efforts to hold HIT vendors accountable for developing processes, systems, and customer support that are responsive to patient safety concerns and proactively work to prevent and resolve patient safety concerns.
3. TMA supports the development of a national “no fault” reporting system for errors and near-misses that occur through the use of EHRs to prevent unintended consequences.
4. TMA supports the development and application of performance standards that are cognizant of the burden of data collection, particularly in the aggregation of multiple quality measures.

Related AMA Policy:
D-478.973 Principles for Hospital Sponsored Electronic Health Records: 1. Our AMA will promote electronic health record (EHR) interoperability, data portability, and health IT data exchange testing as a priority of the Office of the National Coordinator for Health Information Technology (ONC).
2. Our AMA will work with EHR vendors to promote transparency of actual costs of EHR implementation, maintenance and interface production.
3. Our AMA will work with the Centers for Medicare and Medicaid Services (CMS) and ONC to identify barriers and potential solutions to data blocking to allow hospitals and physicians greater choice when purchasing, donating, subsidizing, or migrating to new EHRs.

4. Our AMA will advocate that sponsoring institutions providing EHRs to physician practices provide data access and portability to affected physicians if they withdraw support of EHR sponsorship.

D-478.996 Information Technology Standards and Costs: 1. Our AMA will: (a) encourage the setting of standards for health care information technology whereby the different products will be interoperable and able to retrieve and share data for the identified important functions while allowing the software companies to develop competitive systems; (b) work with Congress and insurance companies to appropriately align incentives as part of the development of a National Health Information Infrastructure (NHII), so that the financial burden on physicians is not disproportionate when they implement these technologies in their offices; (c) review the following issues when participating in or commenting on initiatives to create a NHII: (i) cost to physicians at the office-based level; (ii) security of electronic records; and (iii) the standardization of electronic systems; (d) continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records; and (e) continue its active involvement in efforts to define and promote standards that will facilitate the interoperability of health information technology systems.

2. Our AMA advocates that physicians: (a) are offered flexibility related to the adoption and use of new certified Electronic Health Records (EHRs) versions or editions when there is not a sufficient choice of EHR products that meet the specified certification standards; and (b) not be financially penalized for certified EHR technology not meeting current standards.

Sources:

   https://dashboard.healthit.gov/quickstats


   https://texreg.sos.state.tx.us


   https://www.texmed.org/Template.aspx?id=43388&terms=HIT


Whereas, The American Medical Association considers feminine hygiene products, such as sanitary napkins and tampons, to be medical necessities; and

Whereas, The American Medical Association’s current Policy H-270.953 Tax Exemptions for Feminine Hygiene Products states “Our AMA supports legislation to remove all sales tax on feminine hygiene products”; and

Whereas, The Texas Tax Code provides sales tax exemptions for over-the-counter drugs and medications, including cold remedies, antiperspirants, sunscreens, and wound care products, products that are considered to be medical necessities; and

Whereas, 64 percent of women with limited resources have difficulty affording feminine hygiene products due to prioritization of other basic necessities, and many women make do without proper hygiene products by using toilet paper, tissues, or rags; and

Whereas, Poor feminine hygiene management has been associated with reproductive tract infections, social restriction, and school absenteeism; and

Whereas, The Texas Medical Association supports the removal of the state sales tax on diapers, as they are recognized as basic and essential health care necessities; therefore be it

RESOLVED, That Texas Medical Association recognize feminine hygiene products as basic and essential health care necessities; and be it further

RESOLVED, That TMA support the removal of the Texas sales tax on feminine hygiene products.

Related TMA Policy:

260.108 Addressing the Diaper Gap: The Texas Medical Association encourages physicians to screen for social and economic risk factors in order to support care plans and to direct patients to appropriate local social support resources. TMA will provide information to members on community resources related to free and low-cost diapers and other basic material needs. TMA recognizes diapers, especially for adults, are a basic and essential health care necessity that helps to mitigate disease and illness and enables many to remain at home, and supports efforts to remove the state sales tax applied to diapers (CSPH Rep. 2-A-18).

Related AMA Policy:

H-525.974 Considering Feminine Hygiene Products as Medical Necessities: Our AMA will: (1) encourage the Internal Revenue Service to classify feminine hygiene products as medical necessities; and (2) work with federal, state, and specialty medical societies to advocate for the removal of barriers to feminine hygiene
products in state and local prisons and correctional institutions to ensure incarcerated women be provided free of charge, the appropriate type and quantity of feminine hygiene products including tampons for their needs.

**H-270.953 Tax Exemptions for Feminine Hygiene Products:** Our AMA supports legislation to remove all sales tax on feminine hygiene products.

