The TMA House of Delegates convened at 8 am, May 5, and at 8:30 am, May 6, 2017, at the George R. Brown Convention Center, Houston.

Susan Strate, speaker, and Arlo Weltge, vice speaker, presided at each session of the House of Delegates.

Reverend David Garcia gave the invocation.

Sandra Dee Dickerson, Credentials Committee chair, reported a majority of delegates present.

Minutes of the May 2016 meeting were approved.

TMA Alliance President Debbie Pitts, Tyler, and TMA President Don Read, Dallas, addressed the house.

Special recognition was given to all Alliance members who were present.

The association’s highest honor, the Distinguished Service Award, was presented by Dan McCoy, Richardson, to Robert Gunby, MD, of Dallas.

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

Attending past presidents were asked to stand and be recognized.

Special recognition was given to TMA’s graduating class of the 2017 TMA Leadership College.

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

The following individuals addressed the house:

- Board of Trustees Chair Doug Curran reported on association finances;
- Texas Medical Liability Trust President and CEO Robert Donohoe provided a TMLT update via video;
- TEXPAC Board of Directors Chair Bradford Holland provided a TEXPAC update via video;
- Texas Medical Association Foundation President Deborah Fuller provided a TMAF activity update via video;
- AMA Trustee Stephen Permut presented an update on AMA activities;
- TMA PracticeEdge Board Secretary/Treasurer David Henkes provided a TMA PracticeEdge update via video; and
- TMA Advocacy Division Vice President Darren Whitehurst provided an update on TMA’s advocacy efforts during the 2017 legislative session.

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

**ELECTIONS**: On Saturday, May 6, the following members were elected or reelected:

- **President-Elect** — Doug Curran, Athens.
Secretary/Treasurer — Michelle Berger, Austin

Speaker, House of Delegates — Susan Strate, Wichita Falls.

Vice Speaker, House of Delegates — Arlo Weltge, Houston.


Councilors — Three year term: James Eskew, District 7; Kevin McKinney, District 8; Michael Altman, District 9; David Bailey, District 10; Jed Grisel, District 13; Edward Tuthill, District 14.

Vice Councilors — Three year term: Susan Pike, District 7; Steven Petak, District 9; David Vineyard, District 10; Chad White, District 13; Victor Vines, District 14.

AMA Delegates — Two year term: Jayesh Shah, San Antonio; Robert Gunby, Dallas; David Henkes, San Antonio; Gary Floyd, Keller; Lyle Thorstenson, Dallas; Diana Fite, Tomball; John Gill, Dallas.

AMA Alternate Delegates — Two year term: Jennifer Rushton, San Antonio; Steven Hays, Dallas; John Flores, Little Elm; John Carlo, Dallas; Sherif Zaafran, Houston; Robert Emmick, Austin; Habeeb Salameh, Galveston, resident physician position; and Jessie Ho, Plano, medical student position.

Council Members:

Constitution and Bylaws — Lenore C. DePagter, DO, McAllen; Deborah A. Fuller, MD, Dallas

Health Care Quality — Kenneth McKay Davis, MD, San Antonio; Richard P. Dutton, MD, Dallas; Jeffrey B. Kahn, MD, Austin; Javier D. Margo Jr, MD, Rio Grande City; Robert B. Morrow, MD, Houston; Kurt A. Schoppe, MD, Fort Worth

Health Promotion — Eman N. Attaya, MD, Lubbock; Jayesh B. Shah, MD, San Antonio; Wesley W. Stafford, MD, Corpus Christi

Health Service Organizations — Raymond L. Fowler, Dallas; Hattie E. Henderson, MD, CMD, Houston; Evan C. Meyer, MD, Wichita Falls; Li-Yu H. Mitchell, MD, Tyler

Legislation — Bradford W. Holland, MD, Waco; Bryan G. Johnson, MD, Frisco; Victor A. Simms, MD, Houston; Yasser F. Zeid, MD, Longview

Medical Education — James B. Boone III, MD, El Paso; Ronald L. Cook, MD, MBA, Lubbock; Wendy B. Kang, MD, JD, San Antonio; Thomas James Mohr, Do, San Antonio; Ikemeufuna C. Okwuwa, MD, Odessa; Irvin Sulapas, MD, Houston; Adela S. Valdez, MD, MBA, Edinburg; Brian G. Webb, MD, Fort Worth
Practice Management Services — Jason M. Feuerman, MD, Austin; Susan B. Hudson, MD, New Braunfels; Sameer Islam, MD, Lubbock; Faraz A. Khan, MD, Houston; Megan K. Kressin, MD, Austin; Johnathan D. Warminski, MD, Fort Worth; Alexis Wiesenthal, MD, San Antonio

Science and Public Health — Rakhi C. Dimino, MD, Houston; Richard W. McCallum, MD, El Paso; Garrett K. Peel, MD, MPH, Beaumont; Lois M. Ramondetta, MD, Houston; N. Keith Robinson, MD, Abilene; Christopher M. Ziebell, MD, Austin

Socioeconomics — Jason L. Acevedo, MD, Abilene; John T. Carlo, MD, Dallas; John G. Flores, MD, Little Elm; Gregory M. Fuller, MD, Keller; Felicia L. Jordan, MD, Houston; Luis H. Urrea II, MD, El Paso

AWARDS:

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

First Place:
Outstanding High School Science Teacher – Monica Amyett, Azle High School, Azle.
Outstanding Middle School Science Teacher – Terri Henry, Benold Middle School, Georgetown.
Outstanding Elementary School Science Teacher – Teresa Kelm, Connally Elementary, Waco.

Young Physician Section Chair Sandra Williams, MD, presented the Young at Heart Award to Joel Dunnington, MD, New Braunfels.

Medical Student Section Executive Council Chair Romero Santiago presented the following section awards:
C. Frank Webber, MD, Award — Cedric K. Dark, MD, Houston.
Student Member of the Year Award — Hayley Rogers, University of Texas Medical Branch.

Minority Scholarship Awards — House Speaker Susan Strate announced scholarships for twelve minority Texas college students entering medical school. Thanks to the generosity of donors, TMA Foundation was able to provide each scholarship in the amount of $10,000. Since 1998, TMA has awarded scholarships to encourage outstanding minority students to enter medicine and help meet the medical needs of Texas’ diverse population. Generous physicians, county medical societies, and corporate donors finance the scholarships through the TMA Foundation. Scholarship award recipients in 2017 were: Lucia Guerrero, Baylor College of Medicine; Yajaira Jimenez, Texas A&M Health Science Center College of Medicine; Selvin Villeda, Texas Tech University Health Sciences Center School of Medicine in Lubbock; Tailour Roberson, John P. and Kathrine G. McGovern Medical School at The University of Texas Health Science Center at Houston; Victor Hinojosa, The Texas College of Osteopathic Medicine at the University of North Texas Health Science Center at Fort Worth; Sandrine Defeu, Texas Tech University Health Sciences Center – Paul L. Foster School of Medicine; Dekoiya Burton, The University of Texas at Austin’s Dell Medical School; Allan Fonseca, The University of Texas Rio Grande Valley School of Medicine; Giselle Castillo, The University of Texas Health Science Center at San Antonio, Long School of Medicine; Adrienne Walker, The University of Texas Southwestern Medical School in Dallas; Alexander Cantu, The University of Texas Medical Branch at Galveston School of Medicine; and Artraeu Simms, The University of the Incarnate Word School of Osteopathic Medicine.

Special recognition was given to award winners with an honorary slide show presentation.
ROLL CALL
May 5-6, 2017

COUNTY MEDICAL SOCIETY DELEGATES AND ALTERNATE DELEGATES:

**Bell County Medical Society**
Lisa Jennifer Go, Temple; Robert Daniel Greenberg, Temple; Alan C. Howell, Temple; Collin M. Juergens, Temple; Michael Gabriel Parisi, Harker Heights; John Edward Pliska, Temple; Bindu Raju, Harker Heights; Jenny Thomas Jacob, Round Rock; Andrew J. Widmer, Temple

**Bexar County Medical Society**

**Big Country County Medical Society**
Robert Lee Dickey, Abilene; Noel Keith Robinson, Abilene; Leigh Taliaferro, Abilene

**Brazoria County Medical Society**
Raymond C. Jess, Lake Jackson

**Brazos-Robertson County Medical Society**
Mark J. Florian, Bryan

**Collin-Fannin County Medical Society**
Neha V. Dhudshia, Plano; Aimee C. Garza, Dallas; Richard Leon Grandjean, Allen; Marian D. Steininger, Allen

**Colorado-Fayette County Medical Society**
Bart D. Klaus, Columbus

**Comal County Medical Society**
Emily D. Briggs, New Braunfels; Michelle Z. Koehler, New Braunfels; Judith Lynn Thompson, New Braunfels

**Concho Valley County Medical Society**
Bradly Bundrant, Ballinger; Kathleen A. Cubine, San Angelo

**Dallas County Medical Society**
Drew Wilson Alexander, Dallas; Christine Ann Becker, Dallas; Justin M. Bishop, Dallas; Sue Scher Bornstein, Dallas; Adam C. Carter, Dallas; William Hampton Caudill, Dallas; Vella Victoria Chancellor, Mansfield; Samuel J. Chantilis, Dallas; Christopher Sung Jin Chun, Dallas; Wendy M. Chung, Dallas; Gates B. Colbert, Dallas; John Robert Corker,
Dallas; Emma L. Dishner, Dallas; Alan C. Farrow-Gillespie, Dallas; Raymond L. Fowler, Dallas; Deborah Anne Fuller, Dallas; Angela Fulgham Gardner, Grapevine; Victor Gonzalez, Dallas; Robert D. Gross, Dallas; Robert Ware Haley, Dallas; Sarah Lynn Helfand, Dallas; Eugene Pitts Hunt, Dallas; Rainer Anil Khetan, Dallas; Roger Sunil Khetan, Dallas; Kevin Wayne Klein, Dallas; Katie A. Lee, Dallas; C. Turner Lewis, Dallas; Warren E. Lichliter, Dallas; Daniel B. Pearson, Dallas; Edward Joseph Prejean, Irving; Assad Joe Saad, Dallas; John Stuart Scott, Dallas; Leslie Harold Secrest, Dallas; Arathi A. Shah, Arlington; Monique Ann Spillman, Dallas; Lisa Louise Swanson, Mesquite; Lisa Carole Taylor-Kennedy, Mesquite; Michael Ian Vengrow, Plano; Jim Walton, Dallas

**Denton County Medical Society**
Keith A. Lepak, Little Elm; Udaya Bhaskar Padakandla, Carrollton; Elizabeth Ruth Seymour, Denton; Victor Lee Vines, Ponder

**Ector County Medical Society**
Louise N. De Boer, Odessa; U. Prabhakar Rao, Odessa

**El Paso County Medical Society**
Manuel L. Acosta, El Paso; Jake Barrett Wilson, El Paso

**Ellis County Medical Society**
John M. Sullivan, Ennis

**Fort Bend County Medical Society**
Cedela Abdulla, Sugar Land; Art L. Klawitter, Needville; Sapna Singh, Sugar Land

**Galveston County Medical Society**
Rachel E. Laird, La Marque; David Christian Nickeson, Seabrook; Jeffrey S. Richards, League City

**Grayson County Medical Society**
J. Timothy Parker, Denison

**Gregg-Upshur County Medical Society**
Yasser Fahmy Zeid, Longview

**Guadalupe County Medical Society**
Yu-Jie John Kuo, Seguin

**Harris County Medical Society**
Madhureeta Achari, Houston; Audrey E. Ahuero, Houston; Jessica A. Alexander, Houston; Ronda E. Alexander, Houston; Paul M. Allison, Houston; Anna M. Allred, Houston; David M. Annuth, Houston; Robert L. Arkus, Houston; Syed K. Azeemuddin, Houston; Kulvinder S. Bajwa, Houston; Janette K. Bateman, Pearland; H. S. Bedi, Houston; Jimmie L. Bergeron, Houston; Richard N. Bradley, Houston; Brian M. Bruel, Houston; Lucy A. Buencamino, Houston; Luis H. Camacho, Houston; Sudipta K. Chaudhuri, Houston; Aeneid L. J. Chen, The Woodlands; Steven M. Croft, Houston; Lillete E. Daumas-Britsch, Houston; Richard W. Demmler, Seabrook; Rakhi C. Dimino, Houston; Swapan Dubey, Sugar Land; Betty Jo Edwards, Houston; Lisa L. Ehrlich, Houston; Angelina Farella, Webster; Harry L. Faust, Friendswood; Lewis E. Foxhall, Houston; Lauren E. Fuller, Houston; Arthur Garson, Houston; Clare N. Gentry, Houston; Marina C. George, Houston; Bernard M. Gerber, Bellaire; Noel M. Giesecke, Houston;
P. Ridgway Gilmer, Houston; Alan P. Glombicki, Houston; Leslie M. Haber, Houston; Steven E. Haber, Houston; R. Andrew Harper, Houston; Lindsey D. Harris, Houston; Harris M. Hauser, Bellaire; Hattie E. Henderson, Houston; Matthew D. Hoggatt, Webster; Pamela D. Holder, Houston; David R. Hoyer, Houston; Terah C. Isaacson, Houston; Luckett Johnson, Houston; Felicia L. Jordan, Richmond; Yvonne Kew, Houston; Faraz A. Khan, Houston; Karl W. King, Cypress; Felicity L. Mack, Richmond; Suzanne M. Manzi, Houston; Anna L. C. Mapp, Houston; Aurelio Matamoros, Houston; Paul Martin Mauk, Houston; Almas A. Mecklai, Spring; Jaideep H. Mehta, Houston; Kimberly E. Monday, Pearland; Walter P. Moore, Kingwood; Robert B. Morrow, Sugar Land; Santhoshri Narayanan, Houston; Vincent G. Nelson, Houston; Lonzetta L. Newman, Houston; Mark L. Nichols, Houston; Carla F. Ortique, Houston; Debra M. Osterman, Cypress; Bradford S. Patt, Houston; Eddie L. Patton, Sugar Land; Anne Marie Ponce De Leon, Sugar Land; Spencer A. Pruitt, Pearland; Elizabeth M. Rebello, Houston; Carlos E. Romero, Houston; Susan N. Rossmann, Houston; Manish Rungta, Webster; George D. Santos, Houston; Raul Sepulveda, Houston; Umair A. Shah, Houston; Amber D. Shamburger, Friendswood; Gary J. Sheppard, Houston; Mina K. Sinacori, Houston; Alan W. Skolnick, Sugar Land; Charles E. Soderstrom, Houston; Charlotte M. Stelly-Seitz, Houston; Richard Strax, Houston; Angela K. Sturm, Houston; Spencer H. Su, Sugar Land; Irvin Sulapas, Houston; Sarah L. Svoboda, Houston; Rosa A. Tang, Houston; Carl D. Tapia, Houston; Dexter G. Turnquest, Houston; John R. Vanderzyl, Sugar Land; Carlos J. Vital, Houston; Ronald S. Walters, Houston; Stephen E. Whitney, Houston; George W. Williams, Houston; Sandra J. Williams, Houston; Barbara J. Wilson, Houston; Kevin Scott Winfield, Houston; Sherif Z. Zaafran, Houston

**Harrison County Medical Society**
Valarie Lee Allman, Marshall

**Hidalgo-Starr County Medical Society**
Robert Eugene Alleyn, Edinburg; Lenore C. DePagter, McAllen; Martin Garza, Edinburg; Mark Stewert Gonzalez, McAllen; Chevy Chu Lee, McAllen; Javier D. Margo, Rio Grande City; Noel Edward Oliveira, Edinburg

**Jefferson County Medical Society**
John Kerry Badlissi, Nederland; Benjamin Wallace Beckert, Beaumont; Robert Barry Berndt, Beaumont; David Dean Teuscher, Paige; Moses Edward Wilcox, Nederland

**Kaufman County Medical Society**
Nuggehalli Neil Satyu, Terrell

**Lamar-Delta County Medical Society**
Josie R. Williams, Paris

**Lubbock-Crosby-Garza CMS**
Thomas A. Bowman, Lubbock; Akshar Dash, Flower Mound; John C. DeToledo, Lubbock; Sandra Dee Dickerson, Lubbock; Jack E. DuBose, Lubbock; Allan Louis Haynes, Lubbock; Ann C. Hughes Bass, Littlefield; Kalarickal J. Oommen, Lubbock; Roger Michael Ragain, Lubbock; Eldon Stevens Robinson, Lubbock; Janice Ann Stachowiak, Lubbock; Michelle Babb Tarbox, Lubbock; Davor Vugrin, Lubbock

**McLennan County Medical Society**
John Joseph Bawduniak, Gatesville; Sean D. DeLue, Waco; Robert E. Wolf, Waco
Midland County Medical Society  
Robert Allen Vogel, Midland

Montgomery County Medical Society  
Nefertiti C. Dupont, Missouri City; Ferenc Markos, The Woodlands

Nacogdoches-San Augustine CMS  
Gerard Joseph Ventura, Nacogdoches

Navarro County Medical Society  
Dale Keith Campbell, Corsicana

Nueces County Medical Society  
Lori Reese Anderson, Port Aransas; Ernest Dale Buck, Corpus Christi; Jack Locardi Cortese, Corpus Christi; Justin Paul Hensley, Corpus Christi; Jane Oliver Stafford, Corpus Christi; Wesley Warren Stafford, Corpus Christi; David Loyd Vanderheiden, Corpus Christi; Daniel V. Vijjeswarapu, Corpus Christi

Potter-Randall County Medical Society  
Robert Evans Gerald, Amarillo; Gerad A. Troutman, Amarillo; Rodney B. Young, Amarillo

Rusk County Medical Society  
Brenda Marie Vozza-Zeid, Henderson

San Patricio-Aransas-Refugio CMS  
Lawrence Ray Bailey, Aransas Pass

Smith County Medical Society  
Gina Mapes Jetter, Tyler; James P. Michaels, Tyler; Li-Yu H. Mitchell, Tyler; Paul W. Pitts, Tyler; David Lawrence Young, Tyler

Tarrant County Medical Society  
Joane G. Baumer, Fort Worth; Kendra J. Belfi, Fort Worth; Michael G. Enger, Arlington; Josephine Rebecca Fowler, Arlington; Cheryl Lynn Hurd, Fort Worth; R. Larry Marshall, Fort Worth; Gregory J. Phillips, Fort Worth; Stuart C. Pickell, Fort Worth; Ann E. Ranelle, Fort Worth; Kurt A. Schoppe, Grapevine; Angela D. Self, Euless; Mark M. Shelton, Fort Worth; Linda M. Siy, Fort Worth; Joe M. Todd, Fort Worth; Johnathan D. Warminski, Grapevine; James R. Winn, Southlake

Travis County Medical Society  
Joseph P. Annis, Austin; Tony R. Aventa, Austin; Jessica A. Best, Austin; Scott W. Clitheroe, Austin; Robert Harold Emmick, Austin; Colby C. Evans, Austin; Nancy Thorne Foster, Austin; Albert T. Gros, Buda; Juan M. Guerrero, Austin; Grace L. Honles, Austin; Felix Hull, Austin; Anand Joshi, Austin; Megan K. Kressin, Austin; Gregory M. Kronberg, Austin; Craig Allen Kuhns, Austin; Parag Kumar, Austin; Celia B. Neavel, Austin; Graves T. Owen, Round Rock; Michelle C.M. Owens, Austin; Dennis Samuel Pacl, Austin; A. Melinda Rainey, Dripping Springs; Dora L. Salazar, Austin; Charlotte Hoehe Smith, Seattle; Brian W. Temple, Austin; David N. Tobey, Austin; Emilio M. Torres, Austin; Zoltan Trizna, Austin; Elizabeth Truong, Austin; Belda Zamora, Austin; Guadalupe Zamora, Austin; Mateo Ziu, Austin
Tri-County CMS
   Mark B. Randolph, San Marcos; Alberto Santos, San Marcos

Victoria-Goliad-Jackson CMS
   George Amechi Osuchukwu, Victoria; Caroline Leilani Valdes, Victoria

Webb-Zapata-Jim Hogg CMS
   Sunny Wong, Laredo

Wharton-Matagorda County Medical Society
   Priscilla J. Metcalf, Wharton

Wichita-Archer-Baylor-Clay-Knox CMS
   T. David Greer, Henrietta; Evan C. Meyer, Wichita Falls; Bruce Lee Palmer, Wichita Falls; Jonathan Wayne Williams, Wichita Falls

Williamson County Medical Society
   Kambiz Jahahi, Round Rock; Theodore J. Spinks, Georgetown

EX OFFICIO MEMBERS PRESENT:

Member At-Large, TMA Board of Trustees
   Keith A. Bourgeois, Houston; Douglas W. Curran, Athens; Diana L. Fite, Magnolia; David C. Fleeger, Austin; Gary W. Floyd, Keller; David Norman Henkes, San Antonio; Danny Ken McCoy, Corsicana; Richard Wesley Snyder, Dallas; E. Linda Villarreal, Edinburg

President, TMA Officers
   Don Robert Read, Dallas

President-Elect, TMA Officers
   Carlos Javier Cardenas, Edinburg

Secretary-Treasurer, TMA Officers
   Michelle A. Berger, Austin

Speaker, TMA Officers
   Susan M. Strate, Wichita Falls

Vice Speaker, TMA Officers
   Arlo F. Weltge, Bellaire

Councilor, TMA Board of Councilors
   Michael A. Altman, Houston; James R. Eskew, Austin; Roland Adolph Goertz, Waco; Donald Joseph Gordon, Helotes; Gilberto A. Handal, El Paso; Louis John Kirk, Longview; Charles M. Perricone, Henderson; Vivek U. Rao, Odessa; Edward Wilmar Tuthill, Dallas

Vice Councilor, TMA Board of Councilors
John R. Asbury, Temple; Sandra Esquivel, Weslaco; Kyle Gregory Krohn, Lufkin; Kaparaboyna Ashok Kumar, San Antonio; Susan M. Pike, Georgetown; Jane Catherine Rider, San Angelo

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

Gerald R. Callas, Beaumont; John T. Carlo, Dallas; John Gerard Flores, Carrollton; Gregory M. Fuller, Keller; William S. Gilmer, Houston; Cynthia Ann Jumper, Lubbock; Jennifer Elaine Nordhauser, San Antonio; Jayesh B. Shah, San Antonio; Elizabeth Torres, Sugar Land

**Texas Delegate, Texas Delegation to AMA**

William H. Fleming, Houston; Robert Tau Gunby, Dallas; Asa C. Lockhart, Tyler; Kenneth L. Mattox, Houston; Clifford K. Moy, Frisco; Larry E. Reaves, Fort Worth; Lyle Sheldon Thorstenson, Dallas

**Chair, Council on Constitution and Bylaws**

Mark A. Casanova, Dallas

**Chair, Council on Health Promotion**

Benjamin C. Lee, Dallas

**Chair, Council on Health Service Organizations**

James S. Guo, Houston

**Chair, Council on Medical Education**

Steven Ray Hays, Dallas

**Chair, Council on Practice Management Services**

Chelsea I. Clinton, San Antonio

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

David L. Lakey, Austin

**Member, Council on Legislation**

Naga S. Bushan, Lubbock; James Loyd Humphreys, Helotes; Robert E. Jackson, Houston; Bryan G. Johnson, Frisco; Thomas J. Kim, Austin; Isabel C. Menendez, Portland; Lee Ann Pearse, Dallas; Jason V. Terk, Keller

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

Texas Association of Obstetricians and Gynecologists: Kimberly Carter, Austin

Previous Service Texas Society of Anesthesiologists: Evan G. Pivalizza, Houston

Texas College of Emergency Physicians: Heidi C. Knowles, Forney

Texas Association of Otolaryngology Previous Service: Jeffrey B. Kahn, Austin

Texas Society of Pathologists: Jennifer R. Rushton, Austin

Texas Society of Anesthesiologists: Charles E. Cowles, Pasadena

Texas Academy of Family Physicians: Lindsay K. Botsford, Sugar Land

Texas Association of Obstetricians and Gynecologists: George Sealy Massingill, Fort Worth
TSPP: Richard L. Noel, Houston
Texas Pediatric Society: Ben G. Rainer, Galveston
Texas Allergy, Asthma and Immunology Society: Louise H. Bethea, Spring
Texas Academy of Family Physicians previous service: Troy T. Fiesinger, Sugar Land
Texas Association of Otolaryngology: Bradford W. Holland, Waco
Texas Radiological Society: Tilden L. Childs, Fort Worth

SECTION DELEGATES AND ALTERNATE DELEGATES PRESENT:
U. Prabhakar Rao, MD, Odessa, SCIMGS
Navid Q. Saigal, MD, San Antonio, SCIMGS
Paul T. Brindley, League City, SCMSS, UT Medical Branch
Akshar Dash, Flower Mound, SCMSS, Texas Tech Univ Health Sciences Center
Zachary Donoviel, Harlingen, SCMSS, UTRGV School of Medicine
Leonard W. Edwards, II, Austin, SCMSS, Dell Medical School at UT Austin
Lauren E. Fuller, Houston, SCMSS, Baylor College of Medicine
Waqaas Z. Haque, Plano, SCMSS, UT Southwestern Medical School
Katharine Heffner, Austin, SCMSS, Texas A&M University-Medical School
John V. Lacci, San Antonio, SCMSS, UT Health Science Center at San Antonio
Rachel E. Laird, La Marque, SCMSS, UT Medical Branch
Nicola Park, Houston, SCMSS, UT Health Science Center at Houston
Pranati Pillutla, Lubbock, SCMSS, Texas Tech Univ Health Sciences Center
Tanner S. Shaw, Fort Worth, SCMSS, University North Tex Health Science Ctr
Jake Barrett Wilson, El Paso, SCMSS, Tx Tech Univ Hlth Sci Ctr Paul L Foster Sch Of Med, El Paso, Tx
John Robert Corker, MD, Dallas, SCRFS
Collin M. Juergens, MD, Temple, SCRFS
Samuel E. Mathis, MD, Sugar Land, SCRFS
Andrew J. Widmer, MD, Temple, SCRFS
Anna M. Allred, MD, Houston, SCYPS
Jessica A. Best, MD, Austin, SCYPS
Gates B. Colbert, MD, Dallas, SCYPS
Troy T. Fiesinger, MD, Sugar Land, SCYPS
Alison J. Haddock, MD, Houston, SCYPS
Justin Paul Hensley, MD, Corpus Christi, SCYPS
Heidi C. Knowles, MD, Forney, SCYPS
Paraag Kumar, MD, Austin, SCYPS
George Amechi Osuchukwu, MD, Victoria, SCYPS
Bindu Raju, MD, Harker Heights, SCYPS
Jennifer R. Rushton, MD, Austin, SCYPS
Nicholas P. Steinour, MD, Austin, SCYPS
Lynn N. Stewart, MD, Austin, SCYPS
Brian W. Temple, MD, Austin, SCYPS
Jason V. Terk, MD, Keller, SCYPS
Carlos J. Vital, MD, Houston, SCYPS
Brenda Marie Vozza-Zeid, MD, Henderson, SCYPS
Gabriela M. Zandomeni, MD, Rowlett, SCYPS

PAST PRESIDENTS PRESENT:
Bohn D. Allen, Arlington; Alan C. Baum, Houston; Stephen L. Brotherton, Fort Worth;
Mark J. Kubala, Beaumont; Michael E. Speer, Houston

Members Present (Quorum: 246)
420 (408 voting + 12 nonvoting)
TexMed 2017
TMA's Annual Meeting, Premier Educational Showcase, and Expo
May 5-6 ★ Houston
RENEW YOUR PASSION
www.texmed.org/TexMed

Handbook for Delegates

Download the NEW TexMed 2017 meeting app Apple App Store or Google Play Store
Connect with #texmed2017  facebook.com/texmed  @texmed  @wearetma
WHAT TO DO WHEN

FRIDAY, May 5

6:30-7:30 am
TexMed Orientation: M, Level 2, Montgomery
New members of the house meet for breakfast to review procedures.

7 am-6 pm
Registration: CC, Level 3, Expo Hall

8 am
House of Delegates convenes: CC, Level 3, Expo Hall

Immediately Following Opening Session
Reference committees meet in rooms at M, Level 2:
Financial & Organizational Affairs: Houston Ballroom 1
Medical Education: Liberty
Science & Public Health: Houston Ballroom 2
Socioeconomics: Houston Ballroom 3

Noon-1 pm
Free Networking Lunch: CC, Level 3, Expo Hall

12:30-1:45 pm
Candidate Forum: CC, Level 3, Expo Hall
Learn about the candidates running for TMA offices. Candidates will answer questions from the audience.

3:00-5 pm Sponsored by TMLT
Opening General Session: CC, Level 3, Expo Hall
Physicians in the Age of Terrorism — Stories of the Battlefield by Chancellor William H. McRaven

Connect and Be Heard: Make a Difference in Health Care with Social Media by Kevin Pho, MD

5-6 pm Sponsored by TMLT
Welcome Reception and Book Signing: CC, Level 3, Expo Hall

6-7 pm Sponsored by TMAIT
2017-18 TMA/TMAA Presidents’ Reception: M, Level 2, Harris

TMA Foundation Annual Gala, “Blast Off!”: M, Level 4, Texas 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 — Immunize℠ and Hard Hats for Little Heads, all supported by TMAF.

SATURDAY, May 6

6 am-1:30 pm
Registration: CC, Level 3, Expo Hall

8:30 am
House of Delegates meets: CC, Level 3, Expo Hall

12:30-1:30 pm
Free EXPO Lunch: CC, Level 3, Expo Hall

1:30-2:30 pm
Closing General Session: CC, Level 3, Expo Hall
Civilian Response to an Active Shooter Situation by Pete Blair, PhD

Caucus Meetings

Bexar County Medical Society
Saturday, 6:30 am, CC, Level 3, Room 361A

Collin-Fannin County Medical Society
Friday 6 pm - 6:30 pm, M, Lobby Level, Cueva

Dallas County Medical Society
Saturday, 6:30 am, CC, Level 3, Room 350D

Harris County Medical Society
Saturday, 6:30 am, CC, Level 3, Room 360B

Lone Star Caucus
Friday, 6:30 am, M, Level 2, Houston Ballroom 4
Saturday, 6:30 am, CC, Level 3, Room 351E

Tarrant County Medical Society
Saturday, 6:30 am, CC, Level 3, Room 351D

Travis County Medical Society
Saturday, 6:30 am, CC, Level 3, Room 360A

Medical Student Section
Saturday, 6:30 am, M, Level 2, Brazoria

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 Reports Room, Room 2801.

• 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 only.

• Wi-Fi: The free wireless network is TexMed2017 and the password is texmed. Please note you will need to reconnect to the network when moving between the hotel and the convention center.
CHIEF TELLER
Charles E. Cowles Jr., MD, chair, Harris County Medical Society

CREDENTIALS
Sandra Dee Dickerson, MD, chair, Lubbock-Crosby-Garza County Medical Society
Faraz A. Khan, MD, Harris County Medical Society
Leah Hanselka Jacobson, MD, Bexar County Medical Society
Yvonne Kew, MD, PhD, Harris County Medical Society

FINANCIAL AND ORGANIZATIONAL AFFAIRS
George W. Williams II, MD, chair, Harris County Medical Society
Anees A. Siddiqui, MD, Travis County Medical Society
Ann C. Hughes Bass, MD (resident), Lubbock-Crosby-Garza County Medical Society
Bernard M. Gerber, MD, Harris County Medical Society
Jonathan Wayne Williams, MD, Wichita-Archer-Baylor-Clay-Knox CMS
Kathleen A. Cubine, DO, Concho Valley County Medical Society
Lubna Naeem, MD, Bexar County Medical Society

MEDICAL EDUCATION
Stephen E. Whitney, MD, chair, Harris County Medical Society
Alice Kim Gong, MD, Bexar County Medical Society
Deborah Fuller, MD, Dallas County Medical Society
Lindsay K. Botsford, MD, Harris County Medical Society
Mateo Ziu, MD, Travis County Medical Society
Mr. William Alexander Estes (student), Lubbock-Crosby-Garza Medical Society
Priscilla J. Metcalf, MD, Wharton-Matagorda County Medical Society

SCIENCE AND PUBLIC HEALTH
Udaya Bhaskar Padakandla, MD, chair, Denton County Medical Society
Ben G. Raimer, MD, Galveston County Medical Society
Carla F. Ortique, MD, Harris County Medical Society
Celia B. Neavel, MD, Travis County Medical Society
John J. Nava, MD, Bexar County Medical Society
Sarah Lynn Helfand, MD, Dallas County Medical Society
Tilden L. Childs, III, MD, Tarrant County Medical Society

SOCIOECONOMICS
G. Sealy Massingill, MD, chair, Tarrant County Medical Society
Brenda Vozza-Zeid, MD, Rusk County Medical Society
Brian M. Bruel, MD, Harris County Medical Society
Habeeb Munir Salameh, MD, (resident), Galveston County Medical Society
Katharina Hathaway, MD, Travis County Medical Society
Michael Ian Vengrow, MD, Dallas County Medical Society
Nefertiti C. duPont, MD, Montgomery 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 2017 Texas Caucus Meetings

LEGEND
- Bexar
- Collin-Fannin
- Dallas
- Harris
- Lone Star
- Tarrant
- Travis

Bexar County Medical Society
Jayesh B. Shah, MD, Chair
Michael A. Battista, MD, Co-Chair
Saturday, 6:30 am, CC, Level 3, Room 361A

Collin-Fannin County Medical Society
Carrie E. de Moor, MD, President
Friday, 6-6:30 pm, M, Lobby Level, Cueva

Dallas County Medical Society
Steven R. Hays, MD, Co-Chair
Robert T. Gunby Jr., MD, Co-Chair
Saturday, 6:30 am, CC, Level 3, Room 350D

Harris County Medical Society
Charlotte M. Stelly-Seitz, MD, Chair
Sherif Zaafran, MD, Vice Chair
Saturday, 6:30 am, CC, Level 3, Room 360B

Lone Star
Brad Holland, MD, Co-Chair
Jed Grisel, MD, Co-Chair
Gregory R. Johnson, MD, Co-Vice Chair
Lenore DePagter, DO, Co-Vice Chair
Friday, 6:30 am, M, Level 2, Houston Ballroom 4
Saturday, 6:30 am, CC, Level 3, Room 351E

Tarrant County Medical Society
Robert J. Rogers, MD, Co-Chair
Gary Floyd, MD, Co-Chair
Saturday, 6:30 am, CC, Level 3, Room 351D

Travis County Medical Society
Tony R. Aventa, MD, Chair
Michelle Berger, MD, Vice Chair
Saturday, 6:30 am, CC, Level 3, Room 360A
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 Financial & Organizational Affairs
Reference Committee on Science and Public Health
Reference Committee on Medical Education
Reference Committee on Socioeconomics

Speaker of House of Delegates

Resolution or Action Report
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”?
   - NO: The original item of business is before the house, and the reference committee suggests a “yes” vote.
   - YES: Did the house adopt “adopt”? (Answer provided)

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, without a recommendation from the reference committee.

4. Did the reference committee recommend “refer”?
   - 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.”
   - NO: Did the house adopt “refer”? (Answer provided)

5. Did the reference committee recommend “amend”?
   - YES: Original item is before the house as the Main Motion, with the subsidiary motion “amend” as the immediately pending motion – discussion is on “amend.”
   - NO: Did the house adopt the amendment? (Answer provided)

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? (Answer provided)

7. The speaker will explain the situation.
   - YES: Substitute is enacted.
   - NO: Original item is before the house as the Main Motion – discussion is on the original item.

Flow Chart for Business Items
PROCEDURE FOR BUSINESS ITEMS
May 2017

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 action” (“for decision”).

  If an item is referred “for study,” the body to which it is referred will investigate and report back to the house on that item with its findings and recommendations.
Procedure for Business Items

If an item is referred “for action,” the body to which it is referred (usually the Board of Trustees) 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 usually report back to the house, explaining its findings and the actions that were taken.

If an item is referred without designating whether the referral is “for study” or “for action,” the referral is “for study”.

“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.
### PRINCIPAL RULES

<table>
<thead>
<tr>
<th>Order of precedence</th>
<th>Can interrupt?</th>
<th>Requires second?</th>
<th>Debatable?</th>
<th>Amendable?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PRIVILEGED MOTIONS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. Adjourn</td>
<td>No</td>
<td>Yes</td>
<td>Yes&lt;sup&gt;3&lt;/sup&gt;</td>
<td>Yes&lt;sup&gt;3&lt;/sup&gt;</td>
</tr>
<tr>
<td>2. Recess</td>
<td>No</td>
<td>Yes</td>
<td>Yes&lt;sup&gt;3&lt;/sup&gt;</td>
<td>Yes&lt;sup&gt;3&lt;/sup&gt;</td>
</tr>
<tr>
<td>3. Question of privilege</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td><strong>SUBSIDIARY MOTIONS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Postpone temporarily (Table)</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>5. Close debate</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>6. Limit debate</td>
<td>No</td>
<td>Yes</td>
<td>Yes&lt;sup&gt;3&lt;/sup&gt;</td>
<td>Yes&lt;sup&gt;3&lt;/sup&gt;</td>
</tr>
<tr>
<td>7. Postpone to a certain time</td>
<td>No</td>
<td>Yes</td>
<td>Yes&lt;sup&gt;3&lt;/sup&gt;</td>
<td>Yes&lt;sup&gt;3&lt;/sup&gt;</td>
</tr>
<tr>
<td>8. Refer to committee</td>
<td>No</td>
<td>Yes</td>
<td>Yes&lt;sup&gt;3&lt;/sup&gt;</td>
<td>Yes&lt;sup&gt;3&lt;/sup&gt;</td>
</tr>
<tr>
<td>9. Amend</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>MAIN MOTIONS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10. a. The main motion</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>b. Restorative main motions</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Amend a previous action</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Ratify</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Reconsider</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes&lt;sup&gt;1&lt;/sup&gt;</td>
<td>No</td>
</tr>
<tr>
<td>Rescind</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Resume consideration</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

### INCIDENTAL

<table>
<thead>
<tr>
<th>No order of precedence</th>
<th>Can interrupt?</th>
<th>Requires second?</th>
<th>Debatable?</th>
<th>Amendable?</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>MOTIONS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Appeal</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Suspend rules</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Consider informally</td>
<td>No</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td><strong>REQUESTS</strong></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Point of order</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Parliamentary inquiry</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Withdraw a motion</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Division of question</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Division of assembly</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</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. Requires two-thirds vote when it would suppress a motion without debate.
3. Restricted.
4. Withdraw may be applied to all motions.

### GOVERNING MOTIONS

<table>
<thead>
<tr>
<th>Vote required?</th>
<th>Applies to what other motions?</th>
<th>Can have what other motions applied to it?</th>
<th>Refer to page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Majority</td>
<td>None</td>
<td>Amend</td>
<td>77</td>
</tr>
<tr>
<td>Majority</td>
<td>None</td>
<td>Amend&lt;sup&gt;1&lt;/sup&gt;</td>
<td>75</td>
</tr>
<tr>
<td>None</td>
<td>None</td>
<td>None</td>
<td>72</td>
</tr>
<tr>
<td>Majority&lt;sup&gt;2&lt;/sup&gt;</td>
<td>2/3 Debatable motions</td>
<td>None</td>
<td>66</td>
</tr>
<tr>
<td>Majority&lt;sup&gt;2&lt;/sup&gt;</td>
<td>2/3 Debatable motions</td>
<td>Amend&lt;sup&gt;1&lt;/sup&gt;</td>
<td>62</td>
</tr>
<tr>
<td>Majority&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Main motion</td>
<td>None</td>
<td>68</td>
</tr>
<tr>
<td>Majority&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Main motion</td>
<td>Amend&lt;sup&gt;1&lt;/sup&gt;, close debate, limit debate</td>
<td>58</td>
</tr>
<tr>
<td>Majority&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Main motion</td>
<td>Amend&lt;sup&gt;1&lt;/sup&gt;, close debate, limit debate</td>
<td>55</td>
</tr>
<tr>
<td>Majority&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Rewindable motions</td>
<td>Close debate, limit debate, amend</td>
<td>47</td>
</tr>
<tr>
<td>Majority&lt;sup&gt;2&lt;/sup&gt;</td>
<td>None</td>
<td>Restorative, subsidiary</td>
<td>32</td>
</tr>
<tr>
<td>Majority&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Main motion</td>
<td>Subsidiary, restorative</td>
<td>36</td>
</tr>
<tr>
<td>Majority&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Previous action</td>
<td>Subsidiary</td>
<td>37</td>
</tr>
<tr>
<td>Majority&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Main motion</td>
<td>Close debate, limit debate</td>
<td>38</td>
</tr>
<tr>
<td>Majority&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Main motion</td>
<td>Close debate, limit debate</td>
<td>42</td>
</tr>
<tr>
<td>Majority&lt;sup&gt;2&lt;/sup&gt;</td>
<td>Main motion</td>
<td>None</td>
<td>44</td>
</tr>
</tbody>
</table>

### MOTIONS

<table>
<thead>
<tr>
<th>Vote required?</th>
<th>Applies to what other motion?</th>
<th>Can have what other motions applied to it?</th>
<th>Refer to page</th>
</tr>
</thead>
<tbody>
<tr>
<td>Majority</td>
<td>Decision of chair</td>
<td>Close debate, limit debate</td>
<td>82</td>
</tr>
<tr>
<td>2/3</td>
<td>None</td>
<td>None</td>
<td>84</td>
</tr>
<tr>
<td>Majority</td>
<td>Main motion</td>
<td>None</td>
<td>128</td>
</tr>
</tbody>
</table>

| None           | Any error                     | None                                      | 87            |
| None           | All motions                   | None                                      | 90            |
| None           | All motions                   | None                                      | 94            |
| None           | Main motion                   | None                                      | 96            |
| None           | Indecisive vote               | None                                      | 99            |
THE CHIEF PURPOSES OF MOTIONS

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

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

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

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

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

EXPLANATION OF CONFLICTS OF INTEREST

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

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

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

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

Activities That Might Cause Conflict of Interest

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

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

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

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

Conflicts of Interest — Scenario 1

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

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

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

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

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

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

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

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

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

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

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

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

Wireless keypad systems have been in use in the U. S. for over 20 years. The systems are composed of wireless keypads, wireless receivers, and display software. At the discretion of the Speaker of the House of Delegates, wireless audience response voting systems will be used to facilitate the rapid capture, tabulation, and display of voting results. Each House of Delegates voting member will receive a wireless voting device during the credentialing process.

Frequently Asked Questions

1. **Why is my unit scanned during credentialing?** Each handheld unit has a unique identification code located on the back of the unit. Units are scanned during the credentialing process to allow for retrieval of the units should they not be returned at the close of house business.

2. **Is my vote confidential?** Yes. Under the supervision of the Chief Teller, Texas Medical Association staff captures the results of wireless voting to facilitate the reporting of results to the house. However, only at the request of a voting member to the Chief Teller will the actual vote of that member be reported and only in an instance where a voting member requests validation that his or her vote has accurately been captured by the wireless voting system. A voting member has up to one hour following the close of the house to request this information after which the voting results will be destroyed.

3. **Why does TMA use wireless voting systems?** The TMA Board of Trustees and Speaker of the House of Delegates determined that there were several reasons for moving to a wireless, electronic, voting system. The primary reason was to speed up the process by which votes are captured and reported. Paper ballots historically required up to thirty (30) minutes for results to be tabulated and reported.

4. **Can I change my answer after I key in my vote?** The wireless handheld units will allow a delegate to change his or her vote as many times as necessary during the “active” time period of a called vote. The “active” time period of a called vote is the time between the Speaker of the House stating “Vote Now” and “Time”.

5. **What do I do with my voting device at the end of the House session?** Please leave your voting unit in clear sight on the table where you are sitting. A TMA staff member will collect the voting units following adjournment.
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TMA Component Listing 2017
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Interspecialty Society Committee (continued)

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<td>Habeeb Munir Salameh, MD, Chair Elect</td>
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<td>Mani Akhtari, MD, Immediate Past Chair</td>
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<td>Delegates:</td>
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<td>Kristin A. Harrington, MD</td>
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<td>Sara A. Westgate, MD, PhD</td>
<td>Samuel E. Mathis, MD</td>
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**Sections:**

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<td>Jennifer A. Ukwu, MD</td>
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<td>Sejal S. Mehta, MD, Chair Elect</td>
<td>Young Physician</td>
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<td>Anupama Gotimukula, MD, Alt Delegate</td>
<td>Gerard A. Troutman, MD, Imm. Past Chair</td>
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<tr>
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<td>Kari H. Fay, MD</td>
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<tr>
<td>Kaparaboyna Ashok Kumar, MD</td>
<td>Alison J. Haddock, MD</td>
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<tr>
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<th>Chair/Delegates</th>
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<td>Jennifer E. Nordhauser, Texas Alt Delegate</td>
<td>Lynn N. Stewart, MD</td>
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<td>AMA Delegates:</td>
<td>Delegates:</td>
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<tr>
<td>Neha Kamal Afi</td>
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<td>Mayank Aranke</td>
<td>Katherine B. Hagan, MD</td>
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<td>Katrina N. Barnes</td>
<td>Carla M. Laos, MD</td>
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<td>Jennifer R. Rushton, MD</td>
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<td>Punya Chittajallu</td>
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<td>Marissa M. Forray</td>
<td>Sara S. Woodward Dyrstad, MD</td>
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<tr>
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<td>Mohammad M. Murtuza, MD</td>
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<td>Ashley B. Barasa, MD</td>
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<tr>
<td>Ariane T. Lemieux</td>
<td>Ankita Varma Brahmaroutu</td>
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<td>Mohammad M. Murtuza</td>
<td>Akshar Dash</td>
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<tr>
<td>Christle K. Nwora</td>
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<tr>
<td>Pranati Pillutla</td>
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<td>Alexandra Lee Vaio</td>
<td>Sara S. Woodward Dyrstad, MD</td>
</tr>
<tr>
<td>Shane Wing</td>
<td>Marek A. Podolsky, MD</td>
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MEMORIAL LIST
March 16, 2016 – May 1, 2017

William Elston Anderson, MD, Corpus Christi

Eric G. Comstock, MD, Houston

Jerald Feldman, MD, Houston

Leonilo Garcia, MD, Corpus Christi

J. Travis Glidewell, MD, Houston

Antonio P. Gonzalez, MD, Dallas

R. McIver Hay, MD, Trinity

William E. Hare, MD, Dallas

T. Guy Bragg, III, MD

Robert B. Echols, MD, Rockwall

Raymond E. Liverman, DO, Round Rock

Raymond Lee, MD, Austin

Bernard Z. Albina, MD, Houston

Esteban Alejo, MD, San Antonio

Monte D. Allen, DO, Laredo

Jose D. Alva, MD, El Paso

William Wesley Crabtree, MD, Victoria

Charles Rea Craig, MD, Corpus Christi

Thomas J. Curvin, MD, Rockwall

Crawford J. Daniel, MD, Taylor

Thomas J. Dansby, MD, San Antonio

Jorge De la Torre, MD, Houston

Louis Delclos, MD, Houston

Edward House Dew, MD, Spring

James S. Diamon, MD, Dallas

Ramon F. Diaz, MD, Houston

John A. Dickinson, MD, Fort Worth

Gregory Gordon Dimijian, MD, Dallas

Marlene Domínguez, MD, Houston

Kevin T. Doner, MD

James Reginald Duke, MD, San Antonio

James Wilmoth Dunn, MD, Amarillo

Ralph O. Dunn, Jr., MD, Houston

Edgar Frank Dunton, MD, Dallas

Robert B. Echols, MD, Rockwall

John Allen Ehhardt, MD, Dallas

Raphael J. Emanuel, MD, Dallas

Lee E. Emory, MD, Hitchcock

Mark A. Engleman, MD, Plano

Maurice William Epstein, MD, Dallas

Armando J. Espiritu, MD, Houston

Jeffrey W. Fato, MD, Rosharon

Joseph John Fedorchik, Jr., MD, College Station

Lorand Fekete, MD, Dallas

Jerald Feldman, MD

Nathaniel G. Ferrer, MD, Lubbock

Kenneth R. First, MD, Houston

Stanton P. Fischer, MD, Houston

Morris Joseph Fogelman, MD, Dallas

Delton Wayne Foley, MD, San Antonio

Kenneth Foree, III, MD, Dallas

John Howard Frederick, MD, Windcrest

Gerald D. Friedman, DO, Fort Worth

Peter Gallinhas, Jr., MD, Dallas

Kimberly J. Gambard, MD

Manuel P. Gandarillas, MD, Austin

Allen R. Garcia, MD, San Antonio

Cuitlahuac P. Garcia, MD, San Antonio

Leonilo Garcia, MD, Corpus Christi

Raul G. Garcia, MD, San Antonio

Olie Ray Garrison, DO, Nacogdoches

Mhrete Ab Gebre-Selassie, MD, Huntsville

Tadeusz Glinkowski, MD, Houston

Rogelio Gonzalez, MD, El Paso

William Hyatt Gordon, Jr., MD, Lubbock

Homer L. Graff, Jr., MD, Houston

R. Stephen Grayson, DO, Kingwood

Kenneth Charles Gregory, DO, Round Rock

Lloyd J. Gregory, Jr., MD, Houston

Guy H. Gross, MD, Sherman

Pedro Guana, MD, Sugar Land

Joseph B. Guerrini, MD, Houston

Lillian P. Gustavson, MD, Houston

Nizicaki Guzman, MD, Houston

Curtis R. Haley, MD, San Augustine

Grady L. Hallman, MD, Houston

Doyne B. Hamilton, MD, Corpus Christi

Daniel James Harmon, MD, Waco

James E. Harrell, Sr., MD, Houston

William S. Harwell, MD, Houston

Clint Sandhaway, MD, Dallas

R. McIver Hay, MD, Trinity

William M. Head, MD, Fort Worth

Raymond H. Hernandez, Jr., MD, San Antonio

Samuel C. Hoover, DO, Hurst

Granville Eugene Horton, MD, San Antonio

Edward F. House, Jr., MD, Lubbock

Ben K. Howard, MD, Allen

Ted T. Huang, MD, Galveston

William B. Huckleby, MD, Austin

Joseph Hoyt Jackson, Jr., MD, Corpus Christi

Thomas Mason James, MD, Dallas

Daniel G. Jenkins, MD, Amarillo

Samuel Carlyle Jernigan, MD, Cleburne

Jack Lynwood Judson, MD, Fort Worth

Jerry J. Julian, MD

Kenan Kay Kinnaman, MD, Abilene

Glen Rayburn Kent, MD, Mount Pleasant

Frederick M. Key, Jr., MD, Roanoke

William F. Key, Jr., MD, Clifton

Carey G. King, Jr., MD, Dallas

Nancy Ann Kirchmer, MD, Beaumont

John W. Kirk, MD, Houston

Charles D. Kline, MD, Chappell Hill

Guy E. Knolle, Jr., MD

James K. Knott, MD, Sarasota

William E. Korndorfer, Jr., MD, League City

Puskoor M. Kumar, MD, Fort Worth

Joseph Lawrence LaManna, DO, Dallas

Dan Wayne Laster, MD, Corpus Christi

Jacobo Lastrache, MD, Corpus Christi

Charles A. LeMaistre, MD, San Antonio

Robert L. Leon, MD, Austin

Raymond Eugene Liverman, DO, Arlington
## HOUSE OF DELEGATES COMPOSITION

*As Of: 4-21-2017*

### County society delegates

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### Ex officio-voting positions: *

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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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<td>Speaker</td>
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<tr>
<td>Vice Speaker</td>
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<tr>
<td>At-large members of the Board of Trustees</td>
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<tr>
<td>Councilors</td>
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<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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<tr>
<td>Resident and Fellow Section delegates</td>
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<td>Medical Student Section delegates</td>
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<td>Past Presidents</td>
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### Ex officio nonvoting positions:

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<td>TEXPAC Chair</td>
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<td>Delegates emeritus of the Texas Delegation to the AMA</td>
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### County society alternate delegates

<table>
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<tr>
<td>Ex officio</td>
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<tr>
<td>Less those holding multiple positions</td>
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### Total voting membership

| Total voting membership                                             | 519    |

*Past presidents who are active or emeritus members have a vote, but they are not included in the quorum count.*
MEMBERS OF THE HOUSE OF DELEGATES AND VICE COUNCILORS

May 2017

KEY

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

SPECIALTY CODES

Code Description
A Allergy
ACA Adult Cardiothoracic Anesthesiology
ADL Pediatric Adolescent Medicine
ADM Addiction Medicine
ADP Addiction Psychiatry
AHF Advanced Heart Failure & Transplant Cardiology
AI Allergy & Immunology
ALI Allergy/Immunology, Clin & Lab Immunology
AM Aerospace Medicine
AMF Family Practice, Adolescent Medicine
AMI Internal Medicine, Adolescent Medicine
AN Anesthesiology
APM Anesthesiology, Pain Medicine
AR Radiology, Abdominal
AS Surgery, Abdominal
ASO Advanced Surgical Oncology
ATP Pathology, Anatomic
BBK Pathology, Blood Bank/Transfusion Med.
BIN Brain Injury Medicine
BIP Brain Injury Medicine
CAP Child Abuse Pediatrics
CBG Genetics, Clinical Biochemical
CCA Anesthesiology, Critical Care Medicine
CCE Critical Care Medicine (Emergency Medicine)
CCG Genetics, Clinical Cytopathology
CCM Internal Medicine, Critical Care Medicine
CCP Pediatric Critical Care
CCS Surgery, Critical Care
CD Cardiovascular Disease
CFS Surgery, Craniofacial
CG Genetics, Clinical
CHD Adult Congenital Heart Disease
CHN Neurology, Child
CHP Psychiatry, Child & Adolescent
CHS Congenital Cardiac Surgery (Thoracic Surgery)
CIM Clinical Informatics (Preventive Medicine)
CIP Clinical Informatics
Dermatology
CRS Colon & Rectal Surgery
CS Cosmetic Surgery
CTR Cardiothoracic Radiology
D Dermatology
DBP Pediatrics Developmental-Behavioral
DIA Diabetes
DMP Dermatopathology
DR Radiology, Diagnostic
DS Surgery, Dermatologic
EFM Emergency Medicine/Family Medicine
EM Emergency Medicine
EMP Emergency Medicine Pediatrics
EMS Emergency Medical Services
END Endo, Diabetes & Metabolism
ENR Endovascular Surgical Neuroradiology
EP Epidiology
EPL Epilepsy
ES Endovascular Surgical Neuroradiology
ESM Emergency Medicine, Sports Medicine
ESN Endovascular Surgical Neuroradiology
ETX Emergency Medicine, Medical Toxicology
FM Family Medicine
FMP Family Medicine/Preventive Medicine
FOP Pathology, Forensic
FPG Family Practice, Geriatric Medicine
FPP Psychiatry/Family Medicine
FPR Female Pelvic Medicine & Reconstructive Surgery, OB/Gyn
FSC Family Practice, Sports Medicine
GE Gastroenterology
GO Gynecological Oncology
GP General Practice
Members of the House of Delegates and Vice Councilors
May 2017
Page 2