**Sources:**

Subject: The Benefits of Importation of International Pharmaceutical Medications

Introduced by: Medical Student Section

Referred to: Reference Committee on Socioeconomics

Whereas, The cost of basic prescription drugs in the United States is among the highest in the world due to market exclusivity and a lack of payer negotiating power; and

Whereas, These prescription drug prices impose a substantial financial burden on consumers and represent a significant cause of nonadherence, resulting in worsened health outcomes; and

Whereas, Millions of Americans already obtain their prescription drugs from international markets through extralegal means; and

Whereas, 72 percent of Americans believe prescription drug costs are unreasonable, and 74 percent believe they pay higher prices for prescription drugs than citizens of other countries; and

Whereas, 72 percent of Americans favor allowing the legal importation of prescription drugs from Canada; and

Whereas, There is bipartisan support for a prescription drug importation program as evidenced by the proposal of a federal bill by Sen. Amy Klobuchar (D-MN) and Sen. Chuck Grassley (R-IN) in 2019, proposed federal laws by Sen. Bernie Sanders (I-VT) in 2015 and 2017, and a proposed federal law by the late Sen. John McCain (R-AZ) in 2015; and

Whereas, The Trump Administration is looking into expanding the scope of legal prescription drug importation; and

Whereas, Utah lawmakers are currently proposing a law that would allow the wholesale purchase of prescription drugs from Canada for use in their state Medicaid program; and


Whereas, The State of Maine passed a law (later deemed noncompliant with federal law) allowing its residents to import prescription drugs from licensed pharmacies in several developed countries; and

Whereas, The Texas Board of Pharmacy has attempted (but failed due to noncompliance with federal law) in the past to make a list of reputable Canadian pharmacies that can import prescription drugs into Texas; and

Whereas, In spite of past legal challenges, continued action on the part of states may place pressure on the federal government to relax enforcement of federal laws or eventually even change its policy; and
Whereas, The framework for a national prescription drug importation program already has been developed in
the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, and is only pending approval
by the Secretary of Health and Human Services before being enacted as official policy; and

Whereas, The Food and Drug Administration (FDA) has, in the past, allowed for the legal importation of
prescription drugs in emergency situations; and

Whereas, The FDA already permits the legal importation of Canadian medications under defined
circumstances, suggesting passage of this resolution does not constitute a radical change, but rather an
expansion of existing policy; and

Whereas, A significant share of prescription drugs are considerably more affordable in Canada; and

Whereas, One study commissioned by the State of Vermont found that their recently enacted bill allowing for
importation of prescription drugs from Canada could save payers anywhere from $1 million to $5 million per
year on reduced prices; and

Whereas, The State of Utah established that a similar program would save $70 million in the private sector
and another $20 million in state-funded insurance programs; and

Whereas, Many off-patent prescription drugs that are at risk of sudden price increases or shortages in the
United States are available in international markets, thereby increasing the potential for price competition; and

Whereas, Health Canada, Canada’s FDA counterpart, follows rigorous safety standards quite similar to those
in the United States; and

Whereas, Continued efforts on the parts of individual states to establish prescription drug importation
programs may place sufficient market pressure on pharmaceutical companies to make domestic medication
prices more competitive with those in international markets; and

Whereas, The Texas Medical Association supports programs whose purpose is to contain the rising costs of
prescription drugs; and

Whereas, TMA emphasizes health system reform with cost control reform measures that protect Medicare
quality and freedom of access; therefore be it

RESOLVED, That the Texas Medical Association study the positive and negative effects of potential
programs for Texans to obtain safe, cost-effective prescription drugs from outside the United States; and be it
further

RESOLVED, That the Texas Delegation to the American Medical Association ask the AMA to study current
state and federal laws and regulations regarding obtaining prescription drugs from outside the United States;
and be it further

RESOLVED, That the Texas Delegation to the AMA ask the AMA to study the implications of a prescription
drug importation program that allows for patient purchase or wholesale purchase by the state Medicaid
agency given that it (1) poses no additional risk to the public’s health and safety, and (2) results in a
significant reduction in the cost of covered products, as pursuant to Section 804 of the Federal Food, Drug,
and Cosmetic Act.
Related TMA Policy:

95.041 Ensuring Patient Access to Affordable Prescription Medications: Ensuring Patient Access to Affordable Prescription Medications: The Texas Medical Association will: (1) support programs whose purpose is to contain the rising costs of prescription drugs provided that the following criteria are satisfied: (a) physicians must have significant input into the development and maintenance of such programs; (b) such programs must encourage optimum prescribing practices and quality of care; (c) all patients must have access to medically indicated prescription drugs necessary to treat their illnesses; (d) physicians must have the freedom to prescribe the most appropriate drug(s) and method of delivery for the individual patient; and (e) such programs should promote an environment that will give pharmaceutical manufacturers the incentive for research and development of new and innovative prescription drugs; (2) study the issue of drug pricing, including whether large price increases impact patient access to critical medications; (3) support the application of greater oversight to the establishment of closed distribution systems for prescription drugs; (4) support the mandatory provision of samples of approved out-of-patent drugs upon request to generic manufacturers seeking to perform bioequivalence assays; (5) work with interested parties to support legislation or regulatory changes that streamline and expedite the FDA approval process for generic drugs; and (6) support measures that increase price transparency for generic and brand-name prescription drugs. (Substitute Res. 405-A-16 and Res. 409-A-16).

190.023 Policy Principles for Medicaid and CHIP Legislative Initiatives: Policy Principles for Medicaid and CHIP Legislative Initiatives: The Texas Medical Association supports the following policy principles to guide the evaluation of Medicaid and CHIP budget and legislative initiatives and association advocacy efforts:

A. Ensure patient access to timely, medically necessary primary and specialty health care services. Physician participation in Medicaid is perilously low in many parts of the state. Statewide, fewer than 50 percent of Texas physicians participate in the program, with the number steadily dropping. While the most severe shortages are among subspecialists, particularly those who treat children, access to primary care physicians also is declining.

Physicians are the backbone of a cost-effective system. Without them, the state's efforts to increase preventive care, improve treatment for the chronically ill, and reduce inappropriate emergency room utilization will falter. Competitive reimbursement is a critical component of building an adequate and stable primary and specialty physician network.

Legislative Strategies:
- Promote use of a "medical home" for all patients to coordinate and manage preventive, primary, specialty, and ancillary services and to assure more cost-effective use of resources.
- Advocate enactment of competitive Medicaid and CHIP reimbursement rates. Medicaid rates average 70 percent of Medicare and 50 percent of commercial, failing to cover the costs of providing services. As practice overhead costs rise and payment from other payers stagnates or declines, physicians must make the difficult economic decision to leave Medicaid.
- Promote cost-effective, proactive, and appropriate use of medical services. Long-term health care cost savings are predicated not only on encouraging appropriate utilization of health care services but also on preventing the need for those services in the first place. Texas should proactively promote preventive health services within Medicaid as well as early identification and intervention for patients at risk for - or who already have developed - a chronic illness. Additionally, Texas must expand opportunities to educate patients about appropriate use of the health care delivery system, preventive care, and basic self-care.
**Legislative Strategies:**
Advocate use of health risk assessment for at-risk patients.

Support legislative initiatives to educate patients of all ages, but particularly children, about healthy lifestyles, including exercise and nutrition.

Advocate enactment of initiatives that educate parents about basic self-care techniques and prevention.

Promote use of standardized and centralized "ask a nurse" programs as a means to reduce inappropriate emergency room utilization by Medicaid and CHIP patients.

C. Simplify Medicaid regulatory requirements and streamline the delivery system. The complexity of the Medicaid program is a key factor in deterring physician participation. The proliferation of multiple Medicaid managed care plans and models, for example, split a straightforward delivery system into many components, each with distinct administrative, eligibility, and payment requirements. To make the program more attractive to physicians, Texas should consider options to streamline the Medicaid delivery and payment systems. Efforts also should be made to reduce unnecessary paperwork and their attendant costs.

For patients, the program also is fraught with administrative burdens, including navigating the same complex delivery system physicians contend with. Simplifying the eligibility process is a key component of all the other principles because it encourages patients to seek cost-effective treatment and preventive care from their medical home.

**Legislative Strategies:**
Maintain children's Medicaid simplification and extend those reforms, when feasible, to other populations.

Pursue Internet-based or "smart card" technologies that integrate eligibility, claims submission, and health and human service programs under one platform.

Promote use of community-based HMOs and physician-led accountable care organizations and other emerging innovative models within the Medicaid delivery system, including patient-centered medical homes.

D. Promote and improve health care quality. The foundation of an efficient, effective delivery system is high quality care. Yet measuring quality is notoriously difficult. Texas should work collaboratively with physicians and health care providers to devise realistic, clinically driven ways to measure and improve quality across the spectrum of care.

**Legislative Strategies:**
Advocate Medicaid HMO use of incentive payments for physicians who achieve predetermined, physician-driven performance standards, such as immunization rates, disease management participation, and well-child exams.

Support "e-medicine" efforts that enhance patient care, physician-to-patient and physician-to-physician communications, and outreach. E-medicine must be appropriately compensated.

Reward prevention and wellness promotion as well as innovative treatment and delivery alternatives, such as physician and clinic support of health education, after-hours services, or participation in disease management.

Explore opportunities to incorporate enriched health care education into school curricula (e.g., education that focuses on prevention, nutrition, fitness, and immunizations).
Develop protocols for appropriate transfer of patients from the nursing home to hospitals and from state schools to hospitals. Physicians indicate a common occurrence is transportation of a nursing home or state school patient to an emergency department for routine care that could be treated safely and effectively within the nursing home/school.

E. Assure accountability among all elements of the Medicaid system. Each component of the Medicaid program - patients, physicians, providers, community, and government - has a shared responsibility toward making Medicaid successful. Medicaid policies should articulate, promote, and reward, when met, those responsibilities. For example, physicians have an obligation to practice high quality, evidenced-based medicine as well as to promote preventive care. Patients should help with treatment decision-making, comply with treatment protocols, and begin to assume a nominal share of the cost of care; communities should recognize their unique role in educating patients about the health care system and how to use it.