GPM General Preventive Medicine
GS Surgery, General
GYN Gynecology
HEM Hematology
HEP Hepatology
HMP Pathology, Hematology
HNS Surgery, Head & Neck
HO Hematology/Oncology
HOS Hospitalist
HPA Hospice & Palliative Medicine (Anesthesiology)
HPD Hospice & Palliative Medicine (Radiology)
HPE Hospice & Palliative Medicine (Emergency Medicine)
HPF Hospice & Palliative Medicine (Family Medicine)
HPI Hospice & Palliative Medicine (Internal Medicine)
HPM Hospice & Palliative Medicine
HPN Hospice & Palliative Medicine (Psychiatry & Neurology)
HPO Hospice & Palliative Medicine (Obstetrics & Gynecology)
HPP Hospice & Palliative Medicine (Pediatrics)
HPR Hospice & Palliative Medicine (Physical Medicine & Rehabilitation)
HPS Hospice & Palliative Medicine (Surgery)
HS Surgery, Hand
HSO Orthopedics Hand Surgery
HSP Hand Surgery (Plastic Surgery)
HSS Hand Surgery (Surgery)
IC Cardiology, Interventional
ICE Clinical Cardiac Electrophysiology
ID Infectious Diseases
IEC IM/Emergency Med/Critical Care Med
IFP Internal Medicine/Family Practice
IG Immunology
ILI Internal Med, Clin & Lab Immunology
IM Internal Medicine
IMD Internal Medicine/Dermatology
IMG Internal Medicine, Geriatrics
INM Internal Medicine/Nuclear Medicine
IPM Internal Medicine, Preventative Medicine
ISM Internal Medicine, Sports Medicine
LM Legal Medicine
MBG Medical Biochemical Genetics
MDG Internal Medicine/Medical Genetics
MDM Medical Management
MDP Medical Physics
MEM Internal Medicine, Emergency Medicine
MFM Maternal and Fetal Medicine
MG Medical Genetics
MGG Genetics, Molecular Genetic Pathology
MGP Pathology, Molecular Genetic Pathology
MM Medical Microbiology
MN Internal Medicine/Neurology
MP Internal Med/Psychiatry
MPD Internal Medicine, Pediatrics
MPM Internal Med/Phys Med And Rehabilitation
MR Radiology, Musculoskeletal
N Neurology
NC Nuclear Cardiology
NDN Psychiatry & Neurology, Neurodevelopmental Disabilities
NDP Pediatrics Neurodevelopmental Disabilities
NEP Nephrology
NM Nuclear Medicine
NMN Neuromuscular Medicine
NMP Neuromuscular Medicine (Physical Medicine & Rehabilitation)
NNM Neurology/Nuclear Medicine
NO Otology/Neurotology
NP Pathology, Neuropathology
NPM Neonatal-Perinatal Medicine
NPR Neurology Physical Medicine and Rehab
NR Radiology, Nuclear
NRN Neurology, Diag Rad, Neuroradiology
NS Neurological Surgery
NSP Pediatric Neurological Surgery
NTR Nutrition
NUP Neuropsychiatry
OAN Obstetric Anesthesiology (Anesthesiology)
OAR Orthopedic, Adult Reconstructive
OBG Obstetrics and Gynecology
OBS Obstetrics
OCC Obstetrics/Gynecology, Critical Care Medicine
OFA Orthopedics, Foot and Ankle
OM Occupational Medicine
OMF Surgery, Oral & Maxillofacial
OMM Osteopathic Manipulative Medicine
OMO Orthopedic, Musculoskeletal Oncology
ON Oncology
OP Orthopedic, Pediatric
OPH Ophthalmology
OPR Ophthalmic Plastic & Reconstructive Surgery
ORS Orthopedic Surgery
OS Other Specialty
OSM Orthopedic Sports Medicine Surgery
OSS Orthopedic Spine Surgery
OTO Otolaryngology
OTR Orthopedic, Trauma
P Psychiatry
PA Pharmacology, Clinical
PAN Pediatric Anesthesiology
PCC Pulmonary Critical Care Medicine
PCH Pathology, Chemical
PCP Pathology, Cytopathology
PCS Pediatric Cardiothoracic Surgery
PD Pediatrics
PDA Pediatric Allergy

As of: 4/4/2017
<table>
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<tr>
<th>Name</th>
<th>City</th>
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<td>Jason L. Acevedo, MD</td>
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<tr>
<td>Manuel L. Acosta, MD</td>
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<td>Hector F. Acton, MD</td>
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<td>Tea Edward Acuff, Jr., MD</td>
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*As of: 4/4/2017*
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Evan G. Pivalizza, MD  Houston  AN  9th  Harris CMS  D, SSD
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Clausyl Plummer, MD  San Antonio  PM  5th  Bexar CMS  Ex
Todd Alan Pollock, MD  Dallas  PS  14th  Dallas CMS  D
Anne Marie Ponce De Leon, MD  Sugar Land  FM  9th  Harris CMS  A
Cindy Renea Porter, MD  Texarkana  PD  15th  Bowie CMS  VC
Edward Joseph Prejean, III, MD  Irving  AN  14th  Dallas CMS  D
Spencer A. Pruitt, MD  Pearland  CCP  9th  Harris CMS  A
Roger Michael Ragain, MD  Lubbock  FM  3rd  Lubbock-Crosby-Garza CMS  D
Pervaiz Rahman, MD  Dallas  GE  14th  Dallas CMS  D
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<td>Dawn Yan, MD</td>
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<td>Shiraz A. Yazdani, MD</td>
<td>Lubbock</td>
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<td>David Lawrence Young, MD</td>
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<td>Rodney B. Young, MD</td>
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<td>Syed Ather Yusoof, MD</td>
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<td>Sherif Z. Zaafran, MD</td>
<td>Houston</td>
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<td>Belalda Zamora, MD</td>
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<td>Gabriela M. Zandomeni, MD</td>
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<td>Thomas Michael Zellers, MD</td>
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</table>
2017 Delegates and Alternates by County Medical Society*
As of 4/4/2017

Angelina County Medical Society
Delegate: Kyle Gregory Krohn, MD
Delegate: William Dean Strinden, MD
Alternate: Jose Altagracia Capellan, MD
Alternate: Karl L. Krohn, MD

Bastrop-Lee County Medical Society
Delegate: Estela Mota, MD

Bell County Medical Society
Delegate: Laura Faye Gephart, MD, MBA
Delegate: Alan C. Howell, MD
Delegate: John Edward Pliska, MD
Delegate: Jocelyn M. Wilson, MD

Bexar County Medical Society
Delegate: Josie Ann Cigarroa, MD
Delegate: Chelsea I. Clinton, MD
Delegate: Arthur D. Cortez, MD
Delegate: Suresh Venkayya Dutta, MD
Delegate: John D. Edwards, MD
Delegate: Harold V. Gaskill, MD
Delegate: William W. Gordon, MD
Delegate: Gerald Q. Greenfield, Jr., MD, PA
Delegate: Michael Joseph Guirl, MD
Delegate: Wendy Bay Kang, MD, JD
Delegate: Margaret Ann Kelley, MD
Delegate: Jayesh B. Shah, MD
Delegate: David George Shulman, MD
Delegate: J. Marvin Smith, III, MD
Delegate: Marc T. Taylor, MD
Alternate: Thomas John Gowan, MD
Alternate: Juan Diego Martinez, MD
Alternate: Darlene F. Metter, MD
Alternate: Venkatasubramanian Srinivasan, MD

Big Country County Medical Society
Delegate: Robert Lee Dickey, Jr., MD
Delegate: Ralph F. Heaven, Jr., MD
Delegate: H. Miller Richert, MD
Alternate: Jason L. Acevedo, MD
Alternate: Charlotte M. Akor, MD
Alternate: Noel Keith Robinson, Jr., MD

Brazoria County Medical Society
Delegate: Raymond C. Jess, MD
Alternate: Jonathan P. Grady, MD

Central Texas County Medical Society
Delegate: Sammy Joe Horton, MD

Collin-Fannin County Medical Society
Delegate: Carrie E. De Moor, MD
Delegate: Neha V. Dhudshia, MD
Delegate: Marlene Diaz, MD
Delegate: Aimee Diaz, MD
Delegate: Richard Leon Grandjean, MD
Delegate: Bryan G. Johnson, MD
Delegate: Fareha Abid Kazi, MD
Delegate: Sherine E Boyd Reno, MD
Delegate: Marian D. Steininger, MD
Alternate: Brent B. Belvin, MD
Alternate: Robert W. Brobst, Jr., MD
Alternate: Peter Andrew Brokish, MD
Alternate: Kenny B. Carter, MD
Alternate: Jason R. Fletcher, DO
Alternate: Christopher Shane Hall, MD
Alternate: Mei Melvin Hu, MD
Alternate: Alan David Koenigsberg, MD
Alternate: Brent A. Spencer, MD
Alternate: Daniel Joseph Verret, MD

Colorado Basin County Medical Society
Delegate: James Ray Burleson, MD

Comal County Medical Society
Delegate: Randel Keith Jacks, MD
Delegate: Judith Lynn Thompson, MD
Alternate: Claire Marie Coco, MD

Concho Valley County Medical Society
Delegate: Bradly Bundrant, MD
Delegate: Kathleen A. Cubine, DO
Alternate: Hector F. Acton, MD

Dallas County Medical Society
Delegate: Drew Wilson Alexander, MD
Delegate: Christine Ann Becker, MD
Delegate: Justin M. Bishop, MD
Delegate: Gary Bloomgarden, MD

*Note: If the CMS is not listed, no delegates/alternates were reported
Delegates:

- Sue Scher Bornstein, MD
- Adam C. Carter, MD
- William Hampton Caudill, MD
- Vella Victoria Chancellor, MD
- Samuel J. Chantilis, MD
- Christopher Sung Jin Chun, MD
- Wendy M. Chung, MD, MSPH
- John Robert Corker, MD
- Emma L. Dishner, MD
- Walter Francis Evans, II, MD
- Juliana M. Fort, MD
- Raymond L. Fowler, MD
- Deborah Anne Fuller, MD
- Angela Fulgham Gardner, MD
- Sidney Kambo Gicheru, MD
- John Russell Gilmore, MD
- Victor Gonzalez, MD
- Robert D. Gross, MD
- Robert Ware Haley, MD
- Shelley Anne Hall, MD
- Madeline Weinstein Harford, MD
- Sarah Lynn Helfand, MD
- Eugene Pitts Hunt, III, MD
- Seth David Kaplan, MD
- Rainer Anil Khetan, MD
- Roger Sunil Khetan, MD
- Kevin Wayne Klein, MD
- C. Turner Lewis, III, MD
- Warren E. Lichliter, MD
- Nathan P. Long, MD
- Brad McGowan, MD
- David Wayne Mercier, MD
- David Scott Miller, MD
- Daniel B. Pearson, III, MD
- Todd Alan Pollock, MD
- Edward Joseph Prejean, III, MD
- Pervaiz Rahman, MD
- Assad Joe Saad, MD
- John Stuart Scott, DO
- Pranavi V. Sree ramoju, MD
- Divya Srivastava, MD
- Ronnie F. Stadler, MD
- Robert Eduard Suter, DO
- Laurie Jayne Sutor, MD
- Lisa Louise Swanson, MD
- Lisa Carole Taylor-Kennedy, MD
- John Morrow Truelson, MD
- Michael Ian Vengrow, MD
- Richard Lee Wallner, MD
- Jim Walton, DO, MBA
- Dawn Yan, MD
- Thomas Michael Zellers, MD
- Shashi K. Dharma, MD
- Baochan Nguyen, MD
- Perry Glenn Pate, MD
- Joe B. Ventimiglia, MD

**Denton County Medical Society**

- Tea Edward Acuff, Jr., MD
- Christopher Brian Cianci, DO
- Marilyn R. Janke, MD
- Udaya Bhaskar Padakandla, MD
- Joseph S. Valenti, MD
- Roshni Kandyil Foster, MD, PhD
- Barry R. Jacobs, MD
- Keith A. Lepak, MD
- Jason M. Marchetti, MD
- Charles Okechukwu Onyeama, MD
- Rachel M. Osborn, MD

**Ector County Medical Society**

- U. Prabhakar Rao, MD
- Nalin Harilal Tolia, MD
- Louise Harlal Tolia, MD
- Steven Robert Ellsworth, MD
- Jayaram B. Naidu, MD
- Jeffery Matthew Pinnow, MD
- Ritchie Rosso, Jr., MD

**El Paso County Medical Society**

- Manuel L. Acosta, MD
- Elaine Mowinski Barron, MD
- Juan Manuel Escobar, MD
- Gilberto A. Handal, MD
- Richard W. McCallum, MD
- David Mario Palafax, MD
- Roxanne Marie Tyroch, MD
- Luis Hernando Urrea, II, MD
- Syed Ather Yusuf, MD

*Note: If the CMS is not listed, no delegates/alternates were reported*
Ellis County Medical Society
Delegate: John M. Sullivan, MD
Alternate: Basem M. Jassin, MD
Alternate: Margaret Mary Sullivan, MD

Erath-Somervell-Comanche CMS
Delegate: Kam Woon Ip, MD

Fort Bend County Medical Society
Delegate: Art L. Klawitter, MD
Delegate: Amitha Rao, MD
Delegate: Sapna Singh, MD

Galveston County Medical Society
Delegate: Saleh Elsaid, MD
Delegate: Mary Josephine Godinich, MD
Delegate: Thomas Duke Kimbrough, MD
Delegate: Janusz A. Konikowski, MD
Delegate: C. Joan Richardson, MD
Alternate: Kristene K. Gugliuzza, MD
Alternate: David Christian Nickeison, MD
Alternate: Jeffrey S. Richards, MD
Alternate: Suchmor Thomas, MD
Alternate: Barbara L. Thompson, MD
Alternate: Edward Wheeler, MD

Grayson County Medical Society
Delegate: C. Hunter Richmond, MD
Delegate: Peter A. Selz, MD

Gregg-Upshur County Medical Society
Alternate: Louis John Kirk, III, MD

Guadalupe County Medical Society
Delegate: Yu-Jie John Kuo, MD
Alternate: Richard Edwin Fleming, MD

Hale-Floyd-Briscoe CMS
Delegate: Douglas E. Kopp, MD
Alternate: Michael Thurston Graves, MD
Alternate: Kevin Christopher Jones, DO

Harris County Medical Society
Delegate: Jessica A. Alexander, MD
Delegate: Raymond T. Alexander, MD
Delegate: Paul M. Allison, MD
Delegate: David M. Anmuth, MD
Delegate: Robert L. Arkus, MD
Delegate: Syed K. Azeemuddin, MD
Delegate: Martin Basaldua, MD
Delegate: Janette K. Bateman, MD
Delegate: Mary-Es A. Beaver, MD
Delegate: H. S. Bedi, MD
Delegate: Jimmie L. Bergeron, MD
Delegate: Lindsay K. Botsford, MD
Delegate: Richard N. Bradley, MD
Delegate: Brian M. Bruel, MD
Delegate: Sudipta K. Chaudhuri, DO
Delegate: Aeneid L. J. Chen, MD
Delegate: Charles E. Cowles, Jr., MD
Delegate: Richard W. Demmler, MD
Delegate: Kyle F. Dickson, MD, MBA
Delegate: Rakhi C. Dimino, MD
Delegate: Swapan Dubey, MD
Delegate: Betty Jo Edwards, MD
Delegate: Lisa L. Ehrlich, MD
Delegate: Angelina Farella, MD
Delegate: Lewis E. Foxhall, MD
Delegate: Eta Funk, MD
Delegate: Marina C. George, MD
Delegate: Bernard M. Gerber, MD
Delegate: Alan P. Glombicki, MD
Delegate: James S. Guo, MD
Delegate: Steven E. Haber, MD
Delegate: Alison J. Haddock, MD
Delegate: Monira Hamid-Kundi, MD
Delegate: Ori Z. Hampel, MD
Delegate: Shannon B. Hancher-Hodges, MD
Delegate: R. Andrew Harper, III, MD
Delegate: Lindsey D. Harris, MD
Delegate: Harris M. Hauser, MD
Delegate: Hattie E. Henderson, MD, CMD
Delegate: Matthew D. Hoggatt, MD
Delegate: Pamela D. Holder, MD
Delegate: Terah C. Isaacson, MD
Delegate: Robert W. Jackson, MD
Delegate: Nora A. Janjan, MD, MPSA, MBA
Delegate: Richard H. Johnigan, MD
Delegate: Luckett Johnson, MD
Delegate: Felicia L. Jordan, MD
Delegate: Yvonne Kew, MD, PhD
Delegate: Faraz A. Khan, MD
Delegate: Karl W. King, MD
Delegate: Christine E. Koerner, MD
Delegate: Arthur Lim, MD
Delegate: Felicity L. Mack, MD
Delegate: Aurelio Matamoros, Jr., MD

*Note: If the CMS is not listed, no delegates/alternates were reported
<table>
<thead>
<tr>
<th>Delegate</th>
<th>Alternate</th>
</tr>
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<tbody>
<tr>
<td>Paul Martin Mauk, MD</td>
<td>Audrey E. Ahuero, MD</td>
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<tr>
<td>Almas A. Mecklai, MD</td>
<td>Ronda E. Alexander, MD</td>
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<tr>
<td>Jaideep H. Mehta, MD</td>
<td>Asif Ali, MD</td>
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<tr>
<td>Kimberly E. Monday, MD</td>
<td>Asra Ali, MD</td>
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<tr>
<td>Walter P. Moore, III, MD</td>
<td>John D. Allison, Jr., MD</td>
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<tr>
<td>Robert B. Morrow, MD, MBA</td>
<td>Anna M. Allred, MD</td>
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<tr>
<td>Lonzetta L. Newman, MD</td>
<td>Jacinta O. Anyaoku, MD</td>
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<td>Mark L. Nichols, MD</td>
<td>Kulvinder S. Bajwa, MD</td>
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<td>Richard L. Noel, MD</td>
<td>Lucy A. Buencamino, MD</td>
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<td>Stacy L. Norrell, MD</td>
<td>Luis H. Camacho, MD</td>
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<td>Carla F. Ortique, MD</td>
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<td>Debra M. Osterman, MD</td>
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<td>Bradford S. Patt, MD</td>
<td>Anh Q. Dang, MD</td>
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<td>Eddie L. Patton, Jr., MD</td>
<td>Lilette E. Daumas-Britsch, MD</td>
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<td>Steven M. Petak, MD</td>
<td>Serge De Golovine, MD</td>
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<td>Evan G. Pivalizza, MD</td>
<td>Salil V. Deshpande, MD, MBA</td>
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<td>Elizabeth M. Rebello, MD</td>
<td>Harry L. Faust, Jr., DO</td>
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<td>Carlos E. Romero, MD</td>
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<td>Susan N. Rossmann, MD</td>
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<td>George D. Santos, MD</td>
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<td>Raul Sepulveda, MD</td>
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<td>Umair A. Shah, MD</td>
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<td>Gary J. Sheppard, MD</td>
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<td>Angela Siler-Fisher, MD</td>
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<td>Mina K. Sinacori, MD</td>
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<td>Laura P. Jimenez-Quintero, MD</td>
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<td>Charles E. Soderstrom, MD</td>
<td>Jahangir Jimenez-Quintero, MD</td>
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<td>Charlotte M. Selly-Setz, MD</td>
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<td>Irvin Sulapas, MD</td>
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<td>Sarah L. Svoboda, MD</td>
<td>Suzanne M. Manzi, MD</td>
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<td>Arthur L. Taitel, MD</td>
<td>Anna L. C. Mapp, MD</td>
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<td>Rosa A. Tang, MD</td>
<td>Henry A. Mata, MD</td>
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<td>Robert C. Vanzant, MD</td>
<td>Samuel E. Mathis, MD</td>
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<td>Carlos J. Vital, MD</td>
<td>Santhosshi Narayanan, MD</td>
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<td>Faranak Vossoughi, MD</td>
<td>Vincent G. Nelson, MD</td>
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<td>Ronald S. Walters, MD</td>
<td>Kehinde O. Ogumnakin, MD</td>
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<td>Stephen E. Whitney, MD</td>
<td>Thomas J. Oliverson, MD</td>
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<td>George W. Williams, II, MD</td>
<td>Hina T. Pandya, MD</td>
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<td>Kevin Scott Winfield, MD, MBA</td>
<td>Thomas J. Parr, MD</td>
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<td>Sherif Z. Zaalfran, MD</td>
<td>Anne Marie Ponce De Leon, MD</td>
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<tr>
<td>Rehan Ahmed, MD</td>
<td>Spencer A. Pruitt, MD</td>
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</table>

*Note: If the CMS is not listed, no delegates/alternates were reported*
Cont’d
Alternate: Gurunath T. Reddy, MD
Alternate: Michael S. Rodriguez, MD
Alternate: Manish Rungta, MD
Alternate: Amber D. Shamburger, MD
Alternate: Michael J. Snyder, MD
Alternate: Carl D. Tapia, MD
Alternate: Dexter G. Turnquest, MD
Alternate: John R. Vanderzyl, MD
Alternate: Sandra J. Williams, DO
Alternate: Barbara J. Wilson, MD
Alternate: Crystal C. Wright, MD

Harrison County Medical Society
Delegate: Valarie Lee Allman, MD
Alternate: Robert W. Palmer, Sr., MD

Henderson County Medical Society
Delegate: Tina P. Elkins, MD
Alternate: William Alex Elfarr, MD

Hidalgo-Starr County Medical Society
Delegate: Rudy Alvarez, MD
Delegate: Sarojini G. Bose, MD
Delegate: Sandra Esquivel, MD
Delegate: Martin Garza, MD
Delegate: Mark Stewart Gonzalez, MD
Delegate: Chevy Chu Lee, MD
Delegate: Javier D. Margo, Jr., MD
Alternate: Lenore C. DePagter, DO, MBA
Alternate: Antonio Falcon, MD
Alternate: Victor Hugo Gonzalez, MD

Hill Country County Medical Society
Delegate: Matthew Emanuel Stotz, MD

Hunt-Rockwall-Rains CMS
Delegate: Howard Evan Kweller, MD
Alternate: Dee Gordon McCravy, Jr., MD

Jasper-Newton County Medical Society
Delegate: Larry Donniel Brown, MD

Jefferson County Medical Society
Delegate: Benjamin Wallace Beckert, MD
Delegate: Garrett K. Peel, MD, MPH
Delegate: David Dean Teuscher, MD
Alternate: John Kerry Badlissi, MD
Alternate: Robert Barry Berndt, MD
Alternate: Jurswin Coffy Pieternelle, MD
Alternate: Wagdy S. Rizk, MD
Alternate: Jeremy C. Roebuck, MD
Alternate: Ahmed N. Shobassy, MD

Kaufman County Medical Society
Delegate: Nuggehalli Neil Satyu, MD
Alternate: Rameshchandra P. Vasani, MD

Lubbock-Crosby-Garza CMS
Delegate: Joehassin Cordero, MD
Delegate: Darnel Viray Dabu, MD
Delegate: John C. DeToledo, MD
Delegate: Sandra Dee Dickerson, MD
Delegate: Jack E. DuBose, MD
Delegate: Kalarickal J. Oommen, MD
Delegate: Roger Michael Ragain, MD
Delegate: Eldon Stevens Robinson, MD
Delegate: Michelle Babb Tarbox, MD
Delegate: Davor Vugrin, MD
Alternate: Zachary E. Ballenger, MD
Alternate: Thomas A. Bowman, MD
Alternate: Naga S. Bushan, MD
Alternate: Ronald Lynn Cook, DO
Alternate: Darnel Viray Dabu, MD
Alternate: John C. DeToledo, MD
Alternate: Juan Francisco Fitz, MD
Alternate: Lloyd Marshall Garland, MD
Alternate: Allan Louis Haynes, Jr., MD
Alternate: Sameer Islam, MD
Alternate: Cynthia Ann Jumper, MD
Alternate: Patti Nelson May, MD
Alternate: Ambir R. Mirza, MD
Alternate: Sergiy Nesterenko, MD
Alternate: Mario Pena, Jr., MD
Alternate: Marsha R. Perales-Hull, MD
Alternate: Janice Ann Stachowiak, MD
Alternate: James A. Tarbox, MD
Alternate: Shiraz A. Yazdani, MD

McLennan County Medical Society
Delegate: John Joseph Bawduniak, III, MD
Delegate: Sean D. DeLue, MD
Delegate: Bradford W. Holland, MD
Delegate: Marvin C. Schlecte, III, MD
Delegate: Russell Scott Warren, MD
Alternate: Roland Adolph Goertz, MD, MBA
Alternate: Karen Cervenka Kemper, MD
Alternate: William T. McCunniff, MD
Alternate: Nicholas P. Steinour, MD
Alternate: Charles Herbert Stern, MD

*Note: If the CMS is not listed, no delegates/alternates were reported
Cont’d
Alternate: Robert E. Wolf, MD

Midland County Medical Society
Delegate: James William Huston, MD
Delegate: Robert Allen Vogel, MD

Montague-Wise CMS
Delegate: Brad D. Fagle, MD
Alternate: Shawn L. White, MD

Nueces County Medical Society
Delegate: Jack Locardi Cortese, MD
Delegate: Rafael Francisco Coutin, MD
Delegate: Albert Lee Gest, DO
Delegate: Jerry Dean Hunsaker, MD
Delegate: John Duncan McKeever, MD
Delegate: Mary Dahlen Peterson, MD
Delegate: Jane Oliver Stafford, MD
Delegate: Wesley Warren Stafford, MD
Alternate: Vijay K. Bindingnavele, MD
Alternate: George H. Fisher, Jr., MD
Alternate: Dorothy E. Fuentes, MD
Alternate: Meera Gangadharan, MD
Alternate: Justin Paul Hensley, MD
Alternate: Shah Faizul Islam, MD
Alternate: Jacob J. Moore, MD
Alternate: Daniel V. Vijjeswarapu, MD

Parker County Medical Society
Delegate: Mark Carroll Eidson, MD
Alternate: Sanjeeb Shrestha, MD

Potter-Randall County Medical Society
Delegate: Robert Evans Gerald, MD
Delegate: Rouzbeh Khosrovi Kordestani, MD
Delegate: Robin Elaine Martinez, MD
Delegate: Ryan Bradford Rush, MD
Delegate: Rodney B. Young, MD
Alternate: David Brabham, DO
Alternate: Daniel J. Hendrick, MD
Alternate: William Murray Holland, IV, DO
Alternate: Tarek H. Naguib, MD
Alternate: Gerard A. Troutman, MD

Rusk County Medical Society
Delegate: Brenda Marie Vozza-Zeid, MD
Alternate: Kimberly Nicole Page, MD

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

Smith County Medical Society
Delegate: Gina Mapes Jetter, MD
Delegate: James P. Michaels, MD
Delegate: Li-Yu H. Mitchell, MD
Delegate: Andrew B. Thyen, MD
Delegate: David Lawrence Young, MD
Alternate: Lisa E. Allen, DO
Alternate: Sheldon Ygnacio Freeberg, MD
Alternate: Thomas J. Lambert, Jr., MD
Alternate: Joseph T. Martins, MD
Alternate: Evans S. Smith, MD

Tarrant County Medical Society
Delegate: Susan K. Blue, MD
Delegate: Theresa V. Crouch, MD
Delegate: Donald L. Dolce, Jr., MD
Delegate: Michael G. Enger, MD
Delegate: Lydia R. Essay, MD
Delegate: Josephine Rebecca Fowler, MD
Delegate: Kim E. Higgins, DO
Delegate: Cheryl Lynn Hurd, MD
Delegate: Woody V. Kageler, MD
Delegate: R. Larry Marshall, MD
Delegate: Luis H. Martinez, MD
Delegate: George Sealy Massingill, MD
Delegate: Shirley A. Molenich, MD
Delegate: Gregory J. Phillips, MD
Delegate: Stuart C. Pickell, MD, FACP
Delegate: Ann E. Ranelle, DO
Delegate: Robert J. Rogers, MD
Delegate: Angela D. Self, MD
Delegate: Linda M. Siy, MD
Delegate: Joe M. Todd, MD
Delegate: David F. Turbeville, MD
Delegate: E. Thomas Wightman, Jr., MD
Delegate: Dan A. Willis, MD
Delegate: James R. Winn, MD
Alternate: Ralph F. Baine, MD
Alternate: Joane G. Baumer, MD
Alternate: Shanna J. Brown, MD
Alternate: Brett L. Cochrum, MD
Alternate: Shanna Marie Combs, MD
Alternate: James S. Cox, MD
Alternate: Miguel De Valdenebro, MD
Alternate: Christopher S. Ewin, MD

*Note: If the CMS is not listed, no delegates/alternates were reported
Cont’d
Alternate: Neal J. Richmond, MD
Alternate: Mark M. Shelton, MD
Alternate: Ajay Sobti, MD
Alternate: Veer D. Vithalani, MD
Alternate: Michael E. Wimmer, MD

Travis County Medical Society
Delegate: Tony R. Aventa, MD
Delegate: Kimberly C. Avila Edwards, MD
Delegate: Ira Bell, III, MD
Delegate: Michelle A. Berger, MD
Delegate: Maya B. Bledsoe, MD
Delegate: Dawn C. Buckingham, MD
Delegate: Edward D. Buckingham, MD
Delegate: James R. Eskew, MD
Delegate: Nancy Thorne Foster, MD
Delegate: Osvaldo S. Gigliotti, MD
Delegate: Albert T. Gros, MD
Delegate: Juan M. Guerrero, MD
Delegate: Katharina Hathaway, MD
Delegate: James M. Hicks, MD
Delegate: Felix Hull, MD
Delegate: Jeffrey M. Jekot, MD
Delegate: Jeffrey B. Kahn, MD
Delegate: Thomas J. Kim, MD, MPH
Delegate: Gregory M. Kronberg, MD
Delegate: Pradeep Kumar, MD
Delegate: Daniel J. Leeman, MD
Delegate: Hillary Miller, MD
Delegate: Celia B. Neavel, MD
Delegate: Jack W. Pierce, MD
Delegate: Stephanie D. Roth, MD
Delegate: Dora L. Salazar, MD
Delegate: Ghassan F. Salman, MD, MPH
Delegate: Todd R. Shepler, MD
Delegate: Sarah I. Smiley, DO
Delegate: Emilio M. Torres, MD
Delegate: Xuan Kim Tran, MD
Delegate: Zoltan Trizna, MD, PhD
Delegate: John F. Villacis, MD
Delegate: Stanley S. Wang, MD, JD, MPH
Delegate: Belda Zamora, MD
Delegate: Guadalupe Zamora, MD
Alternate: Esther J. Cheung-Phillips, MD
Alternate: Elizabeth L. Chmelik, MD
Alternate: Scott W. Clitheroe, MD
Alternate: J. Lauren Crawford, MD
Alternate: Antonia M. Davidson, MD
Alternate: Dayna G. Diven, MD
Alternate: Steven C. Diven, MD
Alternate: Robert Harold Emmick, Jr., MD
Alternate: Colby C. Evans, MD
Alternate: Vimal T. George, MD
Alternate: Grace L. Honles, MD
Alternate: Anand Joshi, MD
Alternate: Gurneet Singh Kohli, MD
Alternate: Craig Allen Kuhns, MD
Alternate: Sushmitha Kurapati, MD
Alternate: Anna M. Lozano, MD
Alternate: Jonathan E. MacClements, MD
Alternate: Marcella A. Madera, MD
Alternate: Graves T. Owen, MD
Alternate: Michelle C.M. Owens, DO
Alternate: Dennis Samuel Pacl, MD
Alternate: Anees A. Siddiqui, MD
Alternate: Lynn N. Stewart, MD
Alternate: Erica W. Swegler, MD
Alternate: Brian W. Temple, MD
Alternate: David N. Tobey, Jr., MD
Alternate: Vani S. Vallabhaneni, MD
Alternate: Stephanie M. Vertrees, MD
Alternate: Christopher D. Vije, MD
Alternate: Jay R. Zdunek, DO
Alternate: Mateo Ziu, MD

Tri-County CMS
Delegate: Mark B. Randolph, MD
Delegate: Alberto Santos, DO
Delegate: Cameron H. Gates, DO
Delegate: John E. Lee Sang, MD
Delegate: Michelle C. B. Rodriguez, MD

Victoria-Goliad-Jackson CMS
Delegate: Fred R. Martin, MD
Alternate: John E. Barber, MD
Alternate: George Amechi Osuchukwu, MD

*Note: If the CMS is not listed, no delegates/alternates were reported
Wichita-Archer-Baylor-Clay-Knox CMS
  Delegate:  T. David Greer, MD
  Delegate:  Bruce Lee Palmer, MD
  Delegate:  Jonathan Wayne Williams, MD
  Alternate: Jedidiah James Grisel, MD
  Alternate:  David Sheng Huang, MD
  Alternate:  Evan C. Meyer, MD
  Alternate:  Susan M. Strate, MD

Williamson County Medical Society
  Delegate:  Kambiz Jahadi, MD
  Delegate:  Matthew David Lynx, MD
  Delegate:  Theodore J. Spinks, MD
  Alternate:  Susan M. Pike, MD

Young County Medical Society
  Delegate:  Donald A. Behr, MD
  Alternate:  Hal Davis Huffman, MD

*Note: If the CMS is not listed, no delegates/alternates were reported
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<td>Jason L. Acevedo, MD</td>
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<td>Edward J. Fox, MD, PhD</td>
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<td>A. Tomas Garcia, III, MD</td>
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<td>Pradeep Kumar, MD</td>
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<td>David L. Lakey, MD</td>
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<td>Sandeep G. Mistry, MD</td>
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<td>Richard L. Noel, MD</td>
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<td>Arlo F. Weltge, MD, MPH</td>
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<td>Gabriela M. Zandomeni, MD</td>
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ELECTIONS
May 2017

General officers listed serve one-year terms except secretary/treasurer and 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 Ada Drozd, executive coordinator, Office of the EVP, at ada.drozd@texmed.org or (800) 880-1300, ext. 1540.

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 21</th>
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</table>
| President-Elect               | Carlos J. Cárdenas| No                    | 2017-18          | Douglas W. Curran
|                               |                    |                       |                  | Henderson
|                               |                    |                       |                  | Clifford K. Moy
|                               |                    |                       |                  | Dallas
| Secretary/Treasurer           | Michelle A. Berger| Yes                   | 2017-20          | Michelle A. Berger
|                               |                    |                       |                  | Travis
| Speaker, House of Delegates   | Susan M. Strate    | Yes                   | 2017-18          | Susan M. Strate
|                               |                    |                       |                  | Wichita
| Vice Speaker, House of Delegates | Arlo F. Weltge | Yes                   | 2017-18          | Arlo F. Weltge
|                               |                    |                       |                  | Harris
| Three Trustees*               | Gary W. Floyd      | Yes                   | 2017-20          | Sue S. Bornstein
|                               | E. Linda Villarreal| Yes                   |                  | Dallas
|                               | Dan K. McCoy**     | Yes                   |                  | G. Ray Callas
|                               |                    |                       |                  | Jefferson
|                               |                    |                       |                  | Gary W. Floyd
|                               |                    |                       |                  | Tarrant
|                               |                    |                       |                  | John R. Holcomb
|                               |                    |                       |                  | Bexar
|                               |                    |                       |                  | E. Linda Villarreal
|                               |                    |                       |                  | Hidalgo-Starr

*Trustee positions are “at large,” not slotted. TMA Bylaws provide that all nominees for trustee will be listed on a single ballot. Should Dr. Curran be elected president-elect, there will be a vacancy for trustee.

**Dr. McCoy will not be seeking re-election to the Board of Trustees
COUNCILOR AND VICE COUNCILOR ELECTIONS  
May 2017

COUNCILORS

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<tr>
<th>District</th>
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<th>Eligible For Election</th>
<th>Term of Position</th>
<th>Candidates Announced as of March 24</th>
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<tr>
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<td>James Eskew</td>
<td>Yes</td>
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<td>James Eskew</td>
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<tr>
<td>District 8</td>
<td>Kevin McKinney</td>
<td>Yes</td>
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<td>Kevin McKinney</td>
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<td>District 9</td>
<td>Michael A. Altman</td>
<td>Yes</td>
<td>2017-20</td>
<td>Michael A. Altman</td>
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<tr>
<td>District 10</td>
<td>David Bailey</td>
<td>No</td>
<td>2017-20</td>
<td>Kyle G. Krohn</td>
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<tr>
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<td>Jed Grisel</td>
<td>Yes</td>
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<tr>
<td>District 14</td>
<td>Edward W. Tuthill</td>
<td>Yes</td>
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VICE COUNCILORS*

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<th>Term of Position</th>
<th>Candidates Announced as of March 24</th>
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<td>Steven M. Petak</td>
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<td>2017-20</td>
<td>Steven M. Petak</td>
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<td>Kyle G. Krohn</td>
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<tr>
<td>District 14</td>
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<td>—</td>
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</tbody>
</table>

District elections are held for vice councilors and names are forwarded to the House of Delegates for confirmation. Terms are three years. 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 (800) 880-1300, ext. 1340, immediately.
### AMA DELEGATION ELECTIONS

**May 2017**

#### 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 March 24</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Clifford K. Moy</td>
<td>No</td>
<td>2018-19</td>
<td>Jayesh Shah</td>
</tr>
<tr>
<td>3</td>
<td>David N. Henkes</td>
<td>Yes</td>
<td>2018-19</td>
<td>David N. Henkes</td>
</tr>
<tr>
<td>4</td>
<td>Gary W. Floyd</td>
<td>Yes</td>
<td>2018-19</td>
<td>Gary W. Floyd</td>
</tr>
<tr>
<td>5</td>
<td>Lyle S. Thorstenson</td>
<td>Yes</td>
<td>2018-19</td>
<td>Lyle S. Thorstenson</td>
</tr>
<tr>
<td>6</td>
<td>Diana L. Fite</td>
<td>Yes</td>
<td>2018-19</td>
<td>Diana L. Fite</td>
</tr>
<tr>
<td>7</td>
<td>John T. Gill</td>
<td>Yes</td>
<td>2018-19</td>
<td>John T. Gill</td>
</tr>
</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 April 17</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Vacancy</td>
<td>Yes</td>
<td>2018-19</td>
<td>Robert Emmick</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Laura Faye Gephart</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Steven R. Hays</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Richard McCallum</td>
</tr>
<tr>
<td>2</td>
<td>Vacancy</td>
<td>Yes</td>
<td>2018-19</td>
<td>Jennifer Rushton</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Sherif Z. Zaafran</td>
</tr>
<tr>
<td>3</td>
<td>Vacancy</td>
<td>Yes</td>
<td>2018-19</td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Vacancy</td>
<td>Yes</td>
<td>2018-19</td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>John G. Flores</td>
<td>Yes</td>
<td>2018-19</td>
<td>John G. Flores</td>
</tr>
<tr>
<td>6</td>
<td>John T. Carlo</td>
<td>Yes</td>
<td>2018-19</td>
<td>John T. Carlo</td>
</tr>
<tr>
<td>7</td>
<td>Clausyl Plummer II*</td>
<td>No</td>
<td>May 6, 2017-May 19, 2018</td>
<td>Habeeb Salameh</td>
</tr>
<tr>
<td>8</td>
<td>Jennifer Nordhauser*</td>
<td>No</td>
<td>May 6, 2017-May 19, 2018</td>
<td>Jessie Ho</td>
</tr>
</tbody>
</table>

Delegates and alternate delegates serve two-year terms, Jan. 1, 2017-Dec. 31, 2018; except that the terms for alternate delegates Places 11 and 12, which are designated for a resident and a medical student, are May 6, 2017-May 19, 2018.

*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

One for-profit corporation for which the TMA Board of Trustees serves as the **Board of Trustees**.

- **TMA MEMBER SERVICES, INC.**

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

- **THE PHYSICIANS BENEVOLENT FUND**

One unincorporated nonprofit association for which members of the TMA Board of Trustees are denominated as **Trustees**.

- **PHYSICIAN HEALTH AND REHABILITATION ASSISTANCE 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 IRRREVOCABLE TRUST**
President-Elect
(Vote for one)

Douglas W. Curran, MD

The Lone Star Caucus and the Henderson County Medical Society are pleased to nominate Douglas W. Curran, MD, for president-elect of the Texas Medical Association. Dr. Curran is a practicing family physician with East Texas Medical Center and Lakeland Medical Associates in Athens, Texas. During his 37 years in medicine, he has become a recognized advocate for the patients and physicians of Texas. His commitment to medicine is evidenced most recently by the Texas Rural Health Association’s selection of Dr. Curran as the recipient of the 2016 Rural Health Champion Award.

He played a leading role in the passage of Texas’ groundbreaking medical liability reforms, fought for sweeping patients’ rights reforms, including holding managed-care companies accountable for their actions, championed legislation to improve the Children’s Health Insurance Program and Medicaid, and fought attempts by non-physician practitioners to expand their scope of practice.

Throughout his career, Dr. Curran has been active in the Texas Medical Association, Texas Academy of Family Physicians (TAFP), and American Academy of Family Physicians (AAFP), serving on numerous committees and in various leadership roles. He currently serves as chair of the TMA Board of Trustees. He is a member of TMA’s Select Committee on Medicaid, CHIP, and the Uninsured; and he chaired TMA’s Select Committee on National Health System Reform. Dr. Curran has served as a delegate from Henderson County Medical Society to the TMA House of Delegates for more than 19 years.

Dr. Curran currently serves on the board of directors of TAFP. He is a past president of TAFP; has served as chair of the TAFP Commission on Membership and Member Services and of the TAFP Commission on Legislative and Public Affairs; and is an active member of TAFPPAC. For AAFP, Dr. Curran served on the prestigious Commission for Governmental Advocacy.

As a caring physician and community leader, Dr. Curran is committed to improving access to quality health care for all Texans. He was instrumental in the creation of a rural health clinic and an obstetrical care clinic for patients with no means of payment, and through his participation in the Statewide Preceptorship Program, he has helped foster the interest of the next generation of Texas physicians. Dr. Curran is joined in his endeavors by his wife of 46 years, Sandy Curran; their daughter, Cortney; and their son, Chris, and his wife, Britne. Dr. Curran enjoys serving his church, tending his cattle, sharing in hospitality with friends and neighbors, and shaking a leg every now and then to a good Texas swing band.
**Personal Statement:** “For 37 years, I’ve been blessed to be doing exactly what I’m convinced I was meant for: I’ve cared for the people of my community. I’ve stood beside my colleagues in support of medicine with the conviction that if we fight for our patients’ best interests, we will succeed in crafting good policy for Texas. Today, we face crises of cost and access at the local, state, and national levels that threaten to shake the very foundation of our association. We must unite as never before, and with wisdom and courage, stand strong for the protection of our patients and the sanctity of our profession. I am prepared to be that voice that advocates, that leader for TMA.”

**PROFILE**
Specialty: Family Medicine
Medical School (with year graduated): University of Arkansas for Medical Sciences, 1976
Residency Program: Southwestern Medical School Family Medicine Residency Program at John Peter Smith Hospital
Board Certification(s): American Board of Family Medicine
Primary Residence: Athens, Texas
Practice Type/Employment Status: Direct patient care – solo, small group, or shared overhead
Primary Practice/Employment Location: East Texas Medical Center, Athens, Texas
Do you expect to maintain your current employment status and location through your term in office? Yes
Does your current employment situation require you to work outside of Texas? No
Including the past five years, list all other organizations from which you have received payment, reimbursement, or financial consideration for consulting, advisory, or leadership responsibilities exceeding $1,000 per year in excess of actual expenses: Physician Advisory Board for Blue Cross and Blue Shield of Texas
Have you been convicted of a felony or is your medical license restricted? Please explain. No
What TMA positions have you held?
  - **Current**
    - Chair, TMA Board of Trustees
    - Member, TMA Board of Trustees
  - **Past**
    - Member, Council on Legislation
    - Member, TEXPAC Executive Committee
    - Member, Primary Care Coalition
    - Member, Select Committee on Medicaid, CHIP, and the Uninsured
    - Chair, Select Committee on Health System Reform
    - Member, Task Force on Health System Reform
    - Member, Council on Member Services
    - Member, Committee on Professional Liability

**DISCLOSURE OF AFFILIATIONS**
- American Academy of Family Physicians
- Texas Academy of Family Physicians
- Blue Cross/Blue Shield
- Lakeland Medical Associates
- Texas Medical Association PracticeEdge, LLC
- VaxCARE
President-Elect
(Vote for one)

Clifford K. Moy, MD

The Dallas delegation to the Texas Medical Association is pleased to nominate Clifford K. Moy, MD, for the office of president-elect of the Texas Medical Association.

Dr. Moy is a dedicated and proven leader. He has a long and distinguished history of service to the physicians of Texas and to the Texas Medical Association. Dr. Moy has been a leader in organized medicine since he attended medical school in the 1980s. After serving on Harris County Medical Society’s Medical Student Committee, he chaired TMA’s Medical Student Section and its Resident and Fellow Section. He served in numerous appointed and elected roles in Harris and Travis counties, having lived in both areas of the state during his career, later returning to the Dallas area.

Dr. Moy has served on TMA and American Medical Association councils and committees, and as a member of both organizations’ House of Delegates. He has served on the TMA Delegation to the AMA since 1998, the TMA Committee on Physician Distribution and Health Care Access, the TMA Council on Medical Education, and as chair of a TMA reference committee. He’s worked on numerous county society committees across the state, including current service on the DCMS Communications Committee. Dr. Moy has served as teller in the AMA House and as a member of the AMA Rules and Credentials Committee. He has completed the Glazer Advanced Workshop for Presiding Officers.

Dr. Moy is a trusted leader. This trust has earned him the respect of his peers. He was elected and served as vice speaker and speaker of House of Delegates for seven years. With great effectiveness, humor, and integrity, he guided the House, all while serving on the TMA Board of Trustees. In response to the TMA policy that allows a maximum of 10 years of service on the TMA board, he voluntarily stepped down from the role of speaker to preserve the required three years of service as president-elect to past-president.

**Personal Statement:** “As president-elect, I will enthusiastically communicate our powerful message of ‘Improving the Health of All Texans,’ and advocate our policies to promote the effective and satisfying practice of medicine for our 50,000 members. From my earliest days as a medical student to the present, I have dedicated myself to being a positive voice for medicine to Texas patients, physicians, and medical students. During my term as speaker/vice speaker for seven years, I gave voice to the House of Delegates within the TMA. My breadth and length of experience in our professional organizations, heightened by listening to and engaging physicians, have prepared me for the pressing challenges in medical practice.”
PROFILE
Specialty: Psychiatry
Medical School (with year graduated): John P. and Kathrine G. McGovern Medical School, 1985
Residency Program: UT Southwestern Parkland Memorial Hospital
Board Certifications: General Psychiatry
Primary Residence: Frisco, Texas
Practice Type/Employment Status: Administrative: government, health plan, or health-related, but no
direct patient care
Primary Employer/Employment Location: TMF Health Quality Institute, Austin, Texas
Do you expect to maintain your current employment status and location through your term in office? Yes
Does your current employment situation(s) require you to work outside of Texas? No
Including the past five years, list all other organizations from which you have received payment,
reimbursement or financial consideration for consulting, advisory or leadership responsibilities
exceeding $1,000 per year in excess of actual expenses: Texas A&M Rural Community Health
Institute (consulting)
Have you been convicted of a felony or is your medical license restricted? No
What TMA positions have you held?
  • Speaker House of Delegates, 2012–2015
  • Vice-Speaker House of Delegates, 2008–2012
  • Texas Delegation to the American Medical Association, Delegate, 2004–present
  • Texas Delegation to the American Medical Association, Alternate Delegate, 1998–2003
  • Committee on Physician Distribution and Health Careers, 1994–2003
  • Medical Student Section, chair, 1984–1985
DISCLOSURE OF AFFILIATIONS
  • Member and past chair, AMA Council on Long-Range Planning and Development
  • Immediate past president, McGovern Medical School Alumni Association
  • Member, Communications Committee, Dallas County Medical Society
On behalf of the Travis County Medical Society, we are proud and honored to nominate Michelle Berger, MD, for re-election to the office of secretary/treasurer of the Texas Medical Association.

Prior to her election to the TMA office, she served the Travis County Medical Society (TCMS) in numerous leadership roles, most notably as its president in 2013 and secretary/treasurer from 2010-2011. With 15 years’ past service on the TCMS Executive Board and as a current trustee of We Are Blood, a TCMS affiliate, Dr. Berger has been actively involved in the financial oversight of annual operating budgets of over $33 million. She was chair of the TCMS Delegation to the TMA from 2009-2013 and is currently vice chair of the delegation.

Dr. Berger was president of the Texas Ophthalmological Association (TOA) in 2009. She was a TOA councilor and delegate to the Interspeciality Society Committee (ISC) of TMA and chaired the ISC from 2006 to 2008. She was also a member of the Council on Socioeconomics from 2012-2014. Currently, Dr. Berger is a TMA delegate to the American Medical Association. She is also on the Executive Board of the Phi Beta Kappa Alumni Association of Greater Austin.

Please join us in supporting Dr. Michelle Berger for re-election to the office of Secretary/Treasurer of the Texas Medical Association.

**Personal Statement:** “I have been working with the excellent financial staff of our TMA to formalize procedures of the Compensation Committee and to create financial orientation materials for the Board of Trustees. I ask for your vote to be able to complete these tasks and to help keep TMA in the strong fiscal position we have built over the past years.”
PROFILE
Specialty: Ophthalmology
Medical School (with year graduated): Medical College of Wisconsin, 1977-1981
Residency Program: Scott and White Hospital, 1981-85
Board Certification(s): American Board of Ophthalmology, 1985
Primary Residence: Austin, Texas
Practice Type/Employment Status: Direct patient care – solo, small group, or shared overhead
Primary Practice/Employment Location: Self-solo practice, Austin, Texas
Do you expect to maintain your current employment status and location through your term in office? Yes
Does your current employment situation(s) require you to work outside of Texas? 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?
- Board of Trustees, Secretary/Treasurer, 2014-present
- Texas Delegation to the AMA, alternate delegate, 2009-16
- Texas Delegation to the AMA, delegate, 2017-present
- Council on Socioeconomics, 2012-14
- House of Delegates member, Travis County Medical Society, 1998-present
- Interspecialty Society delegate from Ophthalmology, 1988-present
- Interspecialty Society Committee member, 1992-present, chair, 2006-08
- Ad Hoc Committee on Health Care Reform, 2009-10
- Ad Hoc Committee on ACOs, 2010-11

DISCLOSURE OF AFFILIATIONS
- Austin ENT
- Office of Michelle Berger, MD
The Lone Star Caucus and the Wichita County Medical Society (WCMS) are proud to endorse the candidacy of Susan M. Strate, MD, for re-election as speaker of the Texas Medical Association House of Delegates. As current speaker of the TMA House of Delegates, Dr. Strate has worked to maximize House efficiency and effectiveness, clarify the election process, enhance electronic communication, and update the parliamentary authority.

Dr. Strate has an exemplary record of TMA leadership, serving as chair of the Council on Socioeconomics, the Patient-Physician Advocacy Committee, and TEXPAC. She is a past president of the TMA Foundation and a current member of the TMA Foundation Endowment for Innovation campaign cabinet. She has served as a strong advocate for Texas physicians, providing testimony before Texas legislative committees on some of medicine’s most complex and contentious issues.

A practicing physician for over 30 years in Wichita Falls, Dr. Strate holds staff privileges and provides pathology and laboratory director services at multiple community and rural hospitals, as well as the local public health department.

Since 1996, Dr. Strate has served as president of Texoma Independent Physicians, a 200-plus physician independent practice association, where she has successfully worked to defend the rights of patients and physicians. From 1994 to 1995, she served as chief of staff at Wichita General Hospital and in 1996, as president of WCMS. From 2001 to 2008, Dr. Strate served the Wichita Falls Family Practice Residency Program as its board chair and chief executive officer, fortifying the primary care workforce in the region. Dr. Strate was recognized for her leadership as the 2010 recipient of WCMS’s Distinguished Service Award and the 2011 recipient of the College of American Pathologists Lifetime Achievement award.

From 2012 to 2015, she served on the Texas Institute of Health Care Quality and Efficiency Board of Directors, where she was a strong advocate for Texas patients and physicians.

She currently serves as vice chair of the Texoma Health Information Exchange Board and is a member of the Health Coalition of Wichita County.
With her broad knowledge of the issues, her strong advocacy for physicians and their patients, and her high level of energy, Dr. Strate will continue to ensure the voice of Texas physicians is heard as we seek solutions to the challenges of today’s medical practice.

**Personal Statement:** “As your Speaker, I will continue work to conduct the business of the house efficiently and effectively. I pledge to reach out to physicians across the state, listen to their needs, and work to represent physicians in primary and specialty care in a wide variety of practice settings. We must speak loudly with one united voice and advocate for our patients, as we forcefully work to cut over-regulation, advocate to protect physician freedom of choice in practice model and protect the patient-physician relationship, tort reform, and physician autonomy. I will work to ensure the collective strength of the house in policy making translates into a positive difference in our practices and in the health of our patients.”

**PROFILE**

Specialty: Pathology
Medical School (with year graduated): University of Nebraska College of Medicine, 1979
Residency Program: The University of Texas Southwestern Medical School (The University of Texas Southwestern Medical Center), 1979-83
Board Certification: American Board of Pathology (Anatomic and Clinical Pathology), 1983
Primary Residence: Wichita Falls, Texas
Practice Type/Employment Status: Direct patient care – solo, small group, or shared overhead practice
Primary Practice/Employment Location: North Texas Medical Laboratory, Wichita Falls, Texas
Do you expect to maintain your current employment status and location through your term in office? Yes
Does your current employment situation require you to work outside of Texas? No
Including the past five years, list all other organizations from which you have received payment, reimbursement, or financial consideration for consulting, advisory, or leadership responsibilities exceeding $1,000 per year in excess of actual expenses: None
Have you been convicted of a felony or is your medical license restricted? Please explain. No
What TMA positions have you held?

**Current**
- Delegate, Wichita-Archer-Baylor-Clay-Knox County Medical Society
- Member, TMA Foundation Endowment for Innovation Campaign Cabinet
- Member, TMA Foundation Leadership Society
- Speaker, TMA House of Delegates

**Past**
- Vice Speaker, TMA House of Delegates
- Chair, Council on Socioeconomics
- Chair, Patient-Physician Advocacy Committee
- Chair, TEXPAC Candidate Evaluation Committee
- Chair, TEXPAC Executive Committee
- Consultant, Council on Legislation
- Delegate, Interspecialty Society Committee, Texas Society of Pathologists
- Member, Council on Health Care Quality
- Member, Ad Hoc Committee on Sunset Review of Texas State Medical Board
- Member, Ad Hoc Committee on Patient Safety
- Member, Ad Hoc Committee on Medical Errors
- Member, TMA Foundation Grants Committee
- President, TMA Foundation
- Vice Chair, Select Committee on Patient Safety
DISCLOSURE OF AFFILIATIONS

- Texoma Independent Physicians, President and CEO
- Texoma Health Information Exchange, Board of Directors
- North Texas Medical Laboratory (performs clinical and anatomic pathology services)
- Texas Society of Pathologists, Council on Legislation
- Health Coalition of Wichita County
The Harris County Medical Society (HCMS) is proud to nominate Arlo F. Weltge, MD, for re-election as Vice Speaker of the Texas Medical Association House of Delegates.

During his past year as Vice Speaker, Dr. Weltge has worked with Speaker, Dr. Susan Strate, on a number of projects designed to make the House of Delegates operate more efficiently. Together they have worked with the Speaker’s Advisory Council and involved Leadership College representatives to improve House operations which include the design of the new House of Delegates web site and improved web access to TMA policies.

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 over 35 years. He has been an active member of TMA and the American Medical Association for over 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 over 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. Throughout his years of full-time clinical practice, he has practiced in Nacogdoches, Wharton, and Houston, gaining 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 fundamental strength and essential pillar of the organization is keeping our members engaged in the policy setting body - the House of Delegates - and therefore, connected to our common issues and committed to collaboratively setting policy that drives the efforts of our organization. I would welcome the opportunity to continue to serve as the Vice Speaker of our House of Delegates for the purpose of maintaining and fostering member engagement within our TMA.”