Legislative Strategies:

Promote the purchase/underwriting of long-term care insurance to defray state costs of nursing home coverage.

Advocate federal reform to allow implementation of fair, nominal, sliding-scale cost sharing (similar to the CHIP model) for Medicaid patients. Cost sharing must be easy for the state and health care providers to administer.

Advocate simplification of the Medicaid Preferred Drug List, including an open, accessible process for classifying drugs as preferred or nonpreferred:

Require use of generic drugs when available; all generics would be available without prior authorization unless there is a safety concern.

For brand name drugs, continue use of the supplemental rebate process, but apply it only to drugs whose properties are available in more than one product (e.g., Lantus is the only long-acting insulin, but it requires prior authorization because the manufacturer refused to provide a rebate. Under this proposal, Lantus would remain available. If another brand or generic became available with the same properties, then HHSC could seek a supplemental rebate process so long as at least one drug with the needed properties remained available without prior authorization).

Promote publication of the relative price of Medicaid and CHIP drugs so that physicians are aware of the costs of prescribed drugs.

Promote physician "counter detailing" to encourage evidence-based prescribing of prescription drugs and long-term changes in physician prescribing behavior.

Require the HHSC Pharmaceutical and Therapeutics (P&T) Committee to conduct clinical and safety discussions in public to assure that stakeholders understand rationale for classifying a drug as preferred or nonpreferred.

Establish a formal appeal mechanism when drugs are not approved based on quality.

Require the P&T Committee to establish liaisons to specialty physician organizations to assure broader clinical input regarding drugs on the Preferred Drug List.
Require the Drug Utilization Review Board membership include a mix of physicians to represent the diverse Medicaid population, including pediatricians, obstetricians, primary care physicians and pediatric and adult psychiatrists.

Require HHSC to clearly specify which preferred prescription drugs on the Preferred Drug List are subject to additional clinical edits. Such information should be easily searchable on the VDP website, Epocrates, and the Medicaid HMO pharmacy benefit manager websites.

Require HHSC to provide timely notice of proposed clinical edits and to solicit input from appropriate physician specialties on the criteria. HHSC should provide the rationale for the proposed clinical edit, the potential cost-savings, if any, and the name of the entity that proposed the change.

Require Medicaid HMOs to adhere to prompt payment provisions, except where the statute conflicts with federal law, and assure that any standardized contracting legislation applies to Medicaid and CHIP plans.

Educate physicians and patients about how to report actual fraud and abuse within Medicaid and CHIP, while educating policymakers that clerical and billing errors are not tantamount to fraud.

Require fraud and abuse reports prepared by the Medicaid Office of Inspector General, comptroller, and other oversight agencies to distinguish within their reporting statistics relating to inadvertent coding and billing errors and those relating to actual fraud. State payment recoveries stemming from billing errors are not the same as those resulting from fraud.

F. Maximize use of all available funding streams. Texas should continue to identify options for accessing and maximizing federal Medicaid funds. Texas also should explore mechanisms to use county indigent health care dollars to attract additional Medicaid funds that could be used to subsidize coverage for uninsured patients. Local governments spend substantial tax dollars on health care for uninsured or underinsured patients. Matching these funds potentially could provide Texas additional dollars to fund innovative partnerships that reduce the number of uninsured patients.

**Legislative Strategy:**
Support restoration of Medicaid and CHIP services reduced or eliminated during the 78th legislative session, including, but not limited to, full restoration of:

- Medicaid graduate medical education;
- Funding for public mental health services, particularly for children;
- Adult Medically Needy Program;
- Advocate enactment of federal waivers that allow Texas to draw down additional federal matching funds.

G. Recognize the necessity of an adequate, diverse physician and allied health professional workforce. An adequate, diverse medical workforce is critical to the efficient functioning not only of Medicaid but also of all public and private health care systems in Texas. Medicaid is critical to the workforce debate for two reasons: (1) the program historically has offered significant funding to train future physicians by providing funding for graduate medical education, and (2) Medicaid patients account for the bulk of the workload in medical schools, residency programs, and community clinics where medical students and residents receive valuable, real-world training. Ignoring the growing indications of physician and allied health professional shortages will be at the peril of the entire Texas health care delivery system.
**Legislative Strategy:**

Actively promote restoration of funding for Medicaid graduate medical education and physician residency programs.

H. Encourage innovative partnerships between the public and private sectors to address shared health goals. Government and the private sector each play an important role in the financing, regulation, organization, and innovation of health care. Too often, however, those spheres of influence remain separate, failing to recognize the relative strengths of each. Texas should explore ways to integrate public and private health insurance initiatives to address the mutual concerns of improving quality care and patient safety, reducing the number of uninsured, and promoting prevention and wellness.

A good example of private-public partnerships is TMA-supported legislation passed last year that encourages blending Medicaid funds with employer subsidies to purchase affordable health insurance for uninsured workers. Texas should consider expanding these initiatives and exploring other innovative options.

I. Recognize the diversity of the Medicaid population and devise strategies to address the unique health care needs and costs of each. Medicaid often is evaluated and discussed as one, monolithic system. In fact, it is many. Medicare serves primarily an adult, aged population; private health plans serve primarily healthy, working adults. Medicaid, however, insures a range of populations with vastly different needs (children, individuals with disabilities, the elderly) and in vastly different settings (acute vs. long-term care, community vs. institutions). Medicaid reforms require developing strategies appropriate for the diversity of the populations served and the cost drivers inherent to each.

**Legislative Strategy:**

Collaborate with the governor, lieutenant governor, speaker and legislative leaders to identify potential changes to federal Medicaid and CHIP statutes that would benefit the state, patients, and physicians.

J. Recognize the interdependence of Medicaid and the public health system. As one of the largest health care systems in Texas, Medicaid plays a critical role in supporting public health services. The two most notable examples are disease detection and prevention, services that ultimately benefit not just Medicaid patients but all Texans.

**Legislative Strategies:**

Strengthen the public health infrastructure.

Support public health programs aimed at preventive health care, including immunizations, maternal and child health, cancer screening and prevention, and disease detection and surveillance.


**110.002 Cost Effectiveness:** The Texas Medical Association encourages physicians to become knowledgeable of the actual costs of services they order on behalf of patients in order to join their patients in decisions for the most cost effective expenditures of dollars for quality health care (Amended Res. 28CC, p 179G, A-93; amended CSE Rep. 6-A-03; amended CSE Rep. 1-A-13).

**120.002 Health System Reform Cost Control:** Health System Reform cost Control: The Texas Medical Association emphasizes health system reform with cost control reform measures that protect the freedom of access and the quality of medical care to patients and leaves government in the subordinate position and role

Related AMA Policy:

D-110.993 Reducing Prescription Drug Prices: Our AMA will (1) continue to meet with the Pharmaceutical Research and Manufacturers of America to engage in effective dialogue that urges the pharmaceutical industry to exercise reasonable restraint in the pricing of drugs; and (2) encourage state medical associations and others that are interested in pharmaceutical bulk purchasing alliances, pharmaceutical assistance and drug discount programs, and other related pharmaceutical pricing legislation, to contact the National Conference of State Legislatures, which maintains a comprehensive database on all such programs and legislation.

100.995 Support of American Drug Industry: Our AMA continues to support the American pharmaceutical manufacturing industry in its efforts to develop and market pharmaceutical products meeting proper standards of safety and efficacy for the benefit of the American people.

Sources:
Whereas, Rural hospital closure is defined as, “A facility located in a rural area that provided general, short-term, acute medical and surgical inpatient services” that closed during calendar years 1990-2000, according to the Department of Health and Human Services; and

Whereas, Rural and critical access hospitals in Texas continue to close, even those that operate under positive revenue margins, and more are considered to be at high risk for closure in the coming years; and

Whereas, Texas has recently accounted for the highest number of rural hospital closures nationwide, with 16 closures since 2010; and

Whereas, Compared with specialty, for-profit, teaching hospitals and trauma centers, rural hospital systems have significantly less power when negotiating with commercial insurance companies; and

Whereas, The American Medical Association recognizes that rural hospitals are critical to ensuring patient access to care and physician employment sustainability in rural communities; and

Whereas, The Texas Legislature has introduced policy that permits the Texas Health and Human Services Commission to reimburse rural hospitals directly or permit a managed care organization to reimburse rural hospitals so they can afford to treat their target population; and

Whereas, The Texas Medical Association has passed policy with respect to rural physician independent practice but has not generated similar policy regarding county hospitals; and

Whereas, Based on extensive searches in the literature, there have not yet been studies on rural hospital closures specifically in Texas; and

Whereas, Without understanding financial barriers faced by rural hospitals, it is not possible to identify appropriate methods for legislators and/or the Texas Medical Association to address rural hospital closures in Texas, protect rural physician employment, and improve patient access to care; therefore be it

RESOLVED, That the Texas Medical Association advocate for examining the financial factors contributing to rural hospital closures.

Related TMA Policy:

275.003 Rural Health Clinic Regulations: The Texas Medical Association continues to monitor proposed changes to current rural health clinic regulations and to work with the Centers for Medicare and Medicaid Services to ensure that any modifications to the regulations do not unnecessarily burden rural health clinics or the patients they serve (Committee on Rural Health, p 118, A-95; amended CSE Rep. 1-A-05; reaffirmed CM-RH Rep. 2-A-16).