PROFILE
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; Emergency Medicine Foundation, American College of Emergency Physicians, Teaching Fellowship, 1989-90; 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% (60% 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: The 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
American College of Emergency Physicians
Occasional review for medical defense law firms for the Texas Medical Board and medical legal cases; no listing of specific firms
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
• Delegate to the Texas Medical Association 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
• Chair and member, TEXPAC 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)
The Dallas delegation to the Texas Medical Association is proud to nominate Sue S. Bornstein, MD, for the position of trustee to 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 honor 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 to be elected president-elect of the hospital’s medical staff.

Since 2008, Dr. Bornstein has been executive director of the Texas Medical Home Initiative, a nonprofit physician-led organization dedicated to implementing the patient-centered medical home model of care in Texas.

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

At TMA, Dr. Bornstein is the inaugural chair of the TMA 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 was 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.

At DCMS, Dr. Bornstein was instrumental in forming the Women in Medicine Committee in 2016. She served on the DCMS Board of Directors from 2005-2007, including a term as secretary/treasurer. Dr. Bornstein also is a critical component in 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 front line who work hard to provide their patients with timely, patient-centered, accessible, affordable, and appropriate care. I will add my voice to that of the other primary care physicians on the Board.”
I believe strongly that physicians should have the opportunity to practice in whatever setting suits them best. If elected, I will continue to seek the development of tools to enable physicians to remain in their practice setting of choice.

The 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 ensuring that our public health system remains viable.

The TMA has been tireless in its advocacy for increasing funding for Graduate Medical Education. 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
Specialty: Internal Medicine
Medical School (with year graduated): Texas Tech University Health Science 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: Administrative: government, health plan, or health-related, but no direct patient care
Primary Employer and 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
Including the past five years, list all other organizations from which you have received payment, reimbursement or financial consideration for consulting, advisory or leadership responsibilities exceeding $1,000 per year in excess of actual expenses. None
Have you been convicted of a felony or is your medical license restricted? No
What TMA positions have you held?
- Select Committee on Medicaid, CHIP and the Uninsured 2010–2017, Member
- Primary Care Coalition 2012–2013, Chair
- Committee on Primary Care and the Medical Home 2014–2016, Chair
- Committee on Physician Distribution 2013–2014, Member
- Texas Medical Association Interspecialty Society (Texas ACP delegate) 2007–2014; 2016–2017, Member
- TMA Leadership College 2012–2014, Mentor
- TMA House of Delegates (Texas ACP delegate) 2013–2017, Delegate
- Physician Services Organization Selection Committee 2013, Member
- TMA delegation to the American Medical Association 2014–2016, Alternate Delegate
- Physician Services Organization Steering Committee 2014–2015, Member

DISCLOSURE OF AFFILIATIONS
- PathAdvantage Associated: pathology practice
- American College of Physicians Regent 2017-19
G. Ray Callas, MD

G. Ray Callas, MD, served his country in the United States Navy as a submariner during Operation Desert Storm. He then graduated from Texas A&M University, earned his medical degree from the University of Texas Medical Branch at Galveston School of Medicine, and completed his anesthesiology residency at UTMB.

Dr. Callas is chair of the TMA Council on Legislation, has been a member of the TMA House of Delegates since 2004, and serves on the TEXPAC Board of Directors and TEXPAC Candidate Evaluation Committee. He first joined TMA in 1996, while attending medical school, and is a graduate of the inaugural class of the TMA Leadership College. Dr. Callas also serves as vice-chair of the Texas Medical Liability Trust Board of Directors, chair of the governor-appointed Jefferson and Orange County Board of Pilot Commissioners, and as advisory director of the Beaumont Chamber of Commerce.

He is a board-certified diplomat of the American Board of Anesthesiology. He has practiced medicine with Anesthesia Associates — one of the oldest incorporated and independent anesthesia groups in Texas — since 2004 and has served as secretary of its Board of Directors for 12 years. He serves multiple hospitals and surgical center facilitates in Jefferson County and Beaumont, Texas.

Dr. Callas is relentless in his efforts to protect physicians and their patients through his work with Jefferson County Medical Society (JCMS), Texas Society of Anesthesiologists (TSA), American Society of Anesthesiologists (ASA), Texas Medical Association, American Medical Association, and the Beaumont community.

Dr. Callas has been involved in JCMS since 2005, serving as president in 2010 and is a current member of its Board of Directors. He serves on the TSA Board of Directors, where he is speaker of the House of Delegates and editor of the TSA Bulletin. At TSA, he is actively involved in the Professional Development Committee, Long-Range Planning Committee, and Governmental Affairs Committee; as well as chairing the Anesthesiologists Serving in the Military Committee.

**Personal Statement:** “I passionately believe that physicians must advocate actively for their patients, something I’ve done as chair of the Council on Legislation as I walked the halls of the Texas Capitol and the U.S. Capitol this past year. I want to promote professionalism in medicine and continue the work we started to boost TMA’s public image to our patients, elected officials, and legislators. I want to work for you to oversee and guide the Association as an at-large-member of the Board of Trustees. Whether representing TMA, AMA, my county society, my specialty society, my practice, or my hospital — I speak out on behalf of the medical profession and for our patients. At a time when outside forces are trying to tear us apart, we Texas physicians need a strong and united TMA more than ever.”
PROFILE
Specialty: Anesthesiology
Medical School (with year graduated): The University of Texas Medical Branch at Galveston School of Medicine (UTMB), 2000
Residency Program: Anesthesiology UTMB
Board Certification(s): American Board of Anesthesiology
Primary Residence: Galveston, Texas
Practice Type/Employment Status: Private practice full-time anesthesiologist/board member
Primary Practice/Employment Location: Anesthesia Associates, Beaumont, Texas
Do you expect to maintain your current employment status and location through your term in office? Yes
Does your current employment situation(s) require you to work outside of Texas? No
Including the past five years, list all other organizations from which you have received payment, reimbursement, or financial consideration for consulting, advisory, or leadership responsibilities exceeding $1,000 per year in excess of actual expenses: Texas Medical Liability Trust, Baxter Healthcare, Cadance Pharmaceuticals, Blue Cross and Blue Shield of Texas Physicians’ Advisory Committee
Have you been convicted of a felony or is your medical license restricted? Please explain. No
What TMA positions have you held?
   Current
   • Chair, Council on Legislation
   • Patron member, TEXPAC
   • Member, TEXPAC Candidate Evaluation Committee and TEXPAC Board of Directors
   • Delegate, House of Delegates
   • Alternate Delegate, Texas Delegation to the AMA
   Past
   • Member, Interspecialty Society Committee
   • Member, Balance Billing Task Force
   • District chair, TEXPAC
   • Member, TMA Foundation Board
   • Member, Task Force on Physician Services Organization
   • Mentor, TMA Leadership College (Graduate 2011)
   • Member and chair, Council on Constitution and Bylaws
   • Member, TMA of the Future
   • Chair, Small Districts Caucus
   • Alternate Delegate, TMA House of Delegates

DISCLOSURE OF AFFILIATIONS
• Anesthesia Associates
• Texas Medical Liability Trust
• Mallinckrodt Pharmaceuticals
• Blue Cross Blue Shield of Texas
Tarrant County Medical Society (TCMS) is proud to nominate one of their proven leaders, Gary W. Floyd, MD, to continue as a member of the TMA Board of Trustees. Dr. Floyd received his medical degree from The University of Texas Medical Branch at Galveston in 1976. He completed his pediatric residency at Oklahoma Children’s Memorial Hospital. He has practiced pediatrics for over 35 years in various capacities, including private general pediatric practice, academic pediatrics, pediatric emergency and urgent care medicine, and administrative medicine chief medical officer. He is board certified by the American Board of Pediatrics and is a fellow of the American Academy of Pediatrics.

Dr. Floyd is a recognized leader at the local, state, and national levels of government, as well as his specialty society and medical association. He frequently testifies before Texas House and Senate committees on health care issues dealing with safe management and treatment of patients, protection of physicians’ clinical autonomy, and independent medical judgment. He has been a strong voice for TMA policies before the legislature for many years.

Dr. Floyd is currently serving as an at-large member of the TMA Board of Trustees. He also serves as vice-chair and delegate of the Texas Delegation to the AMA. He is a member of the TEXPAC Patron Club. He previously served on the TMA Council on Constitution and Bylaws, Council on Legislation, and Select Committee on Medicaid, CHIP, and the Uninsured.

Dr. Floyd is a past president of the Tarrant Council Medical Society, Texas Pediatric Society, and Texas Chapter of the American Academy of Pediatrics. He currently serves as vice-chair of AAP District VII, an elected position covering five states (Arkansas, Louisiana, Mississippi, Oklahoma and Texas) as well as chair of the MedStar Ambulance System’s Emergency Physicians’ Advisory Board. Dr. Floyd was most recently appointed to serve as a member of the AMA Council on Legislation. His commitment to serve his colleagues in numerous leadership positions at TCMS, TMA, AMA, TPS, and AAP is a testament to his dedication to patients, colleagues and to the medical profession.

**Personal Statement:** “I have always been a passionate advocate for patients and physicians as evidenced by work in my various practice situations, my roles in organized medicine, and numerous testimonies before Texas House and Senate Committees in each legislative session since 1991 concerning health care issues dealing with the safe management and treatment of patients, and the protection of physicians’ clinical autonomy and independent medical judgment. I believe the House of Delegates is the heartbeat of the TMA, and the members of the Board of Trustees serve to carry out the will of the House and preserve the financial integrity of the organization. I would be honored to continue to represent you on the Board of Trustees, and I look forward to continuing to serve with each of you in our TMA House.”
PROFILE
Specialty: Pediatrics
Medical School (with year graduated): The University of Texas Medical Branch at Galveston, 1972-76;
Residency Program: Pediatrics at Children’s Hospital of Oklahoma, The University of Oklahoma Health Science Center, 1976-79
Board Certifications: American Board of Pediatrics — Lifetime Certificate, 1983
Primary Residence: Keller, Texas
Practice Type/Employment Status: Academic — Self-employed independent physician & consultant
Primary Practice/Employment Location: Self, Keller, Texas
Do you expect to maintain your current employment status and location through your term in office? Yes
Does your current employment situation require you to work outside of Texas? No
Including the past five years, list all other organizations from which you have received payment, reimbursement, or financial consideration for consulting, advisory, or leadership responsibilities exceeding $1,000 per year in excess of actual expenses: None
Have you been convicted of a felony or is your medical license restricted? No
What TMA positions have you held?
- Tarrant County Medical Society Alternate Delegate, 1996-97; Delegate, 1998-present
- Member, Council on Constitution and Bylaws, 2002-06
- TEXPAC, District 9 Chair, 2006-2014; Vice Chair 2005-06, Patron Club Member
- Member, Council on Legislation, 2006-12; Chair, 2011-12; Consultant, 2012-2016
  Chair, Ad Hoc Committee on Retail Health Clinics, 2008-09
- Texas Delegation to the AMA, Alternate Delegate, 2006-2016; Delegate, 2016-present;
  Vice-Chair, Texas Delegation to the AMA, 2016-present;
  AMA Reference Committee B (Legislation), 2011, 2014;
  AMA Reference Committee F, 2015-present
- Select Committee on Medicaid, CHIP, and the Uninsured, 2007-present
- TMA Reference Committee on Socioeconomics in 1999, 2000, and 2003; chair in 2000
- Member, TMA Board of Trustees, 2014-present;
  At-large member, Executive Committee, 2016-present;
  Chair, Investment Committee, 2016-present
- Member, TMA PracticeEdge Board of Trustees, 2016-present

DISCLOSURE OF AFFILIATIONS
- Chair, Emergency Physicians’ Advisory Board for Metropolitan Area EMS Authority, 2017-present
- EPAB Member to Metropolitan Area EMS Board of Directors, 2017-present
- Vice Chair, AAP District VII (AR, LA, MS, OK, TX), 2014-present
- Texas Pediatric Society, Texas Chapter of AAP, Board of Trustees and Executive Board—ex officio member as an AAP district officer, 2014-present
- Member, Texas Medical Foundation Health Quality Institute Board of Trustees, 2015-present;
- Member, TMF HQI Executive Committee, 2016-present;
- Member, TMA Practice Edge Board of Trustees, 2016-present;
- Tarrant County Medical Society Board of Directors, 1996-present;
- Tarrant County Academy of Medicine Board of Directors, 2013-present;
- Testify before House and Senate committees concerning issues pertinent to patients, children, and physicians as needed by TMA, TPS, AMA, and AAP
The Bexar County Medical Society is pleased to nominate John R. Holcomb, MD, for a seat on the TMA Board of Trustees.

Dr. Holcomb has been a member of BCMS and TMA since 1982, and has held many leadership positions at BCMS, including as president in 1993. He currently serves on the BCMS Board, and as a TMA Delegate. At TMA, he served nine years on the Council on Socioeconomics, and as chair, Select Committee on Medicaid, CHIP, and Access to Care for 15 years. He has served on many TMA ad hoc committees, and has made himself available on numerous occasions to provide testimony to the Legislature on matters affecting Texas patients and their physicians. He has also been appointed as a physician resource for a number of Health and Human Services work groups, and the HHSC Executive Waiver Committee, in its deliberations regarding the recent Medicaid 1115 waiver.

Dr. Holcomb is a graduate of Texas A&M University and Southwestern Medical School, and trained in San Francisco and in San Antonio. He is board-certified in internal medicine, pulmonary medicine, and critical care medicine. His practice includes all patients requiring his services, regardless of insurance status or ability to pay. He is affiliated with Methodist Healthcare System in San Antonio, and has served as chief of staff, and on the governing board of that organization. He is a Certified Principal Investigator, and supervises ongoing clinical research studies for new drug applications.

He has served on other boards in the past, including the Texas Society of Internal Medicine, the Patient Safety Alliance, the Texas Hospital Association, and the Methodist Physician-Hospital Alliance. He currently serves on the board of Texas Medical Liability Trust, and is chair of BexarPAC, a political action committee in Bexar County dedicated to election of fair-minded District Court candidates.

Dr. Holcomb is a retired U.S. Army colonel, having served with 1st Special Forces Group, U.S. Army Academy of Health Sciences, Brooke Army Medical Center, 114th Evacuation Hospital, U.S. Army Hospital, Camp Bondsteel, Kosovo and with the 90th ARCOM as Command Surgeon.

Dr. Holcomb has a broad background in leadership and service, and would serve TMA well on the Board of Trustees.
PROFILE
Specialty: Pulmonary/Critical Care
Medical School (with year graduated): Southwestern 1967-1971
Residency Program: University of California Hospitals, 1971-1972 (Internship); University of Texas
    Health Science Center San Antonio 1975-1979 (Residency and Fellowship)
Board Certifications: Internal Medicine, Pulmonary Critical Care
Primary Residence: San Antonio, TX
Practice Type/Employment Status: Direct Patient Care: solo, small group, or shared overhead
Primary Practice/Employment Location: Self, San Antonio, TX
Do you expect to maintain your current employment status and location through your term in office? Yes
Does your current employment situation require you to work outside of Texas? No
Including the past five years, list all other organizations from which you have received payment, reimbursement, or financial consideration for consulting, advisory, or leadership responsibilities exceeding $1,000 per year in excess of actual expenses: TMLT (Board) Multiple Expert Opinions
Have you been convicted of a felony or is your medical license restricted? No
What TMA positions have you held?
  • Council on Socioeconomics, 1998-2002
  • Chair of the Select Committee on Medicaid, CHIP, and the Uninsured, 15 years

DISCLOSURE OF AFFILIATIONS
  • J.R. Holcomb, MD, PA: Medical Practice
  • TMLT Board Member
Board of Trustees
(Vote for three)

E. Linda Villarreal, MD

E. Linda Villarreal, MD, has been in a solo internal medicine, preventive medicine, and wellness practice in Edinburg for 27 years. Prior to solo practice, she spent 10 years as a pharmacist. She is active in TMA, serving on the Patient and Physician Advocacy Committee, Council on Legislation, and as a delegate on the Texas Delegation to the AMA. She is vice director for TEXPAC from Hidalgo County District and a TMA Foundation board member.

Dr. Villarreal has attended TMA's First Tuesdays at the Capitol since its inception, many times the only physician from Hidalgo County. She has been involved with local, state, and national grassroots lobbying efforts advocating for patient care, medical homes, and physician payment reform. Since the early 2000s, Dr. Villarreal has traveled throughout Texas advocating for tort reform. She especially notes an unforgettable "crop duster jump" trip in 2003 with Carlos Cardenas, MD, while out on the advocacy trail.

Dr. Villarreal contributes time to various community organizations. Previously serving as chief of staff at Edinburg Regional Medical Center, she is a past president of Hidalgo-Starr CMS, RGV Health Services District chair, and a past member of the Rio Grande Valley Partnership. Dr. Villarreal has served as board chair for Easter Seals, receiving the Easter Seals’ Humanitarian of the Year award. Dr. Villarreal also served on the American Heart Association board, and was honored as a Heart of Gold recipient. The Zonta Club of West Hidalgo County has recognized her as a Shining Star.

Personal Statement: "Texas is changing. Medicine is changing. We must adapt to it. We owe this to those who have come before us and for those who will be coming after. But I believe that at no other time has organized medicine been so strong in advocating for our patients, for the profession of medicine and for our 50,000-strong membership. My experience as a member of the Board of Trustees has allowed me to see firsthand the diligence on the part of our physician board and our TMA team. I have been fortunate to witness the amazing grassroots effort on the part of all our physicians to protect our profession and promote the continuation of our number one goal which is to encourage and enhance the healthcare of all Texans. My experience, my passion, my geographical location, and background continue to assist me in caring for my own patients in my private practice that has existed since 1989. They have also given me many lessons in the importance of continuing to be involved within the framework of organized medicine to accomplish more not only for South Texas but for the entire state in every way I can.

I was humbled with my first election to the Board of Trustees and will never forget that experience, but even more humbled that “OUR HOUSE” has continued to give me the opportunity, by re-electing me. I am hoping for another term to continue to represent physicians as a Board of Trustee member.”
PROFILE
Specialty: Internal Medicine
Medical School (with year graduated): Universidad de Noreste, Tampico, Mexico, 1980-83,
License of Internado, 1983-84
Postgraduate: San Antonio State Hospital/University of Texas at Houston Medical School; Jan 1984 – Dec 1984
Internship: Huron Road Hospital, Cleveland, OH, Jan 1985-June 1986
Residency: Texas Tech University Health Sciences Center, RAHSC at El Paso 1986-1988
Board Certifications(s): BE
Primary Residence: Edinburg, Texas
Practice Type/Employment Status: Direct patient care - solo, small group, or shared overhead, 100%; Public Health: volunteer
Primary Practice/Employment Location: Self, Edinburg, 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?
- Board of Trustees
- Council on Legislation
- Patient Physician Advocacy Committee
- Texas Delegation to the AMA alternate delegate and delegate
- TEXPAC

DISCLOSURE OF AFFILIATIONS
Cornerstone Hospital, Edinburg
AMA Alternate Delegate
(Vote for four)

Robert H. Emmick, MD

On behalf of the Travis County Medical Society, we are pleased and honored to nominate Robert H. Emmick Jr, MD, as a candidate for alternate delegate to the American Medical Association.

Dr. Emmick’s commitment to organized medicine began 30 years ago when he was elected to leadership positions first in the Medical Student Section, Resident Physician Section, and then in the Young Physician Section. As a practicing doctor, he has served in the TMA House of Delegates from the Brazos-Robertson, El Paso and now Travis County Medical Societies. He also served on the Texas Delegation to the AMA as an alternate delegate for more than 10 years, before resigning in 2011 to move to Alaska. Upon his return to Texas in 2013, he joined the Travis County Medical Society, immediately becoming active in both TCMS and TMA including participation in First Tuesdays at the Capitol.

In addition to his experience in both the TMA and AMA Houses of Delegates, Dr. Emmick has served on the board of directors of the Texas College of Emergency Physicians and on numerous TMA councils and committees, and was chair of the Council on Public Health and chair of the Patient-Physician Advocacy Committee.

Dr. Emmick is board certified in Emergency Medicine and his experience includes a broad range of practice settings as an academic physician, independent contractor and large-group employee. He has been the medical director for three different emergency departments and has served on two medical executive committees, one as chief of staff. He currently works at the Baylor Scott & White Emergency Medical Center in Cedar Park, Texas.

Please join us in supporting Dr. Robert Emmick as a candidate for alternate delegate to the American Medical Association with your vote.

Personal Statement: “Thirty years ago, as an eager young medical student, it was my desire to be part of an impactful profession and not just hold down a job with a paycheck. I wanted the ability to influence my profession and the larger society as a whole. A search for organizations that shared these goals led me to the Texas Medical Association and American Medical Association, and I have been active in organized medicine ever since.

Over the years, disparate forces have tried to separate us from our patients and reduce our profession to just that job with a paycheck. Our TMA has always responded with thoughtful policies that both protect
our patients and upheld our honored profession. I promise to work diligently to help carry those policies forward if elected as an alternate delegate from Texas to the AMA House of Delegates.

I humbly ask for your vote.”

PROFILE
Specialty: Emergency Medicine
Medical School (with year graduated): Texas Tech University School of Medicine (1987 – 1991)
Board Certification(s): American Board of Emergency Medicine
Primary Residence: Austin, Texas
Practice Type/Employment Status: Direct Patient Care: large group practice (over 20 members)
Primary Practice/Employment Location: Baylor Scott & White, Cedar Park, 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?
Texas Delegation to the AMA House of Delegates
Alternate Delegate (Resident) 1993 – 1994
Alternate Delegate 2000 – 2002
Alternate Delegate 2004 – 2011
Texas Delegation to the AMA Young Physician Section
Alternate Delegate 1995 – 1999
Delegate 1999 – 2000
Alternate Delegate 2000 – 2001
Texas Delegation to the AMA Resident Physician Section
Delegation Chair 1993 – 1994
Delegate 1992 – 1995
Texas Delegation to the AMA Medical Student Section
Delegate 1989 – 1990
Alternate Delegate 1988 – 1989
Texas Medical Association House of Delegates
Member 1987 – 2002
2004 – 2011
2014 – Present
TMA Council on Health Services Organizations
Member 2010 – 2011
TMA Patient-Physician Advocacy Committee
Member 2004 – 2010
2001 – 2002
Chair 2006 – 2009
Council on Public Health
Member 1995 – 2001
Chair 2000 – 2001
Vice-Chair 1997 – 2000
Council on Socioeconomics
   Resident Representative 1991 – 1995
   Student Representative 1988 – 1991
Council on Legislation
   Resident Representative 1992 – 1995
Committee on EMS and Trauma
   Resident Representative 1993 – 1994
TMA Young Physician Section
   Executive Council 1995 – 2001
TMA Resident Physicians Section
   Chair 1993 – 1994
TMA Medical Student Section
TEXPAC
   Board of Directors 1996 – 2002
   Candidate Evaluation Committee 1999 - 2002
Texas Medical Association Foundation
   Board of Directors 1999 – 2002
   Vice-President 2001 – 2002

(Disclosure of affiliations is not required of AMA delegates and alternate delegates.)
AMA Alternate Delegate  
(Vote for four)

Laura Faye Gephart, MD, MBA

Dr. Laura Faye Gephart, MD, MBA, from Baylor Scott & White Health Memorial Hospital in Temple, Texas, is seeking election as an Alternate Delegate to the Texas Delegation to the American Medical Association. Dr. Gephart has been active in organized medicine for the last 12 years and first served in the AMA House of Delegates in 2008 as a medical student.

Dr. Gephart’s passion for the policy, politics, and business of medicine inspired her to pursue a Master’s in Business Administration with a focus on health care administration. This appreciation and expertise allowed her to be twice elected to the AMA’s Council on Medical Service as the Resident and Fellow representative. Before dedicating herself to the AMA’s Council on Medical Service, Dr. Gephart was elected twice to the governing council of the AMA’s Medical Student Section. Through her training as a medical student in California and an obstetrics and gynecology resident in Florida, Dr. Gephart has established relationships with many members of the AMA House of Delegates.

Since moving to Texas for fellowship in Female Pelvic Medicine and Reconstructive Surgery, Dr. Gephart has been an active participant in the TMA; serving first on the TEXPAC Executive Board and now on the TMA Board of Trustees as the Resident and Fellow representative. She also served as an AMA delegate through the Residents and Fellows section, allocating her membership so that the state of Texas received another TMA voting seat in the AMA House of Delegates.

Dr. Gephart’s connections with other young doctors around the country within the AMA will make her an invaluable resource to the Texas Delegation to the AMA. Her time on the AMA’s Council on Medical Service has solidified her relationship with future leaders of the AMA. She understands the politics of the AMA House of Delegates, and she will work tirelessly to ensure that Texas’ priorities are efficiently and effectively turned into AMA policies and actions.

As a provider of obstetric and gynecologic care, Dr. Gephart has experience as a primary care provider as well as a surgical subspecialist. She is able to appreciate the multiple approaches and facets to the provision of medical care in Texas and beyond. Dr. Gephart’s addition to the Texas Delegation to the AMA as an Alternate Delegate would be an asset to the delegation.

Personal Statement:  “I would be honored to continue to serve the Texas Medical Association as part of our delegation to the AMA. Our job on the delegation is to help the AMA be more like the TMA. Through my knowledge of, and experience in, the AMA HOD, I can help get Texans elected to leadership positions and adjust policy to help Texas doctors and our patients. I humbly ask for your vote.”
PROFILE
Specialty: Female Pelvic Medicine and Reconstructive Surgery
Medical School: Loma Linda University, MD, MBA, 2010
Residency Program: Intern, Howard University Hospital; Residency, University of South Florida; Fellowship, Scott & White Healthcare
Board Certifications: American Board of Obstetrics and Gynecology
Primary Residence: Temple, Texas
Practice Type/Employment Status: Academic
Primary Employer and Employment Location: Baylor Scott & White Health, Temple, Texas
Do you expect to maintain your current employment status and location through your term in office? No.
Starting September 1, 2017, I will be full-time FPMRS faculty at the University of Texas, Rio Grande Valley.
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, beyond my employer, Baylor Scott & White Health
Have you been convicted of a felony or is your medical license restricted? No
What TMA positions have you held?
- TEXPAC Board of Directors, Resident and Fellow member
- TMA Board of Trustees, Resident and Fellow member

(Disclosures of affiliations is not required of AMA delegates and alternate delegates)
AMA Alternate Delegate
(Vote for four)

Steven R. Hays, MD

The Dallas delegation to the Texas Medical Association is proud to nominate Steven R. Hays, MD, for alternate delegate to the American Medical Association House of Delegates representing the Texas Delegation.

Dr. Hays is a nephrologist in private practice. An Alpha Omega Alpha member, he attended medical school at the University of Illinois College of Medicine, and completed his internship, residency, and fellowship at UT Southwestern, where he served as an honorary Burroughs Wellcome and Hoffman LaRoche fellow. While on faculty at UT Southwestern Medical Center from 1986-1993, he served as a basic scientist and an instructor of medical students, residents, and fellows. He is board certified in internal medicine and in nephrology.

Dr. Hays transitioned to Baylor University Medical Center in Dallas in 1993, serving as a staff physician and continuing as a clinical teaching faculty member at UT Southwestern. In 1993, he joined Dallas Nephrology Associates, a 75-member nephrology group in Dallas-Fort Worth, and served as financial chairman.

Dr. Hays has been a respected leader among his peers for many years. He served as chief of the medical staff at Baylor University Medical Center in Dallas and chairman of the BUMC Medical Board. He serves as medical director of the renal replacement therapy and living kidney donor programs. He is president of the Texas ACP Services, a fellow in the American College of Physicians, and a member in the American Society of Nephrology.

An involved and effective leader in DCMS and TMA since he became a member in 1986, Dr. Hays has advocated on behalf of physicians during First Tuesdays at the Capitol program since 2005. He served on the DCMS Board of Directors and was secretary/treasurer in 2011. He chairs the DCMS Legislative Affairs Committee and has co-chaired the Dallas Delegation to the TMA for more than six years. When appointed to serve on TMA councils and committees, he serves tirelessly. He has served on the TEXPAC Board of Directors and Executive Committee for years, and he chairs the TMA Council on Medical Education.
Nationally, Dr. Hays is Region IV representative to the Living Donor Board of United Network Organ Sharing (UNOS). He donates to local civic organizations and endows funds in memory of his late wife, Suzanne Ahn, MD, with the Dallas Women's Foundation and the Asian American Journalists Association.

Dr. Hays will be a strong addition to the AMA Delegation from Texas. He is the type of physician leader Texas is known for across the United States.

**Personal Statement:** “I have served locally and nationally as a representative to help preserve our voice in the government of medicine. I have the capacity to listen to all viewpoints and represent Texas’ interest in the process of shaping our national healthcare policies.”

**PROFILE**

Specialty: Nephrology  
Medical School: University of Illinois College of Medicine, 1979  
Residency Program: University of Texas Health Science Center at Dallas  
Board Certifications: American Board of Internal Medicine, 1982  
American Board of Internal Medicine, Subspecialty–Nephrology, 1988  
Primary Residence: Dallas, Texas  
Practice Type/Employment Status: Direct Patient Care; large group practice (over 75 members) (80%); Direct Patient Care; non-profit corporation (20%)  
Primary Employer and Employment Location: Dallas Nephrology Associates, Dallas, TX  
Do you expect to maintain your current employment status and location through your term in office? Yes  
Does your current employment situation(s) require you to work outside of Texas? 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: Baylor University Medical Center, Baylor Quality Alliance (Baylor ACO), Dallas Nephrology Associates  
Have you been convicted of a felony or is your medical license restricted? No  
What TMA positions have you held?  
- TMA Delegate, 2007–present  
- TEXPAC Board of Directors, Chair, Senate District 23; 2009–present  

(Disclosures of affiliations is not required of AMA delegates and alternate delegates)
Richard W. McCallum, MD

Richard W. McCallum, MD, FACP, FRACP (AUST), FACC, AGAF is professor and founding chair of the Department of Internal Medicine at Texas Tech University Health Sciences Center and is also director of the Center for Neurogastroenterology and GI Motility, Paul L. Foster School of Medicine in El Paso.

He is recognized nationally and internationally for his pioneering work in gastric electrical stimulation to treat the nausea and vomiting of gastroparesis, as well as his research into the pathophysiology and treatments for gastroparesis. His scientific publications in peer-reviewed journals exceed 450, he has edited 13 textbooks and holds five patents. His research on the pathophysiology and treatments for Gastroparesis is NIH funded, and he recently received another five-year renewal of this grant for $2 million.

Dr. McCallum has been a member of the TMA and the El Paso County Medical Society since his arrival in El Paso in 2009. He has served on the Education Committee of the TMA for the past five years and received the TMA Award for Excellence in Academic Medicine at the Gold level in 2016. He currently is a TMA delegate as well as the assistant treasurer for the El Paso County Medical Society and serves on the Editorial Board of the El Paso Physician. He was the first Medical Director of the RotoCare Texas Tech Free Clinic founded by the Rotary Club in El Paso and continues to supervise the education of the 1st and 2nd year medical students, volunteering his time on Saturday mornings. He is also very active in the El Paso Community with a call-in radio talk show entitled “The Tummy Doctor,” a member of the El Paso Symphony Board, and Rotary. Dr. McCallum also participates in TMA’s First Tuesdays at the Capitol.

McCallum is a native of Brisbane, Australia, and earned his bachelor’s and medical degrees from the University of Queensland. After interning at the New Orleans Charity Hospital (LSU), he completed his residency at Barnes-Jewish Hospital Washington University and fellowship training in gastroenterology at UCLA. He then served on the faculty of Yale School of Medicine before his appointment as gastroenterology division chief and fellowship program director at the University of Virginia. In 1996 he became the chief of Gastroenterology and Hepatology at the University of Kansas as well as director of the Center for GI Nerve and Muscle Function and GI Motility.
McCallum has held several important leadership roles in the American College of Gastroenterology, the American Gastroenterological Association, the American Neurogastroenterology and Motility Society, and the Southern Society for Clinical Investigation. He has been honored by Texas Tech University, the American Gastroenterological Association, American Diabetes Association, the Texas Medical Association, and the Southern Society for Clinical Research.

**Personal Statement:** “I am a very active clinician, educator, researcher and mentor, and feel that with my extensive academic background I have the credentials to effectively represent and be a voice for Texas Physicians at the AMA National level.”

**PROFILE**

**Specialty:** Gastroenterology  
**Medical School:** University Of Queensland Medical School, Brisbane, Australia – MD, 1968  
**Residency Program:** Charity Hospital, LSU Service, New Orleans & Barnes Hospital, Washington University, St. Louis  
**Board Certifications:** Internal Medicine and Gastroenterology  
**Primary Residence:** El Paso, Texas  
**Practice Type/Employment Status:** Direct Patient Care; solo, small group, or shared overhead (50%); Academic (30%); Research (non-clinical) (20%)  
**Primary Employer and Employment Location (city, state):** Texas Tech University Medical Center, El Paso, 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: Salix Pharma, Allergan Pharma, Synergy Pharma, Medronic Corporation, Forest Pharma, Transzyme Pharma, Prostraken Pharma, Evoke Pharma  

Have you been convicted of a felony or is your medical license restricted? No  
What TMA positions have you held?  
- Member of the Education Committee since 2013  
- TMA Award for Excellence in Academic Medicine at the Gold Medal Level, 2016  
- Delegate for TMA from El Paso County Medical Society since 2015  

(Disclosures of affiliations is not required of AMA delegates and alternate delegates)
Jennifer R. Rushton, MD

The Bexar County Medical Society (BCMS) is pleased to nominate Jennifer R. Rushton, MD, for American Medical Association alternate delegate.

Dr. Rushton has been a member of the Texas Medical Association since 2000, first with the Harris County Medical Society and with BCMS after moving to San Antonio in 2010. In 2008, she received her medical license and began practicing pathology in 2010. A 2004 graduate of Baylor College of Medicine, Dr. Rushton completed her residency program at Baylor in anatomic and clinical pathology, followed by fellowships in molecular genetic pathology and hematopathology. She is board certified in each.

Active in organized medicine, Dr. Rushton is a member of the TMA Young Physician Section and formerly served as delegate to the AMA Young Physician Section. She is currently an alternate delegate to the Interspecialty Society Committee. In addition, Dr. Rushton currently serves on the board of directors of the Texas Society of Pathologists and formerly served as chair of the Young Pathologists’ Section. Dr. Rushton also serves as a TMA delegate and is a member of the BCMS Legislative and Socioeconomics Committee. She is a strong supporter of legislative advocacy and has participated in First Tuesdays at the Capitol.

Locally, Dr. Rushton is a practicing community pathologist and physician leader, serving as the medical director of pathology and laboratory medicine for the Baptist Health System, an integrated group of five hospitals in San Antonio. She is also a member of the Baptist Health System Medical Staff Quality Committee.
PROFILE
Specialty: Pathology
Medical School (with year graduated): Baylor College of Medicine, 2000-2004
Residency Program: Anatomic and Clinical Pathology, Baylor College of Medicine, 2004-2008
Fellowship: molecular genetic pathology, 2008-2009
Fellowship: Hematopathology, Baylor College of Medicine, 2009-2010
Board Certification(s): Anatomic and clinical pathology, molecular genetic pathology, hematopathology
Primary Residence: San Antonio
Practice Type/Employment Status: Direct patient care: large group practice (more than 20 members)
Primary Practice/Employment Location: Clinical Pathology Associates, San Antonio
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?
• Delegate to the AMA Young Physician Section
• Alternate delegate to the Interspecialty Society Committee
• Delegate for BCMS
• Alternate delegate for the Young Physician Section
The Harris County Medical Society (HCMS) is honored to nominate Sherif Zaafran, MD, as a candidate for alternate delegate to the American Medical Association.

Dr. Zaafran is a board-certified anesthesiologist who completed both medical school and his residency at the University of Texas Medical School at Houston. In practice since 1999, Dr. Zaafran currently works at the Memorial Hermann hospital in The Woodlands. He serves on the Physician Council for the MH System, chairs the System Joint Operating Council on the Perioperative Surgical Home, and chairs the MH System Anesthesia Committee.

Dr. Zaafran has been a member of TMA since medical school. Throughout his membership, he has been actively involved in the public policy process. He has served on the Committee on Membership, chaired the Council on Health Promotion, and continues to serve as a TMA delegate.

That passion for public policy turned into several leadership positions throughout the years. Dr. Zaafran has chaired the HCMS Board of Medical Legislation and currently serves as vice-chair of the HCMS Delegation to TMA. A Patron level member of TEXPAC, he sits on the Membership and Candidate Evaluation committees, and has been a long-time and very active District Chair. Dr. Zaafran also chairs the Government Affairs Committee of the Texas Society of Anesthesiologists (TSA), the American Society of Anesthesiologists Ad hoc Committee on Out-of-Network Payment, and is a recent gubernatorial appointment to the Texas Medical Board.

Keenly aware of the myriad national issues affecting physicians of all specialties and practice types, Dr. Zaafran’s experience chairing the government affairs committees of HCMS and his state specialty society has prepared him to represent Texas in the AMA House of Delegates. For nearly two decades, Dr. Zaafran has been one of several Texas physicians actively engaged with Congress to limit the federal regulatory burden placed on physicians. He also has promoted the Texas way of doing things in areas such as insurance and tort reform.

If elected, Texas physicians will be well represented by someone who both understands federal issues and can effectively guide the House of Delegates process to make sure Texas views are clearly heard by
AMA. Dr. Zaafran has been working for Texas physicians for years, and he is ready to do it as an alternate delegate to the AMA.

**Personal Statement:** “In the past several years, the politicians and bureaucrats in Washington have made drastic changes to our health care system, many of which have contributed nothing to patient care. Texas has been a strong, pro-physician state for some time now, and our perspective can only improve the AMA’s effectiveness in Washington. I feel that my experiences with TEXPAC, advocating in Austin and Washington for TMA and TSA, my work with the Texas Medical Board, and my experience in hospital leadership positions will allow me to take the unique perspective of Texas medicine, and the issues with which we struggle, to the AMA and use that experience to improve federal healthcare policy. I greatly appreciate your support.”

**PROFILE**
Specialty: Anesthesiology  
Medical School: University of Texas Medical School Houston, 1990-1995  
Residency Program: Baylor College of Medicine Transitional Program, 1995-1996; University of Texas Medical School Anesthesiology, 1996-1999  
Board Certifications: American Board of Anesthesiology  
Primary Residence: Houston, Texas  
Practice Type/Employment Status: Direct Patient Care; large group practice (over 20 members) (95%); Administrative: government, health plan, or health-related, but no direct patient care (5%)  
Primary Employer and Employment Location: US Anesthesia Partners, Houston, Texas  
Do you expect to maintain your current employment status and location through your term in office? Yes  
Does your current employment situation(s) require you to work outside of Texas? No  
Including the past five years, list all other organizations from which you have received payment, reimbursement or financial consideration for consulting, advisory or leadership responsibilities exceeding $1,000 per year in excess of actual expenses: Memorial Hermann Chair of Perioperative Clinical Pathway Committee. Memorial Hermann Chair of Joint Operating Council on Perioperative Surgical Home  
Have you been convicted of a felony or is your medical license restricted? No  
What TMA positions have you held?  
- TMA Delegate  
- Member and Chair of Council on Health Promotions  
- Member of Membership Committee  

(Disclosures of affiliations is not required of AMA delegates and alternate delegates)
Awards, amendments to the Constitution and Bylaws, new or revised policy, and policy sunset review recommendations are not included.

FROM REFERENCE COMMITTEE ON FINANCIAL AND ORGANIZATIONAL AFFAIRS:

Speakers Report 1, TMA Election Process: That the Texas Medical Association make changes to the TMA Election Process to reflect current practices of the house; to promote fair, equitable, cost-effective campaigns; and to make the policy more relevant. Referred with report back at A-17.

REFERRED TO: Speakers and Speakers’ Advisory Committee.

STATUS: See SPKR Report 1-A-17 in this handbook.

Board of Trustees Report 8, Review of International Medical Graduate Section: That the Texas Medical Association International Medical Graduate (IMG) Section continue for an additional year with report back to the House of Delegates, through the Board of Trustees, at the 2017 Annual Session with information that demonstrates specific contributions of the IMG Section. Adopted.

REFERRED TO: Board of Trustees

STATUS: See BOT Report 12 in this handbook.

Board of Trustees Report 10, Task Force on Specialty Societies Represented in the TMA House of Delegates: That (1) specialty societies approved for representation on the Interspecialty Society Committee, as determined by the Texas Medical Association House of Delegates, not undergo subsequent review for that representation; (2) attendance requirements applied to TMA standing committees not be applied to members of the Interspecialty Society Committee; (3) specialty societies approved for representation in the TMA House of Delegates whose elected/appointed delegates or alternates delegates do not participate be contacted to ascertain their continued interest in being represented; and (4) the Council on Constitution and Bylaws consider whether or not societies approved for representation in the House of Delegates be specifically named in TMA Bylaws. Adopted.

REFERRED TO: Council on Constitution and Bylaws

STATUS: In consideration of the recommendations provided by the Task Force on Specialty Societies Represented in the TMA House of Delegates, the Council on Constitution and Bylaws does not recommend an amendment to section 3.227 of the TMA bylaws regarding specialty societies qualifying for delegate representation.

Committee on Physician Health and Wellness Report 1, Texas Physician Health Program/Monitor Relationship and Civil Immunity for Monitors: That the Texas Medical Association draft policy which supports legislation that would: (1) require the Texas Physician Health Program (TXPHP) to provide monitors with copies of drug screen results for applicable participating physicians, and (2) provide civil immunity provisions for monitors of physicians participating in TXPHP. Adopted.

REFERRED TO: Council on Legislation
STATUS: TMA staff attended multiple TXPHP Board Meetings, met and held conference calls with TXPHP staff, as well as with Texas Sunset Advisory Commission (TSAC) staff, and invited TXPHP staff to Committee on Physician Health and Wellness (CPHW) meetings to discuss TMA’s concerns.

Specifically, TMA staff had a call with the Executive Director of TXPHP on November 3, 2016, when the TSAC Staff Report on the Texas Medical Board came out. The call was scheduled because the report did not address CPHW’s two major concerns. The reason the report did not address these two concerns is because the TSAC’s general counsel’s reading of the statute was in line with that of TMA’s Office of the General Counsel (i.e., no changes to the law needed to be made to allow what CPHW is asking for).

TXPHP is currently developing forms (to be signed by monitors) which will permit TXPHP to share test results with them and will draft procedures for the monitors to be considered agents of the state (when acting on behalf of the state) for liability purposes.

Agenda materials from TXPHP’s November 18, 2016 Board Meeting confirmed this interpretation and plan.

Resolution 101, TMA Bylaws Concerning Retired Member Classifications (Travis County Medical Society): That the Texas Medical Association Committee on Membership and Council on Constitution and Bylaws review the category of retired membership and explore redefining the rights and privileges of retired membership to include the right to vote and hold elected positions, with report back at TexMed 2017. Referred.

REFERRED TO: Committee on Membership; Council on Constitution and Bylaws

STATUS: See CM and CCB Joint Report 2-A-17 in this handbook.

Resolution 103, Texas Interventional Pain Treatment Act (Texas Pain Society and Harris County Medical Society): That the Texas Medical Association support passage of legislation making it unlawful to practice interventional pain management using fluoroscopy in this state unless such person has been duly licensed under the provisions of the Texas Medical Board. Adopted as amended.

REFERRED TO: Council on Legislation

STATUS: TMA is pursuing an opinion from the Texas Medical Board to define this as the practice of medicine. This will put us in better shape to do this in lieu of or before pursuing legislation.

Resolution 105, Sunsetting the Official Prescription Form (Dallas County Medical Society and Texas Pain Society [C.M. Schade, MD, PhD]): That the Texas Medical Association work with the Texas Legislature to sunset the Official Prescription Form tracking laws. Adopted.

REFERRED TO: Council on Legislation

STATUS: This is being pursued as an amendment strategy the 2017 legislative session.

Resolution 107, Requiring Doctors to Swear to Be Honest (Bexar County Medical Society): That physicians in Texas not be required by any governmental agency or function to swear that they will not be dishonest in dealings with state agencies or functions, and that they not be required to swear that they will seek out colleagues that they suspect are guilty of misbehavior without specific guidance as to what is considered “misbehavior.” Referred with report back at A-17.
REFERRED TO:  Select Committee on Medicaid, CHIP, and the Uninsured

STATUS:  See SCMCUI Report 1-A-17 in this handbook.

FROM REFERENCE COMMITTEE ON MEDICAL EDUCATION:

Committee on Physician Health and Wellness Report 2, Mental Illness: To approve Texas Medical Association policy which supports legislation that would amend the statute to require “severe and persistent mental illness” and not “any mental illness” reportable to the Texas Medical Board. Referred.

REFERRED TO:  Council on Medical Education


Council on Medical Education Report 3, Opposition to Medical School and Residency Program Curriculum Mandates: To adopt Texas Medical Association policy on Opposition to Medical School and Residency Program Curriculum Mandates. Referred with report back at A-17.

REFERRED TO:  Council on Medical Education


Resolution 201, Recognition of Alternative Recertification Boards (Harris County Medical Society): That the Texas Medical Association (1) formally adopt standards by which it can evaluate recertification programs that would be appropriate for Texas; (2) after adopting standards, begin the process of approving recertification programs offered by competing boards that meet TMA’s standards; and (3) publicize and advocate for the recognition of TMA-approved alternative recertification programs to hospitals throughout Texas. Referred.

REFERRED TO:  Council on Medical Education


Resolution 203, Developing Direct Primary Care in Texas (Harris County Medical Society): That the Texas Medical Association (1) study the development of direct primary care as it is described in statute in Texas, including the creation of programs to assist physicians in establishing, operating, and growing direct primary care practices; and (2) further study efforts to help educate the public, employers, and government officials in direct primary care and encourage the incorporation of direct primary care into the Texas health care economy, in both the private and public health care sectors. Adopted as amended.

REFERRED TO:  Council on Socioeconomics, Council on Practice Management Services

STATUS:  TMA cosponsored the fourth annual Texas Primary Care and Health Home Summit June 9-10, 2016. The event covered new models of primary care including direct primary care and value-based care. Last Fall, TMA collaborated with a Physician Foundation-sponsored conference to increase awareness of opportunities and challenges regarding direct primary care. The TMA Medical Home and Primary Care Committee will be exploring further educational opportunities at its meeting in May 2017. Through the TMA survey, we continue to track cash-based or concierge medicine practices. We have been gathering data on these practices models since 2012.
Additionally, TMA staff have performed extensive market research and interviewed physicians currently practicing within a direct primary care (DPC) model. With the information gathered, TMA Practice Consulting developed a new comprehensive set-up service for physicians starting direct primary care practices. This service includes a customized financial proforma anticipating patient panel growth and pricing; an extensive marketing plan targeting small employers; specialized patient agreements, letters, and forms; and resources for business plan creation and moonlighting. Staff are further researching the needs and implementation differences that physicians may have while transitioning to a DPC model rather than starting new.

Resolution 206, Freedom From Maintenance of Certification (Ori Z. Hampel, MD, Harris County Medical Society): That the Texas Medical Association (1) support the American Medical Association’s Principles of Maintenance of Certification (MOC) H-275.924 to ensure physician’s choice of lifelong learning, and (2) 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.  Adopted as amended.

REFERRED TO: Council on Medical Education; Council on Legislation

STATUS: Policy 175.021 added to TMA Policy Compendium. Also see CME Report 6-A-17 in this handbook.

Resolution 207, Recognition of the National Board of Physicians and Surgeons and the National Board of Osteopathic Physicians and Surgeons (Ori Z. Hampel, MD, Harris County Medical Society): That the Texas Medical Association recognize that recertifications by the National Board of Physicians and Surgeons and the National Board of Osteopathic Physicians and Surgeons are acceptable board recertifications for practicing physicians in the State of Texas for all purposes, including licensure, reimbursement, employment, and admitting privileges at a hospital.  Referred.

REFERRED TO: Council on Medical Education; Council on Legislation


FROM REFERENCE COMMITTEE ON SCIENCE AND PUBLIC HEALTH:

Council on Science and Public Health Report 3, Resolution 304 Increasing Identification, Support, and Reporting of Human Trafficking Victims: That the Texas Medical Association 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.  Adopted.

REFERRED TO: Council on Science and Public Health; Add to TMA Policy Compendium
STATUS: The Council on Science and Public Health is sponsoring a CME program at TexMed 2017; a written CME and a presentation at one of the county medical societies will also be completed in 2017. The TMA Policy Compendium was updated with policy 260.101.

Council on Science and Public Health Report 4, Resolution 307 Complementary and Alternative Medicine: (1) That the Texas Medical Association: (a) advocate for stronger federal oversight and support additional quality studies of complementary and alternative medicine (CAM); (b) monitor Texas regulatory activities and trends in use of CAM to encourage communication between local public health entities and county medical societies, offering timely information on potential risks and scientifically proven benefits of specific CAM products; and (c) encourage physicians to register with the Food and Drug Administration to receive updates on suspected tainted products; (2) That TMA (a) serve as a resource for physicians by monitoring and sharing information on quality, evidence-based studies of CAM related topics, such as the free online continuing medical education programs provided by the National Institutes of Health Center for Complementary and Integrative Health (NCCIH) and resources offered by medical schools engaged in integrative health; and (b) convene physicians in integrative medicine and others with expertise to serve as an ongoing resource for physicians on CAM trends and issues; (3) That TMA recommend that physicians (a) ask about and include use of complementary products in the medication drug list for each patient; (b) counsel those who are using nonprescribed dietary supplements that these are non-regulated and their quality, effectiveness, and safety has not been established, and encourage patients to use reliable resources such as the NCCIH to learn about nonprescribed products or the use of mobile apps that offer up-to-date notices; and (c) counsel patients who are potentially vulnerable to adverse health outcomes because of their age or health condition or who are using prescribed medications to consult their physician before taking nonprescribed CAM products or starting new therapies; and (4) Delete TMA policies 260.063 Herbal Remedies and 260.069 Dangerous Herbal Preparations from the Policy Index. Adopted as amended.

REFERRED TO: Council on Science and Public Health; Add to TMA Policy Compendium

STATUS: A Council on Science and Public Health workgroup has been convened to assist with developing resources for physicians. Information will be added to the public health page of TMA’s website. The TMA Policy Compendium was updated with policy 260.102.

Committee on Maternal and Perinatal Health Report 1, Parental Leave: That the Texas Medical Association: (1) promote awareness and education for physicians, legislators, and the public on the importance of adequate parental leave, especially paid leave, in ensuring good maternal and infant health outcomes and promoting the health and well-being of the family; (2) advocate for state, local, and private adoption of parental leave policies that provide adequate time to give birth, recover, nurse new babies, and allow for parental bonding following the birth or adoption of a child; and (3) recommend at least 12 weeks of paid maternity leave and at least two weeks of paid paternity or partner leave following the birth or adoption of a child. Referred.

REFERRED TO: Council on Science and Public Health

STATUS: See CSPH Report 2-A-17 in this handbook.

Resolution 301, Improvements for Tracking the Wholesale Drug Distribution of Controlled Substances (Dallas County Medical Society and Texas Pain Society): That the Texas Medical Association work with the Texas Legislature to require: (1) wholesale drug distributors to report their ARCOS data directly to the Texas Prescription Monitoring Program, (2) pharmacies to report their sales daily to the Texas Prescription Monitoring Program, and (3) the Texas State Board of Pharmacy to
generate public reports (de-identified) of the top 10 wholesale controlled substances by ZIP code, monthly, or more frequently as indicated. **Adopted as amended.**

**REFERRED TO:** Council on Legislation

**STATUS:** TMA is supporting this as part of an effort to define a technology-driven solution in lieu of mandates to utilize the Prescription Drug Monitoring Program prior to each prescription for a controlled substance.

**Resolution 303, Ban Firearms in State Psychiatric Facilities (Harris County Medical Society):** That the Texas Medical Association pursue amendment of Section 46.035 of the Penal Code so that it is an offense for a concealed handgun license holder to intentionally, knowingly, or recklessly carry a handgun, as defined by state law, into a state-operated mental health facility; that is, a state hospital or a state center with an inpatient psychiatric component that is operated by the Texas Health and Human Services Commission, as defined in 25 TAC, Chapter 412. **Adopted as amended.**

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

**STATUS:** The Task Force on Behavioral Health has worked with Texas Society of Psychiatric Physicians (TSPP) and others on legislation on this issue. While several bills on the topic have already been filed on the matter, an author for the TMA/TSPP-supported bill has been identified and filing of the legislation is expected soon.

**Resolution 304, Increase Funding for and Access to Medication to Cure Hepatitis C (Howard P. Monsour Jr., MD, Harris County Medical Society):** That the Texas Medical Association work with the Texas Legislature, Texas Health and Human Services Commission, and Office of the Governor to increase: (1) Medicaid funding in the FY 2018-19 state budget for medications that have been proven to cure Hepatitis C, and (2) access to these curative Hepatitis C medications by eliminating the regulatory and budget barriers that deter patients in dire need from receiving them. This includes advocacy to relax fibrosis score criteria so it aligns with recent Centers for Medicare & Medicaid Services guidance and promotes access. **Referred for decision and action.**

**REFERRED TO:** Council on Socioeconomics

**STATUS:** A high priority for TMA during the 2017 legislative session will be reforming the Medicaid vendor drug program, including ensuring greater transparency and physician input on the development of clinical protocols and revising the process for adding high cost drugs to the Medicaid formulary. Currently, if a drug costs more than $500k annually, it cannot be added to the Medicaid formulary without legislative approval.

**Resolution 306, Support for a Statewide Definition of “Elder Self-Neglect” and National Adoption of Mandatory Reporting of Elder Mistreatment (Medical Student Section):** That the Texas Medical Association support: (1) the efforts of the Texas Elder Abuse and Mistreatment Institute in its research on elder self-neglect, and (2) the American Medical Association’s efforts on nationwide adoption of laws on the physician duty to report suspected or confirmed elderly abuse. **Adopted as amended.**

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

**STATUS:** Staff have been in contact with the Texas A&M Elder Mistreatment program institute to obtain information on potential activities. Information on this will be finalized later in the year.
Resolution 307, Gender and Sex Options on Medical Paperwork (Medical Student Section): That the Texas Medical Association: (1) recognize the importance of delineating gender identities in patients to promote the delivery of thorough medical care and support the addition of gender and sex options on patients’ medical records, and (2) support patient data collection that is inclusive of non-binary gender identities, as it will allow for relevant medical research. Referred.

REFERRED TO: Board of Councilors

STATUS: See BOC Report 3-A-17 in this handbook.

Resolution 308, Increased Oversight of Suicide Prevention Training for Correctional Facility Staff (Medical Student Section): That the Texas Medical Association will: (1) encourage the Texas Commission on Jail Standards to develop a single, unified, suicide prevention plan for correctional facilities in the state of Texas, and (2) submit and support a proposal to the Texas Commission on Jail Standards to require that all correctional facility officers and staff, both county and city, in the state of Texas, undergo suicide prevention training at hire, and at annual retraining, support increased state oversight of suicide prevention curricula and training of correctional facility officers, with annual recertification. Adopted as amended by substitution.

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

STATUS: The Council on Science and Public Health’s Task Force on Behavioral Health convened a criminal justice workgroup to work on this and related behavioral health issues and received approval from the Board of Trustees to join the Texas Healthy Minds Coalition. TMA staff collaborate with the Coalition and other stakeholders on criminal justice policy priorities. TMA also testified before the House Select Committee on Mental Health, which is also addressing mental health prevention issues associated with criminal justice.

Resolution 309, Physician Collaboration in Active Child Protective Services Investigations (Bexar County Medical Society): That the Texas Medical Association work with Texas Department of Family and Protective Services and Child Protective Services to eliminate barriers to useful and productive interaction with physicians for the benefit of the children. Adopted.

REFERRED TO: Council on Science and Public Health

STATUS: The Texas Pediatric Society presented to the Committee on Child and Adolescent Health at fall meeting and gave an overview of many of the child welfare issues the organization is working on. The committee heard an update on child welfare issues related to legislation during winter meeting. The committee continues to study this issue and will identify any potential areas to get involved.