Practice Incentive/Benefit and Other Recruitment Programs
1. Federal and state rural practice incentive/benefit programs should be sufficiently funded to be successful in recruiting and retaining physicians in rural, underserved communities.
2. Physicians, medical students, and residents should have easy access to information about rural practice incentive programs. Further, the programs should be widely publicized by state authorities, the Texas Medical Association, and the Texas Osteopathic Medical Association, 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 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 telemedicine services in their practices as outreach to patients in underserved communities, when applicable and purposeful in meeting health care needs.
6. 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 the Texas Medical Association and the Texas Osteopathic Medical Association.

Promoting Rural Practice
7. Information on rural physician shortage areas should be readily available through coordinated websites of state agencies such as the Texas Department of State Health Services, the Texas Medical Board, area health education centers, and the Texas 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.
8. 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 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 and services such as nursing, pharmacies, therapists, and medical equipment.
9. Physicians should be informed by state authorities, including the Texas Medical Board, of the unique peer review services offered by the Knowledge, Skills, Training, Assessment, and Research (KSTAR) Program at Texas A&M University Health Science Center for rural hospitals and physicians.
10. 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.
11. 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.

12. Physician practice reentry programs should be widely publicized and monitored to assess their ability to meet demands by state authorities, the Texas Medical Association, and the Texas Osteopathic Medical Association. Further, when licensed physicians allow their Texas medical license to lapse, they should be informed by the Texas Medical Board of the potential obstacles to relicensure should they decide to reenter practice following an extended absence from practice.

13. 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.

14. Federal and state policies that impact rural medicine, e.g., payment policies, should be monitored by the Texas Department of Rural Affairs for their potential impact on the viability of rural practices. The Texas Medical Association and the Texas Osteopathic Medical Association 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, reimbursement policies that discount professional services to be delivered in rural communities discourage rural practice and should be addressed.

15. Physicians in practice and those in training programs should be informed by the Texas Medical Board, Texas Medical Association, Texas Osteopathic Medical Association, and other state authorities of special state medical licensing provisions applicable for practice in rural, underserved areas.

Preparing Physicians for Rural Practice

16. 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 student and residents in rural training tracks.

17. Appropriate screening criteria should be used by medical schools for identifying student-applicants and residents most likely to be successful in rural practice.

18. 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.

19. 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.

20. 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.

21. 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.

22. The impact of changes in resident duty-hour restrictions should be monitored for the impact on rural training programs and health care delivery in comparison to institution-based residency programs.

Rural Access to Care

23. The Texas Medical Association and Texas Osteopathic Medical Association should continue to advocate for a single standard of care for all Texans in all areas of the state.

24. Discussions are needed to develop solutions for providing after-hours care for patients of federally funded health clinics requiring urgent or emergent care to prevent undue burdens on community physicians.
25. Periodic research should be conducted by the Texas Health Professions Resource Center at the 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).

110.007 Cost Containment: Members of the Texas Medical Association are encouraged to voluntarily evaluate their practice patterns to further reduce and improve utilization of expensive hospital and ambulatory services and to control costs. Insurance companies and fiscal intermediaries are encouraged to support cost containment and cost effective care by recommending use of the least expensive setting in which a procedure can be performed safely and effectively. Third party payers should provide payment not only for professional services, but for other costs incurred in physicians’ offices (such as surgical trays, sterile draping, and necessary supplies). Duplicate laboratory procedures and tests should be eliminated (Council on Socioeconomics, p 177, I-94; amended CSE Rep. 1-A-10).

Related AMA Policy:

H-465.979 Economic Viability of Rural Sole Community Hospitals: Our AMA: (1) recognizes that economically viable small rural hospitals are critical to preserving patient access to high-quality care and provider sustainability in rural communities; and (2) supports the efforts of organizations advocating directly on behalf of small rural hospitals provided that the efforts are consistent with AMA policy.


Sources:
Subject: Improving Buprenorphine Access for Opioid Substance Use Disorder Treatment

Introduced by: Medical Student Section

Referred to: Reference Committee on Socioeconomics

Whereas, One in 10 Texans have a substance use disorder, and overdose deaths in Texas have nearly tripled from 1999 to 2014; and

Whereas, The majority of Texans with substance use disorders never receive treatment due to access barriers including provider shortages, lack of insurance coverage, and lack of appointment availability in state-funded facilities; and

Whereas, Four of the top 25 cities in the United States for opioid use disorders are rural cities in Texas (Texarkana, Amarillo, Odessa, Longview); and

Whereas, Patients with opioid use disorders tend to prefer buprenorphine over methadone treatment because they feel that buprenorphine is more effective at suppressing opioid withdrawal symptoms, is less sedating and carries fewer side effects, has a lower risk of abuse, and has greater perceived therapeutic benefits; and

Whereas, Patients more readily choose buprenorphine over methadone because they can access it through any licensed and waived medical health care professional rather than only certified opioid treatment programs, thereby reducing the stigma associated with seeking care for an opioid use disorder; and

Whereas, Buprenorphine reimbursement rates for state-contracted medication-assisted treatment providers are often inadequate to cover the actual costs of purchasing and distributing buprenorphine; Texas physicians have anecdotally reported this same concern already described by physicians in other states; and