Resolution 310, Prevention of Newborn Falls in Hospitals (Medical Student Section): That the Texas Medical Association: (1) work with the Texas Department of State Health Services and other stakeholders to support increased research on newborn falls, (2) encourage education of parents and health care professionals on risk factors and prevention of newborn falls in Texas hospitals, and (3) support implementation of newborn fall prevention plans and post-fall care protocol in Texas hospitals. Referred with report back at A-17.

REFERRED TO: Committee on Child and Adolescent Health; Committee on Reproductive, Women’s, and Perinatal Health
STATUS: See CCAH and RWPH Joint Report 3-A-17 in this handbook.

Resolution 311, Sexual Orientation Change Efforts in Minors (Medical Student Section): That: (1) the Texas Medical Association advocate legislation banning conversion therapy for patients under 18 years of age in Texas on the basis that they are minors, (2) TMA support prohibiting state-licensed therapists from engaging in these scientifically discredited practices, and (3) regulated practices do not include therapies that provide support for youth or the facilitation of youth’s coping and identity exploration and development, including sexual orientation-neutral efforts to prevent or address unlawful conduct or unsafe sexual practices, or therapy that is designed to aid a person in a transition from one gender to another. Referred.

REFERRED TO: Committee on Child and Adolescent Health


FROM REFERENCE COMMITTEE ON SOCIOECONOMICS:

Council on Health Service Organizations Report 2, Medical Orders for Scope of Treatment Coalition Recommendations: To: (1) support 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; and (2) 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. Adopted as amended.

REFERRED TO: Add to TMA Policy Compendium; Council on Health Service Organizations

STATUS: TMA Council on Health Service Organizations continues to work with the Medical Orders for Scope of Treatment Coalition on the recommendations in the report. TMA has updated its Policy Compendium with policy 85.017.

Council on Socioeconomics Report 5, Informing Patients of Denial of Medical Care or Services: That: (1) the Texas Medical Association inform physicians of the current timelines in statute and regulation. Any education effort should cover a physician’s rights under existing utilization review laws and the appropriate steps to take when filing a complaint with the Texas Department of Insurance, the agency charged with regulating utilization review; and (2) amend policy 145.024 Medical Decision Makers Licensed in Texas. Adopted.

REFERRED TO: Add to TMA Policy Compendium; Communications Division

STATUS: This issue is a component of the education provided in presentations for TMA’s Ambassador Program. It is also something staff of the TMA Payment Advocacy Department regularly
mention to practices who call or e-mail with questions about appeals, and the reason why the TMA encourages physicians to file complaints with the Texas Department of Insurance if they’re unhappy with the outcome of an interaction with a health plan. A TMA Practice E-tip on this topic will be released in April 2017. Policy 145.024 has been amended in TMA’s Policy Compendium.

Select Committee on Medicaid, CHIP, and the Uninsured and Committee on Medical Home and Primary Care Joint Report 3, Medicaid Red Tape Reduction and Health Care Coverage: That the Texas Medical Association: (1) reiterate its commitment toward finding a path forward to expand access to health care for poor and low-income Texans; (2) broadly and frequently communicate to the public, the media, and the legislature the vital role health insurance coverage plays toward decreasing health care disparities and improving the physical and behavioral health status and well-being of our patients; (3) establish a study group to (a) evaluate the potential role a Section 1332 waiver alone or in collaboration with a Medicaid 1115 waiver could play in achieving the association’s goals of expanding the availability of affordable, comprehensive health insurance; and (b) develop policy principles to guide the association during any legislative deliberations regarding Section 1332 and/or Section 1115 waivers; and (4) continue to vigorously pursue Medicaid red tape reduction and competitive payments for physicians. Adopted.

REFERRED TO: Reaffirmed existing policy

STATUS: TMA continues to articulate the importance of increasing insurance coverage for low-income Texans and has made this goal a priority during the 2017 legislative session. Congress will be examining Medicaid reform proposals over the next several months, which may provide Texas the opportunity to obtain additional federal dollars to expand coverage as well as implement other Medicaid reforms. In the supplemental report to the House, the Select Committee on Medicaid, CHIP and the Uninsured will propose policy principles relating to federal Medicaid reform.

In February, TMA testified several times urging lawmakers to enact Medicaid physician payments and to reduce paperwork and administrative hassles, including streamlining the Medicaid vendor drug program. Texas’ budget shortfall means legislators are examining ways to reduce Medicaid costs. The association opposes efforts to cut physician payments, eligibility or services.

Resolution 401, Clerical Errors on Medicare Applications (Harris County Medical Society): That: (1) the Texas Delegation to the American Medical Association take to the AMA House of Delegates a resolution requiring that AMA work with the Centers for Medicare & Medicaid Services (CMS) to give fair due process to physicians by creating a “fast track” review process when physicians are being investigated for Medicare fraud that appears to be an innocent clerical error made on a Medicare application; and (2) AMA also work with CMS to immediately reactivate physicians’ Provider Transaction Access Numbers (PTANs) once CMS determines that a clerical error, not fraud, has occurred, thus allowing the Medicare administrative contractor to pay physicians for care provided to Medicare patients, with no penalty applied. Adopted.

REFERRED TO: Texas Delegation to the AMA

STATUS: At the AMA A-16 meeting, the AMA House of Delegates adopted Texas’ resolution to help physicians overcome the sometimes-devastating consequences of minor clerical errors on their Medicare enrollment applications.

Resolution 403, Financial Support for Furloughed Physicians and Psychological Support for Furloughed Health Care Workers (Dallas County Medical Society): That: (1) the Texas Medical Association work with the Texas Legislature to identify state or federal funds with which to compensate physicians who are furloughed after an infectious disease outbreak, and (2) because physicians are not
allowed contact with their families during the furlough, TMA work with the legislature to ensure that social and psychological support are available for the physicians and their families. Referred.

REFERRED TO: Council on Legislation

STATUS: The current budget shortfall facing the Texas Legislature has made it difficult to identify potential state resources for addressing the identified problem for furloughed physicians impacted by an infectious disease outbreak. In fact, funding for programs to identify and contain infectious disease outbreaks is currently at risk as the both the House and Senate have been forced to cut spending.

TMA will continue to work with the Department of State Health Services (DSHS) and local governments to pursue federal funding to mitigate financial hardships on physicians and to provide psychological support for furloughed health care workers. CDC Ebola funds were used to compensate local health facilities in Dallas for loss of revenue (these are funds that go directly to the hospitals) and this could be part of a request for reimbursement. Maybe a request could be made of DSHS to ensure physician lost revenue and counseling is included in future events.

COL also recommends referring this issue to the Public Health Policy & Funding Committee or the Task Force on Infectious Diseases. The PHP&F committee has a lot of local representatives and would have input on recognizing physicians as first responders.

Resolution 404, Addressing the Health Insurance Coverage Gap in Texas (Sue Bornstein, MD, Dallas County Medical Society): That the Texas Medical Association make finding effective solutions to the growing problem of Texans unable to obtain affordable health insurance a high legislative and regulatory priority. Adopted.

REFERRED TO: Reaffirmed existing policy

STATUS: TMA is engaged in ongoing advocacy at both the state and federal level to address the growing number of Texans who lack health insurance. Potential changes to the Affordable Care Act that may address this issue are being closely monitored.

Resolution 405, Ensuring Patient Access to Affordable Prescription Medications (John T. Carlo, MD, Dallas County Medical Society), and Resolution 409, Addressing Abusive Practices in Small-Market Prescription Drug Pricing (Medical Student Section): That the Texas Medical Association: (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. Adopted substitute resolution.

REFERRED TO: Council on Socioeconomics; Add to TMA Policy Compendium
STATUS: Ongoing advocacy efforts continue and proposed changes at the federal level to address these issues are being closely monitored. TMA has updated its Policy Compendium with policy 95.041. Also, see Council on Socioeconomics Report 3-A-17 behind the Socioeconomics tab in this handbook.

Resolution 406, Paying Physicians for In-Office Albuterol Nebulizer Treatments (Webb-Zapata-Jim Hogg County Medical Society): That: (1) the Texas Medical Association support changes in law and regulation to see that the decision as to whether treatments or administration of a medication as medically necessary should be a determination of the physician, not the insurance company; (2) all costs of providing treatments, including the supplies that previously had been deemed the cost of doing business, should be paid in full including medication, masks, tubing, etc., not only for albuterol nebulizers but for all procedures, administered medications, and treatments performed in the office; (3) TMA advocate that the indications for albuterol treatments should include wheezing, asthma exacerbation, bronchiolitis, bronchitis, shortness of breath/hypoxia, chronic obstructive pulmonary disease, fibrosis, and all other acute or chronic lung conditions; and (4) the Texas Delegation to the American Medical Association take this resolution to the AMA House of Delegates for consideration. Referred.

REFERRED TO: Council on Socioeconomics

STATUS: Existing TDI regulations address the issue of medically necessary treatment and the process to appeal denials from insurance companies.

Resolution 407, Navigating Medical Insurance Complaints for Patients (Webb-Zapata-Jim Hogg County Medical Society): That the Texas Medical Association: (1) educate physicians about how patients may go about filing a complaint regarding their insurance company health benefits, and (2) advocate for legislative changes that require insurance companies and third party administrators of all health insurance plans to educate consumers regarding their full and current health care benefits so that physicians are not burdened with teaching patients about health insurance products. Adopted as amended.

REFERRED TO: Communications Division; Council on Socioeconomics; Council on Legislation

STATUS: The Council on Socioeconomics created a template letter in both English and Spanish that physicians may provide to patients to assist them with filing a complaint to Texas Department of Insurance regarding their insurance company health benefits. The template letter has been promoted in both TMA Action and E-tips. TMA is engaged in ongoing advocacy about the importance of consumer education of their health benefits and the need for this education to be provided by their insurance company.

Resolution 410, Health Care Freedom: Protection of Direct Contracting Between Patients and Physicians of All Specialties (Ori Hampel, MD, Harris County Medical Society): That: (1) all Texas physicians, regardless of specialty, as well as health care entities should be allowed to contract with patients directly for the provision of any professional care, surgical and nonsurgical procedures, and diagnostic testing, regardless of whether or not the patient has health care coverage (private, state, or federal) and regardless of whether or not the physician is contracted with a health care coverage entity (private, state, or federal). Restrictions on such care and transactions by private, state, or federal entities should be disallowed in Texas; and (2) any Texas physician or health care entity should be able to directly provide services to a patient for an agreed fee, payment in kind, or no fee, without repercussions by any
private, state, or federal entity. The financial details of such transactions shall remain private between the patient and physician and/or health care entity. **Adopted.**

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

**STATUS:** TMA Policy Compendium updated with policy 235.035.

**Resolution 412, Veterans’ Access to Health Care (Medical Student Section):** That the Texas Medical Association: (1) collaborate with veteran’s organizations and the Texas Health and Human Services Commission to encourage education of veterans on current U.S. Department of Veterans Affairs (VA) health care access policy changes and the Texas Veterans App; (2) formally support AMA policy H-510.985, H-510.986, H-510-989, and H-510-991; and (3) continue to encourage Texas physicians to join the VA registry and participate in the care of veterans. **Referred.**

**REFERRED TO:** Council on Socioeconomics

**STATUS:** TMA continues to encourage Texas physicians to participate in the care of veterans. Recently released reports about the problems associated with the changes made at the VA to address patient access to timely care are being reviewed. TMA will address these issues at the federal level.

**Resolution 413, Delay the Implementation of Downside Risk in Alternative Payment Models**

(Ghassan F. Salman, MD, Travis County Medical Society): That the: (1) Texas Delegation to the American Medical Association take this or a similar resolution to the AMA House of Delegates to request that the Centers for Medicare & Medicaid Services delay the implementation of downside risk in alternative payment models (APMs), and reduce the resulting exposure for physicians to the downside risk in APMs; and (2) Texas Medical Association request that the AMA make this a high priority for legislative advocacy in 2016. **Referred with report back at A-17.**

**REFERRED TO:** Council on Quality; Council on Socioeconomics

**STATUS:** The Chair of the Council on Health Care Quality and staff spoke to the resolution author to discuss the intent of the resolution. It was determined that the intent of the resolution was achieved with TMA’s advocacy to slow MACRA implementation. The Centers for Medicare & Medicaid Services’ “pick your pace” approach under MACRA is supported by the author and no further study is requested at this time. Also see CSE Report 1-A-17 in this handbook.

**Board of Trustees Report 12, Improving Network Adequacy and Out-of-Network Billing Policy:** (1) to adopt BOT Report 12-A-16 Improving Network Adequacy and Out-of-Network Billing Policy; (2) that the Texas Medical Association advocate legislatively for: (a) mediation for all out-of-network services that is available to patients at all facilities while maintaining the current $500 threshold after copayments, deductibles, and coinsurance as well as mandatory increased state agency oversight of insurers that are often brought to mediation; and (b) development of a standard form for physicians to disclose to patients the identity of other physicians or nonphysician practitioners typically utilized in the facility where the planned surgical procedure or labor and delivery will occur. The form should contain disclaimers for unanticipated complications or events and instruct patients on how they may reach out to those physicians and nonphysician practitioners for further information; (3) to reaffirm and ardently pursue legislative goals in TMA Policy 145.032: Improving Network Adequacy in Health Insurance Plans. This adopted House of Delegates policy, which seeks to hold insurers accountable for their actions, is relevant and essential to success; and (4) to refer adopted BOT Report 12-A-16 to appropriate TMA councils and committees to monitor benchmarking laws and develop needed policy. **Adopted.**
REFERRED TO: Council on Legislation

STATUS: Legislation has been filed, SB 507 (Sen. Hancock)/HB 1566 (Rep. Frullo), to address part of what was requested in the BOT report. The bills expand the current mediation process for all out-of-network health care providers practicing at an in-network facility defined as a hospital, ambulatory surgery center, free-standing emergency room, or birthing center. Additionally, it brings in all emergency care situations and adds the Teachers Retirement System as eligible for the mediation process. The $500 threshold for mediation remains in place to qualify and a physician’s right to balance bill is protected. The mediation process itself also was unchanged.

On March 14, 2017, SB 507 was voted out of the Senate Business and Commerce Committee. The bill was modified through a committee substitute due to concerns among the stakeholders including TMA. Sen. Hancock and his staff were very accommodating to our concerns and the product at this point is in-line with the TMA HOD policy on OON surprise billing. To further aid the consumer with the mediation process, standard disclosure language of the mediation process was added for both billing statements as well as the explanation of benefits.

The bill does not include extending the mediation process to out-of-network services at all facilities as contemplated by TMA Policy nor does it push for the development of a standard disclosure form for physicians.

The number of requests for mediation has grown from 14 in 2010 to 1,677 in 2016. Ninety-five percent (95%) of these requests have been resolved at the informal conference call level rather than going through the full process of mediation. With the expansion of new categories in this bill, it is anticipated the number of requests will grow significantly and could serve as the basis for highlighting the narrowing and inadequacy of health plan networks.
TEXAS MEDICAL ASSOCIATION
2017 HOUSE OF DELEGATES ANNUAL SESSION

OPENING SESSION
Friday, May 5, 8 am, Expo Hall, Level 3, George R. Brown Convention Center
(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
   Reverend David Garcia, Mission Concepcion, San Antonio

3. Report of Reference Committee on Credentials
   Sandra Dee Dickerson, MD, Chair

4. Approval of April 29-30, 2016 Minutes
   Michelle A. Berger, MD, Secretary/Treasurer

5. Address of Texas Medical Association Alliance President
   Debbie Pitts

6. Address of Texas Medical Association President
   Don R. Read, MD

7. Board of Trustees Annual Association Finances Report
   Douglas W. Curran, MD, Chair

8. Section Awards
   Young Physician Section, Sandra Williams, DO, Chair
   Young at Heart
   Medical Student Section, Romero Santiago, Chair
   C. Frank Webber, MD
   Student of the Year

9. Presentation of TMA-Established Organizations (video-taped)
   Texas Medical Liability Trust
   Robert Donohoe, President and CEO
   TMA PracticeEdge
   David N. Henkes, MD, Secretary/Treasurer
   TEXPAC
   Bradford Holland, MD, Chair, Board of Directors
   Texas Medical Association Foundation
   Deborah Fuller, MD, President

10. Nominating Speeches
    President-Elect
    Trustees
    AMA Alternate Delegates

11. Recognition of TMA Past Presidents
11. Recognition of TMA Past Presidents
12. Recognition of Outgoing Council and Committee Chairs
13. Acceptance of Handbook Items as Business of the House (see Order of Business)
14. Consideration of Late Reports and Resolutions
15. Moment of Silence for Deceased Physicians
16. Announcements
17. Recess for Reference Committee Hearings
TEXAS MEDICAL ASSOCIATION

2017 HOUSE OF DELEGATES ANNUAL SESSION

REGULAR SESSION
Saturday, May 6, 8:30 am, Expo Hall, Level 3, George R. Brown Convention Center
(The speakers may take items that are not time-specific out of order.)

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

2. Report of Reference Committee on Credentials
   Sandra Dee Dickerson, MD, Chair

3. Announcements

4. American Medical Association Update
   Stephen R. Permut, MD, JD, Immediate Past Chair, Board of Trustees

5. Distinguished Service Award (9:15 am)
   Dan McCoy, MD, to present to Robert T. Gunby Jr., MD

6. Initial Extractions from Reference Committee Reports

7. Elections (9:30 am)

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

9. Call for Reference Committee Reports

10. Adjourn
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES
ORDER OF BUSINESS
2017 ANNUAL SESSION
May 5-6, 2017

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

REPORTS:

1. Report of President
   1. Nominations for Board of Governors, Texas Medical Liability Trust

2. Report of Speakers
   1. TMA Election Process

3. Reports of Board of Trustees
   1. 2016-17 Board Officers and Committees
   2. Disclosure of Affiliations
   3. TMA Collaboration
   4. TMAIT, TMFHQI, and TMLT
   5. TMA Leadership College
   6. Medical Student and Resident Physician Loan Funds
   7. Minority Scholarship Program
   8. Audit of 2015 Financial Statements and 2016-17 Operating Budgets
   9. Investments
   10. Pending Lawsuits Involving TMA
   11. Texas Two Step
   12. Continuation of International Medical Graduate Section
   13. Policy Review

4. Report of Executive Vice President
   1. 2016-17 Update

5. Report of Interspecialty Society Committee (no report)

6. Reports of Committee on Membership
   1. Membership Development
   2. Policy Review

7. Reports of Board of Councilors
   1. Distinguished Service Award — Robert T. Gunby Jr., MD
   2. Bell CMS Bylaws
   3. Resolution 307-A-16
   4. Emeritus Nominations
   5. Honorary Nominations
   6. Policy Review

8. Reports of Committee on Physician Health and Wellness
   1. 2017 Goals; PHR Assistance Fund; Drug Screen Program
   2. Continuing Medical Education Programs

REFERRED TO:

FOA
Informational
SPH
FOA
Informational
FOA
Informational
Informational
FOA
Informational
Informational
Informational
FOA
Informational
FOA
3. Treatment Facilities; Medical Student and Resident Activities (Informational)

4. Policy Review (Informational)

9. Reports of Texas Delegation to the AMA
   1. AMA House of Delegates Meetings in 2016 (Informational)
   2. AMA Membership, Representation, and Delegation Leadership (Informational)

10. Report of International Medical Graduate Section (no report)

11. Reports of Medical Student, Resident and Fellow, and Young Physician Sections (no report)

12. Reports of Council on Constitution and Bylaws
   1. Improving TMA Committee Sunset Review Process (Informational)
   2. Board of Councilors Quorum and Voting Members (FOA)
   3. Authority to Take Action Without a Meeting (FOA)
   4. Membership in a Contiguous Society (FOA)
   5. Proposed Change to the TMA Election Process (FOA)

13. Reports of Council on Health Care Quality
   1. Quality Update (Informational)
   2. Policy Review (SPH)


15. Report of Council on Health Service Organizations (no report)

   1. Policy Review (FOA)

17. Reports of Council on Medical Education
   1. Referral of PHW Report 2, Mental Illness (Informational)
   2. Referral of CME Report 3-A-16, Curriculum Mandates (ME)
   3. Support for Exceptions to Medicare GME Cap-Setting Deadlines (ME)
   4. Rural Training Tracks (ME)
   5. Need for Continued Expansion of GME Capacity (ME)
   6. Referral of Res. 201-A-16 and Res. 207-A-16 (ME)
   7. Policy Review (ME)

18. Report of Committee on Continuing Education
   1. TMA CME Program Update (Informational)

19. Reports of Committee on Physician Distribution and Health Care Access
   1. Long-Range State Health Care Workforce Study (ME)
   2. Enhancements to State Physician Education Loan Repayment Program (ME)
   3. Policy Review (ME)


21. Reports of Council on Science and Public Health
   1. All Hazards Disaster Planning (SPH)
   2. Parental Leave (SPH)
   3. Policy Review (SPH)

22. Report of Committee on Cancer (no report)
23. Report of Committee on Child and Adolescent Health  
   1. Policy Review

24. Report of Committee on Emergency Medical Services and Trauma (no report)

25. Report of Committee on Infectious Diseases  
   1. Policy Review

26. Report of Committee on Reproductive, Women's, and Perinatal Health  
   1. Policy Review

27. Reports of Council on Socioeconomics  
   1. Delay the Implementation of Downside Risk in Alternative Payment Models  
      Informational
   2. Increasing Use of Narrow Networks by Medicare Advantage Plans  
      SOCIO
   3. Prescription Drug Price Negotiation  
      SOCIO
   4. Prescription Drug Value Based Contracting  
      SOCIO
   5. High-Risk Pool Policy  
      SOCIO
   6. MACRA Update  
      SOCIO
   7. Policy Review  
      SOCIO

28. Report of Medical Home and Primary Care Committee (no report)

29. Reports of Patient-Physician Advocacy Committee  
   1. Patient-Physician Advocacy Update  
      Informational
   2. Policy Review  
      FOA

30. Report of Committee on Rural Health (no report)

31. Report of Select Committee on Medicaid, CHIP, and the Uninsured  
   1. Report on Resolution 107-A-16  
      Informational

32. Joint Reports  
   1. Parliamentary Authority Transition for TMA  
      FOA
   2. TMA Bylaws Concerning Retired Member Classification  
      FOA
   3. Resolution 310-A-16 Prevention of In-Hospital Newborn Falls  
      SPH
   4. Resolution 311-A-16 Sexual Orientation Change Efforts in Minors  
      SPH
   5. Preexposure Prophylaxis as HIV Prevention  
      SPH
   6. Federal Medicaid Reform and Implications for Texas  
      SOCIO

33. Report of TEXPAC  
   1. 2017-18 TEXPAC Board of Directors  
      Informational

34. Report of Texas Medical Association Insurance Trust  
   1. TMAIT 2016 Annual Report  
      Informational

35. Report of TMF Health Quality Institute  
   1. TMFHQI 2016 Annual Report  
      Informational

36. Report of Texas Medical Association Foundation  
   1. TMA Foundation 2016 Annual Report  
      Informational

37. Report of Texas Medical Association Alliance  
   1. Alliance Activities and Accomplishments  
      Informational
RESOLUTIONS:

101. Election of TMA Board of Trustees Members
     Lone Star Caucus

103. Texas Medical Board License Renewal Notifications and Payment
     Harris County Medical Society

104. Tort Reform Celebration Day
     El Paso County Medical Society

105. TMA Outreach to Displaced and Refugee Physicians
     Harris County Medical Society

106. Reduced and Alternative Documentation and Administrative Requirements for
     Medical Documentation for Prescribers in Times of Declared Disasters
     Harris County Medical Society

107. Support of Evidence-Based Medicine
     Young Physician Section, Resident and Fellow Section, and
     Medical Student Section

108. Recognition of John R. Holcomb, MD
     Bexar County Medical Society

109. Election Results
     Angelina County Medical Society

110. Integrating Advance Directives Conversation to Maintain Autonomy
     Medical Student Section

111. Addressing Physician Mental Health Status Disclosures
     Medical Student Section

112. Commendation of 2017 Texas Two-Step CPR: Save a Life Campaign
     Arlo F. Weltge, MD, Harris County Medical Society
     Carlos J. Cardenas, MD, Hidalgo-Starr County Medical Society
     Douglas W. Curran, MD, Henderson County Medical Society
     Diana L. Fite, MD, Harris County Medical Society
     A. Tomas Garcia III, MD, Harris County Medical Society
     Keith A. Bourgeois, MD, Harris County Medical Society
     Kayla A. Riggs, Medical Student Section
     Carrie E. de Moor, MD, Collin-Fannin County Medical Society
     Laura Faye Gephart, MD, Bell County Medical Society
     Don R. Read, MD, Dallas County Medical Society
     Richard W. Snyder II, MD, Dallas County Medical Society
     E. Linda Villarreal, MD, Hidalgo-Starr County Medical Society
     David C. Fleeger, MD, Travis County Medical Society
     Michelle A. Berger, MD, Travis County Medical Society
     Dan K. McCoy, MD, Dallas County Medical Society
     Gary F. Floyd, MD, Tarrant County Medical Society
     David N. Henkes, MD, Bexar County Medical Society
     Susan M. Strate, MD, Wichita-Archer-Baylor-Clay-Knox County Medical Society

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203. Resolving the Impact of Travel and Immigration Bans on Health Care Provision
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    Larry Driver, MD

303. Sudden Increase in Liability Claims for Wernicke’s Encephalopathy in Bariatric Patients
    Harris County Medical Society

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    Young Physician Section, Resident and Fellow Section, and
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307. Reducing errors in pharmacy
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308. Expansion of Next Generation 911
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310. Healthy Food in Hospitals
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311. Addressing Access to Maternal Personal Protective Equipment from Radiation
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312. Implementing a Sugar Sweetened Beverage Tax in Texas
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313. Improved Concussion Protocol to Reduce Psychological Morbidity in High School Athletes
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314. Promoting Increased Awareness and Research for Grade School Soccer Related Head Injury
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317. Precision Medicine in Refractory Cancer Treatment and Transparency in Compendia
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318. Access to Special Education Services
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    Webb-Zapata-Jim Hogg County Medical Society

320. Vitamin D3 Supplementation
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404. Allowing Exceptions to the Centers for Medicare & Medicaid Services’ Locum Tenens 60-Day Limit
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405. Minimum Standards for Interstate Sale of Health Insurance Products
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<td>Ben G. Raimer, MD, FAAP, Texas Pediatric Society</td>
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<td></td>
<td>Kimberly M. Carter, MD, Texas Association of Obstetricians and Gynecologists</td>
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<td>Troy T. Fiesinger, MD, Texas Academy of Family Physicians</td>
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<td>Evans Smith, MD</td>
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<td></td>
<td>Ori Hampel, MD (formerly Resolution 102)</td>
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REPORT OF BOARD OF TRUSTEES

BOT Report 1-A-17

Subject: 2016-17 Board Officers and Committees

Presented by: Douglas W. Curran, MD, Chair

Texas Medical Association Bylaws provide that the board shall organize by electing a chair, a vice chair, and a secretary, and that the chair shall appoint committees as needed. In May 201, the board elected Douglas W. Curran, MD, as chair; David N. Henkes, MD, as vice chair; and David C. Fleeger, MD, as secretary. Gary W. Floyd, MD, and E. Linda Villarreal, 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, Don R. Read, MD. The board also welcomed Carrie de Moor, MD, as the young physician member, Laura Faye Gephart, MD, as the resident member, and Kayla A. Riggs as the medical student member for 2016-17.

Board committees for 2016-17 are Investments (Dr. Floyd, chair; Michelle Berger, MD; Dr. Curran; Dr. Fleeger; Dr. Henkes; Dan McCoy, MD; Rick Snyder, MD; and TMA Foundation liaison Craig Norman, RPh) and Educational Scholarship and Loan (Diana Fite, MD, chair; Keith A. Bourgeois, MD; Dr. Read; Dr. Villarreal; Arlo F. Weltge, MD; Dr. Gephart; Ms. Riggs; Dr. S.E. Thompson Scholarship Fund Trustee Raymond S. Greenberg, MD; Resident and Fellow Section representative John Corker; Resident and Fellow Section alternate representative Stephen A. Hermann, MD; Medical Student Section representative Jasmin Aldridge; Medical Student Section alternate representative Sarah Freathy; and TMA Alliance representatives Pam Abernathy, James P. Davis and Rebecca Waller).

Drs. Fleeger, McCoy, and Read; Carrie de Moor, MD; and Ms. Riggs represent the board on the TMA/Texas Osteopathic Medical Association/TMF Health Quality Institute Liaison Committee. Drs. Curran, Fleeger, and de Moor; Keith Bourgeois, MD; and Carlos Cardenas, MD, represent the board on the TMA/Texas Medical Liability Trust Liaison Committee.

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

J. Marvin Smith III, MD, chairs the board’s History of Medicine Committee. Members are Joel S. Dunnington, MD; Mark J. Kubala, MD; Catherine Scholl, MD; Mellick Sykes, MD; Philip T. Valente, MD; Mac Sykes, MD; Margaret Vugrin, MSLS, AHIP; TMA Alliance representative J. J. Waller, MD; RFS representative Brittany Rosales, MD; and MSS representative Jessie Ho.

The TMA board also appoints the Texas Medicine Editorial Board. Members are Owen E. Winsett, MD, chair; Chelsea I. Clinton, MD; Christopher Garrison, MD; John C. Jennings, MD; Roger Khent, MD; Charlotte H. Smith, MD; Gary Ventolini, MD; Alexis Wiesenthal, MD; RFS representative Habeeb Salameh, MD; and MSS representative Chris Massey.
In May 2006, the House of Delegates adopted Board of Trustees Report 18-A-06 as amended to read as follows:

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

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

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

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

The types of material financial interest to disclose are:

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

Attached is a list of affiliations disclosed by all members of the Board of Trustees.
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American Academy of Ophthalmology
   Keith A. Bourgeois, MD

American Academy of Pediatrics
   Gary W. Floyd, MD

American College of Cardiology, Texas Chapter
   Richard W. Snyder, MD

American College of Emergency Physicians
   Diane L. Fite, MD
   Arlo F. Weltge, MD

American Gynecological Association
   Laura Faye Gephart, MD

American Medical Association
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   David C. Fleeger, MD

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   David C. Fleeger, MD

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Cornerstone Hospital
   A. Tomas Garcia III, MD (D)

Doctors Hospital at Renaissance
   Carlos J. Cardenas, MD (B, C, and D)

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   Don R. Read, MD (A, B, C, and D)
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   Diana L. Fite, MD

Fast Pass Urgent Care
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HeartPlace, PA
   Richard W. Snyder, MD

Houston Community College
   Diana L. Fite, MD
   Arlo F. Weltge, MD

International Urogynecological Association
   Laura Fay Gephart, MD

Keith A. Bourgeois, MD, PA
   Keith A. Bourgeois, MD (A, B, C, and D)

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   Douglas W. Curran, MD (C)

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   E. Linda Villarreal, MD

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   Susan M. Strate, MD

North Texas Medical Laboratory
   Susan M. Strate, MD (A)

Northwest Surgery Center
   Michelle A. Berger, MD

OptumInsight
   Susan M. Strate, MD

Park Central Surgical Center
   Don R. Read, MD (B, C, and D)

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   David N. Henkes, MD (B, C, and D)

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   Carlos J. Cardenas, MD (B and C)

Renaissance Medical Foundation
   Carlos J. Cardenas, MD (B and C)

Renaissance Outpatient Rehabilitation Institute DBA Kids Korner
   Carlos J. Cardenas, MD (B and C)
Rotary Club of Dallas
  Don R. Read, MD

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  Keith A. Bourgeois, MD (D)

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  Danny K. McCoy, MD (C)

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  David C. Fleeger, MD

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Texas Medical Association PracticeEdge, LLC
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  David C. Fleeger, MD
  Gary W. Floyd, MD
  Don R. Read, MD

Texas Medical Foundation Health Quality Institute
  David C. Fleeger, MD
  Gary W. Floyd, MD

Texas Medical Liability Trust
  Don R. Read, MD

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  Keith A. Bourgeois, MD

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Texas Society of Colon and Rectal Surgeons
  David C. Fleeger, MD

Texas Society of Pathologists
  Susan M. Strate, MD
Texoma Independent Physicians
Susan M. Strate, MD

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

Workforce Solutions Board of Directors
Carlos J. Cardenas, MD

BY MEMBER:

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  Austin Ear Nose and Throat Clinic (D)
  Bailey Square Surgery Center
  Northwest Surgery Center

Keith A. Bourgeois, MD
  American Academy of Ophthalmology
  Keith A. Bourgeois, MD, PA (A, B, C, and D)
  St. Joseph Medical Center (D)
  Texas Ophthalmology Association

Carlos J. Cardenas, MD
  Doctors Hospital at Renaissance (B, C, and D)
  Frost Bank McAllen, Advisory Board
  Renaissance Gastroenterology Institute (B and C)
  Renaissance Medical Foundation (B and C)
  Renaissance Outpatient Rehabilitation Institute DBA Kids Korner (B and C)
  St. Edward’s University, Board of Trustees
  Workforce Solutions Board of Directors

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Texas Society of Pathologists

E. Linda Villarreal, MD
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
In November 1998, the Board of Trustees adopted a process for considering requests for TMA sponsorship, defined as support given by TMA to external entities. In July 2005, the board amended the Texas Medical Association Sponsorship Process by changing “sponsorship” to “affiliation” throughout. The purpose of the sponsorship process is to provide guidelines for TMA’s association with other groups and organizations. The board believed this purpose would be conveyed more clearly with the term “Sponsorship” changed to the term “Affiliation.” In September 2009, the board amended the name of the TMA affiliation process to TMA Collaboration Process. Renaming the document will alleviate confusion between affiliation with outside entities and the disclosure of affiliations and statement of conflicts of interest by board members.

Examples of collaboration are use of TMA’s name, use of TMA’s logo, use of TMA’s financial resources, TMA membership in coalitions (TMA will not serve as a fiscal agent/treasurer for coalitions), TMA member physician participation in coalitions, and/or TMA staff participation in coalitions. Collaboration is distinct from endorsement. Collaboration may have active participation by TMA; endorsements cannot. TMA will not receive money for collaboration but will receive royalties for endorsements.

The process adopted by the board provides that requests for TMA collaboration be reviewed by the appropriate TMA component, for example a standing committee, a task force, or a section. Consultation with the Office of the General Counsel must precede sending a favorable or unfavorable report to the parent board, council, or committee. The report, after review by the parent component, must be forwarded to the Board of Trustees for the board’s ultimate decision regarding TMA collaboration. When no parent component exists, the report is submitted directly to the Board of Trustees for ultimate decision. If use of TMA’s name or logo is approved, then such use must be coordinated with the Division of Communication to ensure appropriate protections for these service marks.

Over the past 12 months, the Board of Trustees has approved TMA collaboration by approving support to use the TMA logo (1) in the promotion/marketing of the TMA and American College of Medical Quality Texas Quality Summit, Nov. 18-19, 2016; (2) to promote the “Okay to Say” Initiative of the Meadows Mental Health Policy Institute; (3) on the Texas Collaborative for Healthy Mothers and Babies 2016 Annual Conference; (5) for the efforts associated with the Texas Coalition for Healthy Minds; (6) on electronic and published materials for a CME session on MACRA along with logos from Dell Medical School and Travis County Medical Society; (7) in the promotion and publication of the Texas College of Emergency Physicians and HealthCorps Texas Two Step: How to Save a Life Campaign, and (8) sponsorship of the 2016 Texas Primary Care and Health Home Summit.
REPORT OF BOARD OF TRUSTEES

BOT Report 4-A-17

Subject: TMAIT, TMFHQI, and TMLT

Presented by: Douglas W. Curran, MD, Chair

Texas Medical Association Insurance Trust Board of Trustees
The TMA Board of Trustees has responsibility to appoint four members of the TMA Insurance Trust 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 September 2015, the Board of Trustees recommended Richard L. Noel, MD, Houston, to serve a three-year term to fill the seat being vacated by Robert A. Light, MD; Jack L. Cortese, MD, Corpus Christi, to serve a second three-year term; Roberto San Martin, MD, San Antonio, to serve a final three-year term; and Bernard M. Gerber, MD, Bellaire, to serve a final three-year term. Dr. Noel and Dr. San Martin were appointed by the TMA Board of Trustees; Dr. Cortese and Dr. Gerber were elected at the TMAIT annual meeting in September.

TMF Health Quality Institute 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 2017, no physician terms are expiring.

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

Texas Medical Liability Trust 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 2016, no terms were expiring.
REPORT OF BOARD OF TRUSTEES

BOT Report 5-A-17

Subject: TMA Leadership College

Presented by: Douglas W. Curran, MD, Chair

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

This successful program, now in its seventh year, boasts 122 alumni. Ninety alumni scholars serve in TMA leadership via councils, committees, and sections with others representing their county and specialty societies. These physicians serve as thought leaders who can close the divide among clinicians and health care policymakers, and serve as trusted leaders in their local communities.

Participants must be active TMA physician members, 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 2018
Applications for the 2017-18 term are due by May 31, 2017. Visit www.texmed.org/leadership for more information and to download the application. Direct questions regarding the TMALC to Christina Shepherd at leadershipcollege@texmed.org, or call (800) 880-1300, ext. 1443.

Congratulations Class of 2017!
Sixteen scholars will graduate during a luncheon ceremony held at TexMed 2017 on Saturday, May 6:

<table>
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<tr>
<th>Scholar</th>
<th>Specialty</th>
<th>Sponsored By</th>
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<tbody>
<tr>
<td>Anna Allred, MD</td>
<td>Anesthesiology</td>
<td>Harris County Medical Society</td>
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<tr>
<td>Gates Colbert, MD</td>
<td>Nephrology</td>
<td>Dallas County Medical Society</td>
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<td>Ashley Goodnight Hall, MD</td>
<td>Allergy and Immunology</td>
<td>Big Country County Medical Society</td>
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<td>Todd Jarrell, MD</td>
<td>Family Medicine</td>
<td>Travis County Medical Society</td>
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<td>Michelle Koehler, MD</td>
<td>Anesthesiology</td>
<td>Texas Society of Anesthesiology</td>
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<td>Megan Kressin, MD</td>
<td>Pathology</td>
<td>Travis County Medical Society</td>
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<td>David Lam, MD</td>
<td>Neonatology</td>
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<td>Evan Meyer, MD</td>
<td>Emergency Medicine</td>
<td>Wichita County Medical Society</td>
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<tr>
<td>Santhosshi Narayanan, MD</td>
<td>Internal Medicine</td>
<td>Harris County Medical Society</td>
</tr>
<tr>
<td>Mammen Sam, MD</td>
<td>Radiation Oncology</td>
<td>Brazoria County Medical Society</td>
</tr>
<tr>
<td>Kurt Schoppe, MD</td>
<td>Radiology</td>
<td>Texas Radiological Society</td>
</tr>
<tr>
<td>Elizabeth Seymour, MD</td>
<td>Family Medicine</td>
<td>Denton County Medical Society</td>
</tr>
<tr>
<td>Arathi Shah, MD</td>
<td>Pediatrics</td>
<td>Dallas County Medical Society</td>
</tr>
<tr>
<td>Marshall Stein, MD</td>
<td>Urology</td>
<td>Harris County Medical Society</td>
</tr>
<tr>
<td>Nicholas Steimour, MD</td>
<td>Emergency Medicine</td>
<td>McLennan County Medical Society</td>
</tr>
<tr>
<td>Johnathan Warminski, MD</td>
<td>Ophthalmolog</td>
<td>Tarrant County Medical Society</td>
</tr>
</tbody>
</table>

Class of 2017 Curriculum

Live Session Topics
- Acts of Leadership
- Emotional Intelligence
- Personal Leadership
- Team Interaction and Development
- Leading and Influencing With a Hierarchy
- Building Mentor Relationships
- Legislative Process
- Resolution Writing
- Parliamentary Procedure
- Media Training
- Personal Branding
- Using Social Media as a Thought Leader
- Cybersecurity

Self-Study: Scholar Project
REPORT OF BOARD OF TRUSTEES

Subject: Medical Student and Resident Physician Loan Funds

Presented by: Douglas W. Curran, 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, 2016, 55 loans totaling $218,500 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. Two resident loans totaling $4,000 were disbursed from July 1 through Dec. 31, 2015.

In January 2016, the board approved allocations for the 2017-18 school year totaling $656,000, including $40,000 for residents. The loan allocations to the 12 medical schools are based on availability of funds and the history of each school’s utilization. University of the Incarnate Way School of Osteopathic Medicine is included for the first time in this allocation.
REPORT OF BOARD OF TRUSTEES

BOT Report 7-A-17

Subject: Minority Scholarship Program

Presented by: Douglas Curran, MD, Chair

The TMA Minority Scholarship Program has given one hundred and one (101) $5,000 and eleven (11) $10,000 scholarships to underrepresented minority medical students in Texas since it was established in 1998. Eleven Texas medical schools have received an award, and the rotation schedule will continue as funds are available. As of Jan. 9, 2017, for donations toward the 2017-18 school year, the TMA Foundation has collected more than $27,175 in cash and pledges. Additionally, two private donors have made large gifts to this program: Robert J. Bayardo, MD, has donated more than $2 million to date and will eventually bring that total up to $3 million; Patrick Leung, MD, has donated $50,000 to establish the Leung Minority Scholarship Endowment. The program has obtained expenses for the scholarships and recipient travel to TexMed 2017.

This year, the program will award twelve (12) $10,000 scholarships to students matriculating at Texas Tech University Health Sciences Center School of Medicine, Texas A&M Health Science Center College of Medicine, Texas Tech University Health Sciences Center-El Paso Paul L Foster School of Medicine, The University of Texas Southwestern Medical School, The University of Texas School of Medicine in San Antonio, The University of Texas Medical Branch at Galveston, Baylor College of Medicine, The University of Texas Health Science Center at Houston John P. and Kathrine G. McGovern Medical School, University of North Texas Health Science Center at Fort Worth, and newly added, The University of Texas at Austin Dell Medical School, The University of Texas Rio Grande Valley School of Medicine, and University of the Incarnate Word School of Osteopathic Medicine. The TMA Student Loans Department must have received candidate applications by Feb. 24, 2017. TMA will notify scholarship recipients in April and make the presentation ceremony at TexMed 2017 on May 5 in Houston.

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 re-establish 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.
REPORT OF BOARD OF TRUSTEES

BOT Report 8-A-17

Subject: Audit of 2015 Financial Statements and 2016-17 Operating Budgets

Presented by: Douglas Curran, MD, Chair

Audit of 2015 Financial Statements

The audit of 2015 financial statements was presented to the Board of Trustees at its Sep. 23, 2016 meeting. The 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 conformity 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 member.

2016 Operating Budget

For 2016, operating income was $25,131,662 and operating expense was $24,967,940. At year-end, total actual operating income for the year was over budget by $40,912 (0.16 percent). Total actual operating expenses were below budget by $386,310 (1.5 percent), resulting in actual net operating income of $163,722. This surplus was above the budgeted net operating deficit by $427,222. An unaudited report on 2016 operations is attached.

The audit of 2016 financial statements by Holtzman Partners, LLP, will be completed and presented to the Board of Trustees at the board’s 2017 fall meeting. The board will present the audit reports to the House of Delegates in 2017.

2017 Operating Budget

In December 2016, the Board of Trustees approved a 2017 Operating Budget projecting income of $25,590,340, expenses of $25,590,340 and a 2017 Capital Expenditure Budget of $254,750. The operating budget will be presented to the house by board chair Douglas Curran, MD. The board also approved direct financial support of related organizations in 2017 as follows: TEXPAC request for support totaling $431,870; TMA Alliance request for support totaling $309,770; TMA Foundation request for support totaling $115,000; Physician Health and Wellness request for support totaling $249,080; and Association Management Services request for support totaling $1,122,670. Offsetting this expense are projected 2017 fees of $1,094,050 that will be received from specialty societies for their administration by TMA, corporate contributions of $50,000 to TEXPAC, revenue of $148,690 to Physician Health and Wellness, and $15,000 grant revenue received for TMA Foundation programming.

The 2017 expense budget of $25,590,340 represents an increase of $402,090 from the final 2016 expense budget. In support of the expense budget, an income budget of $25,590,340 is projected. This represents an increase of $499,590 from the final 2016 income budget of $25,090,750. As a result, a break-even budget is projected for 2017.

During the 2017 budgeting process, a review of all programmatic activities was conducted. In this review, TMA’s relevance and value to its members was used as the benchmark for the evaluation of all programs to determine the areas that should be expanded or reduced. Containing expenses for approved programs becomes more difficult each year. Thus, either programmatic growth must be restrained or new sources of income must be identified. The 2017 Operating Budget adopted by the board is attached.
### Operating Fund Budget Comparison

<table>
<thead>
<tr>
<th>Income</th>
<th>Building Fund Income</th>
<th>Actual Income</th>
<th>Budgeted Income</th>
<th>Variance</th>
<th>Variance %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Membership Recruitment &amp; Retention</td>
<td>15,828,141</td>
<td>15,828,141</td>
<td>15,800,000</td>
<td>28,141</td>
<td>0.18%</td>
</tr>
<tr>
<td>Royalty Income</td>
<td>2,137,063</td>
<td>2,137,063</td>
<td>2,137,750</td>
<td>2313</td>
<td>0.11%</td>
</tr>
<tr>
<td>Rental Income</td>
<td>1,379,654</td>
<td>1,379,654</td>
<td>1,387,500</td>
<td>7846</td>
<td>0.57%</td>
</tr>
<tr>
<td>Related Organizations</td>
<td>1,164,759</td>
<td>1,164,759</td>
<td>1,120,000</td>
<td>44759</td>
<td>4.00%</td>
</tr>
<tr>
<td>Marketing and Member Services</td>
<td>949,936</td>
<td>949,936</td>
<td>1,086,470</td>
<td>(136,534)</td>
<td>(12.57%)</td>
</tr>
<tr>
<td>Communications</td>
<td>921,703</td>
<td>921,703</td>
<td>826,450</td>
<td>95253</td>
<td>11.53%</td>
</tr>
<tr>
<td>Legal</td>
<td>204,393</td>
<td>204,393</td>
<td>197,560</td>
<td>24833</td>
<td>13.83%</td>
</tr>
<tr>
<td>Educational Programs</td>
<td>281,043</td>
<td>281,043</td>
<td>534,400</td>
<td>(253,357)</td>
<td>(47.41%)</td>
</tr>
<tr>
<td>Marketing and Conferences</td>
<td>436,268</td>
<td>436,268</td>
<td>421,000</td>
<td>15268</td>
<td>3.63%</td>
</tr>
<tr>
<td>Organizational Support Activities</td>
<td>983,607</td>
<td>983,607</td>
<td>994,860</td>
<td>(11253)</td>
<td>(1.37%)</td>
</tr>
<tr>
<td>Medical Education</td>
<td>203,147</td>
<td>203,147</td>
<td>206,910</td>
<td>(3763)</td>
<td>(1.82%)</td>
</tr>
<tr>
<td>Advocacy and Public Policy</td>
<td>126,500</td>
<td>126,500</td>
<td>114,000</td>
<td>12500</td>
<td>10.96%</td>
</tr>
<tr>
<td>Public Health - Quality - Science</td>
<td>123,361</td>
<td>123,361</td>
<td>42,350</td>
<td>81,011</td>
<td>191.29%</td>
</tr>
<tr>
<td>Information Systems</td>
<td>23,980</td>
<td>23,980</td>
<td>19,000</td>
<td>4980</td>
<td>26.21%</td>
</tr>
<tr>
<td>Boards, Councils, Committees</td>
<td>2,575</td>
<td>2,575</td>
<td>0</td>
<td>2575</td>
<td>100%</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td>25,214,042</td>
<td>82,380</td>
<td>25,131,662</td>
<td>40,912</td>
<td>0.16%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>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>2,979,298</td>
<td>2,979,298</td>
<td>3,002,540</td>
<td>(23,242)</td>
<td>(0.77%)</td>
</tr>
<tr>
<td>Organizational Support Activities</td>
<td>4,203,766</td>
<td>4,203,766</td>
<td>4,082,540</td>
<td>119,516</td>
<td>2.93%</td>
</tr>
<tr>
<td>Building Operations</td>
<td>2,082,891</td>
<td>2,082,891</td>
<td>2,117,450</td>
<td>(34,559)</td>
<td>(1.63%)</td>
</tr>
<tr>
<td>Related Organizations</td>
<td>1,967,332</td>
<td>1,967,332</td>
<td>1,936,570</td>
<td>30,762</td>
<td>1.59%</td>
</tr>
<tr>
<td>Legal</td>
<td>1,547,062</td>
<td>1,547,062</td>
<td>1,585,190</td>
<td>(38,128)</td>
<td>(2.41%)</td>
</tr>
<tr>
<td>Public Policy</td>
<td>1,976,230</td>
<td>1,976,230</td>
<td>2,156,990</td>
<td>(180,760)</td>
<td>(8.38%)</td>
</tr>
<tr>
<td>TexMed and Conferences</td>
<td>1,605,654</td>
<td>1,605,654</td>
<td>1,485,320</td>
<td>120,334</td>
<td>8.10%</td>
</tr>
<tr>
<td>Depreciation</td>
<td>1,054,326</td>
<td>1,054,326</td>
<td>1,034,400</td>
<td>19,926</td>
<td>1.93%</td>
</tr>
<tr>
<td>Health Policy - Regulation</td>
<td>1,089,287</td>
<td>1,089,287</td>
<td>1,334,720</td>
<td>(245,433)</td>
<td>(18.39%)</td>
</tr>
<tr>
<td>Information Systems</td>
<td>1,694,314</td>
<td>1,694,314</td>
<td>1,587,340</td>
<td>106,974</td>
<td>6.74%</td>
</tr>
<tr>
<td>Membership Recruitment &amp; Retention</td>
<td>1,900,489</td>
<td>1,900,489</td>
<td>1,896,310</td>
<td>4,179</td>
<td>0.22%</td>
</tr>
<tr>
<td>Marketing and Member Services</td>
<td>793,546</td>
<td>793,546</td>
<td>911,480</td>
<td>(117,934)</td>
<td>(12.94%)</td>
</tr>
<tr>
<td>Public Health - Quality - Science</td>
<td>880,287</td>
<td>880,287</td>
<td>865,140</td>
<td>15,147</td>
<td>1.75%</td>
</tr>
<tr>
<td>Medical Education</td>
<td>421,969</td>
<td>421,969</td>
<td>417,210</td>
<td>4759</td>
<td>1.14%</td>
</tr>
<tr>
<td>Educational Programs</td>
<td>447,615</td>
<td>447,615</td>
<td>457,490</td>
<td>(9,875)</td>
<td>(2.16%)</td>
</tr>
<tr>
<td><strong>Total Expense</strong></td>
<td>24,967,940</td>
<td>0</td>
<td>25,354,250</td>
<td>(386,310)</td>
<td>(1.52%)</td>
</tr>
</tbody>
</table>

| Net Operating Income (Loss)                  | 246,102               | 82,380         | 163,722         | (263,500)| 427,222    |
| Unrealized Gain (Loss) on Investments        | 1,053,735             | 203,316        | 850,419         |          |            |
| Realized Investment Gain (Loss)              | 401,334               | 27,191         | 374,143         |          |            |
| Realized Gain on Sale of Fixed Assets        | 7,467                 | 0              | 7,467           |          |            |
| **Net Operating Balance**                    | 1,708,638             | 312,887        | 1,395,751       | (263,500)| 427,222    |
# Texas Medical Association
## 2017 Operating Budget

<table>
<thead>
<tr>
<th>Income</th>
<th>2017 Budget</th>
<th>2016 Budget</th>
<th>Change</th>
<th>% of Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Membership Recruitment and Retention</td>
<td>$16,125,000</td>
<td>$15,800,000</td>
<td>$325,000</td>
<td>2.1%</td>
</tr>
<tr>
<td>Marketing and Member Services</td>
<td>3,597,970</td>
<td>3,521,220</td>
<td>$76,750</td>
<td>2.2%</td>
</tr>
<tr>
<td>Building Operations</td>
<td>1,515,520</td>
<td>1,387,500</td>
<td>128,020</td>
<td>9.2%</td>
</tr>
<tr>
<td>Related Organization Support</td>
<td>1,308,010</td>
<td>1,268,960</td>
<td>$39,050</td>
<td>3.1%</td>
</tr>
<tr>
<td>Communications</td>
<td>833,450</td>
<td>826,450</td>
<td>7,000</td>
<td>0.8%</td>
</tr>
<tr>
<td>Organization and Support Activities</td>
<td>700,180</td>
<td>753,360</td>
<td>(53,180)</td>
<td>(7.1%)</td>
</tr>
<tr>
<td>Educational Seminars and Publications</td>
<td>534,400</td>
<td>534,400</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Conferences</td>
<td>421,000</td>
<td>421,000</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td>Medical Education</td>
<td>190,910</td>
<td>206,910</td>
<td>(16,000)</td>
<td>(7.7%)</td>
</tr>
<tr>
<td>Information Technology</td>
<td>180,800</td>
<td>184,000</td>
<td>(3,200)</td>
<td>(1.7%)</td>
</tr>
<tr>
<td>Advocacy and Public Policy</td>
<td>106,000</td>
<td>114,000</td>
<td>(8,000)</td>
<td>(7.0%)</td>
</tr>
<tr>
<td>Public Health - Quality - Science</td>
<td>46,500</td>
<td>42,350</td>
<td>4,150</td>
<td>9.8%</td>
</tr>
<tr>
<td>Legal</td>
<td>30,600</td>
<td>30,600</td>
<td>0</td>
<td>0.0%</td>
</tr>
<tr>
<td><strong>Total Income</strong></td>
<td><strong>$25,590,340</strong></td>
<td><strong>$25,090,750</strong></td>
<td><strong>$499,590</strong></td>
<td><strong>2.0%</strong></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Expense</th>
<th>2017 Budget</th>
<th>2016 Budget</th>
<th>Change</th>
<th>% of Budget</th>
</tr>
</thead>
<tbody>
<tr>
<td>Organization and Support Activities</td>
<td>$3,237,440</td>
<td>$3,528,740</td>
<td>(291,300)</td>
<td>(8.3%)</td>
</tr>
<tr>
<td>Communications</td>
<td>3,061,190</td>
<td>2,823,300</td>
<td>237,890</td>
<td>8.4%</td>
</tr>
<tr>
<td>Membership Recruitment and Retention</td>
<td>2,601,170</td>
<td>2,487,100</td>
<td>114,070</td>
<td>4.6%</td>
</tr>
<tr>
<td>Related Organization Support</td>
<td>2,228,390</td>
<td>2,224,740</td>
<td>3,650</td>
<td>0.2%</td>
</tr>
<tr>
<td>Building Operations</td>
<td>2,282,850</td>
<td>2,117,450</td>
<td>165,400</td>
<td>7.8%</td>
</tr>
<tr>
<td>Advocacy and Public Policy</td>
<td>2,232,280</td>
<td>2,157,240</td>
<td>75,040</td>
<td>3.5%</td>
</tr>
<tr>
<td>Conferences</td>
<td>1,532,040</td>
<td>1,475,700</td>
<td>56,340</td>
<td>3.8%</td>
</tr>
<tr>
<td>Legal</td>
<td>1,360,060</td>
<td>1,315,810</td>
<td>44,250</td>
<td>3.4%</td>
</tr>
<tr>
<td>Marketing and Member Services</td>
<td>1,326,040</td>
<td>1,286,250</td>
<td>39,790</td>
<td>3.1%</td>
</tr>
<tr>
<td>Information Technology</td>
<td>1,215,490</td>
<td>1,200,020</td>
<td>15,470</td>
<td>1.3%</td>
</tr>
<tr>
<td>Health Policy - Regulation</td>
<td>1,196,990</td>
<td>1,334,470</td>
<td>(137,480)</td>
<td>(10.3%)</td>
</tr>
<tr>
<td>Public Health - Quality - Science</td>
<td>874,450</td>
<td>846,480</td>
<td>27,970</td>
<td>3.3%</td>
</tr>
<tr>
<td>Depreciation on Furniture and Equipment</td>
<td>542,700</td>
<td>543,000</td>
<td>(300)</td>
<td>(0.1%)</td>
</tr>
<tr>
<td>Depreciation on Building</td>
<td>519,500</td>
<td>491,400</td>
<td>28,100</td>
<td>5.7%</td>
</tr>
<tr>
<td>Educational Seminars and Publications</td>
<td>497,400</td>
<td>481,850</td>
<td>15,550</td>
<td>3.2%</td>
</tr>
<tr>
<td>Medical Education</td>
<td>469,440</td>
<td>457,490</td>
<td>11,950</td>
<td>2.6%</td>
</tr>
<tr>
<td>Boards, Councils and Committees</td>
<td>412,910</td>
<td>417,210</td>
<td>(4,300)</td>
<td>(1.0%)</td>
</tr>
<tr>
<td><strong>Total Expense</strong></td>
<td><strong>$25,590,340</strong></td>
<td><strong>$25,188,250</strong></td>
<td><strong>$402,090</strong></td>
<td><strong>1.6%</strong></td>
</tr>
</tbody>
</table>

## Net Budget Surplus

| Net Budget Surplus                          | $ -         | $(97,500)   | $97,500 |            |            |
TMA and Separate Fund Investments
Members of the 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, the Physician Health and Rehabilitation Assistance 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 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; TMA’s small-cap equity investment managers, SouthernSun; 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 managed by TMA. The committee and board review quarterly composite reports prepared by The Quantitative Group.