Whereas, Medicaid and private insurance companies often require prior authorization for buprenorphine treatment in addition to a formal opioid use disorder diagnosis, resulting in administrative delays in treatment that increase the likelihood of relapse and overdose; and

Whereas, The Texas Medical Association supports equitable access to evidence-based medication-assisted treatment for individuals with substance use disorders; and

Whereas, The American Medical Association supports the expansion of buprenorphine access and the elimination of required physician waivers to prescribe buprenorphine for patients with opioid use disorder; and

Whereas, Only 4 percent of physicians in the United States have the appropriate waiver required to prescribe buprenorphine, further restricting patients with opioid use disorder from accessing this treatment option; therefore be it
RESOLVED, That the Texas Medical Association support state efforts to increase the reimbursement rate of buprenorphine to better reflect its actual cost and medication-assisted treatment overhead costs to physicians; and be it further

RESOLVED, That TMA support the elimination of preauthorization requirements for insured patients with opioid use disorders seeking buprenorphine treatment; and be it further

RESOLVED, That TMA support the elimination of physician waiver requirements to prescribe buprenorphine to patients diagnosed with opioid use disorder.

Related TMA Policy:

95.045 Evidence-Based Management of Substance Use Disorders: The Texas Medical Association believes that substance use disorders are complex diseases with biological, psychological, and sociological components, and that these disorders should be recognized and treated as are all other diseases. TMA believes that effectively addressing substance use disorders requires major initiatives for prevention, risk reduction, and treatment, inclusive of the following strategies for physician education and for improving public health programming to address these disorders in Texas.

Physician education on:
- The evidence-based prescription of addicting medications, especially benzodiazepines and opiates;
- The increased public- and private-sector access to nonpharmacological management of pain and anxiety;
- The goal of universal screening of adolescents and adults including pregnant and postpartum women for substance use disorders as part of their preventive and primary care; and
- Improving public- and private-sector access to evidence-based medication-assisted treatment for all substance use disorders for which such an intervention is clinically indicated.

Public health programming to:
- Improve public- and private-sector access to evidence-based treatment of substance use disorders, and aggressive, early linkage of patients in need;
- Support public health policymaker commitments to financing improved data collection on drug overdoses and fatalities and to a robust public health response to the data;
- Increase the availability of harm reduction measures for current users, including access to clean syringes, naloxone, and Housing-First recovery models; and
- Continue federal and local efforts to interrupt access to illegally obtained drugs (CSPH Rep. 7-A-18).

95.040 Addressing Prescription Drug Abuse and Overdose: Following is Texas Medical Association policy on addressing prescription drug abuse and overdose:

1. That TMA collaborate with state and local public health agencies to promote increased public education programming on the misuse of prescribed medications, support community programs such as ‘take back’ programs, and targeted programs for special populations, particularly women of reproductive age and families with adolescents and teenagers.

2. That TMA endorse the education of health care workers and opioid users about the use of naloxone (and other opioid antagonists) in preventing opioid overdose fatalities.

3. That TMA implement a plan to promote physician awareness and participation in educational programs on pain relief.
4. That TMA support continued expansion of public funding for treatment and recovery support for persons at risk of substance use and misuse, with a priority given to programs for pregnant and postpartum women.

5. That TMA support improved access to substance use treatment, especially through co-location of physical health, mental health, and substance use services and through wider availability of evidence-based medication-assisted treatments.

That TMA advocate for legislation that (1) allows for appropriate storage and for a trained individual, acting under a standing order issued by a physician, to administer an opioid antagonist to prevent deaths from opioid overdose (2) allows first responders, such as police and fire fighters to have access to and administer an opioid antagonist in the event of an emergency overdose (3) reduces barriers for medical professionals to prescribe and dispense naloxone (or other opioid antagonists) to family members and friends of an identified patient, and for administrators to do so without fear of legal repercussions, as described as Third Party Prescription/Standing Order Distribution.

That TMA support providing legal protection from drug possession charges for persons seeking medical attention after overdose, as described in model 911 Good Samaritan fatal overdose prevention laws (CSPH and TF-BH Joint Rep. 1-A-15).

Related AMA Policy:

D-95.972 Expanding Access to Buprenorphine for the Treatment of Opioid Use Disorder:

1. Our AMA’s Opioid Task Force will publicize existing resources that provide advice on overcoming barriers and implementing solutions for prescribing buprenorphine for treatment of Opioid Use Disorder.

2. Our AMA supports eliminating the requirement for obtaining a waiver to prescribe buprenorphine for the treatment of opioid use disorder.

Sources:


11. "Questions regarding Potential TMA Policy to Improve DSHS Substance Use Disorder Services." E-mail to Alicia Kowalchuk. December 27, 2018.