The Dec. 31, 2016, net assets of the funds managed by these investment managers were: TMA, $28,461,981; Texas Medical Association Library, $2,423,630; Annie Lee Thompson Library Trust Fund, $3,305,431; May Owen Irrevocable Trust, $2,741,062; Dr. S. E. Thompson Scholarship Fund, $5,700,160; Physicians Benevolent Fund, $3,801,986; and Texas Medical Association Special Funds Foundation, $2,304,131.

Dec. 31, 2015, Investment Manager Performance Report
Since Dec. 31, 1993, the composite annualized performance for all equity investments has been 8.44 percent versus the Standard and Poors annualized rate of return of 9.17 percent. The one-year rate of return was 11.61 percent versus the S&P 500 return of 11.96 percent. Equity investment allocation by manager is approximately 65 percent at Luther King Capital Management, 15 percent in SouthernSun small/mid-cap stock funds, 16 percent in iShares blended mutual funds, and 3.5 percent in Dodge & Cox international stock fund.

Fixed income investment manager Vaughan Nelson Investment Management achieved a 5.7 percent annualized return versus the Barclays US Aggregate annualized return of 5.64 percent for the period June 30, 1992 through Dec. 31, 2016. The one-year rate of return was 2.73 percent versus the index return of 2.65 percent.

Alternative mutual fund investments have experienced annualized return of 0.21 percent versus HFRI Fund of Funds Composite annualized return of 0.63 percent for the period June 30, 2014 through Dec. 31, 2016. The one-year rate of return was 10.25 versus the benchmark return of 0.71 percent.
At each of its meetings, the Board of Trustees reviews an audit trail of pending lawsuits involving the association. An updated report, prepared in March by the Office of the General Counsel, is attached.
POTENTIAL AND PENDING LEGAL ACTION
IN INVOLVING THE TEXAS MEDICAL ASSOCIATION
March 2017

A. LITIGATION AS PLAINTIFF

1. AMA, TMA, et al v. Aetna, and CIGNA

In late 1998, Ingenix, Inc., a wholly owned subsidiary of United HealthCare Group, purchased a “usual, customary, and reasonable” (UCR) database from the Health Insurance Association of America, an insurance trade association. The UCR database served as the basis for several large health insurers’ adjudication of out-of-network claims, including those of Aetna, CIGNA, and WellPoint. According to information and belief, the Ingenix database did not represent actual UCR charges for physicians which was known by Ingenix and the insurers using the database. In fact, the New York attorney general issued a report stating that the Ingenix data base misstated physician payments by an average of 28 percent.

The same attorneys who successfully represented state, county medical associations, and the physician class in the Florida MDL RICO class action lawsuits filed new class action lawsuits to recover damages for out-of-network physicians in early 2009 on behalf of several state and county medical associations, physicians, and the AMA against Aetna, CIGNA, and WellPoint. The lawsuits alleged that Aetna, CIGNA, WellPoint, and Ingenix conspired to improperly and fraudulently adjudicate claims using the Ingenix database. In addition, the lawsuits alleged that the insurers used their own flawed systems to make UCR determinations when the Ingenix data base was incapable of providing data. Therefore, the lawsuits alleged that by systematically making UCR determinations without compliant and valid data, the insurers breached their obligations to properly pay for care provided to their members and insureds on an out-of-network basis. In so doing, the suits alleged that the Defendants shifted the risk to patients and damaged physicians who were underpaid and suffered losses from the costs of attempting to collect amounts that should have been paid in the first instance, and from waived fees when the improperly low UCR payments caused patients to qualify for hardship waivers or discounts.

The lawsuits against Aetna and CIGNA were originally filed in a federal court in New Jersey (where cases against Aetna and CIGNA brought by patients who had been treated on an out-of-network basis were pending). The case against WellPoint was filed in federal court in California.

Aetna

A preliminary settlement agreement was reached in this case in 2012. That settlement agreement failed, however, when insufficient class members agreed to its terms. With the failure of the settlement agreement, the case was assigned to a new Judge, who initially denied the provider Plaintiffs’ motion to amend the complaint. In addition, the Judge dismissed all of the medical society claims, with the exception of the provider Plaintiffs that had previously been enjoined by the MDL Managed Care Litigation case. In her ruling, the court noted that the issue of provider standing was on appeal to the Third Circuit in another case. On September 11, 2015, the Third Circuit ruled that assignment of benefit language need not include specific language assigning the right to sue for a provider to have standing to bring ERISA claims for non-payment of health benefits.

Plaintiffs’ lawyers filed a notice of supplemental authority with the court regarding the Third Circuit decision. On March 23, 2016, the Plaintiffs moved for leave to file an amended complaint.
to add the Plaintiffs who had previously been enjoined from pursuing these claims. In addition, the motion sought to substitute a physician’s medical practice for that physician as a Plaintiff because patients’ assignments of benefits were made to the practice. Briefing was complete as of April 29, 2016. On February 7, 2017, the Court held a hearing on the motion at which the Court denied the motion to allow the Plaintiffs to substitute the medical practice for the physician. The Plaintiffs filed the amended complaint without the substituted medical practice on February 8, 2017. The Defendants have 30 days to respond, after which the parties will brief class certification.

**CIGNA**

The CIGNA case was dismissed in the District of New Jersey by Judge Chesler based on the finding that the assignments of benefits to the physicians by their patients were not adequate to confer ERISA standing insofar as they did not specifically assign the right to bring litigation. Judge Chesler also ruled that the Association Plaintiffs likewise did not have standing. Although the Third Circuit had not specifically addressed this issue when Judge Chesler ruled, his ruling differed from the law in effect in other circuits. The Third Circuit later adopted the approach taken in other Courts that an assignment of benefits to a medical provider confers the right to sue to enforce those benefits.

On June 24, 2014, Judge Chesler issued an order granting Defendants’ motion for summary judgment and dismissing all claims. On July 23, 2014, the attorneys appealed Judge Chesler’s rulings in this case on behalf of the medical associations and physicians to the Third Circuit Court of Appeals and thereafter filed their briefs. On May 2, 2016, the Third Circuit reversed Judge Chesler’s ruling with respect to the provider Plaintiffs, finding that they had standing to sue. However, the Third Circuit upheld Judge Chesler’s ruling on the Association Plaintiffs, finding that they did not have standing. The attorneys for the Association Plaintiffs are evaluating the best way to proceed.

**WellPoint**

Judge Gutierrez denied the petition for class certification, leaving only the individually named physicians and medical societies as the sole Plaintiffs in the case. The Court issued a procedural schedule with expert report and other deadlines for the case to proceed on the individual Plaintiffs’ claims. Subsequently, the medical societies and provider Plaintiffs reached a confidential settlement. Most of the subscriber Plaintiffs dismissed their case after they were unable to reach a settlement agreement. A few of the individual subscribers are continuing the litigation.

2. **Texas Medical Association v. Texas Board of Chiropractic Examiners**

(Concerning a challenge to the Chiropractic Board’s rules on diagnosis, manipulation under anesthesia (MUA), and needle electromyography (EMG))

The Texas Court of Appeals issued its opinion on April 5, 2012. The opinion affirmed trial court judgment invalidating the Needle EMG and MUA rules, held that it had no jurisdiction to consider a cross-point asserted by TMA in support of the trial court’s invalidation of the “diagnosis” rule, and reversed the trial court’s invalidation of diagnosis rule. The Court of Appeals also denied TMA’s motion for rehearing on July 6, 2012. TMA filed its Petition for Review with the Supreme Court of Texas on August 16, 2012.

Result: Trial Court Level:
The lawsuit filed in October 2006 asked a Travis County District Court to invalidate the Chiropractic Board’s rules that would permit chiropractors to make diagnoses, to perform needle EMG, and to perform spinal MUA. Diagnosis and both procedures challenged constitute the practice of medicine. Both procedures can cause serious injuries to patients. MUA is a surgical procedure, and EMG is a diagnostic medical procedure. Texas law prohibits chiropractors from performing surgery or from diagnosing physical diseases, disorders, deformities, or injuries.

EMG is a dynamic invasive diagnostic procedure during which the physician inserts an electrode into a patient’s muscles in order to diagnose the cause of neuromuscular disease ranging from carpal tunnel syndrome to amyotrophic lateral sclerosis (Lou Gehrig’s disease).

The results of needle EMG are employed to make critical medical decisions regarding the need for surgery, further testing such as an MRI, medications, and the determination of disability. Misdiagnosis can mean delayed or inappropriate treatment (including unnecessary surgery) and diminished quality of life for patients. MUA is a surgical technique chiropractors employ supposedly to alleviate acute and chronic neck and back pain. Texas’ chiropractic law specifically prohibits chiropractors from performing any type of surgical procedure.

On October 24, 2006, the Texas Board of Chiropractic Examiners (TBCE) filed a request with the attorney general of Texas, seeking an opinion on the legality of the definition of “surgical procedure” under the Chiropractic Act, Texas Occupations Code §201.002(a)(4). TMA filed comments with the attorney general pointing out that litigation is currently pending on this same issue. On March 22, 2007, the attorney general declined to issue an opinion on the ground that the request relates to the subject of pending litigation.

On February 8, 2007, TMA invited the Texas Medical Board (TMB) into the lawsuit. On March 27, 2007, TMB filed its response to TMA’s Petition to Join and has since been an active party to the litigation and appeal.

A motion by TBCE concerning a plea to the jurisdiction of the court and TMA’s standing to challenge the TBCE rules was heard and denied on December 17, 2007. TBCE subsequently appealed the district court’s order, denying its plea to the jurisdiction. On November 26, 2008, in a substituted opinion, the appellate court affirmed the district court’s order, which found that the trial court had proper jurisdiction to hear TMA’s MUA claims. The appellate court also overruled TBCE’s motion for rehearing en banc. On January 2, 2009, TBCE proposed a rule to state that MUA was within the scope of practice of a chiropractor. This rule was adopted in May 2009, and subsequently, the pleading in the lawsuit was amended to reflect this action.

In November 2009, pursuant to a hearing relating to motions for summary judgment, Judge Yelenosky ruled in favor of the plaintiffs and held that needle EMG and MUA were beyond the statutory authority of a chiropractor, and that the Chiropractic Board authorizing such through a rule was beyond the authority of that board. However, the judge reserved the challenge to use of “diagnosis” as it relates to scope of practice, and stated that a trial on August 16, 2010, would be held regarding whether TBCE could allow chiropractors to “diagnose” medical conditions.
On March 31, 2010, TBCE and the Texas Chiropractic Association (TCA) sought to have the court strike the pleadings filed by TMA and TMB. TBCE and TCA also sought to have the case thrown out on a plea to the Jurisdiction, arguing that neither TMA nor TMB had standing to challenge the rules issued by TBCE. The court rejected both the motion and the plea.

On July 21, 2010, plaintiffs and defendants filed their Second Motions for Partial Summary Judgment, in an attempt to dispose of the remaining issues in the case. These issues primarily focused on the use of the term “diagnosis”, although constitutional challenges were left outstanding.

On August 17, 2010, Judge Yelenosky wrote an opinion letter pertaining to the Motions for Summary Judgment, announcing his intended ruling and to explain his reasoning. In that letter, the judge wrote that “diagnosis” is synonymous with “analyze, examine, or evaluate.” He wrote that the use of a synonym for a statutory term is by definition consistent with and a reasonable interpretation of it. The judge wrote, “The court’s conclusion that the use of the word “diagnosis” is not prohibited, however, is not the same as saying that the unqualified use of the word is permitted.” The judge wrote that he will grant TMA and TMB’s Motion for Summary Judgment as to the invalidity of Rule 75.17(d) and asked for an order to that effect.

On September 7, 2010, the court entered its final judgment and order in the case. In its Final Judgment, the court granted TMA’s and TMB’s Motion for Summary Judgment challenging the rules concerning manipulation under anesthesia, needle electromyography, and diagnosis. Therefore, it ordered that the rules concerning manipulation under anesthesia, needle electromyography, and diagnosis are invalid and void.

Appellate Court Level:

TBCE and TCA each filed an appellant’s brief challenging the court’s ruling. TMA and TMB (attorney general’s counsel) filed a joint appellees’ brief on January 28, 2011.

The court heard oral argument from both sides on September 13, 2011. The panel consists of Chief Justice Jones, Justice Pemberton, and Justice Henson. The appellants had two attorneys argue, an attorney for TBCE and one for TCA.

TMA and TMB filed a joint post submission brief on September 23, 2011, to address issues that arose during oral argument.

In an April 5, 2012, opinion, the Third Court of Appeals ruled Texas chiropractors may not perform needle EMG and MUA. The 58-page appellate court decision supports arguments from TMA and others that the Texas Board of Chiropractic Examiners had exceeded its legal authority in passing rules that would have allowed chiropractors to perform needle EMGs and MUA. TMA filed a motion for rehearing, and on July 6, 2012, the Third Court of Appeals withdrew its April 5 opinion, denied the motion for rehearing, and issued essentially the same opinion. The opinion affirmed the trial court judgment invalidating the Needle EMG and Manipulation Under Anesthesia rules, held that it had no jurisdiction to consider a cross-point asserted by TMA in support of the trial court’s invalidation of the “diagnosis” rule. The diagnosis issue was not decided.
The appeals court justices, however, sent a portion of the case back to the state district court for consideration of the constitutionality of the Texas Chiropractic Act and the Scope of Practice Rule. The Texas Constitution restricts the practice of medicine to a single school of medicine:

The Legislature may pass laws prescribing the qualifications of practitioners of medicine in this State, and to punish persons for mal-practice, but no preference shall ever be given by law to any schools of medicine. Texas Constitution, Article 16, Sec. 31.

TMA filed a Petition for Review with the Supreme Court of Texas on August 15, 2012. TBCE filed a response. The Supreme Court of Texas is not required to grant the Petition for Review.

On October 9, 2012, The Supreme Court of Texas requested TBCE and TCA to respond to TMA’s petition for review. On December 5, 2012, TCA and TBCE filed their responses to TMA’s Petition for Review.

TMA filed its Brief on the Merits on February 18, 2013. TCA and TBCE filed their Briefs on the Merits on April 10, 2013.

On June 14, 2013, the Supreme Court of Texas denied TMA’s petition for review. It did not issue an opinion, but rather declined to consider the case. Because the Texas Court of Appeals (Austin) affirmed TMA’s successful challenge of the needle EMG and MUA Chiropractic Board regulations, chiropractors are not permitted to perform needle EMG or MUA.

The effect of the Supreme Court of Texas not considering the court of appeals decision regarding diagnosis is that the issue of chiropractors diagnosing medical condition is not resolved. (See also A. Litigation as Plaintiff 4. TMA v. Texas Board of Chiropractic Examiners in which the diagnosis issue is raised.)

3. TMA v. The Texas State Board of Examiners of Marriage and Family Therapists

The Texas State Board of Examiners of Marriage and Family Therapists (TSBEMFT), which is administratively attached to the Texas State Board of Social Worker Examiners, proposed a rule that would permit marriage and family therapists to “diagnose.” The rule required marriage and family therapists during their “relationships with clients” to “base all services on an assessment, evaluation, or diagnosis of the client.”

Result: In February 25, 2008, TMA filed written comments with TSBEMFT requesting that the term “diagnosis” be removed from the proposed rule. TMA pointed out that, as opposed to the definition of “practicing medicine,” “marriage and family therapy” is defined, in pertinent part, as those acts that: “involve applying family systems theories and techniques” and “the evaluation and remediation of cognitive, affective, behavioral, or relational dysfunction in the context of marriage or family systems.”

Because the diagnosis of medical conditions (which includes mental and physical conditions) is the practice of medicine, the term “diagnose” was carefully and intentionally omitted from the Texas statutory definition of the practice of marriage and family therapy. The inclusion of the rule would permit marriage and family therapists to...
diagnose medical conditions, and by doing so, unlawfully expand the practice of marriage and family therapy into the practice of medicine.

TSBEMFT, stating that the term “diagnose” was in *Merriam-Webster Dictionary*, adopted the rule.

In January 2009, TMA filed suit against TSBEMFT, challenging its adopted rules authorizing its licensees to diagnose illness.


TSBEMFT deposed Priscilla Ray, MD, TMA’s expert witness, on March 23, 2012. Dr. Ray was an excellent witness. Since marriage and family therapists (MFTs) are allowed (by the rule) to make a “diagnostic assessment” of whether a client has a mental disorder as classified in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)*, and must base all of their services on a client’s “diagnosis,” the question Dr. Ray bored in on is: How are they to do that when one of the prongs of the *DSM* analysis requires an evaluation of whether there are any medical issues that cause or contribute to the apparent mental disorder? Some medications can cause depression, for example, and analyzing whether that is the case and to what extent requires medical training, which marriage and family therapists do not have. Dr. Ray also discussed the stigmatizing effect that a mental disorder diagnosis can have, both personally and professionally, to illustrate the danger of having an untrained person diagnose someone as having a mental disorder.

The deposition of TSBEMFT’s expert witness, Wayne Denton, MD, was also obtained.

On July 12, 2012, TMA filed a Motion for Summary Judgment. On July 13, 2012, the Defendants filed a Motion for Summary Judgment. On July 31, 2012, TMA filed its response to the Joint Motion for Summary Judgment of Defendant and Intervenor. On October 19, 2012, the Defendants and Intervenor filed a Joint Response to TMA’s Motion for Summary Judgment. On November 20, 2012, the judge held a hearing in the case. Judge Yelenosky made a similar ruling as he did in the TMA v. TBCE case regarding diagnosis. He invalidated the first portion of the rule (which allows an MFT to make a diagnostic assessment of disorders in the *DSM*), but repeatedly stated he does not have a problem with the term “diagnosis.” He reiterated his position from the chiropractic case that “diagnosis” is a synonym for “assess and evaluate.” The issue is not the word “diagnosis,” he said, but rather “what” they can diagnose.

Judge Yelenosky signed a Final Judgment on January 23, 2013, which granted TMA’s Motion for Summary Judgment in part (with respect to 22. Tex. Admin. Code § 801.42(13)) and denied it in part (with respect to 22 Tex. Admin. Code § 801.44(q)). 22 Tex. Admin. Code § 801.42(13), which states that The following are professional therapeutic services which may be provided by a Licensed Marriage and Family Therapist or a Licensed Marriage and Family Therapist Associate… (13) diagnostic assessment which utilizes the knowledge organized in the *Diagnostic and Statistical Manual of Mental Disorders (DSM)* as well as the International Classification of Diseases (ICD) as part of their therapeutic role to help individuals identify their emotional, mental, and behavioral problems when necessary was declared invalid and void. 22 Tex. Admin. Code § 801.44(q), which states that “A licensee shall base all services on an assessment, evaluation or diagnosis of the client” was held not to exceed the scope of practice of
MFTs. The Final Judgment also denied TSBEMFT’s Motion for Summary Judgment in part and granted it in part.

Both TSBEMFT and TMA filed Notices of Appeal on January 24, 2013. The TSBEMFT filed its Joint Brief of Appellants/Cross Appellees. TMA filed its appellate brief on May 13, 2013. TMA filed its Cross Appellant’s Brief on May 10, 2013. Oral argument was held before the Third Court of Appeals on October 16, 2013.

The Texas Third Court of Appeals sided with TMA concluding “that the diagnosis of mental diseases or disorders is excluded from the statutory scope of practice for licensed marriage and family therapists.”

Appellants’ Joint Motion for En Banc Reconsideration was filed on December 8, 2014. TMA filed an Opposed Motion to Reject and Return Amicus Brief filed by the Association of Marital and Family Regulatory Boards on March 4, 2015. On March 10, 2015, the Court denied Appellants’ Joint Motion for En Banc Reconsideration and denied Appellee Texas Medical Association’s Opposed Motion to Reject and Return Amicus BriefFiled by the Association of Marital and Family Regulatory Boards.

Additionally, several attempts were made (and failed) on behalf of licensed marriage and family therapists (LMFTs) in the 2015 session of the Texas Legislature to reverse the impact of the appellate court’s “no diagnosis” holding. One such attempt would have directed the licensing boards governing the state’s mental health professionals to use the DSM, ICD, and other diagnostic classification systems, and their billing codes, for evaluation, treatment, and other activities by their respective licensees and in connection with payment. That measure, House Concurrent Resolution 84, was vetoed by the governor.

TSBEMFT and the Texas Association for Marriage and Family Therapists (TAMFT) filed a Joint Petition for Review on May 26, 2015. TMA filed a Response to Petitioner’s Petition for Review on July 24, 2015. TSBEMFT and TAMFT filed a Joint Reply to Response for Petition for Review on August 6, 2015. TSBEMFT and TAMFT filed their brief on the Merits on November 12, 2015. TMA filed a Response Brief on the Merits on December 31, 2015. In its brief, TMA argued, among other things, that the plain meaning of “marriage and family therapy” does not include diagnosis. TSBEMFT and TAMFT filed a Joint Reply Brief on January 19, 2016.

Amicus briefs have been filed on behalf of the California Association of Marriage and Family Therapists and the Association of Marital and Family Therapy Regulatory Boards.

On May 27, 2016, the Supreme Court of Texas denied the Petition for Review. On June 13, 2016, TSBEFMT’s and TAMFT filed a Joint Motion for Rehearing. On July 15, 2016, the Court requested a response from TMA. TMA filed its Response to the Motion for Rehearing on July 20, 2016. In its motion, TMA argued that there was no evidence of potentially devastating consequences if, as a result of the appellate court decision favoring TMA’s position, LMFTs were not able to perform diagnoses of clients. On August 8, 2016, TSBEFMT’s and TAMFT filed a Joint Reply to Response Motion for Rehearing. On September 2, 2016, the Court granted the Petition for Review. Oral arguments were made on October 11, 2016.
On February 24, 2017, the Supreme Court of Texas delivered its opinion, reversing the judgment of the court of appeals. Ruling in favor of the plaintiffs TSBEMFT and the TAMFT on the validity of the diagnostic-assessment rule, the high court said that the Texas Licensed Marriage and Family Therapists Act “authorizes the diagnostic-assessment rule and the Medical Practice Act does not prohibit it.” The Court said that while an LMFT’s authority to provide a diagnostic assessment is subject to real limitations, the act authorizes the diagnostic-assessment rule adopted by the TSBEMFT.

It disagreed with TMA’s construction of “diagnosis” as including the identification of a disease or disorder, which is the practice of medicine. The Court pointed to other provisions in the Occupations Code which it said indicate the authority to for the MFTs to make diagnostic assessments of emotional, mental, and behavioral problems as part of their efforts to evaluate and remediate mental dysfunctions within the marriage and family setting.

4. **TMA v. Texas Board of Chiropractic Examiners**

(Regarding scope of practice, specifically pertaining to vestibular-ocular-nystagmus (VON) testing)

On January 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.

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 August 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 August 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 efforts pertaining to this public records request is discussed further in the attorney general section of this audit trail.
TMA is concerned about 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 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.

Result: 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 January 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.

TMA filed a Motion for Summary Judgment, and TBCE filed its own Motion for Summary Judgment. On December 5, 2011, the parties’ cross motions for summary judgment came on for hearing.

Judge Hurley granted Texas Medical Association’s Motion for Summary Judgment and denied the cross Motion for Summary Judgment of the Texas Board of Chiropractic Examiners. The granting of TMA’s motion invalidated TBCE’s vestibular testing rule by declaring it to be beyond the lawful scope of chiropractic. The court’s order essentially granted TMA all relief it sought in the lawsuit.
On March 15, 2012, TBCE filed its Notice of Appeal, and filed its Appellant’s Brief on June 26, 2012. TMA filed an Appellee Brief on July 24, 2012 arguing the following: 1) the vestibular system is not part of the spine or musculoskeletal system of the human body; 2) the vestibular testing rules unlawfully authorize chiropractors to practice medicine; 3) considerations of “patient safety” and whether chiropractors can fulfill their desired role as primary care doctors are for the legislature, not the court; 4) whether chiropractors are trained adequately to perform vestibular testing and interpret the results is irrelevant to whether vestibular testing is within statutory limits on the practice of chiropractic; and 5) TBCE’s interpretation of the Chiropractic Act is not entitled to deference.


On November 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.

Because the case has been remanded to the trial court, TMA filed its First Amended Original Petition on September 13, 2013. In its amended petition, TMA has 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 has 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 February 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. TMA filed a Response on March 20, 2014. Oral arguments on the Plea to the Jurisdiction were heard in Travis County District Court on April 3, 2014. On May 14, 2014, the court denied the Defendants’ Plea to the Jurisdiction. On June 24, 2014, TBCE appealed the denial of the Plea to the Jurisdiction. On September 5, 2014, TBCE filed Appellants’ Brief in the accelerated appeal of the denial of Defendants’ Plea to the Jurisdiction. TMA subsequently filed a brief, and TBCE filed its Reply Brief of Appellants on October 31, 2014. On December 8, 2014, the Third Court of Appeals held that there was no reversible error in the district court’s order and therefore affirmed it. On January 6, 2015, the Appellants filed a Motion for Panel Rehearing and/or En Banc Rehearing. The Motion for Panel Rehearing and/or En Banc Rehearing were overruled by the Third Court of Appeals on February 23, 2015.

On October 23, 2015, the court denied the Petition for Review.

On June 16, 2016, TBCE filed a Motion for Partial Summary Judgment relating to the diagnosis issue. On July 8, 2016, TMA filed a Response to the Motion for Partial Summary Judgment. On July 15, TBCE and TCA filed a reply to response to the motion for partial summary judgment. A hearing was held on July 20, 2016. On July 27, 2016, Judge Hurley denied the motion.

At the August 2-3, 2016 trial, 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 August 13, 2016.

On October 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 October 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 December 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 December 7, 2016, Judge Hurley signed supplemental findings of fact and conclusions of law.

In January 2017, TBCE filed an appeal with the Third Court of Appeals.

5. **TMA v. Texas State Board of Dental Examiners**
   (Regarding scope of practice, specifically whether dentists may diagnose and evaluate sleep disorder)

On April 25, 2014, TMA filed comments on the Texas State Board of Dental Examiners (TSBDE’s) March 28, 2014, proposed rules regarding dental treatment of sleep medicine. TMA generally opposed the rules on the ground that the proposed rules exceed the scope of dentistry in

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permitting dentists to screen for sleep disorders (including the use of sleep studies) and treat sleep disorders (including obstructive sleep apnea and benign snoring).

On June 6, 2014, TSBDE adopted the rule proposal without incorporating any changes recommended by stakeholders, including TMA.

Result: TMA (represented by David Bragg) filed a lawsuit against TSBDE and Julie Hildebrand, executive director, on November 25, 2014, seeking a declaration that the rule exceeds the lawful scope of practice of dentistry and is therefore void.

As a new executive director and many new members have been appointed to the board, the lawsuit has been temporarily stayed to give TSBDE a chance to review its position and resolve the issues that gave rise to the lawsuit. A stay order was signed by Judge Covington on August 13, 2015.

New proposed rules regarding the dental treatment of sleep disorders were published in the Texas Register on March 18, 2016.

TMA and the Texas Neurological Society (TNS) jointly submitted a comment letter on the proposed sleep apnea rules to the TSBDE on April 15, 2016. Despite the objections of TMA and TNS, the Dental Board adopted the proposed rules without changes. TMA and TNS in their letter had expressed opposition to the proposed rules as exceeding the scope of the practice of dentistry by implying that dentists could jointly diagnose sleep apnea with physicians. The Dental Board responded “that the word "independently" does not grant diagnostic authority to dentists; it emphasizes that dentists may only treat obstructive sleep apnea (OSA) pursuant to a physician's diagnosis of OSA.” TMA also had expressed concern that the proposed rules implied that dentists could screen for sleep apnea and other sleep disorders. In its response, the Dental Board said that there was no need for clarification because dental treatment of OSA must “be accomplished with and pursuant to a doctor’s diagnosis.” TMA also questioned whether the adopted rules sufficiently address concerns regarding a dental screening that fails to trigger a dentist’s referral to a physician for the diagnosis and treatment of other, potentially serious conditions such as stroke. The rules were adopted without changes in the July 29, 2016 edition of the Texas Register, and became effective August 7, 2016. On the advice of counsel the TMA Board of Trustees decided to not challenge these new rules at this time but to monitor the TSBDE enforcement of the rules and the conduct of licensed Texas dentists.

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.

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.

The jury awarded the plaintiff $1.9 million.

Result: TMA joined with the Texas Alliance for Patient Access and the Texas Osteopathic Medical Association in filing an amicus brief on September 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.
1. The Court of Appeals for the First District of Texas in Houston issued its opinion on November 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 January 30, 2015, Ms. Williams filed a motion for rehearing and en banc consideration with the Court of Appeals. On February 26, 2015, the First Court of Appeals requested a response to the motion for rehearing. A response was filed on April 1, 2015.

On September 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 September 2, 2016 the Supreme Court of Texas requested briefs on the merits from both parties. Both sides filed Briefs on the Merits on November 9, 2016. Dr. Benge and Kelsey-Seybold filed a Merits Brief as Cross-Respondents on December 29, 2016. Ms. Williams filed a Response to Petitioners’ Brief on the Merits on December 29, 2016. On February 13, 2017, both sides filed Reply Briefs.

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 have not yet been set.

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.

Result: 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 August 27. Dr. Gomez’s brief was filed on October 27. MH’s reply brief was filed on November 26.

Oral arguments were made on February 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.

Trial had been set for January 17, 2017, but Defendant MH had scheduling conflicts. After a conference with the court, the trial was postponed until March 17, 2017.

(Regarding an action to restrain and enjoin the Texas Medical Board (TMB) from implementing new rule 190.8, which was scheduled to go into effect June 3, 2015.)

In 2011, Teladoc challenged in state court, on a procedural rulemaking basis, TMB’s interpretation of its existing rules in a June 2011 letter to Teladoc. Although TMB successfully defended that action at the trial court level, Teladoc prevailed in a 2-1 appellate court decision overturning the trial court. This ruling was based on the appellate court’s conclusion that the TMB letter to Teladoc constituted rulemaking and that the procedures required for rulemaking were not followed. TMB filed a petition for review to the Supreme Court of Texas. Teladoc filed a response to the petition on August 4, 2015. TMB filed a reply to the petition on August 19, 2015. The court has not yet accepted or denied the petition for review.

In early 2015, TMB initiated emergency rulemaking in an attempt to update its telemedicine rules. Teladoc challenged the emergency rules, and a trial court found a procedural error in the rulemaking, concluding that TMB did not adequately justify the need for emergency rulemaking.

In March 2015, TMB then published proposed rules on telemedicine using the regular rulemaking process. TMA commented favorably on the proposed rules. TMB then adopted those rules as proposed, setting the effective date of June 3, 2015, for new rule 190.8.

More specifically, new rule 190.8(1)(L) provides that the prescription of a dangerous drug or a controlled substance without establishing a defined physician-patient relationship (rather than a proper professional relationship as required in the previous rules) constitutes failure to practice in an acceptable professional manner consistent with public health and welfare. The new rule also specifies that a defined physician-patient relationship must include, at a minimum, establishing a diagnosis through the use of acceptable medical practices, which includes documenting and performing a physical examination that must be performed by either a face-to-face visit or in-person evaluation as defined in Section 174.2(3) and (4) of the TMB rules. The requirement for a face-to-face or in-person evaluation does not apply to mental health services, except in cases of behavioral emergencies.

After TMB’s adoption of the proposed rules, Teladoc filed suit in federal district court challenging new rule 190.8. Among other things, Teladoc argues that the TMB members who are medical licensees are competitors and private actors in an antitrust conspiracy to unreasonably restrain trade. Further, Teladoc argues that the effect of the rules would be to increase prices, limit patients’ ability to choose physicians available through Teladoc, limit the benefits of innovation, and reduce physician output. Teladoc also argues that TMB does not have sufficient state oversight for it to enjoy the state action exemption to the Sherman Act, the relevant federal antitrust statute. Subsequently, Teladoc filed an application for a temporary restraining order and preliminary injunction.

Result: On May 20, 2015, TMA filed an amicus curiae brief in support of TMB’s response in opposition to Teladoc’s application for a temporary restraining order and preliminary injunction. In TMA’s amicus curiae brief, TMA provided information to aid the court in its understanding of the distinctions between the terms “telemedicine” and “telephonic consultation,” as well as the distinctions between telephonic consultations and traditional on-call services. TMA argued that in order to establish a single standard of medical practice and to afford protections to patients who receive medical care, the TMB regulations are a justifiable exercise of the authority granted to TMB by the Texas Legislature.
A hearing was held on May 22, 2015, to consider Teladoc’s request for a temporary restraining order and preliminary injunction. On May 29, 2015, Judge Pitman entered an order granting Teladoc’s motion for a temporary restraining order and preliminary injunction, which enjoined new rule 190.8 from taking effect and enjoined TMB from taking any action to implement, enact, and enforce new rule 190.8 pending final resolution of the claims brought by Teladoc in their complaint.

On June 19, 2015, TMB filed a 12(b) motion addressing the state action protections provided state agencies, which arguably insulate the agency from federal antitrust claims. On July 6, 2015, Teladoc filed an amended complaint that caused Judge Pitman to dismiss TMB’s 12(b) motion on July 6, 2015.

On July 23, 2015, the TMB board members were dismissed from the suit in their individual capacity.

TMB filed an amended motion to dismiss and an amended answer on July 30, 2015. Teladoc filed its Opposition to Defendant’s Motion to Dismiss the Amended Complaint on August 25, 2015. TMB filed its Reply in Support of Amended Motion to Dismiss on September 25, 2015. Teladoc filed a Supplemental Response to Defendants’ Amended Motion to Dismiss on October 23, 2015. TMB filed a Reply to Plaintiff’s Supplemental Response on October 27, 2015.

On December 14, 2015, Judge Pitman denied TMB’s Amended Motion to Dismiss. On January 8, 2016, TMB filed Notice of Appeal to the 5th Circuit Court of Appeals. Trial proceedings have been stayed pending appeal. A trial is tentatively scheduled to begin February 13, 2017.

On June 24, 2016, TMA and AMA filed an amicus curiae brief with the Fifth Circuit.

An amicus curiae brief filed the American Antitrust Institute raised the issue of whether the defendants ought to have moved to certify Judge Pitman’s order for Appeal. On July 6, defendants’ filed a Motion to Certify Order for Appeal. Plaintiff’s filed a Response on July 13, 2016 opposing the motion. Defendants filed a Reply in support of the motion on July 14, 2016. On August 15, 2016, Judge Pitman issued an order denying the Motion to Certify Order for Appeal.

On October 17, 2016, TMB filed an Unopposed Motion to Voluntarily Dismiss Appeal before the 5th Circuit and the appeal was dismissed the same day.

On October 25, 2016, Judge Pitman issued an order lifting the stay previously imposed by his court and ordered that the parties submit a revised joint proposed scheduling order on or before November 8, 2016. On November 2, 2016, all parties submitted a Joint Motion to Stay the proceeding until April 19, 2017. On November 4, 2016, Judge Pitman granted the motion to stay until April 19, 2017. The issue of the proper scope and laws governing for telemedicine in Texas is before the Texas legislature.

4. Glen Hegar, et al. v. The Texas Small Tobacco Coalition and Global Tobacco, Inc. (Regarding whether a tax on certain tobacco manufacturers violates the Equal and Uniform Clause.)
The case centers on H.B. 3536 (2013 R.S.) which imposes a 55-cent fee on each pack of
cigarettes produced by Small Tobacco. The goal of the bill, according to its author, was to tax
smaller cigarette manufacturers in the same way Big Tobacco is taxed. Big Tobacco pays the
state in accordance with the settlement of a lawsuit that Small Tobacco was not a party to.
Both the Trial Court and Court of Appeals sided with Small Tobacco, agreeing that the tax at
issue violates the Equal and Uniform Clause of the Texas Constitution. Such a ruling, if upheld,
would result in significantly less tax revenue for the state to cover the health costs associated with
tobacco use.

TMA submitted an amicus curiae brief to the Supreme Court of Texas on September 9, 2015,
arguing that “(w)hether produced and sold by Small Tobacco or by Big Tobacco, tobacco
products cause the same health problems and inflict the same physical and financial burdens upon
Texas citizens and the State budget” and “(b)oth should, therefore, have to pay their fair share of
tobacco-related health costs whether that be through a judgment, settlement, tax or otherwise.”
TMA’s brief asked the court to grant the Petition for Review to determine if H.B. 3536 is an
appropriate way to ensure that tobacco companies, not taxpayers, pay those health care costs.

Result: The Supreme Court of Texas granted the Petition for Review on October 9, 2015 and
heard oral arguments on December 8, 2015. The Court’s decision was delivered on April
1, 2016 and held that the tax was not “an arbitrary, unreasonable, or unreal one,” and it
thus does not violate the Equal and Uniform Clause. The Court of Appeal’s judgment
was reversed and the case was remanded for consideration of the Coalition’s remaining
challenges.

A Motion for Rehearing was filed on behalf of Texas Small Tobacco Coalition and
Global Tobacco, Inc. on June 17, 2106. The Motion for Rehearing was denied on
September 23, 2016.

5. Texas Association of Acupuncture and Oriental Medicine v. Texas Board of Chiropractic
Examiners, et al.
(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 December 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.”

Result: The appeal hearing took place on December 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

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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.” A decision is
expected sometime in 2016.

The 3rd 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.

TAAOM filed a Motion for Rehearing on October 4, 2016. The Texas Board of
Chiropractors Examiners filed its response on December 29, 2016. TAAOM filed a reply
on January 10, 2017.

On February 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.

TAAOM requested an extension of time to file a further motion for rehearing was filed
on March 1, 2017 and granted on March 2, 2017. The new deadline for TAAOM to file a
motion for rehearing is April 5, 2017.

6. **Doctors Hospital at Renaissance, Ltd., et al. v. Andrade**
(Regarding whether a hospital can be vicariously liable for the alleged professional negligence of
a doctor who is also a limited partner of that hospital.)

Plaintiffs claim that Rodolfo Lozano, MD was negligent during the delivery of Baby Andrade at
Doctors Hospital at Renaissance (DHR). Dr. Lozano was a limited partner of DHR. Plaintiffs
sued Dr. Lozano for negligence and DHR (and its general partner) alleging that they were
vicariously liable for the acts of Dr. Lozano solely because he was a limited partner.

TAPA, TMA and THA filed an amicus curiae brief on February 17, 2016 arguing that the law
clearly distinguishes between the practice of medicine and the provision of health care services.

Oral arguments took place on March 10, 2016.

Result: On May 27, 2016, the Supreme Court of Texas, agreeing with the amicus brief filed by
TAPA, TMA, and THA, held that the limited partnership and its general partner were not
vicariously liable for Dr. Lozano.

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

Result: On August 30, 2016, TAPA, TMA, THA and others filed an amicus curiae brief in the case in support of 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 October 11, 2016.

On February 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.”

8. In Re: Dung Chi Nguyen, M.D., Dung Chi Nguyen, M.D., P.A. and Neurology Consultants
(Regarding whether a defendant physician’s attorney must contact a nonparty patient to deliver a deposition notice in violation of physician-patient confidentiality)

The plaintiff in this case was sexually assaulted while undergoing a sleep study that was ordered by her neurologist, Dung Chi Nguyen, MD. Dr. Nguyen contracted with another defendant, who employed the sleep study attendant who perpetrated the sexual assault.

The plaintiff filed suit asserting, in part, that the defendants were liable for damages due to negligent hiring, failing to implement appropriate policies and procedures, negligent supervision, negligent retention of staff, failure to provide adequate security and protect patients from harm, etc.

During deposition testimony, Dr. Nguyen testified that, after the assault, another patient of his practice who had also undergone a sleep study at this facility had called to request a female attendant for a recommended repeat study. At a follow up visit after the repeat study, this patient advised Dr. Nguyen that she felt “uneasy” during her first sleep study which was attended by the alleged perpetrator of the assault on plaintiff.

After this deposition testimony, counsel for the plaintiff served discovery on Dr. Nguyen seeking the medical records, and deposition, of this unidentified nonparty patient (“Jane Doe”). After a series of motions and hearings, the court ruled (with conditions) that Dr. Nguyen’s counsel must contact Jane Doe and provide her with notice of the deposition.

It is Dr. Nguyen’s position that the court’s order requiring his counsel to contact Jane Doe in order for her to appear and give testimony about her communications with Dr. Nguyen and his staff violates the patient-physician privilege and HIPAA. The privilege may be asserted by a physician on the patient’s behalf. The court’s ruling that the patient is permitted to testify under a pseudonym does not remedy this violation of privilege. In addition, Jane Doe, who would appear at the deposition unrepresented and without preparation for her deposition, would be placed at risk of inadvertently waiving a privilege or releasing protected health information.
On December 30, 2016, Dr. Nguyen filed a Petition for Writ of Mandamus with the Supreme Court of Texas.

Result: On January 4, 2017, TAPA, TMA, TOMA, and THA filed an amicus curiae brief in the case in support of Dr. Nguyen’s position that he may claim the physician-patient privilege on behalf of his patient, Jane Doe, and opposition to the court’s order that Dr. Nguyen’s attorney contact a nonparty patient to deliver a deposition notice in violation of physician-patient confidentiality.

On February 3, 2017, the Supreme Court requested that the real party in interest file a response to the Petition for Writ of Mandamus. The Response to the Petition for Writ of Mandamus was filed on March 6, 2017.

The Court has not yet ruled on the Petition for Writ of Mandamus.

9. **Community Health Systems Professional Services Corporation, et al. v Henry Andrew Hansen, II, MD**

(Regarding whether a physician’s termination, under a contract provision allowing termination without cause after a set period and after conditions were met, requires the employer to prove that it terminated the physician on without-cause grounds to disprove a breach-of-contract claim)

This case decides, among other issues, the applicability of a no-cause termination clause in a physician’s retention contract with the nonprofit health corporation that employed him. Henry Hansen, MD, had a five-year contract with the nonprofit health corporation that employed him that allowed the agreement to be terminated without cause—and consequently no due process—if certain conditions were met. When the corporation terminated Dr. Hansen’s employment without cause and afforded Dr. Hansen no due process, there was a dispute regarding whether the proper conditions were met that would have allowed the employer to exercise the no-cause termination.

Dr. Hansen filed suit alleging, among other claims, that the conditions attached to the no-cause termination waiver had not been satisfied, and thus he should have been provided due process upon termination. After two years of litigating the case, the defendants filed motions for summary judgment claiming that the conditions had indeed been met. The trial court granted the defendants’ motions for summary judgment and Dr. Hansen appealed. On appeal, the appellate court reversed the summary judgment decision on the breach of contract claim. The defendants appealed to the Supreme Court of Texas.

One of the four issues before the Supreme Court in this case was whether Dr. Hansen’s employer—a nonprofit health corporation—should have had to prove the satisfaction of the condition on which it based its use of the no-cause termination provision of the contract.

Result: On February 28, 2017, TMA filed an amicus curiae brief emphasizing the need for due process for physicians employed with nonphysician owned entities. The brief discussed that the foundation of the corporate practice of medicine doctrine was a policy favoring a physician’s independent medical judgment. The brief further claimed that due process was particularly important to protecting that independent medical judgment where state law has allowed nonphysician entities to employ physicians.

On March 2, 2017, the Supreme Court of Texas heard oral arguments in the case.

The Court has not yet ruled on the case.
D. ATTORNEY GENERAL REQUESTS

1. Whether Doctors of Osteopathy are Authorized to Issue Certificates of Medical Examination Under Chapter 574 of the Health and Safety Code (RQ-0133-KP/KP-0124)

On October 6, 2016, Senators Charles Schwertner (Chair, Senate Committee on Health & Human Services) and Joan Huffman (Chair, Senate Committee on State Affairs) filed a request with the Attorney General of Texas (AG) seeking an opinion regarding “whether doctors of osteopathy are authorized to issue certificates of medical examination and other relevant documents under chapter 574 of the Health and Safety Code.”

The genesis for this request was a ruling by Harris County Probate Court Judge Rory Olsen that doctors of osteopathy (DOs) do not have the legal authority to issue Certificates of Medical Examination. In keeping with this ruling, Judge Olsen ordered his staff not to accept recommendations for involuntary psychiatric commitment from DOs.

Judge Olsen cited a section of the Texas Health and Safety Code that says, "a physician shall examine the person," and defines a physician as "a person licensed to practice medicine in this state." He said the term physician implies an MD and rejected arguments about the law already establishing that physicians can be either medical doctors or doctors of osteopathic medicine because a "specific" provision in the code trumps a more "general" one.

On September 16, 2016, TMA, Harris County Medical Society, the Federation of Texas psychiatry, and the Texas Osteopathic Medical Association submitted a joint letter to Judge Olsen asking him to reconsider his interpretation.

Similarly, the TMB wrote a letter, stating that “all physicians licensed by the board enjoy the same legal status, regardless of whether they received their medical degree from a school of osteopathic medicine (DO) or allopathic medicine (MD).”

Judge Olsen responded by saying his “suggestion is that instead of trying to strong arm me into adopting your position, which I do not believe to be correct, that we work together to change the law.”

This prompted Senators Schwertner and Huffman to file the request for an AG opinion.

Judge Olsen has agreed to continue allowing DOs to sign commitment requests until the AG issues an opinion.

On October 20, 2016, TMA submitted a letter brief to the AG stating that “(t)he plain language of the law, as well as established principles of statutory construction, require interpreting the Texas Health and Safety Code, Chapter 574, as defining “physician “ as inclusive of both doctors of osteopathic medicine as well as doctors of medicine; both are licensed as physicians to practice medicine in Texas.”

Result: On December 20, 2016, Attorney General Ken Paxton issued opinion KP-0124 which stated, refusing to accept a certificate of examination for mental illness from a physician solely on the basis that the physician holds a degree designation of doctor of osteopathy rather than a degree of medicine appears to constitute the type of discrimination that the Legislature specifically sought to avoid.” Mr. Paxton goes on to say that “we find no
authority to reject a certificate of medical examination for mental illness solely on the
degree designation distinction.”

E. TMA COMMENTS ON REGULATORY ISSUES

1. Texas Medical Board Proposed Rules concerning Violation Guidelines (22 TAC §190.8)

This proposed rule relates to the ability of physicians to treat the close contacts of patients with
certain contagious diseases (including pertussis). TMA’s Committee on Infectious Diseases
brought this issue to TMB, and TMA was present at a March 31, 2014, workgroup held to work
on a draft rule.

TMB published a proposed rule on May 23, 2014, that contained even more diseases than those
initially suggested by TMA.

TMA commented on the proposed rule in a June 20, 2014, letter that thanked TMB for working
with physicians on a solution to this issue. In the letter, TMA also proposed some edits to
definitions (particularly the definition of ‘close contacts’), which were not accepted by the board.

Result: On July 25, 2014, TMB adopted rules that would allow physicians to treat close contacts
of patients diagnosed with certain infectious diseases (including pertussis) without
establishing the otherwise required professional relationship. TMA will monitor the
effectiveness of this rule change and be prepared to comment if it believes the disease list
should be edited or if the limited definition of ‘close contacts’ limits the effectiveness of
the rule.

At an August 10, 2015, stakeholder meeting, TMB discussed potentially to-be-proposed
rules that would incorporate many of the suggestions made in TMA’s June 20, 2014,
comment letter. Some implementation issues that came up as a result of stakeholder input
will delay publication of any proposed rule.

In the April 1, 2016 Texas Register, the TMB proposed amendments to §190.8 to allow
physicians to provide post-exposure prophylaxis for more communicable diseases by
changing the definition of “close contacts”, to better reflect guidance published by the
Centers for Disease Control, and adding Varicella zoster to the list. TMA suggested this
proposed change and, therefore, did not comment. The TMB adopted the proposed rule
and published notice of the adoption in the July 1, 2016 Texas Register.

2. Texas Medical Board Emergency Rules and Proposed Rules concerning Violation Guidelines
(22 TAC 190.8; 22 TAC §§174.2, 174.5, 174.6, 174.8)

On January 16, 2015, TMB adopted an amendment on an emergency basis to Rule 190.8(1)(L),
relating to Violation Guidelines. On January 23, 2015, TMB distributed a stakeholder notice
soliciting feedback, stating that the purpose of the emergency amendment is to protect the public
health and welfare by clarifying that a face-to-face visit or in-person evaluation is required before
a practitioner can issue a prescription for drugs. The amendment adds language to paragraph
(1)(L) in order to clarify a “defined physician-patient relationship” and the requirements for
establishing same before prescribing drugs. The amendment clearly defines the minimum
elements required to establish a defined physician-patient relationship. The elements include a
physical examination that must be performed either by a face-to-face visit or an in-person
evaluation, as those terms are defined under existing board rules.
The emergency rule also included amendments to §§174.2, 174.5, 174.6, and 174.8, concerning Telemedicine. The amendments to §174.6, relating to Telemedicine Medical Services Provided at an Established Medical Site, revise language to be consistent with other parts of this rule and §190.8(1)(L) by substituting the term “defined” for “proper” before the phrase “physician-patient relationship,” clarifying that a defined physician-patient relationship is defined by §190.8(1)(L) of the TMB rules (described above). Subsection (c) is amended to clarify that patient site presenters are not required at established medical sites when mental health services are being provided, unless there are “behavioral emergencies.” The term “behavioral emergencies” is defined to provide clarity as to what constitutes a behavioral emergency. Subsection (d)(1) is added to expand which types of patient residential locations may be considered established medical sites, and the limits of services that may be provided at these locations. The amendment allows a patient’s private home, which includes a group or institutional setting where the patient is a resident, to be considered an established medical site if the medical services being provided in this setting are limited to mental health services. Subsection (d)(2) is added, setting forth the requirements that must be met in order for medical services, other than mental health services, to be provided at the patient’s home, including a group or institutional setting where the patient is a resident. They include requirements that: a patient site presenter be present; a defined physician-patient relationship be established; and the patient site presenter have sufficient communication and remote medical diagnostic technology to allow the physician to carry out an adequate physical examination while seeing and hearing the patient in real time, with all such examinations being held to the same standard of acceptable medical practices as those in traditional clinical settings. The amendments further clarify that the use of an online questionnaire or questions and answers exchanged through email, electronic text, chat, or telephonic evaluation or consultation with a patient do not meet the requirements to establish a defined physician-patient relationship.

The amendment to §174.8, relating to Evaluation and Treatment of the Patient, changes language to be consistent with other parts of this rule stating that medical treatment and diagnosis via telemedicine is held to the same standards for acceptable medical practices as those in traditional in-person clinical settings. In subsection (a)(2), language is amended related to establishing a diagnosis through the use of acceptable medical practices. Such practices include establishing a defined physician-patient relationship, including documenting and performing a patient history, mental status examination, and physical examination, all of which must be performed as part of a face-to-face or in-person evaluation as defined in §174.2(3) and (4) of this title (relating to Definitions). This amendment further restates the exception to the requirement for a patient-site presenter that applies to mental health services, except in cases of behavioral emergencies, and the need for appropriate diagnostic and laboratory testing to establish diagnoses, as well as identify underlying conditions or contra-indications to treatment recommended or provided.

On February 6, 2015, TMA submitted written comments in response to the emergency rule in advance of TMB’s February 12-13, 2015, meeting. In its comment letter, TMA acknowledged the need to protect the public interest through the enactment of the Texas Medical Practice Act to regulate the granting of that privilege and its subsequent use and control, and recognized TMB as the primary means of regulating the practice of medicine in Texas.

TMA’s letter expressed support for the position that a physician-patient relationship must meet minimum requirements, including establishing a diagnosis through the use of acceptable practices (i.e., face-to-face or in-person evaluation as those legal terms of art are defined in regulation). TMA also offered its support for each state to protect the health and welfare of its citizens and further acknowledges that physicians providing diagnostic and treatment services, through electronic or other means, that are non-episodic and routinely delivered require licensure from the
state in which the patient is physically located — providing the state with the opportunity and
responsibility to regulate the practice of medicine and ensure that medical care delivered by
electronic or other means is provided in accordance with accepted standards of care and
applicable state laws, rules, and regulations.

In regard to the proposed amendments to Chapter 174, TMA suggested that the rules clarify the
parameters of appropriate on-call service arrangements. First, TMA recommended that TMB
amend Section 174.11 to clarify the need for communication and agreement between a physician
who has established a physician-patient relationship with the patient and a physician providing
on-call coverage. TMA’s letter stated that it is paramount that there be mutual agreement among
the relevant professionals to enter into an on-call arrangement. Furthermore, as the purpose of an
on-call arrangement is to ensure timely access to care, the covering physician must be available
locally for patient care when appropriate.

To ensure that physicians who are in a call arrangement with colleagues to provide after-hours
medical care (but not via telemedicine) can continue to provide that care, TMA’s letter urged
TMB to include regulatory permission for traditional call arrangements in Section 190.8(1)(L)
(Disciplinary Violations) as well as in Chapter 174 (Telemedicine) to make sure that the TMB
disciplinary guidelines do not preclude or interfere with physicians’ traditional ability to treat
patients as a part of appropriate on-call service arrangements.

Result: At the TMB meeting held on February 12-13, 2015, TMB voted to publish the emergency
rule in the Texas Register as a proposed rule subject to the regular 30-day notice and
comment period.

On March 6, 2015, TMB published a proposed rule — with the same language as was
included in the emergency rule — for review and comment.

TMA submitted a comment letter on April 4, 2015, regarding the proposed rules that
reiterated the points made in TMA’s February 6 comment letter: that TMA supports the
proposed rule as it provides for safe, high-quality care (including via telemedicine) and
does not interfere with traditional on-call arrangements made by many physicians. The
letter also stated TMA’s desire to continue working with TMB to improve telemedicine
in the state.

On April 10, 2015, TMB voted to adopt the rules as published, with an effective date of
June 3, 2015. On April 29, 2015, Teladoc filed a lawsuit to enjoin the Texas Medical
Board from implementing new rule 190.8. The lawsuit is still pending. (See also C.

3. **Texas Medical Board Proposed Rule concerning Pain Management (22 TAC §§170.1-170.3)**

On May 8, 2015, TMB published proposed rules regarding Chapter 170 Pain Management. The
main change in the proposed rules was to convert what are currently guidelines into rules. Other
changes included a requirement that, prior to the prescription of dangerous drugs on controlled
substances, a physician must consider reviewing prescription data in the Prescription Access in
Texas (PAT) system maintained by the Texas Department of Public Safety and obtaining baseline
toxicology drug screens to determine the patient’s drug levels or document in the medical record
the physician’s rationale for not doing so.
TMB had previously held a stakeholder meeting on this topic on March 18, 2015, but the draft proposed rule at that time did not mention anything about reviewing the PAT or obtaining drug screens. The changes discussed at that meeting mostly related to extended-release hydrocodone and abuse-deterrent formulations, neither of which were in the rule as proposed in the Texas Register.

On June 7, 2015, TMA submitted a comment letter that shared its concern with TMB about having a stakeholder meeting at which the biggest changes to a now-proposed rule were not even mentioned. TMA, therefore, suggested delaying implementation until another stakeholder group could be convened or, alternatively, limiting the application to the treatment of chronic pain.

Result: At its June 12, 2015 board meeting, TMB voted to adopt the proposed rules, with many of the changes suggested by TMA. Most notably, the application of new section 170.3(1)(C) (which would require that prior to prescribing dangerous drugs or controlled substances, a physician would have to consider reviewing the PAT system and obtaining drug screens or document in the medical record a rationale for not doing so) will be explicitly limited to the treatment of chronic pain.

TMB did not, however, take TMA’s suggestion to either remove the requirement to consider reviewing the PAT and obtaining a baseline drug screen or delay voting on this rule until after the PAT transition to the pharmacy board and additional stakeholder input could be given.

The “one pharmacy” rule was a topic at a November 4, 2015, stakeholders meeting and the subject of a TMB rule proposal in the February 12, 2016 Texas Register. TMA did not have issue with the proposed rule and, accordingly, did not comment. The adopted rule was published in the July 1, 2016 Texas Register.

4. Texas Medical Board Proposed Rule concerning Physician Call Coverage (22 TAC §§177.18-177.20)

In comments on previously proposed TMB rules, TMA and other stakeholders brought up issues related to on-call services as related to both traditional patient care as well as telemedicine. In response to this feedback, TMB convened a Telemedicine Stakeholder meeting on July 23, 2015. At the stakeholder meeting, TMB staff identified the following 3 areas of interest for a potential rule change: “reciprocal services”, “same specialty” and models and systems being developed that should be considered while developing the rule.

The TMB’s Telemedicine Committee (composed of TMB members, not stakeholders) subsequently met on August 27, 2015 and directed TMB staff to draft proposed revisions to the Telemedicine On-call Services rule. In the January 29, 2015 Texas Register, new §§177.18 – 177.20 relating to Physician Call Coverage Medical Services were proposed.

The proposed rules, unlike existing §174.11, would apply to all call coverage arrangements, not just those via telemedicine. There would be different requirements for “Expanded Call Coverage” Models (not same or similar specialty or not reciprocal) and “Limited Call Coverage” Models (same or similar specialty and reciprocal).

Expanded Call Coverage Models would require physicians to enter into a call coverage agreement (“CCA”) which (1) establishes the mutual responsibility of the covering and covered physician to meet the standard of care, (2) provides a list of all physicians who may provide
coverage, (3) requires the covering physician to have access to the patient’s medical records, (4) requires reports related to previously diagnosed, non-emergent conditions be made within 7 days, (5) requires reports related to non-previously diagnosed non-emergent conditions be made within 72 hours, (6) requires reports related to emergencies be made within an appropriate time, and (7) requires that the covered physician make the written report part of the patient’s medical record.

Limited Call Coverage Models would require that physicians enter into a verbal or written CCA which (1) establishes the mutual obligation of the covering and covered physician to meet the standard of care and (2) requires documentation related to the patient care be provided to the covered physician within an appropriate amount of time after the call coverage. Also, coverage under this model would be limited to whether the patient should be referred to seek emergency care, be seen by the covering physician or receive treatment that is limited to a 72-hour maximum and requires a follow-up visit with the covering or covered physician.

In a February 25, 2016 comment letter, TMA expressed concern with respect to the proposed rules. Specifically, TMA had concerns with language that would have made covering and covered physicians “mutually responsible” for each other’s care. Generally, TMA also had concerns regarding the applicability of the proposed rules. This concern was evidenced by the excerpts of many of the physician comments included as an addendum to the comment letter. TMA closed the letter by asking the TMB to withdraw and reconsider the proposed rules.

On March 2, 2016, TMB staff sent around a revised version of proposed §§177.18 – 177.20. The revised version addresses TMA’s biggest concern by removing the “mutually responsible” language. It also revised the language so as to avoid the implementation of any new burden for traditional (now called “Reciprocal”) call coverage models. The revised version still permits an expanded model of call coverage (now called “Non-Reciprocal”).

In summary, the revised draft would propose to recognize current call coverage standards of care in TMB rules and expand what type of call coverage is permissible (such as when call coverage is not by a physician in the same or similar specialty or not reciprocal) so long as the seven itemized standards are met. The expanded coverage could be provided via telephone or other technologies.

Result: On March 4, 2016, TMB met for a regularly scheduled board meeting. At that meeting, instead of adopting proposed §§177.18 – 177.20 or revised §§177.18 – 177.20, TMB withdrew the rule from consideration.

TMB staff subsequently called a Telemedicine Stakeholder meeting on May 2, 2016 to discuss the concerns raised by commenters to proposed §§177.18 – 177.20 as well as to consider revised §§177.18 – 177.20.

On July 1, 2016, TMB published new proposed rules for new §§177.18 – 177.20. The July 1 proposed rules are very similar to revised rules circulated in March 2016. The changes between the two versions relate mostly to organization and clearly delineating the differences in obligations that a covering physician has from that of a physician who is requesting the coverage. For instance, the July proposed rules make it clear that the covering physician is responsible for meeting the standard of care, and for creating and transmitting to the requesting physician a report regarding the care provided during the call coverage period.
TMB adopted the rules as published at its August 25, 2016 board meeting. The adopted rules were published in the September 30, 2016 Texas Register, with an effective date of October 9, 2016.

5. Texas Medical Board Proposed Rule concerning Informal Board Proceedings (22 TAC §187.18)

On July 1, 2016, TMB published proposed rules amending §187.18, which relates to the board’s informal settlement conferences (ISC). Among the board’s stated purposes in amending the rules was to comport with the board’s actual practices and to clarify certain requirements relating to evidence that may be considered or presented before the board. Perhaps the most significant changes related to witness statements. The rules explicitly include “written statements by witnesses” and “oral or written statements by complainant [sic] or a victim of an alleged sexual or assaultive offense by a licensee” as materials that may be presented before the board. Further, the rules authorize the board to present “oral or written testimony” by witnesses who are in a position to testify regarding a licensee’s compliance with board orders, rules, or laws. Lastly, the proposed rules remove the authorization to question a witness testifying in the ISC.

TMA solicited and received feedback from several involved parties. Physicians and attorneys who represent physicians in board proceedings all responded in earnest and expressed concern about the ISC process in general. TMA also collected survey responses from TMA members regarding physician experiences with the board. TMA thus saw the TMB’s proposed rules as an avenue for commenting on and seeking reform of the ISC process.

On July 29, 2016, TMA submitted a comment letter to TMB expressing deep concern that if the proposed rules were a reflection of how ISCs operate, there was a significant need for reform and redefinition of the ISC process in general. The theme of the letter was that ISCs—which the legislature intended to be an informal meeting—have morphed into a quasi-hearing, accompanied with many formal requirements but without any of the usual protections. TMA pointed out that it was fundamentally unfair to have different standards apply to witness testimony—that physicians cannot present oral witness testimony while the board can—and also that physicians are unable to cross-examine those witnesses. TMA asserted that these formalistic requirements were lopsided in the board’s favor, but also that these requirements should not be included for regulations of what should be an informal meeting.

TMA requested that TMB withdraw the rules and instead convene a stakeholder’s meeting in order to discuss how better to redefine the ISC process.

After finishing the comment letter, TMA met with staff from the Sunset Advisory Commission and discussed the ISC process and other possible reforms that could be made at TMB. The Sunset Advisory Commission is currently reviewing the TMB and will draft legislation including reforms for the TMB in the upcoming legislative session. TMA shared with Sunset staff TMA’s comment letter and a summary of the feedback TMA received from physicians and attorneys relating to the ISC and formal hearings processes.

TMA continues to monitor any developments relating to these rules.

Result: The proposed rules were officially withdrawn in the January 20, 2017 Texas Register. TMA expects the TMB to hold off finalizing these rules until after the 2017 Texas legislative session.
6. **Texas Board of Chiropractic Examiners Proposed Rules of Practice concerning Vestibular-Ocular-Nystagmus Testing (22 TAC §75.17)**

TMA attended the hearing on the proposed rules pertaining to vestibular-ocular-nystagmus (VON) testing and prepared comments to the proposed rules. Furthermore, TMA made an open records request pertaining to information and emails surrounding the contemplation and proposal of these rules. TMA has filed a lawsuit against TBCE due to the attempted expansion of chiropractors into the practice of medicine and due to the potential hazard to Texans. TMA’s comments on the proposed rules are summarized as follows:

VON testing should not be performed by chiropractors, regardless of any additional chiropractic education or training they may obtain pertaining to the test. 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 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. This proposed rule exceeds the rulemaking authority of the board, just as the proposed rule of the Texas State Board of Podiatric Medical Examiners exceeded its rulemaking authority when it proposed a rule allowing podiatrists to treat parts of the body other than the foot. *(See Texas Orthopaedic Association v. Texas State Board of Podiatric Medical Examiners, 254 S.W.3d 714, 722 (Tex.App. — Austin 2008, pet. denied)).*

Furthermore, TBCE placed the phrase “differential diagnosis” in the introductory remarks to its proposed rule. TMA commented that this is a disingenuous attempt to establish in rule what the law specifically does not authorize.

TMA described the medical implications of vestibular testing, and strongly asserted that the board’s proposed 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 asserted that vestibular testing is 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. It takes years of medical training and education in the intricacies of the audio vestibular system in order to perform, read, and interpret electronystagmographies (ENGs) and videonystagmographies (VNGs), reach a correct diagnosis, and treat patients effectively. Chiropractic education, including the additional training included in the proposed rule, is insufficient to provide the level of education, skill, and expertise necessary to perform and interpret an ENG or VNG.

TMA further asserted that it is a danger to the health of Texans for individuals who are not licensed by TMB to perform ENG or VNG testing. The ears and eyes are not part of the spine and musculoskeletal system of the human body, which is what the practice of chiropractic is limited to statutorily. Furthermore, disorders affecting the biomechanical condition of the spine and musculoskeletal system of the human body do not cause vestibular system pathology. Vestibulocular-nystagmus testing does not fall within the statutory scope of practice of chiropractic.
Result: TMA filed suit against TBCE on this issue and obtained a favorable trial court decision, which has been appealed. (See also A. Litigation as Plaintiff 4. TMA v. Texas Board of Chiropractic Examiners.)

7. **Texas Department of Licensing and Regulation Proposed Rules concerning Orthotics and Prosthetics (16 TAC Chapter 114)**

In the January 8, 2016 *Texas Register*, the Texas Department of Licensing and Regulation (TDLR) published proposed rules which will transfer the functions and regulation of orthotists, prosthetists, prosthetist assistants, orthotist assistants, prosthetists/orthotist assistants, and technicians from the Texas Department of State Health Services to TDLR. While much of the proposed rulemaking merely involves the renumbering and redesignation of current prosthetic/orthotic rules with no substantive changes, there are several proposed changes that are substantive, and these have elicited comments from TMA and TOA. The substantive changes proposed by the new advisory board under TDLR track the changes that were proposed in the Fall of 2015 by the Texas Board of Orthotics and Prosthetics under DSHS.

TMA submitted a comment letter to TDLR on February 8, 2016 with recommendations that reiterate those made previously.

Result: TDLR disagreed with TMA’s and TOA’s comments and made no changes in response to them. The rules were adopted by TDLR and published in the June 17, 2016 *Texas Register*, with an effective date of October 1, 2016.

8. **Texas Department of Licensing and Regulation Proposed Rules concerning Midwives (16 TAC Chapter 115)**

The Texas Department of Licensing and Regulation proposed rules governing the licensure and regulation of midwives. They were published in the *Texas Register* on January 1, 2016. As a result of the passage of S.B. 202 in 2015, the midwives program was transferred from the Texas Department of State Health Services to the Texas Commission of Licensing and Regulation (TCLR), and was renamed the Midwives Advisory Board.

On February 1, 2016, TMA, the American Congress of Obstetricians, and the Texas Association of Obstetricians and Gynecologists submitted a joint comment letter to TDLR (which in turn makes recommendations to the TCLR) regarding several substantive proposals. Their comments regarding the proposed rules were as follows:

- Define a “quorum” necessary for the advisory board to conduct business. The joint commenters recommended that it be defined as a majority (one-half) of the advisory board’s members.
- Continue requiring client referral and transfer for certain conditions, e.g., prior cesarean section without vertical or classical incision, multiple gestation, and history of antepartum or neonatal death.
- Require accredited education and professional certification for midwives.

Result: TDLR adopted final rules, which were published on June 17, 2016 in the *Texas Register*, with an effective date of October 1, 2016.
Concerning the recommend to add a definition for “quorum,” the department said that no definition was necessary as the language was consistent with language used by TDLR for several other boards. No change was made.

Concerning the recommendation to continue requiring referral and transfer for certain high-risk conditions, the department disagreed, stating “[t]hese referral and transfer issues are health and safety issues and as such it is appropriate for them to be further considered by the advisory board in their work group.” No change was made.

Concerning requiring accredited education and professional certification for midwives, the department said the Midwives Advisory Board “had earlier identified raising the standards to meet the current standards of the North American Registry of Midwives. The board referred this comment and all related comments regarding an increase in initial standards to its appointed workgroup to further study and review the standards and possibly make a recommendation at a later date. Therefore, the Department does not believe that any change should be made to the rules based on these comments at this time.”

9. **Texas Board of Nursing Proposed Rules concerning Advanced Practice Nurses and Advanced Practice Registered Nurses (22 TAC §§221.1-221.4, 221.6-221.17, 22 TAC §§221.1-221.15)**

Joined by eight other societies and associations, TMA on June 30, 2014, submitted a comment letter to the Texas Board of Nursing (TBN) concerning its proposed rules regarding scope of practice and standards for advanced practice registered nurses (APRNs) that were published in the *Texas Register* on May 30, 2014. TMA expressed concern about the authority that the proposed rules would grant to APRNs to engage in medical diagnoses. Examples include: a reference to “education in diagnosis” in the propose definition of “Certified Clinical Nurse Specialist”; and a rule addressing scope of practice which states that “[t]he APRN acts independently and/or in collaboration with the health team in…diagnosis…”. TMA stated that the Nursing Practice Act expressly defines “professional nursing” as not including acts of medical diagnosis, and recommended that all references to “diagnosis” be deleted from the proposed rules.

TMA also commented on provisions that would require APRNs to adhere to nursing standards promulgated by national nursing organizations. TMA strongly urged TBN to recognize that APRNs should follow standards adopted by medicine and not nursing when performing acts under the delegated authority of a physician.

The proposed rules would allow for the exemption of certain nursing specialty titles from a general prohibition against the use of those titles. Examples include “Acute Care Clinical Nurse Specialist,” and “Critical Care Nurse Practitioner.” Because the proposed rules did not provide much detail, TMA recommended that TBN give physicians and patients more information and guidance on the required education and training of these “specialty title” APRNs. TMA expressed additional concerns about the “specialty title” rule. Due to the limited training and experience required in the abbreviated programs leading to APRN licensure, it is the delegating physician who must assess the training, education, experience, and competence of each APRN when considering delegation. TMA said that both the physician and the APRN must meet the applicable medical standards of care, and both must understand and agree to the scope of that delegated authority.

In addressing the provisions of the 2013 legislation regarding prescriptive authority agreements (Senate Bill 406), TBN proposed a rule recognizing that these agreements may vary based on a
number of factors, including the complexity of the situation, the area of practice, and the
educational preparation and experience of the APRN. TMA recommended that the phrase “as
determined by the delegating physician” be added at the end of this subsection. TMA also
recommended that the rules be revised to reference existing TMB rules regarding delegation and
prescriptive authority agreements.

Result: TMA received a letter from TBN notifying it that the proposed rules had been withdrawn
and extending an invitation to meet to discuss TMA’s concerns. TMA has accepted this
invitation and created a committee of physicians to meet with TBN. Notice of withdrawal
was published in the August 1, 2014 Texas Register. A delegation from TMA met with
TBN on September 10, 2014, to discuss the rules. Other groups (such as the Texas
Society of Anesthesiologists) also met with TBN to discuss the rules. The rules have not
yet been republished, but TMA will continue to monitor and will comment if necessary.
It is likely that another legislative effort to expand scope will occur in 2017.

10. Texas State Board of Examiners of Marriage and Family Therapists Proposed Rules
concerning Diagnosis

The Texas State Board of Examiners of Marriage and Family Therapists (TSBEMFT), which is
administratively attached to the Texas State Board of Social Worker Examiners, proposed a rule
that would permit marriage and family therapists to “diagnose.” The rule required marriage and
family therapists in their “relationships with clients” to “base all services on an assessment,
evaluation, or diagnosis of the client.”

In February 25, 2008, TMA filed written comments with TSBEMFT requesting that the term
“diagnosis” be removed from the proposed rule. TMA pointed out that, as opposed to the
definition of “practicing medicine,” “marriage and family therapy” is defined, in pertinent part, as
those acts that “involve applying family systems theories and techniques” and “the evaluation and
remediation of cognitive, affective, behavioral, or relational dysfunction in the context of
marriage or family systems.”

Because the diagnosis of medical conditions (which includes mental and physical conditions) is
the practice of medicine, the term “diagnose” was carefully and intentionally omitted from the
Texas statutory definition of the practice of marriage and family therapy. The inclusion of the rule
would permit marriage and family therapists to diagnose medical conditions, and by doing so,
unlawfully expands the practice of marriage and family therapy into the practice of medicine.

Result: The Texas State Board of Examiners Marriage and Family Therapists, stating that the
term “diagnose” was in Merriam-Webster Dictionary, adopted the rule. TMA filed suit
against TSBEMFT, and the Texas Supreme Court issued an opinion on February 24,
2017 allowing the use of certain diagnostic codes. (See also A. Litigation as Plaintiffs 3.
TMA v. The Texas State Board of Examiners of Marriage and Family Therapists.)

11. Texas State Board of Dental Examiners Proposed Rules concerning Dental Treatment of Sleep
Disorders (22 TAC §108.12)

On January 23, 2013, TMA submitted comments to the Texas State Board of Dental Examiners
(TSBDE) on its agenda item on board policy on diagnosis and treatment of sleep apnea by
dentists. TMA’s letter expressed concerns with TSBDE considering adopting any policy related
to this as sleep apnea is a medical condition and therefore beyond the scope of practice of
dentistry.
TSBDE held a subsequent board meeting on April 26, 2013, concerning dental treatment of sleep disorders. TSBDE did not publish proposed language on this issue prior to the meeting, but TMA nevertheless submitted a comment letter on April 25, 2013, reiterating its opposition on this matter. TMA stated that it is beyond the scope of practice of dentistry in Texas to diagnose a medical disease or disorder, including a sleep disorder, or to independently treat such disorder once diagnosed.

TSBDE subsequently published proposed rule 22 TAC 108.12 in the May 24, 2013 issue of the Texas Register. TMA submitted comments to these proposed rules on June 18, 2013. In such comments, TMA had the following concerns:

- TSBDE restated dental scope of practice, but made a subtle yet significant change from the Dental Practice Act, which would allow dentists to diagnose, operate, or prescribe for directly related and adjacent masticatory structures. The Dental Practice Act does not specifically authorize diagnoses and treatment of these structures.
- The proposed rule would require a dentist to ensure that a physician evaluated a patient in compliance with the Medical Practice Act and TMB rules. This requirement would necessitate knowledge and oversight beyond the scope of a dentist’s training or license.
- The rules stated that a dentist “should” screen patients for a sleep disorder. TMA opposed the tacit requirement that dentists screen for a medical disorder, and opposed any diagnosis or independent treatment by dentists of sleep disorders.

TSBDE formally published proposed rules in the September 13, 2013 issue of the Texas Register. The proposed rules contained new language that would allow dentists to order a sleep study, but the sleep study must be interpreted by a licensed Texas physician. TMA commented on these proposed rules in a strongly worded letter to TSBDE on October 8, 2013. The dental board did not adopt the rules, but decided to continue to review them.

On April 25, 2014, TMA filed comments on TSBDE’s March 28, 2014, proposed rules regarding dental treatment of sleep medicine. In its 13-page comment letter, TMA generally opposed the rules on the ground that the proposed rules exceed the scope of dentistry in permitting dentists to screen for sleep disorders (including the use of sleep studies) and treat sleep disorders (including obstructive sleep apnea [OSA] and benign snoring).

Among TMA’s specific concerns regarding the rule proposal were the following:

- The rule proposal’s restatement of the scope of dentistry conflated two statutory provisions in a manner that could be misleading;
- The rule proposal contained broad language authorizing dentists to screen for obstructive sleep apnea and benign snoring, including through the use of sleep studies;
- The rule proposal contained broadly drafted language authorizing the dentists to independently diagnose, treat, and monitor any dental comorbidity related to benign snoring or OSA with a non-exhaustive list of dental comorbidities;
- The rule proposal contained language that would authorize a dentist to use an oral appliance to treat and monitor benign snoring when no apneic episodes are reported or discovered, provided that the dentist merely considers referral to a licensed Texas physician in accordance with the standard of care.

Result: On June 6, 2014, TSBDE adopted the rule proposal without incorporating any changes recommended by stakeholders, including TMA.
TMA filed a lawsuit against TSBDE and Julie Hildebrand, executive director, on
November 25, 2014. The lawsuit is still pending. *(See also A. Litigation as Plaintiffs 5.
TMA v. Texas State Board of Dental Examiners.)*

New proposed rules regarding the dental treatment of sleep disorders were published in
the *Texas Register* on March 18, 2016.

On April 15, 2016 TMA and the Texas Neurological Society submitted a joint comment
letter. Despite the objections of the TMA and others, the Dental Board adopted changes
to its rules on sleep disorders at its June 3, 2016 meeting. The adopted rules were
published in the *Texas Register* on July 29, 2016. TMA had expressed opposition to the
proposed rules as exceeding the scope of the practice of dentistry by implying that
dentists could jointly diagnose sleep apnea with physicians. The Dental Board responded
“that the word "independently" does not grant diagnostic authority to dentists; it em-
phasizes that dentists may only treat obstructive sleep apnea (OSA) pursuant to a
physician's diagnosis of OSA.” TMA also expressed concern that the proposed rules
implied that dentists could screen for sleep apnea and other sleep disorders. In its
response, the Dental Board said that there was no need for clarification because dental
treatment of OSA must “be accomplished with and pursuant to a doctor’s diagnosis.”
Some question whether the adopted rules sufficiently address concerns regarding a dental
screening that fails to trigger a dentist’s referral to a physician for the diagnosis and
treatment of other, potentially serious conditions such as stroke. TMA will monitor the
enforcement of the new rules on sleep apnea.

12. State Board of Dental Examiners Proposed Rules Concerning the Blue Ribbon Panel on
Dental Sedation/Anesthesia Safety (22 TAC § 100.12)

In the September 23, 2016 *Texas Register*, the State Board of Dental Examiners proposed rules
concerning the establishment of the Blue Ribbon Panel on Dental Sedation/Anesthesia Safety.
The panel’s purpose is “to review, study, and report to the Legislature and the Sunset
Commission findings and recommendations on the use and misuse of sedation/anesthesia in
dentistry.” The panel is to make recommendations to the Sunset Commission and the Texas
Legislature by January 2017. The proposed recommendation for an advisory panel followed a
Sunset Commission staff report that found that dental anesthesia can be high risk to patients, and
that related complaints to the dental board have increased. The Commission recommended a 5-10
member blue-ribbon panel; the dental board, in its proposal, instead recommended a 5-10
member panel composed of active participants on the dental board’s dental review panel. In
response, TMA in its comment letter recommended that a Texas physician currently practicing as
an anesthesiologist be included on the panel. The panel already has held two meetings, and
several others are scheduled to take place before the end of the year.

The Dental Board adopted rules regarding the Blue Ribbon Panel without changes to the
proposed rules; these rules were published in the December 16, 2016 *Texas Register*. In its
explanation for refusing to adopt TMA’s recommendation to include an anesthesiologist on the
panel, the Dental Board said that the Sunset Commission did not specify the makeup of the panel;
“[i]f the Commission thought it necessary to include an anesthesiologist, they would have
directed the Board to appoint one.”

The Blue Ribbon Panel submitted its report on dental sedation/anesthesia safety on January 4,
2017 to the Sunset Commission. Its key recommendations were as follows:
• Give the Dental Board the authority to conduct inspections of dentists administering sedation/anesthesia.
• Give the Dental Board the authority to review dental office sedation records, which may be used as an indicator for an onsite inspection by the Dental Board.
• Require sedation providers to have emergency protocols.
• Require staff training in recognizing and managing dental sedation/anesthesia related emergencies, with specialized training for those who sedate/anesthetize children under 8 years of age.
• Require dental offices where portable providers of anesthesia/sedation function to have basic ventilation equipment onsite.
• Require the Dental Board to continue using an independent panel of expert sedation/anesthesia providers to advise the board.
• Require the Dental Board to publish de-identified sedation-related major events and mishaps.
• Require the Dental Board to collect data regarding sedations performed by Texas dentists.
• Require that the sedation record for a dental procedure be a part of the dental record, even if the sedation provider is a non-dentist (such as an anesthesiologist).

The Blue Ribbon Panel recommendations were submitted at the January 11, 2017 meeting of the Sunset Commission. The commission decisions direct the dental board to revise rules to ensure dentists with one or more anesthesia permits maintain related written emergency management plans. The decisions also provide that level 2–4 sedation/anesthesia permit holders’ emergency plans must include current Advanced Cardiac Life Support (ACLS) rescue protocols and advanced airway management techniques. The decisions also direct that, for level 2–4 sedation/anesthesia permit holders treating pediatric patients, emergency management plans must include current Pediatric Advanced Cardiac Life Support (PALS) rescue protocols and advanced airway management techniques.


After a two-year draft rule revision process, the Texas Department of Insurance (TDI) proposed rules regarding independent review organizations (IROs). The proposed rules were published in the November 28, 2014 Texas Register with a 30-day comment period. TMA submitted its formal comments regarding the proposed rules in a December letter to the department. TMA had previously provided comments to TDI regarding the draft rules in December 2013 and August 2014. In its communications with the department, TMA has repeatedly requested that the department revise the rules to do the following:
• In the IRO application, require the applicant to submit evidence that it is doing business in the state in accordance with current law, such as a letter from the Secretary of State indicating that the applicant has filed the appropriate information to conduct business in Texas.
• In the IRO application, require the submittal of written evidence such as the bylaws, rules, and regulations regulating the conduct of the applicant, and require that this evidence be accompanied by the notarized certification of an officer or authorized representative regarding the authenticity of the evidence submitted.
• Require that personnel conducting independent reviews for an IRO provide health services in the same or similar specialty and with the same licensure. This
recommendation should apply in both the non-workers’ compensation and the workers’ compensation contexts.

- Require that an IRO be under the direction of a medical director who is a physician licensed in Texas.

It should be noted that TMA was successful in keeping out of the proposed rules a fee increase for independent reviews. Such an increase, had it been proposed and adopted, could have had a negative impact on non-network physicians offering services to injured workers.

Result: TDI adopted final IRO rules, which were published in the May 8, 2015 Texas Register. Regarding TMA’s comments, above, TDI responded as follows:

- TDI did not make the requested change to its rules to require submittal of evidence that an IRO applicant is doing business in the state in accordance with state law (such as a letter from the Secretary of State indicating that the applicant filed the appropriate information). TDI revised the rule to list as an example of Texas incorporation “a copy of the Certificate of Formation from the Secretary of State.”

- TDI did not make the requested change to its rules to require the submittal of written evidence such as the bylaws, rules, and regulations regulating the conduct of the applicant, nor do the rules require that this evidence be accompanied by the notarized certification of an officer or authorized representative regarding the authenticity of the evidence submitted.

- TDI did not make the requested change to require that personnel conducting independent reviews for an IRO provide health services in the same or similar specialty and with the same licensure.

- TDI did not make the requested change to require that all physicians conducting independent reviews and all medical directors be licensed in Texas.

The adopted rules keep the fees to be paid to an IRO by utilization review agents and other payers for each independent review at $650 (tier one) and $460 (tier two). This is likely to be a priority issue during the Texas legislative session beginning in 2017.


On May 27, 2016, TDI published proposed rules that would amend the out-of-network claim dispute resolution process in accordance with Senate Bill 481 (85th Regular Session). SB 481 lowers the threshold for patients to initiate mediation for certain claims for services provided by out-of-network, facility-based physicians at in-network hospitals from $1,000 to $500 (after copayments, deductibles, and coinsurance). Additionally, the bill, as passed, amended the definition of “facility-based physicians” to include assistant surgeons.

On June 27, 2016, TMA submitted a comment letter to TDI highlighting issues with the rule and requesting that the proposed rules be amended to address those issues. These issues and TMA’s concern with those issues include the following:

- The proposed rules authorized claims dispute resolution for money owed to certain “facility-based” physicians. TMA pointed out that SB 481 limited these physicians to those working in only “hospitals” and thus the language of the proposed rules should be
changed to “hospital-based” physicians or to at least make the rule clearer to ensure it
does not exceed the scope of the bill.
• TDI proposed to make what it deemed to be nonsubstantive changes. TMA pointed out
instances in which the proposed changes made the rules less clear, and thus
recommended keeping the language as it is currently.
• TDI sought to ensure that providers could not deliberately reduce claim amounts below
the threshold with the sole purpose of avoiding required mediation. While TMA would
not support such actions, TMA argued that the proposed rules were too narrow and did
not consider legitimate and proper instances in which claim amounts could be reduced.

Result: Final rules were published in the Texas Register on October 28, 2016. TDI responded to
TMA’s comments as follows:
• Concerning the “facility-based” versus “hospital-based” issue, TDI agreed with
TMA and kept existing language referring to certain “hospital-based” physicians.
TDI also agreed with TMA’s recommendation regarding the amounts that are
counted toward the $500 mediation threshold, by adding language to include the
amount unpaid by the administrator or insurer in the calculation.
• In the section regarding the scope of the rules relating to out-of-network claim
dispute resolution, TDI had proposed that several headings be revised by deleting
the proviso that the subchapter applied only to claims filed on or after November
1, 2010. TMA recommended that this qualifying statement be retained because it
added clarity to the rules. TDI agreed with TMA’s recommendation and kept the
provisos in the rules.
• TDI had proposed in several places (e.g., definition of “claim”) that the term
“health care services and/or supplies” be revised by replacing the term “and/or”
with “and.” TMA opposed this change, stating that a claim may consist only of
health care services, only health care supplies, or some combination thereof. TDI
agreed with TMA, and left the current language in the rule.
• TMA had recommended that the rules acknowledge situations in which a
reduction in claim amount below the $500 mediation threshold may be
legitimate. TMA recommended that the rule be modified to provide that a claim
does not lose its status as a qualified claim if a reduction in the claim amount
occurs: without the consent of the enrollee; after receipt of a TDI notice that the
enrollee has made a request for mediation; and with the specific intent of
avoiding mediation. TDI generally disagreed, but did add language to make it
clear that the amount involved is that remaining after claim adjudication.
• TMA had questioned why the authorization form regarding the disclosure of an
enrollee’s protected health information (among the list of items included in the
TDI mediation request form) did not include the hospital-based physician and the
hospital-based physician representative in the list of persons to whom authorized
disclosures may be made under the authorization form. TDI agreed to alter the
form to make it clear that the hospital-based physician and the hospital-based
physician’s representative are included in the list of persons to whom authorized
disclosures may be made.

15. Texas Department of Insurance Informal Working Draft Rules on HMOs, Including Network

On Friday, January 9, 2015, TMA and several specialty societies and associations (the
Associations) jointly filed a 34-page letter with the Texas Department of Insurance (TDI),
commenting on the network adequacy and out-of-network payment provisions of TDI’s informal working draft rule proposal on HMOs.

The Associations expressed strong support for the department’s proposal to incorporate some of the consumer protection provisions found in the preferred provider benefit plan (PPBP) and exclusive provider benefit plan (EPBP) network adequacy rules into the HMO rules. Examples of the new consumer protections that TDI proposed incorporating into the HMO rules are remedies for consumers who detrimentally rely on inaccurate provider directories, required disclosures regarding limited hospital networks, and requirements for HMOs to provide an annual network adequacy report to TDI for monitoring of the networks.

While the Associations supported the added consumer protection measures referenced above, the Associations also:

[expressed their] initial disappointment that in an environment of: (1) heightened consumer dissatisfaction with the networks offered by insurers and HMOs and (2) demonstrated insurer disregard for compliance with the basic elements of TDI’s new PPBP/EPBP network adequacy standards, the Department has failed to use the informal working draft HMO rule proposal as a means of significantly strengthening the long-standing HMO network adequacy provisions and has, instead, even proposed taking some significant steps to loosen existing TDI regulation of HMO network adequacy.

On page 4 of the letter, the Associations summarize their primary concerns with TDI’s informal working draft proposal. Among those concerns are that “the rule proposal works to reduce the value of HMO products available to consumers and to increase consumer out-of-pocket expenses by: (1) doubling the miles HMO consumers may be required to travel for coverage for primary care and general hospital care in rural areas; (2) proposing less rigorous standard under which an HMO may obtain an access plan (which effectively acts as a waiver that relieves HMOs from their obligation to comply with the core network adequacy requirements); and (3) creating a new framework under which the HMO’s long-standing duty to hold the consumer harmless when a physician or provider is not reasonably available in-network may be lost if the consumer fails to use one of three out-of-network providers selected by the HMO.

Based upon those general concerns and many other specific concerns detailed in the comment letter, the Associations respectfully requested that, as TDI moves forward, it focuses on strengthening the existing network adequacy standards applicable to HMOs, requiring compliance with the HMO network adequacy standards to be the rule (not the exception), and reducing HMO reliance on alternatives to network adequacy by providing more up-front vetting of HMO networks and monitoring of HMO networks, while strengthening important back-end protections for consumers to rely upon in instances of HMO compliance failures.

It is important to note that the TDI draft proposal is in the informal working draft stage and is subject to further revision before publication of a final rule proposal. TMA will continue to monitor the development of the rules and will provide additional comments to TDI when the rules are formally proposed, which was not expected to occur until after the 2015 legislative session.

Result: TDI proposed rules related to HMOs, which were published in the October 7, 2016 Texas Register. TMA filed 101 pages of comments on a total proposed rewrite of the HMO rules on November 7, 2016. As of the date of the most recent updating of this document, TDI has not finalized the proposed rules.
16. *Texas Department of Insurance Proposed Rules Concerning Communications with Insureds; Readability; Mandatory Disclosure Requirements, and Plan Designations (28 TAC §3.3705)*

In the December 9, 2016 Texas Register, the Texas Department of Insurance (TDI) proposed rules relating to nature of communications with insureds, readability, mandatory disclosure requirements, and plan designations “because of an inadvertent clerical error omitting unchanged subsections (l)(3) - (q) in the adoption of amendments to the section.”


TMA offered strong support for the reinstatement of omitted subsections 28 TAC 3.3705(l)(3)-(q), which contain numerous important insurer disclosure provisions related to the plan’s network adequacy.

Specifically:
- TMA also supported reinstatement of subsections (l)(4)-(l)(9), which are basic provider listing requirements that are imperative to reinstate at a time when: (1) consumers need sufficient and accurate information to select a network provider (if they so choose) and (2) insurer network directory listings are notoriously inaccurate.
- TMA supported the reinstatement of subsection (m) which requires insurers that rely on a local market access plan to provide notice of this fact to each individual and group policy-holder participating in the plan at policy issuance and at least 30 days prior to renewal of an existing policy.
- TMA supported the reinstatement of subsection (o) which sets forth basic disclosures that an insurer must make regarding reimbursement of out-of-network services.
- TMA supported the reinstatement of subsection (p) which establishes separate plan designations for networks that comply with the network adequacy requirements for hospitals (i.e., “Approved Hospital Care Network” or “AHCN”) and networks that do not comply with the network adequacy requirements for hospitals (i.e., “Limited Hospital Care Network.” or “LHCN”).
- TMA supported the reinstatement of subsection (q) which outlines steps that a network previously designated as an Approved Hospital Care Network must take when it no longer complies with the network adequacy requirements for hospitals (though TMA recommended changing the time period in this section from 30 days to 15 in order to limit the potential for insurers to mislead consumers regarding the strength of their hospital networks).

Result: As of the date of the most recent updating of this document, TDI has not adopted the proposed rules. TMA staff continues to monitor the progress of this rulemaking.

17. *Texas Health and Human Services Commission Proposed Rules Concerning Medicaid and Other Health and Human Services Fraud and Abuse Program Integrity (1 TAC §§371.1005, 371.1009, 371.1011, and 371.1015)*

In the August 12, 2016 *Texas Register*, the Health and Human Services Commission (HHSC) proposed rules relating to inspections by the Texas Inspector General (IG). More specifically, the rules laid out efforts by the IG to reduce duplication of efforts between the IG and HHSC’s Medicaid/CHIP division, and also revised the items that a provider must disclose and that the IG may consider for a provider’s screening before enrollment into the Medicaid program. TMA expressed support for the IG’s efforts to maintain integrity in the Medicaid program and also for...
the effort to reduce duplication of enforcement efforts. But TMA expressed concern that the IG’s
consideration of a physician-applicant’s background was too far-reaching. The rules authorized
the IG to take into consideration a physician-applicant’s misdemeanor offenses and even
expunged offenses. TMA argued that not even the Texas Medical Board considers such a broad
scope of background information when licensing physicians, and that the IG should not exceed
the scope of the board’s inquiries for licensing. In fact, TMA argued, Texas law prohibits the IG
from imposing stricter standards for Medicaid enrollment than for licensing.

Result: On February 3, 2017, HHSC published notice of its intent to adopt the rules as proposed.

18. Texas Health and Human Services Commission Proposed Rules Concerning Prescribed
Pediatric Extended Care Center Services (1 TAC §§363.201, 363.203, 363.205, 363.207,
363.209, 363.211, 363.213, 363.215)

In the August 12, 2016 Texas Register, the Health and Human Services Commission (HHSC)
proposed rules relating to Prescribed Pediatric Extended Care Centers (PPECC) services. A
PPECC provides non-residential, center-based care as an alternative to private duty nursing for
individuals under the age of 21 with complex medical needs. TMA submitted a brief comment
letter to the proposed rules. The rules required that prescribing physicians actually see the patient
within 30 days of the patient’s admission to a PPECC. TMA expressed concern that this was a
restriction on a physician’s practice and a physician’s ability to delegate tasks to an allied health
professional. TMA expressed concern that this requirement could lead to needless extra visits.
TMA proposed instead that physicians would merely be subject to existing standards of care
before prescribing admission to a PPECC rather than spell out additional requirements.

Result: On October 21, 2016, HHSC published notice in the Texas Register that it would adopt
the rules as proposed. HHSC determined that the requirements on physician’s practice
was pursuant to HHSC’s authority to determine limitations on covered Medicaid services.

19. Texas Health and Human Services Commission Amendments to HHSC Medicaid Provider
Agreement (effective October 1, 2016) and Uniform Managed Care Contract Terms and
Conditions (effective September 1, 2016)

In August 2016, the Health and Human Services Commission (HHSC) amended the HHSC
Medicaid Provider Agreement, a document that all Medicaid providers must sign. In September
2016, HHSC amended the Uniform Managed Care Contract Terms and Conditions (UMCC)
which governs the contractual requirements imposed on Medicaid managed care organizations
(MCO). HHSC made these changes effective without first publishing in the Texas Register its
intent to make these changes. HHSC did solicit feedback regarding the changes to the UMCC
from the Texas Association of Health Plans (TAHP) but disregarded all of the association’s input.

The changes to both the Provider Agreement and the UMCC impose extraordinarily onerous
burdens on providers and MCOs relating to HIPAA compliance and privacy breach notifications.
Among the most onerous requirements is the requirement that providers provide a breach
notification to HHSC within one hour of a privacy breach for certain types of information and
another requirement that providers provide HHSC with a breach notification for suspected (not
actual) breaches of protected information.

In collaboration with TAHP, the Texas Hospital Association, the Texas Association of
Community-Based Health Plans, the Texas Pediatric Society, and the Texas Academy of Family
Physicians, TMA composed and submitted a comment letter to HHSC strongly opposing both the
substance of the changes to the Provider Agreement and the UMCC and also the seemingly secretive manner in which those changes were made effective. The comment letter also points out that the burdensome requirements are made worse because the requirements were poorly drafted, often using unclear or ambiguous terminology. The letter asserts that the changes amount to an ad hoc rule that should have been made effective only after a public rulemaking and public input process. The letter requests that HHSC withdraw these changes and convene a stakeholder meeting to more carefully craft more reasonable requirements.

Result: HHSC has not yet responded to TMA’s comment letter. On February 23, 2017, HHSC suspended the requirements of its previously amended section of the UMCC. The section is to remain suspended for 45 days and HHSC will issue necessary clarification within that time. HHSC did not address the changes to the provider agreement. TMA staff will continue to monitor.

20. Medicaid and Children’s Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, Medicaid and CHIP Comprehensive Quality Strategies, and Revisions Related to Third Party Liability; Proposed Rules (42 CFR Parts 431, 433, 438, et al.)

On June 1, 2015 (80 Fed. Reg. 31097 et seq.), the Centers for Medicare & Medicaid Services (CMS) published a proposed rule intended to modernize Medicaid and Children’s Health Insurance Program (CHIP) managed care regulations to update the programs’ rules and strengthen the delivery of quality care for beneficiaries. As the first major update to Medicaid and CHIP managed care regulations in more than a decade, CMS believes that the proposed rules will “improve beneficiary communications and access, provide new program integrity tools, support state efforts to deliver higher quality care in a cost-effective way, and better align Medicaid and CHIP managed care rules and practices with other sources of health insurance coverage.” The CMS summary portion of the 201-page proposed rule states:

- The proposed rule would align the rules governing Medicaid managed care with those of other major sources of coverage, including coverage through Qualified Health Plans and Medicare Advantage plans; strengthen actuarial soundness payment provisions to promote the accountability of Medicaid managed care program rates; and promote the quality of care and strengthen efforts to reform delivery systems that serve Medicaid and CHIP beneficiaries. It would also ensure appropriate beneficiary protections and enhance policies related to program integrity. This proposed rule would also require states to establish comprehensive quality strategies for their Medicaid and CHIP programs regardless of how services are provided to beneficiaries. This proposed rule would also implement provisions of the Children’s Health Insurance Program Reauthorization Act of 2009 (CHIPRA) and addresses third party liability for trauma codes.

On July 27, 2015, TMA, the Texas Pediatric Society, Texas Association of Obstetricians and Gynecologists, American College of Obstetricians and Gynecologists-Texas Chapter, and American College of Physicians Services-Texas Chapter submitted a joint letter in general support for the proposed rules. The comment letter expressed the organizations’ collective belief that, on the whole, the proposed rules will significantly improve state and federal oversight of managed care plans, enhance state and MCO accountability, and advance mutual goals of improving quality and availability of services to beneficiaries.

The comment letter offered support for the proposed rules relating to the establishment of actuarially sound payment rates, emphasizing the need to utilize accurate and up-to-date
information, along with a documented methodology, in determining such capitated payments and risk adjustments. The comment letter also offers support for the implementation of the medical loss ratio (MLR) in the Medicaid managed care system, as well as the inclusion of activities such as services coordination, case management, outreach and education, and activities supporting state goals for community integration of individuals with more complex needs as activities that improve health care quality to be included in the numerator of the MLR calculation. The letter also offered comments on, and expressed general support for, proposals to:

- Pay for inpatient care for short stays — defined as 15 days per month — for psychiatric and substance use disorder treatment at psychiatric facilities;
- Offer education and assistance to beneficiaries regarding MCO plans and enrollment;
- Implement MCO network adequacy standards, monitoring, and reporting requirements based on accurate information (comments encourage CMS to establish provider-to-patient ratios and wait time measures);
- Institute standardized performance measures and performance improvement projects for MCOs; and
- Require MCOs to adopt evidence-based practice guidelines and make such guidelines available to providers and patients.

Finally, the letter encourages CMS to not adopt or implement the Medicare Advantage Star Ratings system in the Medicaid managed care context. Rather, the comment letter points out the “unique nature of Medicaid beneficiaries, many of whom tend to be sicker and have more health care needs than an ‘average’ patient population.” Accordingly, the letter urges, a Medicaid managed care rating system should weigh the variables of overall health disparities, health literacy, socioeconomic factors, and comorbidities, as well as the unique needs of children, pregnant women, and patients with disabilities or special health care needs.

Result: The Final Rule was published in the May 6, 2016 Federal Register, effective July 5, 2016.

21. Texas Department of State Health Services Proposed Rules Concerning Definition, Treatment, and Disposition of Special Waste from Health Care-Related Facilities (25 TAC §§1.132-1.137)

In the July 1, 2016 Texas Register, the Executive Commissioner of the Health and Human Services Commission, on behalf of the Department of State Health Services proposed amendments to the rules governing the definition, treatment and disposition of special waste from health care-related facilities. The proposals would affect how fetal tissue is handled and disposed of. Current rules allow disposition to include grinding followed by disposition in a sanitary landfill. The proposed rules would broadly define “fetal tissue,” and would require that fetal tissue be disposed of only by interment or cremation. TMA and the Texas Hospital Association jointly submitted a letter to DSHS raising several questions concerning the practical implications of the proposed rules. Among these questions were the following:

- Is incineration followed by interment a viable disposal alternative?
- Will the disposition of fetal tissue require a death certificate and subsequent care by a funeral director in each case?
- How should the rules address the disposition of fetal tissue resulting from spontaneous miscarriages, ectopic pregnancies or molar pregnancies?
- Who pays for the costs of cremation and/or interment of fetal tissue?

The department held a public hearing on the proposed rules on August 4, at which a number of proponents and advocates testified. TMA will monitor the progress of this rulemaking.
On September 1, 2016, the department republished rules that were identical to the July proposed rules. TMA and THA again submitted a joint comment letter, which incorporated the comments from their earlier letter, and added several more key concerns and questions for the department’s review:

- Add an exemption from the special-waste treatment and disposition requirements for cases of fetal demise from miscarriage, an ectopic pregnancy, or a molar pregnancy occurring in a physician’s office or hospital facility; or while the person is under the care of a physician practicing in the physician’s office or hospital facility for treatment related to pregnancy; or both.
- If the department does not adopt the previous recommendation, it should develop and disseminate information for physicians and hospitals to give to pregnant women concerning compliance with the special-waste treatment and disposition rules.
- Respond to the question if a woman loses a fetus due to a miscarriage, an ectopic pregnancy, or a molar pregnancy, and the fetal tissue is not brought to a physician’s office or hospital facility for disposition, does the hospital or physician face a penalty for noncompliance?
- Address who will be responsible for the costs associated with disposition of fetal remains.
- Address the apparent conflict between requiring burial or cremation and the requirements to obtain a fetal death certificate as a condition of burial or cremation by a funeral home.
- Explain the process of acquiring a death certificate following miscarriage, an ectopic pregnancy, or a molar pregnancy.
- Promote public awareness of the new rule to patients and their families dealing with pregnancy loss.
- Explain how the proposed fetal-tissue rules would correlate with recent state legislation allowing the parents of certain unintended, intrauterine fetal deaths to request the release of the remains.

The department held another public hearing on the proposed rules concerning the definition, treatment, and disposition of special waste from health care-related facilities on November 9, 2016.

TMA staff attended the November 9, 2016 hearing at which proponents and opponents of the proposed rules reiterated comments made at the prior hearing. DSHS adopted the proposed rules with changes; published in the Texas Register on December 9, 2016. On December 15, 2016, Whole Woman’s Health and others filed a lawsuit against the Commissioner of State Health Services to enjoin the enforcement of these rules. The court granted the injunction, thereby prohibiting implementation of the rules. Had the rules not been enjoined, beginning December 19th all health care-related facilities would have been required to dispose of fetal tissue through interment, incineration followed by interment, or steam disinfection followed by interment. This would apply to any termination of pregnancy that occurs within a health care-related facility. Following two days of testimony, the judge who issued the preliminary injunction announced on January 4, 2017 that he was delaying the start date of the rule for at least three weeks to consider his ruling. On January 27, 2017, Judge Sam Sparks ruled that the rules were vague and arbitrary, and that the state is prohibited from requiring health care facilities to bury or cremate fetal remains.

22. United States Pharmacopeial Convention Proposed Rules concerning Sterile Compounding
(General Chapter USP <797>)
The United States Pharmacopeial Convention (Convention) published proposed revisions to USP General Chapter <797> concerning sterile compounding. These were published in Pharmacopeial Forum 41(6) [November-December 2015].

TMA submitted a comment letter on January 31, 2016. In its letter, TMA echoed the key concerns expressed by national and statewide groups representing allergists and immunologists. The main concern relates to the proposal to delete the current exemption from certain sterile compounding guidelines for allergen extracts. TMA said that Texas allergists and others have indicated that they would be unable to prepare allergen immunotherapy if the proposals were adopted. TMA recommended that the current standards applicable to allergenic extracts (including the exception for allergen extracts as compounded sterile pharmaceuticals [CSPs]) be maintained. TMA recommended that any proposed revisions to USP <797> be developed in collaboration with affected stakeholders, and based on a thorough impact analysis. TMA also recommended that the Convention develop a dedicated platform for stakeholder input on the standards, including input from affected medical specialties who practice in an office-based or urgent care setting and are administering sterile preparations. No decision had been made on the proposed revisions.

According to sources at the American Medical Association, USP received over 8,000 comments on their proposed revisions to USP General Chapter 797. The USP Expert Committee is not scheduled to meet until October to review these comments, so it will likely be some time (several months after October 2016) before USP releases a revised draft for further public review and comment.


The U.S. Food and Drug Administration published a draft guidance on drug products compounded under insanitary (sic.) conditions that may cause contamination and serious adverse patient events. The draft guidance was published on August 4, 2016 in the Federal Register. TMA on October 3, 2016 submitted a comment letter to the FDA expressing concern about the adverse impact the guidance would have on sterile compounding, including allergen extract compounding in physicians’ offices. TMA’s main concern related to the FDA’s proposed requirement that all sterile compounding be performed in an ISO Class 5 environment, which entails burdensome requirements relating to equipment, space and personnel. TMA said that there are many allergy-related procedures that entail little if any risk to patients that can be done in physicians’ offices – for example, the preparation of individualized injections for allergy patients. There are also other types of in-office procedures that have been performed widely for many years, such as the drawing up of botulinum toxin with an anesthetic, with no heightened concerns relating to the potential for adverse events. Finally, TMA said that the FDA’s adoption of the guidance at the same time that the U.S. Pharmacopeia is considering changes to the USP<797> guidelines regarding sterile compounding would cause unnecessary confusion. TMA recommended that the FDA withdraw the draft guidance and work with the USP Convention, allergists and other affected physicians to ensure that patients have continued access to sterile compounding including allergen extracts.

24. Texas Sunset Advisory Commission Staff Report: Texas Medical Board (November 2016)

The Texas Sunset Advisory Commission conducts regular assessments of the continuing need for state agencies and programs. According to the commission’s assessment schedule, the Texas Medical Board was due for review during the 2017 legislative session. As part of its assessment,
the Sunset Commission issued a report containing recommendations to the legislature regarding
the medical board and whether there is a continuing need for the agency and, if so, how it can be
improved and made more effective. The commission then solicited public input about the medical
board.

In its report on the Texas Medical Board, the Sunset Commission made several recommendations
regarding improvements that the legislature could make to the medical board’s operation. These
recommendations included increasing effectiveness of monitoring of pain management clinics
and the Prescription Monitoring Program data, allowing the medical board to set its own licensing
fees rather than allowing only the legislature to do it, and adopting the Interstate Medical
Licensure Compact.

After the commission issued its report and in preparation for a public hearing the commission
would hold on the subject of the medical board, TMA submitted another comment letter to the
commission to distribute to legislative members on the Sunset Commission. TMA’s letter
expressed general support for most of the report’s recommendations, but with one exception:
TMA did not support the recommendation to remove the statutory limitation on the medical
board’s authority to set fees. TMA expressed that allowing the medical board to have complete
discretion regarding fee-setting would subject licensees to unexpected and possibly substantial
fee increases.

TMA’s letter also expressed concern that the sunset report did not address the deficiencies of the
medical board’s disciplinary process and proposed legislative changes to correct some of these
deficiencies. First, the board should be able to establish more than one remedial plan for a
physician in the physician’s lifetime, especially if a remedial plan is for minor violations and has
the purpose to inform and to educate. Second, TMA encouraged full disclosure of the board’s
expert reports prior to an informal settlement conference. Additionally, TMA expressed support
for the board’s authority to investigate and impose disciplinary measures for a physician who
makes false and malicious complaints about a competitor. Finally, TMA explained the need for
expedited resolution of board complaints at the State Office of Administrative Hearings—this
would provide physicians quicker access to a fair and objective arbiter.

Result: The legislative members on the Sunset Commission deliberated over the merits of all
public comments received, including TMA’s. On January 5, 2017, the Sunset
Commission published a list of proposed changes to the initial recommendations. Among
those proposed changes were amendments reflecting some of the concerns that TMA
raised. There are proposals to allow more frequent remedial plans for a physician and to
ensure that licensees have all expert reports prior to an informal settlement conference.

TMA will continue to monitor the status of the medical board’s sunset bill as it proceeds
through the legislative process and urge more changes to address perceived deficiencies
outlined in TMA’s letters to the Sunset Commission.
State of the Association

2016 was an extremely successful year for the Texas Medical Association, closing with a total of 50,007 members, a net gain of 1,269 members, and a year-over-year membership increase of 2.6 percent. There also was an increase in the number of 100-percent groups from 234 to 240.

Highlights of 2016 accomplishments include:

- TMA’s comprehensive comments on the proposed Medicare Access and CHIP Reauthorization Act (MACRA) rule helped win extensive changes in the rule. Of TMA’s 50 suggestions, the Centers for Medicare & Medicaid Services completely accepted 21, partially accepted 13, and rejected 16. Physicians submitted 656 comments on the rule through the TMA portal, approximately 17 percent of all comments.
- TMA’s MACRA team created three major TMA conference presentations: a TeleTown Hall meeting (2,500 participants), five lunchtime webinars (555 participants), and a statewide seminar series (425 participants); a practice calculator, a readiness checklist, and numerous physician education resources.
- TMA PracticeEdge has over 500 primary care physicians, 12 accountable care organizations (ACOs), and more than 110,000 patients.
- TMA PracticeEdge has launched a national physician services organization with California and Florida and received a $300,000 grant from The Physicians Foundation.
- TMA Practice Consulting developed and launched five new practice management consulting services to meet changing market demands: online visibility assessment, compliance gap analysis, direct primary care support, MACRA readiness, and patient-centered medical home recognition services.
- The TMA Education Center expanded its catalog to 145 programs, including 32 electronic and hard-copy practice management publications, 47 live and on-demand practice management webinars, four podcasts, and five live seminars and webcasts. The Education Center processed 3,067 individual registrations and recorded 3,480 continuing medical education (CME) completions, representing 2,935 individual physicians. Among nonmember Texas physicians, 843 completed courses, enabling TMA to capture the contact information for follow-up membership campaigns.
- The TMA Hassle Factor Log recovered more than $1 million for physicians and saved physicians more than $250,000 in staff training and education expenses.
- TMA Leadership College enrolled 16 scholars; currently, the college has 122 alumni with 95 (77.8 percent) serving in TMA leadership positions.
- The TMA and TEXPAC websites were refreshed/redesigned. The TMA refresh has led to significant improvements in the value of the home page directing users to quality TMA content. For example, there were 8,091 visits to TMA Knowledge Center’s Knowledge Base for the 12 months ending Oct. 15, 2016, a 458-percent increase from the previous 12 months. TEXPAC’s redesigned website had 215 percent more traffic during the March primary season compared with the 2014 primaries.
- Kansas State Medical Society and the Medical Society of Delaware joined TMA’s hosted technology clients, bringing the total to nine states hosted and five others whom TMA assists with various applications and/or processes.
- Two Texas physicians serve on the American Medical Association Board of Trustees, six serve on AMA councils, and nine more serve in leadership positions for AMA sections and AMPAC.
• TMA’s social media presence saw strong growth; as of Oct. 1, 2016, Twitter had 18,538 followers — up 11 percent — and Facebook had 3,813 followers — up 21 percent. TMA recruited 1,006 new members using low-cost Facebook ads.