Subject: Revising the Texas Department of Insurance Division of Workers’ Compensation Designated Doctor Training and Education Process

Presented by: Bexar County Medical Society

Referred to: Reference Committee on Socioeconomics

Whereas, The American Medical Association’s *Guides to the Evaluation of Permanent Impairment, 4th edition*, has for more than 10 years been the book legally mandated by the legislature to use by Designated Doctors to calculate the impairment of an injured worker in Texas; and

Whereas, In order to become a Designated Doctor, the Texas Department of Insurance Division of Workers’ Compensation (TDI-DWC) has mandated that a physician must take several days away from his practice, pay to attend a TDI-DWC Designated Doctor educational course, and then pass an examination with questions dealing specifically on the proper use of the AMA *Guides to the Evaluation of Permanent Impairment, 4th edition*; and

Whereas, The TDI-DWC also has mandated that in order to continue to participate in the Designated Doctor program, a Texas physician must repeat this process of paying to sit through a course and take the exam every two years, even though the book, *Guides to the Evaluation of Permanent Impairment, 4th edition*, remains the same; therefore be it

RESOLVED, That the Texas Medical Association work with the Texas Department of Insurance Division of Worker’s Compensation (TDI-DWC) through the regulatory process to ensure that the TDI-DWC examination being given has questions that are accurate and have been validated; and be it further

RESOLVED, That TMA work with the TDI-DWC to eliminate the requirement for physicians to repeat the course and exam process every two years; and be it further

RESOLVED, That TMA work with the TDI-DWC to develop less costly methods of obtaining and maintaining the appropriate level of education required to ensure that the Designated Doctors are using the *Guides to the Evaluation of Permanent Impairment, 4th edition* accurately and that injured workers are being evaluated fairly.

Related TMA Policy:

335.005 Workers’ Compensation Impairment Ratings: The Texas Medical Association voted to work through the regulatory process to prevent the Texas Division of Workers’ Compensation from limiting the ability of licensed physicians who have otherwise met necessary requirements from performing impairment ratings and becoming designated doctors in the State of Texas (Amended Res. 28J, p 129, I-95; reaffirmed CSE Rep. 1-A-05; amended CSE Rep. 1-A-15).

335.014 Workers’ Compensation Delivery System: Texas Medical Association supports the following in pursuit of a fair, efficient, and accountable workers’ compensation delivery system in Texas:
(1) Continue dialogue with legislative and executive branch policymakers to maintain the out-of-network medical fee reimbursement formula based on an annual MEI adjustment that may result in fair and reasonable physician payments;

(2) Continue to educate policymakers and regulators on the need for employer accountability when dealing with injured workers and encouraging return to work initiatives;

(3) Consider all appropriate strategies to help correct injustices within the system for doctors, specifically reducing inappropriate carrier gaming and reducing administrative hassles and burdens;

(4) Diligently work with Texas Department of Insurance in the regulatory arena to improve physician input and physician stakeholder involvement to produce much needed reforms to the workers' compensation system (CSE Rep. 1-A-09).

Related AMA Policy:

H-365.981 Workers' Compensation: Our AMA:

(1) will promote the development of practice parameters, when appropriate, for use in the treatment of injured workers and encourages those experienced in the care of injured workers to participate in such development.

(2) will investigate support for appropriate utilization review guidelines for referrals, appropriate procedures and tests, and ancillary services as a method of containing costs and curbing overutilization and fraud in the workers' compensation system. Any such utilization review should be based on open and consistent review criteria that are acceptable to and have been developed in concert with the medical profession. Physicians with background appropriate to the care under review should have the ultimate responsibility for determining quality and necessity of care.

(3) encourages the use of the Guides to the Evaluation of Permanent Impairment. The correct use of the Guides can facilitate prompt dispute resolution by providing a single, scientifically developed, uniform, and objective means of evaluating medical impairment.

(4) encourages physicians to participate in the development of workplace health and safety programs. Physician input into healthy lifestyle programs (the risks associated with alcohol and drug use, nutrition information, the benefits of exercise, for example) could be particularly helpful and appropriate.

(5) encourages the use of uniform claim forms (CMS 1500, UB04), electronic billing (with appropriate mechanisms to protect the confidentiality of patient information), and familiar diagnostic coding guidelines (ICD-9-CM, CPT; ICD-10-CM, CPT), when appropriate, to facilitate prompt reporting and payment of workers' compensation claims.

(6) will evaluate the concept of Independent Medical Examinations (IME) and make recommendations concerning IME's (i) effectiveness; (ii) process for identifying and credentialing independent medical examiners; and (iii) requirements for continuing medical education for examiners.

(7) encourages state medical societies to support strong legislative efforts to prevent fraud in workers' compensation.

(8) will continue to monitor and evaluate state and federal health system reform proposals which propose some form of 24-hour coverage.

(9) will continue to evaluate these and other medical care aspects of workers' compensation and make timely recommendations as appropriate.

(10) will continue activities to develop a unified body of policy addressing the medical care issues associated with workers' compensation, disseminate information developed to date to the Federation and provide updates to the Federation as additional relevant information on workers' compensation becomes available.