• The Family of Medicine elected two new physician-legislators, defeated an anti-medicine incumbent, and prevented several others from taking office. TEXPAC’s Get-Out-the-Vote campaign made the difference in several key primary and runoff races.

• TMA staff prepared a comprehensive physician workforce report that the Texas Higher Education Coordinating Board, Texas Department of State Health Services, and legislative staff are using to identify the ongoing need for increased graduate medical education slots, workforce/specialty shortages, and medical school funding/expansion.

• TMA Knowledge Center received and responded to 12,400 telephone and email inquiries.

• TMA Foundation Endowment for Innovation raised nearly $1 million in its quiet phase.

• TMA launched a $250,000 image campaign with three vendor partners.

• Fifteen hundred member physicians participated in a TeleTown Hall meeting on Zika.

• The TMA Minority Scholarship doubled in size for each medical school (from 5,000 to $10,000).

2017 Plan
Under the direction of your Board of Trustees and guided by TMA’s councils and committees, your association remains committed to meeting the advocacy, service, and education needs of our members.

Some objectives for 2017 include:

• Fight for a healthy environment through a successful 2017 legislative session;

• Reign in licensing boards that expand scope through rule, not legislation;

• Grow TEXPAC through better marketing, 100-percent group recruitment, and complete implementation of the TEXPAC membership option;

• Meet the 2017 dues budget and overall operating budget;

• Achieve a 31st straight year with a clean, unqualified audit opinion on all TMA organizations;

• Achieve the Accreditation Council of Continuing Medical Education new commendation criteria;

• Continue discussions with Tennessee, Pennsylvania, and Nevada state medical associations as possible hosted technology clients;

• Transition all accounting activities of The Physicians Foundation to the TMA Finance Department;

• Develop CME on MACRA, including promotion of practice calculators to help practices navigate cost and benefit, and new materials related to Advancing Care Information;

• Successfully implement the TMA image campaign with measurable results obtained through earned media, paid advertising, events, and social media;

• Boost reach of all TMA social media channels (Twitter, Facebook, YouTube, LinkedIn, and Instagram) by 50 percent over 2016 levels;

• Launch the public phase of TMA Foundation’s Endowment for Innovation Campaign;

• Develop an awareness and education campaign for physicians on adverse childhood experiences and their impact on lifelong personal health; promote the use of effective tools for screening and care;

• Report on recommendations that will promote TMA’s role in improving access to quality, evidence- and value-based public behavioral health services; and

• Train at least 100 physicians and local public health authorities on state and local public health functions and responsibilities regarding infectious disease emergencies and disaster preparedness and on the role of the physician in supporting local public health.

TMA Fall and Winter Conferences
2016 Fall Conference: In total, 451 physicians and students attended 2016 TMA Fall Conference; the theme of the conference was MACRA, Zika, and What’s Next? At the General Session, John Carlo, MD,
moderated a panel discussion on MACRA with David Gans, senior fellow for industry affairs at the
Medical Group Management Association; Clifford Moy, MD, director of behavioral health at TMF
Health Quality Institute; and Rich Steinle, president and chief executive officer of Innovista Health
Solutions. Following the MACRA panel discussion, TMA President Don Read, MD, moderated a panel
discussion on Zika: What to Tell Your Patients with Drs. David Lakey, chief medical officer and
associate vice chancellor for population health of The University of Texas System; John Hellerstedt,
commissioner of the Texas Department of State Health Services; and Catherine Eppes, assistant professor
and director of obstetrical quality and safety at Baylor College of Medicine.

The Dawn Duster session featured attorney Tara Kepler of Kepler Health Law. Her talk, Telemedicine:
Understanding It, Dealing with It, and Driving It, gave an overview of telemedicine and telehealth while
speaking to the legalities of practicing telemedicine.

2017 Winter Conference: There were 534 physicians and students in attendance at 2017 TMA Winter
Conference; the theme of the conference was Physician Leaders Unite. The program included an update
on AMA by AMA President-Elect Andrew Gurman, MD, followed by a panel discussion on Physician-
Led ACOs: How to Preserve Independence AND Compete Effectively With Big Health Care. Douglas
Curran, MD, moderated the panel discussion with Drs. Kevin Spencer, Garth Vaz, Tom Garcia, Luis
Benavides, Luis Urrea, and Lloyd Van Winkle. After the panel discussion, Ray Callas, MD, gave a
legislative update from the TMA Council on Legislation, and Brian Williams, MD, spoke about Race,
Violence and Medicine and his experiences as the lead trauma surgeon on call when Parkland Memorial
Hospital was called upon to treat victims of the Dallas police shooting in July of 2016.

At the Dawn Duster session, Steven Hays, MD, chair of the TMA Council on Medical Education,
moderated a panel discussion on Future Directions of Continuing Certification: MOC Innovation and
Input with Drs. John Moorhead, chair of the American Board of Medical Specialties Board of Directors,
and Lois Nora, president and chief executive officer of the American Board of Medical Specialties.

Human Resources
The association has 143 regular full-time and six part-time equivalent positions, 7.25 of which are funded
by outside sources. The TMA Insurance Trust has 20 regular full-time equivalent positions.

The following people were promoted in 2016:

• Genevieve Davis was promoted to associate vice president, Health Policy.
• Clayton Stewart was promoted to director, Legislative Affairs.
• Sylvia Salazar was promoted to associate vice president, Membership and Leadership Development.
• Michael Hebert was promoted to associate vice president, Membership Operations.

Consistent with House of Delegates policy on health insurance, TMA continues to offer health and dental
insurance to employees and their dependents.

TMA also offers a flexible spending account, which allows eligible employees to set aside a certain
amount of their paycheck into a dependent care and/or medical expense reimbursement account before
paying income taxes. Reimbursement of medical expenses not covered by insurance includes deductibles,
copays, prescription drugs, dental services, and the like, as outlined by the Internal Revenue Service.

TMA’s renewal increase for the 2016-17 plan year was 9 percent for the standard PPO, 9 percent for the
high-deductible health plan PPO (medical), and 0 percent for dental.

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
Carra Benson, TMA Health Policy
Ky Camero, TMA Conference and Association Management Services
Trevor Delling, TMA Marketing
Rebecca Lawson, TMA Conference and Association Management Services

10 Years
Ada Drozd, TMA House of Delegates
Herman Gonzalez, TMA Printing and Mailing Services
Debra Heater, TMA Communications
Neil Higginbotham, TMA Technology and Information Systems
Marisol Navarro, TMA Human Resources
Sara Regalado, TMA Conference and Association Management Services
Kelly Walla, TMA General Counsel
Trent Wycoff, TMA Membership Operations

15 Years
Rachel Aleman, TMA Finance
Baldo Barrera, TMA Printing and Mailing Services
Burke Crosby, TMA Technology and Information Services
Stephen Davis, TMA Finance
Chris Johnson, TMA Office of Trust Fund Administration
Sylvia Salazar, TMA Membership Development

20 Years
Aaron Haley, TMA Network Operations
Steve Levine, TMA Communications
Grant Mclnnes, TMA Software Development
Omar Morales, TMAIT Insurance Sales
Melissa Wilson, TMA Conference and Association Management Services

25 Years
Deb Celusniak, TMA Graphic Services
Lisa Jackson, TMA Conference and Association Management Services
Helen Kent Davis, TMA Governmental Affairs
Donna Kinney, TMA Health Policy
Linda Neely, TMA Administrative Services

30 Years
Louis J. Goodman, TMA EVP/CEO
Arnold Serrano, TMA Printing and Mailing Services

35 Years
Linda Kuhn, TMA Physician Health and Wellness
Doris Rapp, TMAIT Account Services
Lisa Stark Walsh, TMA Foundation

The Physicians Foundation
Over the course of the last year, The Physicians Foundation has focused on empowering physicians
during a transitional time when many are uncertain about the future of our health care system. The
foundation issued its inaugural 2016 survey of patients, which revealed that despite the pressures physicians face, a majority of patients are satisfied with their primary care physician, with nine out of 10 survey participants so reporting. However, out-of-pocket costs and insurance issues are creating an ever-growing financial burden, threatening consumer access to adequate health care.

The 2016 biennial physician survey, also commissioned by the foundation and now in its third edition, collected data from more than 17,000 physicians across the United States, who reported experiencing increasing pressure on their medical practices from issues such as increased regulatory burdens, diminished time with patients, the shrinking physician workforce, and difficulties with access and payment. The findings made it clear that the new administration must engage with and listen to physicians to begin course correcting a strained health care system.

In August, The Physicians Foundation supported the launch of Poverty and the Myths of Health Care Reform, a thought-provoking and data-rich book that documents the impact of social determinants on health care costs. The book by the late Richard Cooper, MD, was commissioned by The Physicians Foundation. A video featuring commentary by Joseph Valenti, MD, a foundation board member, highlights the impact social determinants have on the health care system. The book is published by Johns Hopkins University Press.

In 2016, The Physicians Foundation gave $5 million to 30 different organizations to support grants that empower physicians in their delivery of care. TMA was awarded a $150,000 two-year grant, covering 2015-17, to support the TMA Leadership College. The foundation looks forward to providing additional grant support that focuses on key physician initiatives in 2017.

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. Working with two contract lobbyists, the Coalition of State Medical Societies wrote formal comment letters and made four visits to Capitol Hill to meet with senators, representatives, and key congressional staff to lobby on the Affordable Care Act, Medicaid, MACRA, U.S. Department of Veterans Affairs scope of practice expansion, recovery audit contractor audits, telemedicine, and regulatory relief.

TMA PracticeEdge
Just completing its second year of operations, TMA PracticeEdge continues to exceed expectations. The organization manages 12 physician-led ACOs representing 500+ physicians and more than 110,000 patient lives in commercial, Medicare, and Medicare Advantage contracts. This represents a 200-percent growth over last year at this time. Moreover, I’m pleased to report that TMA PracticeEdge is achieving its mission of protecting the future of independent medicine with approximately 80 percent of its ACO physicians practicing in solo practice or small groups of three or less.

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1 www.physiciansfoundation.org/healthcare-research/the-physicians-foundation-2016-patient-survey.
4 www.youtube.com/watch?v=tRw87bMDm4k.
TMA Membership

TMA membership surpassed the 50,000-member milestone! TMA ended 2016 with 50,007 members, a net gain of 1,269 members and a year-over-year membership increase of 2.6 percent. Compared with the same time last year, membership in the active dues-paying categories (active, first year in practice, and candidate) increased by 528 members or 1.7 percent. Residents increased by 138 members or 2.6 percent. Students increased by 327 members or 6 percent.

Additionally, TMA exceeded the $15.8 million dues budget by approximately $48,000. TMA’s retention rate remained strong at 94 percent.

Key 2017 Membership Recruitment and Retention Strategies

In 2016, TMA conducted a survey to better understand member and nonmember needs, 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:

1. Engaging young physicians,
2. Better serving female physicians,
3. Addressing shifts in practice settings like larger groups and more employed physicians,
4. Helping physicians with feelings of diminished authority and autonomy,
5. Boosting physician image, and
6. Increasing grassroots strength and leadership via the county medical societies.

The committee, working with the TMA Board of Trustees, has been tasked with deciding how to best apply the research findings to successful recruitment and retention efforts and to recommend and prioritize specific strategies and tactics to help TMA progress in each of the key focus areas.

The survey results will help TMA better represent, serve, and communicate with members and potential members. Additionally, the results will help TMA and county medical societies allocate resources to efforts members value most and to gain a better understanding of key membership segments including female and young physicians. These activities are part of an overall TMA strategic planning process that will continue and culminate with a TMA Summer Strategic Planning Session.

Summary

The committee will continue its work to finalize specific strategies and tactics. In the meantime, recruitment and retention plans include a focus on the areas recommended by the survey research, leveraging TMA’s legislative work at the Capitol, and more in-the-field and relationship-building activities. With all membership staff focused on these key areas, and a few large group wins, it could be a banner year for TMA.
Acting upon a nomination by the Dallas County Medical Society, the Board of Councilors has selected Robert T. Gunby Jr., MD, of Dallas to receive the association’s Distinguished Service Award. The award will be presented on Saturday, May 6, 2016, at the business session of the House of Delegates.

Dr. Gunby has been a member of the Dallas County Medical Society and the Texas Medical Association for 40 years. He received his medical degree from Medical College of Georgia. After graduating, he completed a rotating internship with Baylor University Medical Center in Dallas before completing his three-year residency in obstetrics and gynecology, also at Baylor.

Dr. Gunby has been in private practice since 1977. He has served as the medical director of labor and delivery and as assistant chief of the Department of Obstetrics and Gynecology at Baylor University Medical Center in Dallas for more than 20 years. In 1998, he was elected president of Dallas County Medical Society. Dr. Gunby has been a TMA delegate to the American Medical Association since 2003.

Dr. Gunby was a member of the TMA Council on Socioeconomics for six years and was its chair for two years. He has been active in the House of Delegates, serving as an alternate delegate from 1988 to 1991, and as a delegate since 1992. Dr. Gunby was installed as the Texas Medical Association president in 2005.

His long history of exceptional and distinguished service to organized medicine is well known by the leadership and members of the Dallas County Medical Society and the Texas Medical Association.
REPORT OF BOARD OF COUNCILORS

Subject: Bell County Medical Society Bylaws

Presented by: Dan L. Locker, MD, Chair

1 Bell County Medical Society Bylaws
2
3 The Board of Councilors approved amendments to the Bell County Medical Society’s bylaws.
2017 Goals
1. Identify, strongly urge treatment of, and review rehabilitation provided to physicians with potentially impairing conditions.
2. Encourage physicians to (a) focus on developing healthy lifestyles and avoiding potentially impairing conditions; and (b) seek early care for self and colleagues who experience such conditions.
3. Educate physicians and their spouses, medical students, and others regarding health conditions that may compromise quality of care provided to patients.
4. Facilitate effective collaboration with county medical society PHW committees, district coordinators, and the Texas Physician Health Program to further the goals of all entities.
5. Solicit donations to augment the Physician Health and Rehabilitation Assistance Fund.
6. Encourage a unified approach for responding to physicians referred to the committee and providing responsible advocacy.

PHR Assistance Fund
During 2016, the PHR Assistance Fund received $7,961 in donations. The 2017 campaign benefiting the fund, Have a Heart for Physicians, will occur during May. In February, the PHW Committee mailed letters to county medical societies, county alliance presidents and presidents-elect, and hospitals inviting them to help promote the campaign through direct mailings, journal or newsletter articles, and/or other appeals at meetings. Other avenues of promoting the campaign include reference to the fund and campaign during educational presentations, letters to physicians attending or completing a PHW continuing medical education course, letters to physicians completing their participation in the TMA drug screen program, addition of donation information in PHW conference brochures, advertisements in various publications, and on-hold messages. The PHW exhibit during TexMed 2017 will provide an opportunity for attendees to donate to the fund. The committee’s goal this year is to raise $10,000 in donations for the PHR Assistance Fund.

For the last five years, the PHR Assistance Fund has made loans to an average of two physicians per year, with an average loan of $3,375. Loan proceeds help physicians with treatment and recovery expenses and short-term living expenses for the family.

Drug Screen Program
The TMA Drug Screen Program was established in September 1996 to provide a statewide, random method for drug screening of physicians in agreement with county medical society PHW committees, district coordinators, and hospital-based peer assistance committees. Seven levels of participation are available to physicians, ranging from four to 96 screens per year. There are 20 participants in the program, and another 392 have either completed or no longer participate in the program.
Live Presentation, Internet, and Home Study Courses

The PHW Committee offers 29 continuing medical education courses, all of which are designated as ethics and/or professional responsibility education, for presentation by regional education team members at county medical society, hospital medical staff, and other meetings. The courses also are available on the internet and through home study, and 12 have been combined into six two-credit courses. During 2016, team members gave 61 presentations to 2,084 participants. Another 1,148 physicians completed the courses by internet and home study.

During 2016, the committee reviewed seven existing courses. Six of the courses were combined into two-credit courses for internet and home-study formats. Eleven courses will be scheduled for review during the 2016-17 cycle. One course will be combined into a two-credit course for internet and home-study formats. Another two-credit course also will be reviewed.

Rebuilding the Physician: Blueprint for Growth (2016)

Rebuilding the Physician: Blueprint for Growth, the committee’s fall conference, was held Oct. 14-15 in Frisco. There were 26 participants.

Physician Resilience: Bouncing Back From the Pressures of Medicine (2016)

Physician Resilience: Bouncing Back From the Pressures of Medicine workshops were held in four locations during the year. There were 59 participants.

Burnout: Recognition and Prevention (PHW Training Session and Retreat) (2017)

The committee held a training session and retreat Feb. 24-25 in Fort Worth. The program was designed for physicians of all specialties, including members and potential new members on the committee’s education teams; hospital leadership; and others interested in learning more about (a) physician stress, burnout, and suicide; (b) giving effective presentations; (c) how burnout correlates with medical errors and complaints lodged with the Texas Medical Board; and (d) strategies for protecting themselves against burnout and strengthening themselves both professionally and personally. There were 55 participants.

Let’s Get Active … and Healthier

Let’s Get Active … and Healthier will be presented during TexMed 2017. The program is designed for physicians and residents of all specialties and other health care professionals. Participants will take a yoga class taught by an instructor. A lecturer will present didactic information in conjunction with the yoga class, qualifying the activity for continuing medical education credits.

Teamwork — Interdisciplinary Approaches

Teamwork — Interdisciplinary Approaches will be presented during TexMed 2017. The program is designed for physicians and residents of all specialties and other health care professionals. Topics will be Physician Collaboration and Communication, and Interprofessional Education and Practice.
Physician Interrupted: Disruption Comes in Many Forms (2017)

On Oct. 6-7, the committee will sponsor a conference, Physician Interrupted: Disruption Comes in Many Forms, in Galveston. Topics will include Disruption Defined and Stress Multiplied, Challenging Patient Encounters, Hospital Disruptions, Professionalism in Medicine, Electronic Health Record: Patient-Physician Encounters, Disruption-Busting Boundaries, Disruptive Office Dynamics, Regulatory Intrusions, and Creating and Maintaining Work-Life Balance.

Physician Resilience: Bouncing Back From the Pressures of Medicine (2017)

Physician Resilience: Bouncing Back From the Pressure of Medicine workshops will be held in Amarillo, El Paso, Galveston, and Tyler during the year.
Subject: Treatment Facilities; Medical Student and Resident Activities

Presented by: Harry L. Faust Jr., DO, Chair

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**Treatment Facilities**

The committee completed review of the treatment facilities surveyed in November 2016 to ascertain if they meet committee-established criteria. A list of facilities meeting the criteria will be distributed to PHW leadership and provided to physicians and family members seeking evaluation and/or treatment. The treatment facility packet includes resources for physicians regarding disruptive behavior/anger management, maintaining professional boundaries, physical disabilities, sexual misconduct, stress management, prescribing controlled substances, wellness coaching services for physicians, personalized education programs for physicians, and fitness-for-duty evaluations.

**Medical Student and Resident Physician Activities**

During 2016, the committee developed two new courses for medical students: Women in Medicine: The Path Forward, and Creating and Maintaining Student Life Balance. The committee’s annual letter to medical schools will mention availability of speakers and the topics offered. The courses also are available online.

The committee offers publications yearly to medical students and resident physicians through medical schools and residency training program coordinators. The committee will offer the Substance Abuse Among Physicians: Early Symptoms/Future Consequences brochure to both groups, the Medical Student Stress and Burnout brochure to medical schools for distribution to students, and Do You Know a Resident Who Needs Our Help? to residency training program directors for distribution to resident physicians. The committee will charge a fee to offset expenses.
Subject: AMA House of Delegates Meetings in 2016

Presented by: David N. Henkes, MD, Chair

**2016 Annual Meeting**

More than 100 Texas physicians, residents, medical students, and alliance members representing TMA, various sections, and national specialty societies participated in the AMA Annual Meeting of the House of Delegates, June 4-8, 2016, in Chicago. The Texas delegation left the meeting having elected three candidates it ran for AMA office and winning adoption of three Texas policy statements.

**MACRA**

The Centers for Medicare & Medicaid Services' (CMS') proposed rule to implement the Medicare Access and CHIP Reauthorization Act (MACRA) brought out a sharp divide in the House of Medicine. AMA leaders, who supported MACRA as a mechanism to eliminate Medicare's Sustainable Growth Rate (SGR) formula and as a way of enhancing the quality of American health care, invited CMS Acting Administrator Andy Slavitt to address the delegates and called for continued physician input into the rulemaking process and stated CMS' draft regulation reduced the reporting burden on physicians and simplified the process of measuring quality care. Other factions, led by the Texas delegation, sharply criticized the draft rule as too expensive and too complicated. Texas came to the meeting armed with a detailed, 20-page position statement on the big problems in the proposed rule, which offered a significantly different perspective.

By the end of the meeting, the House of Delegates adopted two resolutions directing AMA to take a tougher stance on the draft rule which: (1) directed AMA to push CMS to expand exemptions for small practices from the MACRA requirements and to "reduce the reporting burdens and administrative hassles and costs" on all physician practices, and (2) asserted the draft rule violates congressional intent, initially asked for at least a one-year delay in the current Jan. 1, 2017, start date for MACRA reporting. The final language called for a suitable reporting period" with no specified start date.

**MOC**

Whether they come in medical school or decades after physicians start to practice, expensive and high-stakes examinations elicited strong, negative reactions from the house. Acknowledging many physicians' intense dissatisfaction with the maintenance of certification (MOC) process, especially the exams conducted by the American Board of Medical Specialties (ABMS), delegates adopted a comprehensive AMA Council on Medical Education report on MOC. It called for AMA to "review alternative pathways for board recertification" and advocate an MOC process that's evidence-based, clinically relevant, and cost-effective. A group of state medical societies, supported by Texas, pushed the house to endorse tougher language. With two-thirds of the delegates voting "aye," the house directed AMA to "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."

The delegates reiterated support for physicians' lifelong learning through quality, cost-effective continuing medical education. The U.S. Medical Licensing Examination Step 2 Clinical Skills (CS) examination was the other test to attract significant attention from the house. Critics noted medical students spend more than $25 million a year to take the test, which 99.8 percent pass on the first or second
attempt. Delegates agreed, adopting a plan to facilitate a transfer of jurisdiction for CS exams directly to the nation's accredited medical schools.

Veterans Administration Physicians

The U.S. Veterans Administration's proposed rule that would allow advanced practice registered nurses to practice independently within the VA health system drew the delegates' ire. Texas delegates testified that an important concept is missing in the VA's draft rule, citing that the team needs to be physician-led. The house voted to direct AMA to fight the proposal vigorously because it is "antithetical to multiple established policies of our AMA." The adopted action plan included a directive for AMA to push Congress and the Obama administration to "disapprove or otherwise overturn" the VA's draft rule if necessary. In an effort to bring more physicians into the VA, delegates urged the VA to address the complex mess of medical school loan repayment programs for physicians who want to work for VA.

Texas Resolutions

The Texas delegation brought two resolutions to the meeting, both positively received by the house. The AMA delegates: (1) adopted Texas' proposal to help physicians overcome the some-times-devastating consequences of minor clerical errors on their Medicare enrollment applications. The TMA House of Delegates approved that proposal at A-16, and (2) enacted Texas' proposal for AMA to support creation of a National Health IT Safety Center to "minimize patient safety risks through collection, aggregation, and analysis of data reported from electronic-health-record-related adverse patient safety events and near misses." This resolution came from TMA's Ad Hoc Committee on Health Information Technology.

Other Action Taken

Delegates addressed various other economic, legislative, and organizational topics. The house:

• Directed AMA to write model state legislation requiring insurers to pay for telemedicine services as they do for in-person services, requiring coordination of care with a patient's primary physician, and - on a motion from former TMA President Robert Gunby, MD, of Dallas - requiring a valid patient-physician relationship before providing telemedicine services, requiring those delivering telemedicine services to be licensed in the state where the patient receives services, and requiring that the standards of care for telemedicine services be consistent with those for in-person services;
• Called on Congress to act immediately to make funding available to combat the Zika virus and to set aside emergency funds for future public health threats, and voted for AMA to oppose quarantine measures for patients infected with Zika;
• In reaction to the lead contamination of water supplies in Flint, MI, voted to encourage timely removal of lead water service lines and regular testing of water at schools and health care facilities;
• In the wake of the Orlando nightclub massacre, called on AMA to recognize gun violence as a public health crisis and reaffirmed previous policy calling for an end to any ban on gun violence research;
• In response to a resolution that resident physicians pushed through the TMA House of Delegates at A-15, adopted new policy stating that "resident and fellow trainees should not be financially responsible for their training";
• Established guidelines for physician-focused and physician-led alternative payment models;
• Voted to improve state-run prescription drug monitoring programs, to increase access to naloxone, to support the establishment of addiction medicine as a subspecialty, and to oppose the use of pain as a fifth vital sign;
• Adopted new ethical guidelines for telehealth and telemedicine;
• Called for parity in health insurance coverage for eating disorders;
• Said states should not apply sales taxes to feminine hygiene products; and
• Installed Andrew Gurman, MD, an orthopedic hand surgeon from Pennsylvania, as the AMA’s 171st president.

2016 Interim Meeting
About 100 Texas physicians, residents, and medical students, representing TMA, various sections, and national specialty societies, participated in the Nov. 12-15, 2016 Interim Meeting of the AMA House of Delegates in Orlando. The Texas delegation left the meeting with positive action on the one policy provision it took to the house.

The AMA house voted unanimously to "actively engage the new administration and Congress in discussions about the future of health care reform, in collaboration with state and specialty medical societies, emphasizing our AMA's extensive body of policy on health system reform, ensuring that any ACA replacement not cause individuals currently insured to become uninsured. Leaders of the Texas delegation, who pushed the "actively engage" language along with other southern and conservative states, said the 2016 elections brought physicians an opportunity to rebuild America's health care systems.

Many of the ideas in President Elect Trump's "Great Again" health care platform and the health care agenda in House Speaker Paul Ryan's "Better Way" plan are consistent with TMA policy. TMA actively opposed passage of ACA in 2010 but has since adopted an approach to "keep what's good, fix what's broken, and find what's missing." Six years of near absolute gridlock in Washington, DC, prevented even the tiniest ACA reforms from passing. One very significant achievement was the repeal of Medicare's Sustainable Growth Rate (SGR) formula via the Medicare Access and CHIP Reauthorization Act (MACRA), which passed in 2015.

MOC
MOC opponents came back to the house demanding that AMA take a tougher stance. Delegates definitely moved in that direction. The house:

• Said MOC should not be mandatory for recredentialing, privileging, or insurance panel participation. That added to existing AMA policy that said MOC should not be required for licensure, credentialing, reimbursement, network participation, or employment.

• Directed AMA to advocate and develop model state legislation and model medical staff bylaws to ensure MOC "not be a requirement for: (1) medical staff membership, privileging, credentialing, or recredentialing; (2) insurance panel participation; or (3) state medical licensure." The TMA House of Delegates adopted similar policy in May 2016, based on a new law that recently passed in Oklahoma.

After a long and contentious debate, told AMA to "formally, directly, and openly ask the American Board of Internal Medicine (ABIM) if they would allow an independent outside organization, representing ABIM physician stakeholders, to independently conduct an open audit of the finances of both the American Board of Internal Medicine, a 501(c)(3) tax-exempt, non-profit organization, and its Foundation" before Dec. 31, 2016.

Other Action Taken
The house asked the AMA Board of Trustees to study and take action on a Texas resolution seeking to put a stop to yet another case of serious over-reach by the Centers for Medicare & Medicaid Services (CMS). The issue involves CMS quality measures that interfere with physicians' professional judgment of the clinical needs of individual patients. A recent CMS-mandated "quality core measure" for hospitals requires physicians to administer 30 cc/kg of crystalloid fluid for all patients with potential serious infections. While that's good medicine in most cases of sepsis, it could be fatal for patients with certain cardiac, renal, or liver problems. The CMS requirement has no exceptions, leaving physicians caught between appropriate patient care and hospital administrators' push for top quality scores.
Delegates addressed various other economic, legislative, public health, and organizational topics. The house:

- Directed AMA to advocate an exemption from MACRA and the Merit-Based Incentive Payment System for small practices;
- Said the association should advocate that the U.S. Food and Drug Administration remove physician offices and ambulatory surgical centers from its definition of "compounding facility";
- Adopted new policy outlining principles to guide the support and transparency of value-based pricing programs for pharmaceuticals;
- Reaffirmed its position that the legal age to buy tobacco products should be raised to 21;
- Directed AMA to develop model state legislation to limit cell phone use to hands-free while driving; Voted to support a ban on direct-to-consumer advertising for prescription drugs and implantable medical devices;
- Voted to support whistleblower protections for health professionals who are retaliated against for raising issues such as health care quality and patient safety;
- Directed AMA to advocate eliminating "fail-first" insurance company policies for addiction and substance abuse disorders;
- Asked the AMA Board of Trustees to decide whether to push for legislation requiring insurance companies to collect patients' financial responsibilities - such as deductibles and coinsurance - directly from the patient;
- Called for eliminating the tax liability when employers help repay student loans for physicians who work in underserved areas; Directed the association to issue a statement in support of U.S. health professionals, including medical students, residents, or fellows, who are recipients of Deferred Action for Childhood Arrivals status;
- Called for incorporating integrated services for general medical care, behavioral health care, and substance-use care into existing psychiatry, addiction medicine, and primary care training programs' clinical settings;
- Said medical students should have access to confidential behavioral and physical health services;
- Adopted policy stating the use of human chorionic gonadotropin for weight loss is inappropriate; and;
- Referred for further study a call to recognize neuropathic pain as a disease state.
As of Dec. 31, 2016, American Medical Association membership in Texas totaled 16,378 compared to 16,317 during the same time last year, an increase of 114 members. The year-over-year membership increase was .4 percent. The student category saw a decrease of 67 student members, or 1.6 percent. The resident category increased by 114 members, or 4.3 percent. The physician category increased by 14 members. It should be noted that the physician membership category includes the nondues-paying categories of retired, exempt, and honorary, in addition to active physicians.

**Representation in AMA**

The Texas Delegation to the AMA is allowed 17 elected delegates and alternate delegates to the AMA House of Delegates. Numerous Texas physicians and medical students hold positions of leadership within the AMA organizational structure. Former TMA President Susan R. Bailey, MD, was reelected to her second one-year term as Speaker of the AMA House of Delegates, Laura Faye Gephart, MD, was reelected to the resident position on the AMA Council on Medical Service, and Cynthia A. Jumper, MD, was elected to her first term on the AMA Council on Medical Education.

Texas physicians also served on the AMA Board of Trustees and five of the AMA’s seven elected and appointed councils during 2016. Texans holding elected or appointed positions on AMA entities include: Susan Rudd Bailey, MD, speaker and Council on Constitution and Bylaws; Stephen L. Brotherton, MD, and Monique A. Spillman, MD, PhD, Council on Ethical and Judicial Affairs; Justin Bishop, and Lyle S. Thorstenson, MD, AMPAC; Lynne M. Kirk, MD, Council on Medical Education; Russell W.H. Kridel, MD, Board of Trustees; Asa C. Lockhart, MD, and Laura Faye Gephart, MD, Council on Medical Service; and Clifford K. Moy, MD, Council on Long-Range Planning and Development.

Paul Wick, MD, served as immediate past chair and member of the Senior Physicians Group Governing Council. Matthew Brooker, DO, served as the Young Physician Section representative to the GLBT Advisory Committee; John G. Flores, MD, was elected to the Organized Medical Staff Section Governing Council; Theresa Phan was reelected as Vice Speaker of the AMA Medical Student Section; William Estes was elected to the MSS Governing Council; Surendra K. Varma, MD, served on the Academic Physician Section and was the section liaison to the Council on Medical Education; Robbie Good was elected chair of the Region 3 Medical Student Section and Nazish Malik was elected secretary/treasurer of the Region 3 Medical Student Section.

Texans serving as ex officio members of the AMA House of Delegates were past presidents J. James Rohack, MD; Nancy W. Dickey, MD; and Joseph T. Painter, MD.

In addition to the 17 delegates and 17 alternate delegates representing the Texas Medical Association in the AMA House of Delegates in 2015, many other Texas physicians served in the AMA house. Delegates and alternate delegates were: C. Bob Basu, MD, American Society of Plastic Surgeons, Paul R. Bergstresser, MD, Society for Investigative Dermatology, Donna Bloodworth, MD, American Academy of Pain Medicine, Tilden L. Childs III, MD, American College of Radiology, Ronald J. Crossno, MD, American Academy of Hospice and Palliative Medicine, Gary Dennis, MD, National Medical Association, Seemal Desai, MD, American Academy of Dermatology, John Early, MD, American

Jerome Jeevarajan and Jared Bell served as Region 3 medical student delegates, and William Estes and Carlos Martinez served as Region 3 medical student alternate delegates. Laura Faye Gephart, MD, and John Corker served as RFS sectional delegates. Texas physicians and students also served on various AMA residency review committees, sections, councils, and editorial boards.

AMA Meetings
Two Texans played a lead role in completing the first comprehensive update in 50 years of the AMA Code of Medical Ethics. As outgoing chair of the AMA Council on Ethical and Judicial Affairs, Fort Worth orthopedic surgeon and former TMA President Stephen L. Brotherton, MD, led the process of reviewing each individual ethics opinion for clarity, timeliness, ongoing relevance, and consistency across the code. For the past two AMA house meetings, Fort Worth plastic surgeon Larry Reaves, MD, chaired a special reference committee that took delegates' comments on the "CodeMod" project. Other Texas physicians playing leadership roles at the June meeting were Les Secrest, MD, of Dallas, who served on the Reference Committee on Public Health; Michelle Berger, MD, of Austin, who served on the Reference Committee on Science and Technology; Dr. Floyd, who served on the Reference Committee on Finance and Governance; and David Lichtman, MD, of Fort Worth, who served on the Reference Committee on Medical Practice.

At the November meeting in Orlando, the Texas delegation honored two longtime members who served in their final meeting: TMA Immediate Past President Tom Garcia, MD, of Houston, and Needville family physician Art Klawitter, MD. Four Texans volunteered their time to serve on reference committees at the meeting. Paul Friedrichs, MD, of San Antonio, chaired the reference committee on science and public health; Linda Villarreal, MD, of Edinburg, served on that same panel. Galveston's Kevin McKinney, MD, was a member of the reference committee on medical education; and Gary Floyd, MD, of Fort Worth, served on the reference committee on AMA finance and governance. While none of the AMA physician leadership spots were up for election at the Orlando meeting, six young Texans grabbed the opportunity to move up:

- Two Texans won slots as new AMA Resident and Fellow Section alternate delegates: Michael Metzner, MD, of San Antonio, and Samuel Mathis, MD, of Houston.
- Emily Dewar from UT Houston and Jerome Jeevarajan from The University of Texas Southwestern Medical School in Dallas were elected Region 3 delegates.
- Luis Setia from the Texas A&M University College of Medicine and Hayley Rogers from The University of Texas Medical Branch at Galveston were elected Region 3 alternate delegates.
At the AMA’s Jan. 28, 2017, meeting, David N. Henkes, MD, was reelected chair; Asa C. Lockhart, MD, and Gary W. Floyd, MD, were reelected co-vice chairs; and Clifford K. Moy, MD, and Michelle A. Berger, MD, were reelected for places one and two as at-large members of the Delegation Review Committee.
REPORT OF COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 1-A-17

Subject: Improving TMA Committee Sunset Review Process

Presented by: Mark A. Casanova, MD, Chair

Background

At the 2016 Winter Conference, the Board of Trustees approved a report detailing the findings and recommendations of the Board of Trustees (BOT) Task Force on TMA Committee Sunset Review Process. The task force’s report was in response to Resolution 106-A-15, TMA Sunset Review of Councils, Committees, and Sections, which was referred to the board for study.

Upon review and deliberation of the issues raised in Resolution 106-A-15, the board discerned the need for greater collaboration of all parties involved in and affected by sunset recommendations. The board further recognized the importance of transparency of criteria and inclusive communication of process prior to sunset recommendations coming before the House of Delegates. These observations largely comprise the five recommendations issued in the BOT Task Force Report, which are as follows:

1. That, as part of their appointment, council and committee members be provided with annual objectives and goals and how they align with TMA’s overall strategic efforts;
2. That criteria for sunset review align with TMA strategic goals and objectives and that the criteria be communicated to councils and committees in a transparent and efficient manner at the beginning of each year with ongoing collaboration with the Board of Trustees as the year progresses;
3. That sunset review be accomplished as reasonably and efficiently as possible and that for any major change (discharge, reorganization), the Board of Trustees actively participate and collaborate with all affected councils or committees and, if necessary, seek external member input prior to forwarding recommendations to the House of Delegates;
4. That TMA provide (1) an orientation of council and committee chairs as to their roles and the association’s organizational structure; and (2) a mechanism for better communication between council chairs and the Board of Trustees and between council chairs with each other; and
5. That the Council on Constitution and Bylaws be asked to consider issues identified in this report in light of options for alternatives to standing committees such as use of subcommittees to allow organizational effectiveness and efficiency.

Implementation Plan

While these recommendations contain some novel concepts, they are in general alignment with efforts the board and other TMA components already have initiated or are in the process of undertaking. TMA’s Council on Constitution and Bylaws has found that, as a supplement to TMA Bylaws, parliamentary procedure provides a good deal of direction concerning the functions of committees, subcommittees, and special groups. The council has recommended adoption of the new American Institute of Parliamentarians Standard Code of Parliamentary Procedure (AIP) to ensure TMA is following the most up-to-date parliamentary procedures.

The council recommends the following action plan in conjunction with the adoption of AIP and its principles concerning committee operations. Together, these activities will serve to further promote and enhance the clarity and effectiveness of the committee sunset review process.
1. Production of two council and committee orientation online videos — one for chairs and one for members — that new council or committee appointees can view any time. These orientation videos would clearly describe the functions and work products expected of TMA councils and committees, as well as other general requirements including attendance. Further, the orientation videos could discuss the TMA governance process and the process of committee sunset review.

2. Creation of a simple, one-page overview of TMA’s committee sunset process, to be included in committee meeting packets on an annual basis. This process would lay out ongoing goals for all committees, as well as describe the Board of Trustees’ role in assisting with sunset review.

3. Implementation of a standard sunset review form that allows the committee to indicate which TMA 2020 goal(s) it supports, how it has fulfilled its purpose over the review period, and whether the committee has met its attendance requirements as provided for in the bylaws. The parent council will review these forms and produce recommendations for committee continuance or sunset.

4. Special review by the BOT of council recommendations involving sunset of a committee. The board will consult with others as needed, including council and committee chairs, when considering a recommendation for sunset.
The TMA Council on Health Care Quality oversees and supports the direction for TMA activities on quality including policy; advocacy; and education on quality improvement, patient safety, performance measurement, and clinical effectiveness. The council has developed several clinical tools and online resource centers on the TMA website to assist physicians with practice transformation to quality- and value-based care. The council has been very active in several activities, which are summarized below.

**Medicare Access and CHIP Reauthorization Act (MACRA) and new Quality Payment Program**

The council has carefully monitored the ongoing rulemaking process on the implementation of MACRA and changes to quality programs by the Centers for Medicare & Medicaid Services (CMS). To help educate physicians on MACRA, TMA launched an online [MACRA Resource Center](#) in April 2016. The MACRA proposed rule was published in May 2016, and the final rule was published in October 2016. To implement the provisions in MACRA, CMS created a new Quality Payment Program that encompasses the new payment paths as required under the new law: the fee-for-service Merit-Based Incentive Payment System (MIPS) and advanced alternative payment models (APMs).

The first performance period for the new Quality Payment Program began on Jan. 1, 2017. Leading up to the new performance period, the council engaged in several activities to advocate for physicians and to educate them about the new program. Most educational events provided continuing medical education (CME) credits. In 2016, the council submitted a comment letter on CMS’ quality measure development plan and specified a list of principles and guidelines CMS should use in developing quality measures for physicians under MACRA. In response to the new rules, and to educate members about the changes, the council focused its CME quality track at TexMed 2016 on MACRA, cohosted a TMA TeleTown Hall meeting on MACRA, presented a live CME webinar (and enduring material) on the quality category of the new MIPS program, included education on MACRA at the TMA Quality Summit, and ran several articles on MACRA in the Quality section of *Texas Medicine*. Additionally, the council will again focus its quality track at TexMed 2017 on MACRA and the new Quality Payment Program.

The council will continue to identify opportunities for clinical tools, education, and resources to help physicians learn about and successfully participate in the new program.

**Physician Quality Reporting System (PQRS) and Value-Based Payment Modifier (VM) Program**

The PQRS and VM programs subject physicians to automatic pay cuts to their Medicare Part B payments for nonparticipation. To fulfill the quality reporting requirement for both programs, physicians must report data on quality measures to PQRS in the first quarter of 2017 for the 2016 performance period. With council input, TMA continues to offer members an online [PQRS and VM Resource Center](#), which council staff regularly update, that includes education and resources to help physicians navigate program requirements. Under MACRA, CMS consolidated these two programs, along with the meaningful use program, into the new MIPS in 2017.

**TMA and American College of Medical Quality (ACMQ) Texas Quality Summit**

In 2016, the council collaborated with Prathibha Varkey, MD, president of ACMQ to cohost a TMA Quality Summit in November 2016. The summit included a six-hour workshop on the fundamentals of
quality improvement and patient safety taught by expert faculty from ACMQ. The workshop held interactive sessions focusing on the tools, practices, and theories of leadership and strategy necessary for implementing successful quality improvement and patient safety programs in daily practice. Also part of the summit was a day of presentations by physician leaders and experts in the field of quality from the council, TMA, and ACMQ. Topics focused on population health, value-based care, payer perspectives on quality, MACRA, MIPS, APMs, and leading-edge transformations in physician practice. Physician participants could earn up to 12.5 AMA PRA Category 1 Credits™ with ethics and/or professional responsibility. Additionally, the summit served as the capstone for the second class of the TMA Accountable Care Leadership Program, and the program’s graduation ceremony was held at the summit.

**TMF Health Quality Institute**

In 2014, the TMF Health Quality Institute was awarded a multiyear contract by CMS to serve as the state’s Quality Innovation Network Quality Improvement Organization (QIN-QIO). Under this contract, TMF QIN-QIO provides no-cost technical assistance and education on quality improvement and patient safety. At the council’s urging, TMA continues to collaborate with and promote services provided by TMF QIN-QIO, connecting members to free services that help them improve patient and quality outcomes, as well as navigate Medicare requirements to avoid payment penalties and maximize value-based payments. TMF QIN-QIO administers these networks: antibiotic stewardship, behavioral health, cardiovascular health and Million Hearts, chronic care management, Health for Life-Everyone with Diabetes Counts, immunizations, meaningful use, medication safety, nursing home quality improvement, patient and family, quality improvement initiatives, quality payment program (MIPS, APMs), readmissions, sepsis, and value-based improvement and outcomes (PQRS, VM programs). Council member Ronald S. Walters, MD, serves on the TMF Board of Trustees, and council member Robert B. Morrow, MD, is the immediate past chair of the TMF board.

**TexMed Quality Poster Session**

Through sponsorship from the TMF Health Quality Institute, the council hosts a TexMed Poster Session and competition at TexMed annually. The council hosted a poster session at TexMed 2016, and will host its fifth session at TexMed 2017. For this event, TMA members are invited and encouraged to submit an abstract in one of three categories: quality research, quality improvement, or clinical project. Abstracts are judged, and members with the highest scores are invited to TexMed for poster presentations for the purpose of exchanging best practices in the field of quality improvement and relevant clinical topics. Abstracts are published on the Quality Poster Session webpage of the TMA website to help disseminate information to a broader physician audience. Council members Cliff T. Fullerton, MD, and Pranavi V. Sreeramoju, MD, serve as contest judges. Of note, the one-hour poster session at TexMed provides free CME and regularly attracts high attendance of 100 or more TMA members.

**TexMed Quality Track**

TMA has held a track on quality and patient safety programming since TexMed 2009, and the council has hosted the track since TexMed 2012. This year, MACRA will appear on several track agendas due to the significant impact it will have on the majority of practices in Texas. For this reason, staff from the councils on Health Care Quality and Practice Management Services have teamed up to develop one, unified CME track with a global approach to MACRA. The councils will host the track over two days, and staff anticipate more than 150 physicians, primarily in small or solo practice of all specialties, to attend and receive education on MACRA and the new Quality Payment Program, “pick your pace” approach to MIPS and APMs, preparing practices for quality-based payments, population health, value-based care, data analytics, and a deep dive into specific requirements for MIPS performance categories.
The University of Texas Health Science Center at Houston, School of Public Health (UTSPH)

Physician Work Group
Council members Lisa L. Ehrlich, MD, and Jeffrey B. Kahn, MD, participate in UTSPH’s physician work group to provide physician input and guidance for its Transparency and Healthcare in Texas think tank. UTSPH is applying to establish a CMS Qualified Entity Certification Program at the school. Once certified, the school will be able to receive Medicare data to evaluate physician performance in Texas and publicly disseminate CMS-approved reports on such data. Members update the council of their progress and solicit input when appropriate.

Physician Practice Quality Improvement Award Program
The Physician Practice Quality Improvement Award Program is administered by the TMF Health Quality Institute and is cosponsored by TMA and the Texas Osteopathic Medical Association. The award program recognizes high-performing physician practices for their quality improvement work. TMA and the council have been involved in the award criteria, program marketing, and promotion through TMA communication channels. TMA will continue to promote its next award cycle (2016-17 program year).

Chronic Care Management
Under the Medicare Part B Physician Fee Schedule, Medicare pays for non-face-to-face care management services provided to Medicare beneficiaries with two or more chronic conditions. Medicare started the Chronic Care Management Services program in January 2015. With council input, TMA continues to offer an online Chronic Care Management resource center to help members evaluate program requirements with an aim to helping them improve their patient outcomes and increase practice revenue.

TMA Publications on Quality
Council members regularly contribute to articles on quality for Texas Medicine. In 2016, several council members were interviewed and provided comments for articles on issues pertaining to Medicare’s PQRS and VM programs, first-ever standardized quality measures set to create a uniform approach to measuring and paying for quality by all payers, the launch of TMA’s MACRA Resource Center, preparing for MACRA implementation, TMA and ACMQ Texas Quality Summit, and MACRA and the new “pick your pace” approach to participation in MIPS and APMs.
Subject: Referral of Committee on Physician Health and Wellness Report 2, Mental Illness

Presented by: Steven R. Hays, MD, Chair

The Committee on Physician Health and Wellness Report 2 Mental Illness at A-16 asked for new TMA policy supporting legislation that would amend state statute to require “severe and persistent mental illness” and not “any mental illness” to be reportable to the Texas Medical Board. This report was referred to the Council on Medical Education.

Texas Medical Board Behavioral Health Reporting Requirements

The council shares the committee’s concerns about the personal and professional information on behavioral health status that physicians and resident physicians are required to report to the Texas Medical Board. The board routinely requests this information on forms used to apply for or renew a medical license or resident permit. Any information of the type the board collects should be only information necessary for the board to fulfill its mission of protecting the public. It is preferable not to seek changes to the reporting requirements through state legislation as requested in the committee report but rather through collaborative activities with the board.

Any loss of a member of the medical community as a result of suicide is a tragic loss, and the rate of suicide continues to be of grave concern. The council places a high priority on doing what is necessary to remove impediments to behavioral health care for members and learners of the medical profession. It is also important to sustain the emerging emphasis on physician health and wellness. The council believes the Committee on Physician Health and Wellness deserves recognition for the extensive collection of resources it makes available to physicians and residents through a variety of continuing medical education courses and other services.

Anecdotal information provided to the council indicates that the board’s reporting requirements in the past did have a chilling effect on the willingness of physicians, residents, and medical students to seek behavioral health services. For example, some conditions such as depression can be circumstantial, one-time occurrences. In the past, the board required the reporting of any diagnosis or occurrence. Any collection of information by the board should focus on the impact on a physician’s professional competency or impairment. In the case of medical students and residents, reporting should be limited to the inability to learn and perform patient care duties. It is also important to note that impairment can result from physical and neurological conditions and is not limited to behavioral health.

Changes to Reporting Requirements

The council has been working with the board for more than a decade to improve the board’s reporting requirements on behavioral health. This was accomplished through meetings and correspondence. As part of this liaison, the council reserved time on each meeting agenda for the past five years for a dialogue with leadership of the Texas Medical Board. Incremental changes have been made over time to the board’s reporting requirements. Currently, the board focuses the reporting of behavioral and physical conditions on impairment and also on whether treatment has reduced or ameliorated the condition, as noted in the following three questions on the board’s licensing forms:

Question 49
Within the past five (5) years, have you been diagnosed with or treated for any psychotic disorder, delusional disorder, mood disorder, major depression, personality disorder, or any
other mental condition which impaired or does impair your behavior, judgment, or ability to function in school or work?

**Question 50**
Within the past five (5) years, have you had or do you currently have any physical or neurological condition, including any disease or condition generally regarded as chronic, which impaired or does impair your behavior, judgment, or ability to function in school or work?

**Question 51**
If you answered ‘Yes’ to questions 48 or 49, are the limitations caused by your mental condition or substance abuse/dependency problem reduced or ameliorated because you receive ongoing treatment (with or without medication) or because you participate in a monitoring program?

**Texas Medical Board Visits to Medical Schools**
Another result of the council’s collaboration with the board has been annual visits by board staff to medical schools to strengthen relations with medical students. These visits are to inform students about the board’s reporting requirements, explain how the board uses the information, and promote awareness of the services available through the Texas Physician Health Program.

**Sharing of Outcomes**
The council will continue to collaborate with the board on physician and resident reporting requirements and will share the results with the Committee on Physician Health and Wellness.
REPORT OF COMMITTEE ON CONTINUING EDUCATION

CM-CE Report 1-A-17

Subject: TMA CME Program Update

Presented by: Aurelio Matamoros, MD, Chair

Reaccreditation of TMA’s CME Provider Program

The Texas Medical Association has been (re)surveyed by the Accreditation Council for Continuing Medical Education (ACCME) and awarded Accreditation with Commendation for six years (effective November 2016) as a provider of continuing medical education for physicians.

ACCME accreditation seeks to assure the medical community and the public that the Texas Medical Association provides physicians with relevant, effective, practice-based continuing medical education (CME) that supports U.S. health care quality improvement.

ACCME employs a rigorous, multilevel process for evaluating institutions’ CME programs according to the high accreditation standards adopted by all seven ACCME member organizations. These organizations are the American Board of Medical Specialties, American Hospital Association, American Medical Association, Association for Hospital Medical Education, Association of American Medical Colleges, Council of Medical Specialty Societies, and Federation of State Medical Boards.

ACCME New Criteria for Accreditation With Commendation

ACCME has adopted a Menu of New Criteria for Accreditation with Commendation, with a transition phase during which accredited providers that aim to achieve Accreditation with Commendation have the option of demonstrating compliance with the current or the new commendation criteria. As always, compliance with the commendation criteria is optional for CME providers and is not required to achieve accreditation.

At its meeting on Jan. 27, TMA’s Committee on Continuing Education adopted the ACCME Menu of New Criteria for Accreditation with Commendation.

Update on CME Providers in TMA’s Intrastate Accreditation Program

Upon recommendations from the Subcommittee on Accreditation, the committee made 16 accreditation decisions in 2016 regarding TMA’s accredited organizations. TMA’s current roster of CME-accredited organizations contains 57 organizations. The breakdown for type of organization is as follows: 47 hospitals or hospital systems, one physician group, two state specialty societies, one state agency, two regional health education centers, one university student health center, one quality improvement organization, one hospice, one regional medical staff organization for emergency services, and one county medical examiner’s office.

2016 Texas CME Conference

TMA offers an annual two-day conference for physicians and staff who plan and implement continuing medical education activities. The program provides updates on CME issues, trains CME providers to meet accreditation requirements, and provides networking opportunities for CME providers.

The 2016 Texas CME Conference was June 22-24 at the Sheraton Austin at the Capitol, with 118 CME professionals in attendance. The conference focused on leading and driving change in CME. Tymothi Peters of the University of California San Francisco School of Medicine and Steve Singer of ACCME gave the Mark Gregg Memorial Distinguished Lecture on Expecting More: Bringing Innovation,
Inspiration, and Creativity to Boost CME’s Impact. Other topics included maintenance of certification and CME, quality improvement, strategies for streamlining regularly scheduled series, strategies for meeting the proposed menu of accreditation with commendation criteria, preparing for Joint Accreditation Certification, how to write an executive summary to grantors, joint providerships, CME program evaluation, and the basics of CME for newcomers.
Subject: Delay the Implementation of Downside Risk in Alternative Payment Models

Presented by: John Carlo, MD, Chair

Background

At A-16, the following was referred to the Council on Socioeconomics, with a report due at the 2017 Annual Session:

That the: (1) Texas Delegation to the American Medical Association take this or a similar resolution to the AMA House of Delegates to request that the Centers for Medicare & Medicaid Services delay the implementation of downside risk in alternative payment models (APMs), and reduce the resulting exposure for physicians to the downside risk in APMs; and (2) Texas Medical Association request that the AMA make this a high priority for legislative advocacy in 2016.

On June 27, 2016, TMA sent a comprehensive letter with formal recommendations to the Centers for Medicare & Medicaid Services (CMS) on the implementation of the Medicare Access and CHIP Reauthorization Act (MACRA), including the recommendation that CMS not force any physician to accept more risk than he or she can manage financially. As a part of the final regulation, CMS eliminated the requirement for marginal risk and minimum loss rate.

Other APM Changes

On Dec. 20, 2016, CMS announced a new Center for Medicare and Medicaid Innovation model, the Medicare Accountable Care Organization (ACO) Track 1+ Model, that will test a payment design incorporating more limited downside risk than currently is present in tracks 2 or 3 of the Medicare Shared Savings Program. The model is designed to encourage small practices to advance to performance-based risk and also allows hospitals, including small rural hospitals, to participate.

Beginning in 2018, this will allow clinicians to join an advanced APM to potentially earn an incentive payment under the Quality Payment Program. ACOs will have the opportunity to join the Track 1+ Model as part of the Shared Savings Program application cycles in 2018-20.

Track 1+ Model Details

The new Track 1+ Model is based on the Shared Savings Program Track 1, but incorporates elements of Track 3 including: prospective beneficiary assignment to allow ACOs to know in advance the patient population for which they are responsible; the introduction of downside risk; and the option to request a Skilled Nursing Facility (SNF) 3-Day Rule waiver to provide greater flexibility to Track 1+ ACOs.

ACOs can share in savings up to a maximum 50-percent shared savings rate based on quality performance. The Track 1+ Model has a fixed 30-percent loss-sharing rate. Additionally, the maximum level of downside risk would vary based on the composition of ACOs, with lower levels of risk potentially available to qualifying physician-only ACOs and/or ACOs that include small rural hospitals. Track 1+ ACOs will have a choice of symmetrical thresholds from which to start sharing in savings or losses (the same options offered to tracks 2 and 3 ACOs).

Track 1+ ACOs will enter into one of two risk arrangements (either a revenue- or benchmark-based loss-sharing limit) based on whether any of the following three criteria are met: (1) the ACO includes an ACO participant (as identified by taxpayer identification numbers/CMS certification numbers) that is an
inpatient prospective payment system hospital, cancer center, or rural hospital with more than 100 beds, or is owned or operated by, in whole or in part, such a hospital or by an organization that owns or operates such a hospital; (2) the ACO includes an ACO participant that is owned or operated by, in whole or in part, a rural hospital with 100 or fewer beds that is not itself included as an ACO participant; and (3) the ACO includes an ACO participant rural hospital with 100 or fewer beds that is owned or operated by, in whole or in part, a health system.

If none of these criteria are met, the ACO’s loss-sharing limit would be 8 percent of ACO participant Medicare fee-for-service revenue (in year 1, 2018). In years 2 and 3 (2019 and 2020), if the nominal risk-requirement revenue standard for advanced APMs under the Quality Payment Program increases above 8 percent of APM entity revenues, ACOs in the Track 1+ Model with a revenue-based loss-sharing limit would be offered the option to accept higher risk in order to continue to be considered participants in an advanced APM. In subsequent years of the model, the loss-sharing limit will be aligned with the required nominal amount for advanced APMs.

The loss-sharing limit under this structure would be determined by CMS near the start of the ACO’s agreement period under the model (based on the ACO’s initial application to the model or application for renewal under the model), and redetermined annually based on an annual certification process. Changes to the loss-sharing limit (to the revenue- or benchmark-based methodology) would be made by CMS based on the annual certification process that occurs prior to the start of a performance year under the model. The Track 1+ ACO’s loss-sharing limit could be adjusted up or down on this basis.
REPORT OF PATIENT-PHYSICIAN ADVOCACY COMMITTEE

CM-PPA Report 1-A-17

Subject: Patient-Physician Advocacy Update

Presented by: Jaideep Mehta, MD, Chair

The Patient-Physician Advocacy Committee presents the following informational report regarding the committee’s recent actions.

Amicus Curiae Involvement

The Patient-Physician Advocacy Committee reviewed the case of a physician who alleged a hospital had retaliated against him after the physician had made reports to relevant authorities regarding potential violations of rules and regulations relating to the hospital. The physician had alleged the hospital and its agents advocated for patient care by recommending improvements in operations and seeking additional training for its nursing staff. Further, when no action was taken to adopt suggested improvements, the physician filed complaints with state and federal authorities, asserting that the hospital had numerous occurrences involving unsafe conditions and violations of standards of care.

Upon review, the committee recommended submitting to the court an amicus brief supporting the ability of a physician to report safety issues without fear of retaliation. The recommendation was approved by the Board of Trustees Chair. TMA’s amicus brief stressed the need for a culture of safety in health care and emphasized that physicians who report violations of safety standards ought to be afforded protection under the Texas Citizens Participation Act in order to encourage the freedom of physicians and other health care workers to candidly communicate concerns about safety concerns.

The committee also recommended amicus involvement in two other cases. The first involved a physician-medical examiner who was sued by the husband of a decedent after the physician classified the decedent’s death as a homicide. When the husband’s trial ended in a mistrial, county medical examiner’s office reconsidered the series of tests it had undergone and, as a result, changed the manner of death classification from homicide to undetermined. When this caused the prosecutor’s office to drop the homicide charges against the husband, the husband alleged the physician and others violated his civil rights by intentionally falsifying the autopsy. At the district court level, the court issued a preliminary finding that the physician’s course of action violated the husband’s clearly established constitutional rights. The committee recommended that TMA file an amicus brief in support of the physician that would assert protection for the physician’s medical judgment, and that the court should not encroach on that medical judgment, and that would express discouragement of the ability of a plaintiff to recast a health care liability claim as a civil rights claim.

The other case in which the committee recommended involvement was the case of a cardiologist whose employment at a nonprofit health care corporation was terminated at the recommendation of the corporation board’s financial advisor. The cardiologist was terminated because of his practice losses at the facility and, allegedly in part, because of bad behavior. When he was terminated, the facility did not provide any due process, but terminated him pursuant to a “without cause” provision in his contract, even though the provision may not have been properly applied and though the facility may have still had cause to fire him. The committee recommended that TMA file an amicus brief in general support of the importance of due process rights for a physician, and in support of the corporate practice of medicine prohibition.
Texas Medical Board
The committee has been involved with the TMB to learn more about its processes and procedures and to offer improvements. The committee also provided input in TMA’s efforts to address concerns regarding the TMB licensure and disciplinary process as part of the Texas Sunset Commission’s scheduled review of licensing agencies. The committee has on various occasions invited the board’s executive director, general counsel, and medical director to its committee meetings to discuss a variety of concerns.

Sham Peer Review
The committee reviewed and recommended retention of TMA policy relating to sham peer reviews. The committee will form a subcommittee to review sham peer reviews in greater depth and will seek more permanent solutions to the issue.
Subject: Report on Resolution 107: Requiring Doctors to Swear to Be Honest

Presented by: Ryan Van Ramshorst, MD, Chair

Background
At the 2016 annual meeting, the House of Delegates referred Resolution 107, Requiring Doctors to Swear to Be Honest (Bexar County Medical Society). The resolution calls for the following:

“That physicians in Texas not be required by any governmental agency or function to swear that they will not be dishonest in dealings with state agencies or functions, and that they not be required to swear that they will seek out colleagues that they suspect are guilty of misbehavior without specific guidance as to what is considered ‘misbehavior.’

Discussion
In early 2016, the new Inspector General (IG) of the Texas Health and Human Services Commission Office of the Inspector General (OIG), Stuart Bowen, announced a new IG Integrity Initiative to reduce waste, fraud, and abuse. Styled a “community policing initiative,” it called for Medicaid providers to pledge to report all suspected fraud, abuse, and waste to the IG. Many Texas Medical Association members were naturally concerned about a coercive program requiring or strong-arming them to sign what they viewed as an unnecessary pledge to act as tattle-tales on their colleagues.

With this in mind, last April, the Select Committee on Medicaid, CHIP, and the Uninsured joined by members of the Board of Trustees met with the IG to discuss their concerns regarding the Integrity Initiative. Mr. Bowen clarified that the initiative is completely voluntary and that no physician would be forced to seek out and report on other physicians suspected of misbehavior. Additionally, he acknowledged actual fraud is low among physicians and that unintended errors are not tantamount to fraud. He outlined his desire to establish a constructive rapport with TMA and ongoing discussions about fair strategies to reduce actual fraud, waste and abuse.

After the IG clarified that the program is voluntary, TMA received no further complaints. Rather, committee leaders and county medical societies have indicated their support for the IG’s transparent, collaborative, approach. Since there have been no additional complaints since the IG clarified the initiative is voluntary, the Select Committee believes no further action is needed at this time. However, since a future IG could implement a compulsory pledge, the committee will continue to closely monitor the initiative.

Conclusion
Given the clarification received from Mr. Bowen and the collaborative relationship that the committee has developed with the OIG, the Select Committee on Medicaid, CHIP, and the Uninsured does not recommend specific action, but will continue to constructively work with the OIG to ensure physicians accused of waste, fraud, or abuse be accorded appropriate and timely due process.
Subject: 2017-18 TEXPAC Board of Directors

Presented by: Bradford W. Holland, MD, Chair

Appointment of TEXPAC Board of Directors
TMA Bylaws provide that the TMA Board of Trustees shall provide general policy and operational supervision of TEXPAC, that the TEXPAC Board of Directors shall report to the Board of Trustees, and that members of the TEXPAC Board of Directors shall be appointed by the Board of Trustees.

In April 2017, the TMA Board of Trustees appointed the following TEXPAC officers for 2017-18:

• Robert Rogers, MD, Chair, TEXPAC Board of Directors
• Alexander Kenton, MD, Chair, Candidate Evaluation Committee
• Brad Patt, MD, Chair, Membership Committee

The Board of Trustees also appointed the TEXPAC district chairs, executive committee and Candidate Evaluation Committee, attached to this report.
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### TEXPAC Executive Committee

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<td>Robert Rogers, MD</td>
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<td>Harris</td>
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Background and Organization

The Texas Medical Association Insurance Trust (TMAIT or the Trust) operates under the authority of an eight-member board that includes 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 2016, the trustees met in person in January, April, 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 July.

The Board of Trustees is assisted by the TMAIT Advisory Committee, composed of nine TMA physicians and a TMA Alliance member appointed by the trustees for the purpose of reviewing claims and underwriting decisions appealed by the membership. The advisory committee, which includes a variety of medical specialists, provides a member the opportunity for a panel of his or her peers to review insurance carrier decisions concerning underwriting and claim matters. The advisory committee is one of the principal strengths of TMAIT, as it gives each member a forum for further consideration of decisions that affect insurance coverage.

To expand the insurance market for the Trust and our members, in 2000, TMAIT established its own insurance agency, TMAIT Financial Services, Inc. (the Agency), 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, from marketing, enrollment and billing to claims assistance. With direct access to all membership information, TMAIT staff can supply an immediate response to a member’s inquiry about insurance benefits. Staff are assisted by actuarial, legal, financial, tax, and technology advisors who offer advice on a broad range of technical issues. Staff serve as a liaison between the membership and the insurance carriers, and provide a member service that generally is not available to an individual purchasing coverage through the commercial insurance market.

The TMAIT 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.
2016 Financial Results

Overall, the insurance program experienced a gain of about $7.7 million in 2016 as compared to a loss of about $2.4 million in 2015. The 2016 gain was largely attributable to exceptionally positive results for the LTD plan. The results by plan, with comparative information for 2015, are presented below.

- The life insurance plan experienced a gain of about $500,000 for 2016, as compared to a loss of about $700,000 in 2015. There were 26 death claims in both 2016 and 2015. The total payments in 2016 were $6.2 million, significantly lower than the $9.9 million paid in 2015 when claims were the highest in the history of the program.
- The business overhead plan experienced a gain of about $1.1 million during 2016 as compared to a gain of about $700,000 during 2015.
- The LTD plan experienced a gain of $7.4 million in 2016. The plan incurred losses of about $2.3 million over the previous two years. The gain in 2016 resulted from an unusually low number of new claims (only four) and an exceptionally high number of terminating claims (31). Terminations occur as a result of recovery, death, or reaching the end of the benefit period.
- In 2016, the health plans produced a loss of about $1.3 million as compared to a loss of $1.4 million in 2015. In both years, the loss was expected as a result of the trustees’ decision to subsidize rates in order to reduce the impact of the high cost of health insurance on the plan participants.

In years like 2016 in which the experience is favorable, gains are credited to the Trust’s Premium Stabilization Funds (PSF), which provide added security and stability for the Insurance Program. At the close of the 2016 policy year (Oct. 31, 2016), the Insurance Program had a combined PSF balance of $87.7 million.

2016 Program Enhancements

We continued to improve and expand our coverage options for physicians during 2016.

- Effective Nov. 1, 2015, we made the following enhancements to the LTD plan:
  - Increased the specialty occupation (Own Occ) period from five to seven years.
  - Liberalized the partial disability benefit.
  - Increased the mental and nervous limitation from two to three years.
  - Liberalized the age reductions: from $2,000 at age 65 to $5,000 at age 65; from $400 at age 70 to $2,000 at age 70; termination at age 75.
  - Eliminated the third-party offset.
  - Increased the available monthly maximum for the 90-day elimination period option to $15,000 subject to a 12/12 pre-existing condition limitation.
  - Increased the available monthly maximum for the 30-day elimination period option to $10,000, subject to a 12/12 pre-existing condition limitation.

- We enhanced the Business Overhead plan effective Nov. 1, 2015, as follows:
  - Raised the maximum monthly benefit from $35,000 to $50,000.
  - Revised the wording to permit benefit payments to the physician’s office (as opposed to just the claimant).

- We also added personal auto, homeowners, and umbrella policies to our portfolio in 2016.
2017 Initiatives
During 2017, we are continuing to work to improve marketing and administrative services for our members.

• During the 2016 open enrollment period, we implemented online shopping capabilities for health, dental, and life insurance. In 2017, we are working to add online shopping for disability, business overhead, critical illness, and other ancillary products.

• During 2017, we will continue to enhance tracking and reporting capabilities with our Customer Relations Management (CRM) platform in order to better serve TMA members.

• Throughout 2017, our digital marketing partner will assist us in our digital marketing efforts and provide sales and marketing content for our website, publications, brochures, and email campaigns.

Effective Nov. 1, 2016, we implemented the following enhancements to the LTD and life insurance plans.

• The LTD Loyalty program provides a 25 percent premium discount for all LTD participants who are age 50 or over and have been insured 10 or more years on or after Nov. 1, 2016.

• We have added to the LTD plan at no cost a Student Loan Reimbursement provision.

• We have implemented a “No Cost Insurance” program which provides the following coverage at no cost for one year to qualifying new TMA members and qualifying residents.
  – $5,000 monthly LTD benefit
  – $50,000 of life insurance

We will closely monitor legislative developments related to the Affordable Care Act (ACA) throughout 2017. While significant change appears to be almost certain, the nature and timing of such change is unclear at this time. Nevertheless, it is likely that the market and regulatory environment for health insurance will experience another round of major upheaval in the coming months and years. This will have a profound effect on TMAIT and TMA physicians.

Our decision to maintain, on a grandfathered basis, the association group health plans for TMA members that have been in effect for many years now seems fortuitous. While the ACA has prevented new enrollment in those plans since Nov. 1, 2013, we have continued to operate them on a closed group basis. In spite of the challenges inherent in such an environment, those plans remain financially viable and continue to provide the same quality coverage that they have in the past. The association group plans and the assistance that we provide in securing coverage in the individual market have allowed our staff to maintain a high level of expertise in the health insurance business. This places the TMAIT and the Agency in a great position to respond to any changes that may arise from the “repeal and replacement” of the ACA.
Attachment A

TMAIT Statistics

**Benefit Payments**

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<th>Plan</th>
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<td>Business Overhead</td>
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**Miscellaneous**

- Total Contributions: $24.1 million
- Combined Premium Stabilization Fund: $87.7 million

**2016 Program Highlights**

- Rate of Return on Invested Assets: 3.0%
- LTD Payments: 1,235
- Disabled Physicians Receiving LTD Payments: 86
- New LTD Claims: 4
- Death Claims: 26
- Applications: 886
- Coverage Quotes: 2,332
- Billings: 30,282

**2016 Enrollment by Plan**

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<td>Health</td>
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TMF Health Quality Institute has worked with Texas physicians for more than 45 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, 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 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 14,000 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.

Earlier this year, TMF was selected to provide support for small medical practices in the CMS Quality Payment Program. Through this program, TMF will provide 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 available immediately—free to all MIPS-eligible clinicians—and will deliver support for up to a five-year period.
TMF will also be supporting physicians that are part of this program in Arkansas, Colorado, Kansas, Louisiana, Mississippi, Missouri, Oklahoma and Puerto Rico.

We are honored to be partnered with Texas Medical Association (TMA) 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 TMF's website for information about eligibility for and criteria of this noncompetitive recognition program. We are grateful to the 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.
2016 Accomplishments

The TMA Foundation raised more than $2 million in 2016, the second highest amount in its history. More than $900,000 of the amount raised was donated to TMAF’s General Endowment through the Endowment for Innovation Campaign. The total raised in 2016 was donated by 1,270 individuals (102 more than 2015) and 80 institutional donors. The generosity of donors, plus investment earnings from endowments, enabled TMAF to approve $623,460 in grants to support programs that primarily were carried out in 2016.

Included among the grants are $546,470 in support for 10 TMA health improvement, quality-of-care, and science initiatives: Hard Hats for Little Heads; Be Wise — ImmunizeSM; Ernest and Sarah Butler Awards for Excellence in Science Teaching; Minority Scholarship Program; Walk With a Doc Texas; Award for Excellence in Academic Medicine; University of Health; Hepatocellular Carcinoma Awareness Campaign; Quality Summit; Cutting Edge — the History of Texas Surgery exhibit; and the Texas Two-Step: How to Save a Life initiative. This is comparable to the amount granted to TMA for its 2015 programs.

For every $1 TMA invested in TMAF in 2016, TMA receives a five-and-one-half-fold benefit in community health improvement and positive physician image.

TMAF also operates two annual community grant programs that invite county medical societies and TMA Alliance and medical student chapters to apply for grants to support local community health improvement programs. Under these 2016-17 grant programs, TMAF approved $39,490 in grant support for 12 programs.

See Attachment A for all 2016 TMA and community grant programs.

Additional achievements include the following:

- TMAF raised nearly $400,000 through the 2016 gala, thanks to generous sponsors, guests, and the efforts of chairs from Dallas, Lea Ann Pearse, MD and Mr. Einar Vagnes;
- Increased the talent and expertise among TMAF board members during 2016 with new members from Corpus Christi, as well as representatives from the TMA Young Physician Section and TMA Medical Student Section;
- A record number, 23 individuals, achieved major donor status in 2016 (eight major donors upgraded their major gifts to higher levels and 15 became new major donors); each were recognized at the 2017 TMA Winter Conference, and their names have been added or moved up on the Major Donor walls on the 10th floor of the TMA building. This brings the total number of major donors to 202 as of December 31, 2016. Major Donor status begins at $10,000 in cumulative donations with additional levels for subsequent increased giving; see Attachment B.
- The 2017 TMAF John P. McGovern Champion of Health Award was given to the top winner. The top winner received a $5,000 grant, and the second place winner was given a $250 grant.
Foundation Grants Support 2017 TMA Programs

- Hard Hats for Little Heads
- Be Wise—Immunize
- Ernest and Sarah Butler Awards for Excellence in Science Teaching
- Minority Scholarship Program
- Walk with a Doc Texas
- University of Health
- Texas Two-Step: How to Save a Life Initiative

These grants support the expansion of several initiatives: (1) Walk With a Doc Texas aims to expand from 36 sites in 2016 to 39 in 2017; (2) Be Wise — Immunize will offer additional Local Impact Grants to TMA and TMAA members who want to provide immunizations to their community; (3) the Minority Scholarship Program will provide 12, $10,000 scholarships to a first-year medical student at each Texas Medical School, up from 11 in 2016; and (4) Hard Hats for Little Heads aims to distribute 30,500 helmets to youth, up from 28,987 in 2016.

Blast Off! On Friday, May 5, 2017

TMA Foundation’s 24th annual gala will take place on Friday, May 5, at the Marriott Marquis, Houston, during TexMed 2017. Michael Speer, MD, TMA board member and TMA past president, is the lead Ambassador. The lead sponsor for the event is H-E-B. Confirmed sponsors from the $30,000 level to the $3,000 level as of Feb. 6 are: H-E-B; Pfizer, Inc.; Texas Medical Liability Trust; Texas Medical Association Insurance Trust; Prudential; Texas Health Resources; University of North Texas Health Science Center; Houston Academy of Medicine/Harris County Medical Society; Vaughan Nelson Investment Management; Hidalgo-Starr County Medical Society; Luther King Capital Management; The Quantitative Group at Graystone Consulting; Rudd & Wisdom, Inc.; Travis County Medical Society; Texas A&M University Health Science Center; Texas Oncology, PA - Corporate Office; TMF Health Quality Institute; and TMA.

In the pre-dinner receptions, guests will have the opportunity to enjoy the silent auction and participate in a game of Heads or Tails. In the ballroom guests may bid in the live auction and donate to the Make-A-Difference drive, which supports Hard Hats for Little Heads. Showcase your galactic glamour at this planetary celebration (think metallic, silver and space motifs) or come in your business casual best.

The event is the single largest fundraising effort of TMAF and makes TMA health improvement, science, and quality-of-care programs possible.

Through April 28, regular individual tickets are $210 and special VIP tickets are $260; after April 28 they increase to $235 and $285 respectively. Individuals may sponsor a table of eight for $2,000. For more information and to purchase tickets, contact TMAF at (800) 880-1300, extension 1466 or (512) 370-1466.
TMA GRANTS - In support of TMA’s health improvement, science and quality of care 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 315,000 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. In 2016, local grants were made to protect the following communities from potentially deadly diseases:

- Austin Ideal Medicine
- El Paso Paul L. Foster School of Medicine
- Fort Worth Mercy Effect
- Houston McGovern Med School- UTHSC at Houston
- Kilgore Faith Family Medicine Clinic
- Lubbock SPIN and Lubbock-Crosby-Garza CMS Alliance
- Manvel Love to Share Foundation America
- Paris Lamar-Delta CMS, Paris-Lamar County Health District
- Presidio Presidio County Health Services
- San Antonio Bexar CMS Alliance
- Tyler Smith CMS Alliance
- Weatherford Parker CMS

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 the program’s inception in 1994, more than 260,000 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 in healthy physical activity to reverse the consequences of a sedentary lifestyle, especially obesity. Thirty-six TMA physician members have established walks that engage patients in walking with them at least once a month for 12 months. Participants enjoy healthy food and lifestyle education through brief presentations before each walk, conversation with the physician and take-home educational hand-outs.

TMA Award for Excellence in Academic Medicine: This program recognizes physicians for their role in preparing the future physician workforce. There are four award levels and the highest level, the Platinum Award, carries a cash award. The program forges stronger relations between organized medicine and physicians in academic medicine and demonstrates TMA’s support for preparing the future physician workforce to meet the health needs of all Texans. (This program has been discontinued.)

Hepatocellular Carcinoma Awareness Campaign/TMA’s Committee on Cancer: The Committee on Cancer and a group of leading hepatologists and oncologists are offering an awareness and detection campaign directed towards primary care physicians and high-risk groups fostering an understanding of the increasing incidence of Hepatocellular Carcinoma. The program includes live presentations, webinars, PSAs, journal submissions, blog articles and TMA advertisements.

University of Health/Texas Public Health Coalition: The University of Health is a public health forum held four times a year to discuss Texas’ role in public health and safety and the economic impact of public health issues. Sessions focus on public health infrastructure, immunizations, obesity, tobacco use cancer control and related topics. Legislative members and their staff are the target audience for these University of Health public forums.

"Cutting Edge" — the History of Texas Surgery," Traveling Exhibit: TMA’s History of Medicine Committee produced a traveling exhibit consisting of four banners based on its History of Surgery exhibit. The exhibit is traveling to the host city of Texas Surgical Society meetings and will be on exhibit at the meeting and then remain on display in a prominent location in that city until moving to the next host city.

Quality Summit: TMA’s Council on Health Care Quality and the American College of Medical Quality (ACMQ) collaborated on a quality summit called “Quality Strategies for a Prosperous Practice.” Texas Quality Summit was a two-day conference in November 2016 to provide timely information and education on quality and physician performance.
COUNTY MEDICAL SOCIETIES AND ALLIANCE CHAPTERS: Medical Community Grants

Drive Thru, Prevent Flu/Lamar Delta County Medical Society. The Paris-Lamar County Health District is partnering with the Lamar-Delta County Medical Society and other community partners to provide an efficient method for residents to receive the influenza vaccine. This year’s “drive-thru” shot clinic will reach 400 citizens, age 18 or older. The easy access option will be a particular asset to both the elderly and also to a vast majority of the rural community who find it difficult to visit a regular walk-in clinic.

Healthy Kids Shared Medical Appointments /Smith County Medical Society. This project will create shared 90-minute medical appointments for overweight and obese children at the Tyler Family Circle of Care (TFCC), a federally qualified health center in Smith County. Patients and their caregivers benefit from learning about their health through participating and interacting with other patients, as well as learning from the multidisciplinary team led by a physician, nutritionist, mental health specialist and other health educators.

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 physicians (TMA members), partnering hospitals, donating ancillary services, charitable community clinics, and other providers serve the target population of the uninsured working poor. To date, PATC has served more than 1,000 patients and provided more than $9.5 million worth of donated care that this population would otherwise be unable to access.

Immunization Project; Tarrant County Medical Society Alliance Foundation (TCMSAF): TCMSAF partners with Immunization Collaboration of Tarrant County by providing funding, volunteers, and leadership as part of a collaboration of over 40 agencies and organizations, public and private, committed to providing the systematic eradication of childhood, vaccine-preventable diseases in Tarrant County since 1991. The collaboration serves over 7,000 children with 20,000 doses of vaccine each year as well as distributing between 15,000 and 20,000 pieces of educational materials throughout the county.

One Healthy Option for the Children of Texas; Williamson County Medical Society: For children in Texas, restaurants can be food deserts, absent of healthy foods on children’s menus. This program gives parents in Williamson County a web-based tool to help them judge the nutritional quality of children’s menus to make healthy choices when dining out.

TMA MEDICAL STUDENT CHAPTERS Medical Student Community Leadership Grants

Alliance Refugee Wellness Fair/Baylor College of Medicine. This biannual event addresses healthcare disparities in the medically underserved refugee population resettled in Harris County by providing direct medical and preventative health services, education about health and wellbeing, and resources for greater access to care. In partnership with several non-profit refugee resettlement agencies in Houston, including Alliance, the YMCA, and Interfaith Ministries of Houston, this initiative provides refugees with practical, culturally competent resources to navigate the Harris Health System and ease their transition to self-sustained living.

Helping Hands Vaccination Drive/University of Texas Medical Branch. Working together, the UTMB TMA, Family Medicine Interest Group (FMIG), Helping Hands and Gold Humanism Honor Society provides influenza vaccines to the underserved and uninsured of Galveston and surrounding counties at the Luke Society, a local street-side clinic that sees upwards of 100 clients per clinic. Unused vaccines will be shared with St. Vincent’s Clinic, which serves a similar population, to be used at their first annual HOPE Health Fair.

The Jefferson Health Initiative/University of Texas Health Science Center at Houston McGovern Medical School: This free weekly fitness class geared towards parents and their children is held at Jefferson Elementary School, a school located in the Northside neighborhood where families face significant socioeconomic challenges that interfere with their access to healthcare and a healthy lifestyle. The classes also feature discussions that emphasize education and reflection on the impact of dietary habits on health.

Frontera de Salud: McGovern Medical School Texas-Mexico Border Health Service Initiative; UT Health McGovern Medical School TMA Medical Student Chapter: This student-led community outreach program addresses health disparities along the Texas-Mexico border by promoting a healthy lifestyle among Cameron County residents. Frontera collaborates with Commissioner Benavides and the Cameron County Health Department to provide health screenings, home visits, health education workshops, and community assessments to 200-400 residents.
**Partnership to Improve Child Health in Northwest San Antonio; University of Texas Health Science Center at San Antonio TMA Medical Student Chapter:** The student chapter will lead a partnership with Family Service Association of San Antonio to provide physical exam screenings and immunizations to children in their Head Start and Early Head Start Programs. For the first year, this program will consist of two physical exam events and a later a Be Wise — Immunize event.

**Pediatric Club Fall Health & Obesity Awareness Fair; Texas Tech University Health Science Center-Lubbock Campus:** In 2011, the Lubbock Board of Health reported that 38.7 percent of adults living in Lubbock are overweight, and that 77.6 percent of adults don’t eat the daily recommended serving of five fruits or vegetables. The annual Pediatric Club Health and Obesity Awareness Fair is focused on helping kids learn ways they can exercise in fun ways at home and how they can feature healthy snacks and meals in their daily diet.

**Patient Education Station; The University of Texas Medical Branch TMA Medical Student Chapter:** This program partners two free clinics, the Luke Society and St. Vincent's Free Student-Run Clinic, to aid low income patients in smoking cessation and provide them with tools they need to be successful. There are three components to the program: (1) developing volunteers and teaching motivational interviewing techniques in regards to smoking cessation; (2) providing resources to patients ready to quit smoking to optimize their chances of success; and (3) giving healthcare providers objective measurements of pulmonary function to guide the treatment of concurrent COPD.
Attachment B

TMA Foundation Major Donors

Visionaries
Dr. Roberto J. and Agniela (Annie) M. Bayardo
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Pon Satitpunwaycha, MD

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Dr. Paul and Mrs. D’Anna Wick
Mr. and Mrs. Clarence* Woliver
Dr. Dale and Mrs. Mertie L. Wood

*Deceased
REPORT OF TEXAS MEDICAL ASSOCIATION ALLIANCE

TMAA Report 1-A-17

Subject: Alliance Activities and Accomplishments

Presented by: Debbie Pitts, President

Public Health Outreach
The Texas Medical Association Alliance (TMAA), partnering with community organizations including local health departments and immunization coalitions, has contributed to more than 315,000 immunizations administered to the state’s children since the inception of Be Wise — ImmunizeSM in October 2004.

As a major participant in the Hard Hats for Little Heads program, TMAA helped distribute almost 29,000 helmets to Texas youth in 2016. And since 1994, the Texas Medical Association and TMAA have distributed more than 260,000 helmets.

County alliances also participate in the promotion and logistics for Walk with a Doc events in several locations across the state.

In addition, county alliances customize local programs to fight underage drinking, family violence, bullying, smoking/tobacco use, and elder abuse, as well as bring attention to the need for tissue and organ donation.

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 2017 First Tuesdays is expected to keep pace with, if not exceed, prior years’ attendance levels. Almost 300 attendees participated in the February 2017 event. Alliance members continue to support TEXPAC with approximately 800 members. In addition, TMAA’s 12 voting members serving on the TEXPAC Board of Directors have a 100-percent attendance record at TEXPAC board meetings.

Susan Todd, Fort Worth, who has chaired First Tuesdays at the Capitol since its inception in 2003, passes the torch to Patty Loose, Austin, this year. Susan Todd was TMAA president in 2002-03, and Patty Loose was TMAA president in 2015-16. Both are members of the TEXPAC Board and have been active in TMA’s legislative and political activities for many years.

TMA Foundation
The alliance continues its involvement and promotion of the Texas Medical Association Foundation (TMAF) by assisting with the annual gala and its ongoing efforts to heighten awareness of the foundation and its value to the association and TMAA. The official family holiday sharing card was repeated in 2016, raising nearly $2500. County alliances also contribute manpower and funds to support the annual gala during TexMed.

Alliance members serving on the TMAF Board of Trustees include Angela Donahue, Patrick Hearn, and D’Anna Wick. Mrs. Donahue serves as an at-large member on the Executive Committee.
The alliance will celebrate 100 years of service to medicine and the medical family in 2018. A steering committee composed of past and current alliance leaders across Texas have begun plans for an exciting celebration to acknowledge this important milestone. The evening event is scheduled for Thursday, May 17, at the JW Marriott Resort in San Antonio during TexMed 2018. Karen Lairmore, Belton, will preside over the festivities as the 2017-2018 president.
AGENDA
REFERENCE COMMITTEE ON FINANCIAL AND ORGANIZATIONAL AFFAIRS
Friday, May 5, 2017
Marriott Marquis, Level 2, Houston Ballroom 1

1.  Presidents Report 1 – Nominations for Board of Governors, Texas Medical Liability Trust
2.  Speakers Report 1 – TMA Election Process
3.  Board of Trustees Report 11 – Texas Two Step
4.  Board of Trustees Report 12 – Continuation of International Medical Graduate Section
5.  Board of Trustees Report 13 – Policy Review
7.  Board of Councilors Report 4 – Emeritus Nominations
8.  Board of Councilors Report 5 – Honorary Nominations
11. Council on Constitution and Bylaws Report 2 – Board of Councilors Quorum and Voting Members
12. Council on Constitution and Bylaws Report 3 – Authority to Take Action Without a Meeting
17. Speaker and Council on Constitution and Bylaws Joint Report 1 – Parliamentary Authority Transition for TMA
18. Committee on Membership and Council on Constitution and Bylaws Joint Report 2 – TMA Bylaws Concerning Retired Member Classification
19. Resolution 101 – Election of TMA Board of Trustees Members (Lone Star Caucus)
20. Resolution 103 – Texas Medical Board License Renewal Notifications and Payment (Harris County Medical Society)
21. Resolution 104 – Tort Reform Celebration Day (El Paso County Medical Society)

22. Resolution 105 – TMA Outreach to Displaced and Refugee Physicians (Harris County Medical Society)

23. Resolution 106 – Reduced and Alternative Documentation and Administrative Requirements for Medical Documentation for Prescribers in Times of Declared Disasters (Harris County Medical Society)

24. Resolution 107 – Support of Evidence-Based Medicine (Young Physician Section, Resident and Fellow Section, and Medical Student Section)

25. Resolution 108 – Recognition of John R. Holcomb, MD (Bexar County Medical Society)

26. Resolution 109 – Election Results (Angelina County Medical Society)

27. Resolution 110 – Integrating Advance Directives Conversation to Maintain Autonomy (Medical Student Section)

28. Resolution 111 – Addressing Physician Mental Health Status Disclosures (Medical Student Section)

29. Resolution 112 – Commendation of 2017 Texas Two-Step CPR: Save a Life Campaign (Arlo F. Weltge, MD; Michelle A. Berger, MD; Keith A. Bourgeois, MD; Carlos J. Cardenas, MD; Douglas W. Curran, MD; Carrie E. de Moor, MD; Diana L. Fite, MD; David C. Fleeger, MD; Gary F. Floyd, MD; A. Tomas Garcia III, MD; David N. Henkes, MD; Laura Faye Gephart, MD; Dan K. McCoy, MD; Don R. Read, MD; Kayla A. Riggs; Richard W. Snyder II, MD; Susan M. Strate, MD; E. Linda Villarreal, MD)

30. Resolution 113 – HIPAA and Physician Rating Websites (Harris County Medical Society)

Note:
Resolution 102 was referred to the Reference Committee on Socioeconomics and is now Resolution 415.
Supplement

REPORT OF TMA PRESIDENT

PRES Report 1-A-17

Subject: Nominations for Board of Governors, Texas Medical Liability Trust

Presented by: Don R. Read, MD, President

Referred to: Reference Committee on Financial and Organizational Affairs

The trust instrument that controls the operations of the Texas Medical Liability Trust (TMLT) requires that nominations for its 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.

The following nominations are made by the TMLT Board of Governors to fill two three-year terms beginning in 2016:

Mark S. Gonzalez, MD, McAllen, cardiovascular disease, for reelection to Place 1;
Russell B. Krienke, MD, Austin, family medicine for reelection to Place 2; and
Pamela D. Holder, MD, Houston, pathology, for reelection to Place 3.

Recommendation: Approval of Drs. Mark S. Gonzalez, Russell B. Krienke, and Pamela D. Holder, nominees of the TMLT Board of Governors, to be placed before TMLT policyholders for election.
REPORT OF SPEAKERS

Subject: TMA Election Process

Presented by: Susan M. Strate, MD, Speaker

Referred to: Reference Committee on Financial and Organizational Affairs

At A-16, the Speakers of the House of Delegates submitted SPKR Report 1, TMA Election Process to recommend timely updates to the TMA Election Process adopted in 2012. The report was crafted with the advice and counsel of the Speakers’ Advisory Committee (SPAC), which comprises representatives from each caucus as well as the Medical Student, Resident and Fellow, and Young Physician sections. The House of Delegates considered the report and recommended referral back to the speakers and the SPAC for additional review and clarification of issues outlined in the initial report.

The following report proposes changes to more accurately reflect current practices of the house; promote fair, equitable, cost-effective campaigns; ensure compliance with existing TMA Bylaws, and increase the policy’s relevancy.

Recommendation: Approval of revised TMA Election Process, as follows:

295.013 Election Process: The Texas Medical Association recognizes the following election process:

The Texas Medical Association House of Delegates (HOD) holds at-large elections for the association’s president-elect (who serves the following year as president, and the year after as immediate past president), secretary/treasurer, speaker and vice speaker of the house, nine at-large members and the young physician member of the Board of Trustees, a councilor for each district, and delegates and alternate delegates to the AMA. The house confirms district elections of vice councilors.

Nominations
Members of the house and county medical societies will receive advance information on elective positions to be filled at the next annual session and the deadline protocol for nominations. Candidates and/or those who nominate candidates will notify HOD staff at TMA headquarters by the published deadline as soon as possible so that the names of candidates seeking election or reelection may be distributed to members of the house and county medical societies, in advance of the election.

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. All candidates nominated from the floor must have completed the required candidate information as stated in the TMA Election Process. Candidates are encouraged to complete this information in advance and send it to HOD staff at TMA headquarters at least one week prior to before the opening session of the meeting at which the election is to be held. Candidates nominated from the floor will complete the requisite information onsite and provide the information as soon as practicable to be distributed to the house prior to the election. Information on candidates to be nominated from the floor will be distributed to the house as quickly as possible, but no later than the opening session.
Guidelines

The intent of the following guidelines is to encourage fair, open, and equitable campaigning by (1) specifying permitted and prohibited election related activities; (2) fostering opportunities for candidates to educate their colleagues about the issues; (3) informing voters about candidate experiences and views; (4) keeping costs down; and (5) maintaining dignified and courteous conduct appropriate to the image of the medical profession. The TMA Election Process containing with campaign guidelines will be posted on the TMA website at http://www.texmed.org/hod/.

Campaigns are often spirited, and your House of Delegates speaker and vice speaker expect candidates to state their positions and plans for TMA directly and positively.

Campaign expenditures and activities should be limited to prudent and reasonable levels necessary for adequate candidate exposure to delegates. Mindful that access to resources is not equal, candidates and their sponsoring organizations should exercise restraint in campaign spending.

The nominating county society, caucus, or individual will send a candidate announcement to house members of the house by email or via U.S. Mail prior to annual session rather than distribute announcement cards at delegate seats at the meetings. Candidates may make personal phone calls and send letters. Including the initial announcement and one follow up, a maximum of two mass communications (an impersonal, one-way email or mail communication to all or part of the HOD membership, sponsored by or on behalf of a candidate) may be used for campaign purposes.

Candidates may make use of personal websites, blogs, social media, videos, etc. One of the two permitted mass emails may be used to communicate links to a candidate’s electronic campaign material; this email must start with “TMA Campaign” in the subject line. TMA will post links to candidate websites on its website.

The candidate’s county society or caucus may distribute campaign stickers or ribbons or buttons at the annual session (see note below).* No other Campaign memorabilia shall be distributed.

Candidates may display one 24”x36” poster may be displayed in the Credentials Committee area at the entrance to the HOD meeting; TMA will provide easels. Candidates may not distribute any other campaign materials at the meeting.

Candidates will provide information as requested by the speakers to include a candidate profile form. TMA will publish candidate information in the Handbook for Delegates and on the TMA website, eliminating the need for campaign literature. TMA will send an announcement indicating where HOD members can find candidate information can be found.

Any candidate for at-large trustee or any office that includes an ex officio seat on the TMA Board of Trustees (president, president-elect, secretary/treasurer, and speaker and vice speaker of the House of Delegates) shall provide full disclosure of affiliations on a form developed by the speaker of the house—by the time of the election.

TMA will host a forum for candidates at the annual session.
Candidates for TMA office should not attend meetings of county medical societies unless officially invited. Candidates may accept reimbursement of travel expenses by the county society in accordance with the policies of the society.

Compliance
Each candidate will be provided a copy of these guidelines and is expected to abide by them. Candidates are to inform those involved in their campaign efforts about the guidelines by sending a copy or by calling attention to the guidelines in the election process posted on the TMA website.

When candidates or their supporters are unclear about whether an intended campaign action is permitted, before taking action, they should seek the opinion of the speaker of the House of Delegates by contacting HOD staff at TMA headquarters. The speaker, in consultation with the vice speaker and the association’s immediate past president, will respond with a ruling concerning the proper interpretation of the guidelines and inform all candidates in order to maintain a level playing field.

Any violation by a candidate or supporter of which the speaker becomes aware will be investigated. Should the speaker, vice speaker, and immediate past president rule that a violation has occurred, the speaker will make an announcement at the house meeting.

Elections
TMA elections are held on the second day of the annual session at a time determined and published by the speakers in advance.

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

The house will hold a run-off election to fill any vacancy that cannot be filled because of a tie vote, or, when necessary, to resolve any ties to determine which candidate(s) shall be elected to which term(s).

With the exception of delegates and alternate delegates to the AMA, those elected candidates who are elected will assume office at the adjournment of the HOD meeting at the annual session. AMA delegates and alternate delegates will assume office on Jan. 1 of the year following their election except those who are elected to fill vacancies, in which case they will assume office at the adjournment of the annual session (SPKR Rep. 1-A-12).

*At the meeting with the speakers on Feb. 1, 2013, caucus chairs agreed that candidates will not make use of stickers, ribbons, or buttons.
Texas Medical Association
CANDIDATE PROFILE FORM

1. Name:

2. Specialty:

3. Medical school and post graduate education (with years):

4. Residency program:

5. Board certification(s):

6. Primary residence (city, state):

7. What is your current practice status? Check all that apply and provide percentages:

<table>
<thead>
<tr>
<th>Practice Type</th>
<th>% Total to Equal 100%</th>
</tr>
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<tbody>
<tr>
<td>Direct Patient Care: solo, small group, or shared overhead</td>
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<tr>
<td>Direct Patient Care: large group practice (over 20 members)</td>
<td></td>
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<tr>
<td>Direct Patient Care: nonprofit corporation [formerly 5.01(A) corporation]</td>
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<td>Academic</td>
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<tr>
<td>Public Health</td>
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<tr>
<td>Administrative: government, health plan, or health-related, but no direct patient care</td>
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<tr>
<td>Research (nonclinical)</td>
<td></td>
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<tr>
<td>Non-medical and not health related; please define industry:</td>
<td></td>
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<tr>
<td>Retired from practice</td>
<td></td>
</tr>
<tr>
<td>Other, please describe:</td>
<td></td>
</tr>
</tbody>
</table>

8. Primary employer and employment location (city, state):

9. Do you expect to maintain your current employment status and location through your term in office?

10. Does your current employment situation(s) require you to work outside of Texas? If yes, what is the nature of that work and how many days each month do you work outside of Texas?

11. 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.

12. Have you been convicted of a felony or is your medical license restricted? Please explain.

13. What TMA positions have you held?
In 2016, the TMA Board of Trustees approved TMA’s involvement in the Texas College of Emergency Physicians’ (TCEP) unique community service project to train Texans on how to save lives with hands-on, hands only CPR. The TMA Foundation approved a financial grant for TMA to present to TCEP. Nine Texas medical schools and more than 650 students provided this free CPR training to over 4,200 Texans on Feb. 2 in 10 Texas cities.

Again this year, TMA was a sponsor and the TMA Foundation approved a financial grant for the program which was held on Feb. 11-12 at 42 sites across 14 Texas cities making the “Texas Two Step” what organizers believe to be the largest event of its kind in the U.S.

Seven hundred and fifty medical students representing all 11 Texas medical schools trained over 6,500 Texans in the technique in 2017.

**Recommendation:** That the Texas Medical Association recognize and congratulate the Texas Two Step CPR Board of Directors and leadership and the Texas medical students for their collaboration and superb success of the annual “Texas Two Step” community service project.
At the 2016 Annual Session, the House of Delegates adopted the recommendation “that the International Medical Graduate Section continue for an additional year with report back to the House of Delegates at the 2017 Annual Session on contributions of the IMG section.” Following is a report on IMG activities and the Board of Trustees recommendation.

Meetings

In 2016, the section met twice, in April at TexMed and TMA’s Fall Conference in September. Only the TexMed meeting had a quorum.

The section meeting at TexMed was well attended. In fact, the section meeting at TexMed is historically the most popular IMG section meeting and continues to have the best attendance and robust discussions. During this meeting section members discussed strategies to implement that will help the section focus on their three main objectives: to maintain relevance, grow IMG participation, and grow IMG visibility within TMA. Key tactics discussed included a focus on promoting the section using various marketing techniques, creation of a mentoring program for IMG physicians that are new to Texas, and providing networking events to give IMG physicians the opportunity to discuss the unique issues they face in and outside of medicine.

This is the second year in a row that participation in the IMG section has been low during TMA Fall Conferences. Because of low attendance, the section is changing the format of its meetings for 2017.

Historically, the section meets at TexMed and Fall Conference with a conference call during Winter Conference. For 2017, the section will meet during Winter Conference instead of Fall Conference and again at TexMed. Conference calls will be scheduled as needed. During the 2017 Winter Conference, the section will host a networking event Friday evening and the business meeting will be held on Saturday morning. The section’s schedule at TexMed will remain the same and include Governing Council elections every other year.

Section Activities

The section’s advocacy focus has been on licensing issues and the Conrad 30 – J1 visa waiver program. The program works by allowing each state to streamline the U.S. immigration process by providing waivers for a maximum of 30 IMGs per year. Without the waiver, these physicians must leave the United States upon completion of their residency training and wait two years in their home country before applying for immigration to the United States through normal channels. The waiver enables the physicians to “waive” the two-year waiting period if they make a commitment to practice for three years in underserved communities in the United States. With the program set to expire, section leaders turned their attention to expansion and continuation of the program. Advocacy efforts included a letter to the Texas congressional delegation, a “Call to Action” in the Sept. 15 Action newsletter asking IMG physician members to send their Senate and House congressional representatives a similar message using the TMA Grassroots Action Center, and a report from the section submitted to the 2016 House of Delegates Annual Session recommending raising the Conrad 30 annual cap, expanding HHS’ waiver
program to include physicians in private practice and other settings, and providing funding to allow
southwest border commission to process J-1 visa waivers.

Future plans include a focus on increasing IMG membership in TMA, increasing IMG meeting
participation, and a continued focus on advocacy efforts.

**Recommendation:** That the International Medical Graduate Section continue for two years with a report
back to the House of Delegates, through the Board of Trustees, at the 2019 Annual Session with
information on specific contributions of the IMG Section.
House of Delegates (HOD) policies in the association’s Policy Index are reviewed periodically for relevance and appropriateness. For the 2017 Annual Session, the Board of Trustees is asked to recommend to the House of Delegates retention, amendment, or deletion of the following policies:

220.002 Military Medical Reserve Personnel, Strengthening of: In an effort to promote and improve recruitment and retention of reserve military medical personnel and to strengthen the reserve component, which includes the reserves and the National Guard, the Texas Medical Association approved the following multi-faceted approach toward rejuvenation and improvements:

1. Retired military medical personnel should become eligible for reserve status.
2. Federal laws should be enacted to delay obligations and prevent financial devastation for people called to active reserve duty.
3. Federal and state laws should be enacted to protect active duty reservists from “long tail” liability action.
4. Improvements should be sought in professional utilization of military medical personnel during both active duty periods and “weekend drill.”
5. Pay and allowances for reservists called to active duty should be adjusted upwards to approach pay and allowances for those with similar rank and qualifications in regular and long-term reserve status.
6. A statutory system of limitations on call-up, retention, and recall of reservists should be developed in order to provide stability and predictability to reserve status and duty.
7. The basis for such a system should be defined statutorily using credits or “points” to prioritize options available to individual reservists as to call-up, retention, rotation, and recall.
8. Existing laws for selective service and retirement credits should be utilized as models for development of practical equitable criteria to be applied (Board of Trustees, p 25, I-92; reaffirmed BOT Rep. 13-A-03).

300.002 TexMed. TexMed will be scheduled in late April, whenever possible, dependent upon availability of meeting space at convention centers and hotels. San Antonio will be kept in the TexMed rotation and dates of major patriotic, local, cultural, or religious events will be avoided when planning for the annual meeting (Board of Trustees, p 15, I-97; amended Res. 29), p 155, A-08; amended BOT Rep. 13-A-07).

These policies remain relevant and are recommended for retention.
300.001 Recognition of Council and Committee Members and Chairs. Council and committee chairs and members will be recognized at the luncheon held during association fall conferences (Res. 29G, p 155, 1-97; amended BOT Rep. 13-A-07).

This policy needs to be revised due to the fact that there is no longer a luncheon during TMA’s fall conference. Chairs completing tenure on TMA councils and committees are recognized at the annual meeting of the TMA House of Delegates through a slide presentation. The HOD speakers recognize all board, council, and committee members by asking them to stand following this presentation.

Recommendation 1: That Policies 220.002 and 300.002 be retained.

Recommendation 2: That Policy 300.001 be amended as follows:

“Council and committee chairs and members will be recognized at the luncheon held during association fall conferences the annual meeting of the TMA House of Delegates.”
REPORT OF COMMITTEE ON MEMBERSHIP

CM-M Report 2-A-17

Subject: Policy Review

Presented by: Charles E. Cowles Jr., MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

TMA periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness. The Committee on Membership’s recommendation for amendment is as follows.

Increasing and maintaining resident membership remains of vital importance to TMA. It is recommended that the following policy be amended by substituting the vague phrase “timely” with the more precise word “regular.” Additionally, the third item was based primarily on a change in insurance carriers at one residency program and is no long a factor. Any significant loss of resident membership gets prompt attention from TMA membership staff.

305.006 Resident Physician Membership Participation and Retention. The Texas Medical Association, in cooperation with county medical societies in which resident physicians are trained, will (1) develop and implement a timely regular, coordinated system to process resident membership applications; and (2) develop outreach programs with the goal of increasing resident physician interest, membership and participation; and (3) encourage retention or renewal of resident physician members in counties where resident membership has decreased because of discontinuation of TMAIT as the provider of insurance to residents (Resident Physician Section, p 136, A-97; reaffirmed BOT Rep. 13-A-07).

Recommendation: Retain as amended.
REPORT OF BOARD OF COUNCILORS

BOC Report 4-A-17

Subject: Emeritus Nominations

Presented by: Dan L. Locker, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

The House of Delegates, upon nomination by the county medical society (CMS) 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 nominations of Alan C. Baum, MD, Donald R. Butts, MD, and Thomas Coopwood, MD, for emeritus membership and recommends their election by the House of Delegates.

A brief sketch follows for Dr. Baum, Dr. Butts, and Dr. Coopwood.

Alan C. Baum, MD (Harris CMS)
Dr. Baum received his medical degree from the University of Texas Medical Branch in Galveston where he was awarded the Ashbel Smith Distinguished Alumnus Award in 1999. He has been a member of Harris County Medical Society and TMA for 45 years.

Dr. Baum has served as Chairman of the Board of Trustees and as President of TMA. He is a former President of the Texas Ophthalmology Association. He has served as Chief of Staff at Memorial Southeast Hospital and has been the Ophthalmology Section Chairman at both the Memorial Southeast and Southwest Hospitals.

Donald R. Butts, MD (Harris CMS)
Dr. Butts received his medical degree from The University of Texas Medical School at Galveston. He has been a member of Harris County Medical Society, TMA, and the American Medical Association for 47 years.

Dr. Butts received his board certification from the American Board of Colon and Rectal Surgery in 1972. He has served as President of Harris CMS and its delegate to TMA, and as chief medical staff of Houston Northwest Medical Center. At TMA, he served on the Cancer, Patient-Physician Advocacy, and Membership committees and is a member of TMA’s 50 Year Club. He served on the Harris CMS Board of Medical Legislation and Council of Specialty Societies, and on the board of the Houston Academy of Medicine and Texas Medical Liability Trust. Also, he lobbied in Washington, DC for Tort Reform.

Thomas Coopwood, MD (Travis CMS)
Dr. Coopwood received his medical degree from Balor College of Medicine. He has been a member of TMA for 37 years. He has been a member of the Travis County Medical Society for 33 years. Previously he was a member of Harris County Medical Society.

Dr. Coopwood has served as President of the Travis CMS and on its Mediation, Nominating, and ED/EMS Advisory committees, and on its ad hoc committee for Wrong Site Wrong Procedure and Trauma Coverage, serving as chair of the latter. He also represented Travis CMS on the boards of the Central Texas Medical Foundation and the Blood and Tissue Center of Central Texas.

Recommendation: That the House of Delegates elect Alan C. Baum, MD, Donald R. Butts, MD, and Thomas Coopwood, MD, to emeritus membership in the Texas Medical Association.
Subject: Honorary Nominations

Presented by: Dan L. Locker, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

The TMA Board of Councilors has approved the nominations of John Paul Schulze, MD; C. Richard Stassney, MD; and William J. Walton, MD, for honorary membership and recommends their election by the House of Delegates. A brief sketch follows for each member.

**John Paul Schulze, MD (Nueces CMS)**
Dr. Schulze received his medical degree at The University of Texas Southwestern Medical School in Dallas in 1955. He has been a member of TMA for 58 years. He has been a member of the Nueces County Medical Society (NCMS) for 56 years. Previously, he was a member of the Dallas County Medical Society for two years. He has served as the Nueces CMS president, on the NCMS Board of Censors, and as NCMS alternate delegate to TMA.

**C. Richard Stassney, MD (Harris CMS)**
Dr. Stassney received his medical degree at Baylor College of Medicine in Houston. He has been a member of the Harris County Medical Society, American Medical Association, and TMA for 48 years.
Dr. Stassney served as the director of the Texas Voice Center in Houston and has served in several clinical professor academic appointments in the Houston area. Also, Dr. Stassney served on the Texas State Board of Medical Examiners (now the Texas Medical Board). He has received numerous honors and awards, including The Best Doctors in Texas, America’s Top Doctors, and Texas Super Doctors, and awards from the Houston Association of Communication Disorders and the American Academy of Otolaryngology/Head and Neck Surgery. Dr. Stassney has authored several publications.

**William J. Walton, MD (Dallas CMS)**
Dr. Walton received his medical degree from Dalhousie University in Nova Scotia, Canada. He has been a member of TMA for 46 years. He has been a member of the Dallas County Medical Society (DCMS) for 42 years. Previously, he was a member of the Bell County Medical Society for two years.
Dr. Walton has served as president of Dallas CMS, DCMS delegate to TMA, DCMS cochair of the Delegation to TMA, and chair of the DCMS Membership Committee. He also has served on the TMA Council on Constitution and Bylaws; TMA Select Committee on Medicaid, Chip, and the Uninsured; TMA Ad Hoc Committee for Health Care Reform; and TMA Select Committee on Health Care Reform.

**Recommendation:** That the TMA House of Delegates elect John Paul Schulze, MD; C. Richard Stassney, MD; and William J. Walton, MD, to honorary membership in the Texas Medical Association.
REPORT OF BOARD OF COUNCILORS

Subject: Policy Review

Presented by: Dan L. Locker, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

TMA periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness. The Board of Councilors’ recommendations for retention or amendment are as follows.

The Board of Councilors recommends the following policy be amended as indicated:

**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 supports AMA policy on physician-assisted suicide.

**Recommendation 1:** Adopt as amended.

The Board of Councilors recommends retention of the following policies:

**30.034 Diagnostic Needle Electromyography:** Diagnostic needle electromyography constitutes the practice of medicine and should be performed only by licensed physicians (Res. 301-A-06).

**85.009 Do Not Resuscitate Orders:** The Texas Medical Association supports the right of terminally and chronically ill patients to utilize DNR orders in nonhospital settings (Medical Student Section, p 139, A-97; reaffirmed BOC Rep. 5-A-07).

**105.014 Texas Medical Disclosure Panel:** The Texas Medical Association supports the Texas Medical Disclosure Panel in its ongoing review and update of the list of procedures requiring disclosure (Medical Student Section, p 138, A-97; reaffirmed BOC Rep. 5-A-07).

**Recommendation 2:** Retain.
REPORT OF COMMITTEE ON PHYSICIAN HEALTH AND WELLNESS

CM-PHW Report 4-A-17

Subject: Sunset Policy Review

Presented by: Harry L. Faust Jr., DO, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

TMA periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness. The Committee on Physician Health and Wellness reviewed the following policies and offers recommendations for amendment:

The following policies are recommended for retention with amendments:

**95.014 Drug Screening of Physicians:** The Texas Medical Association will continue to maintain a voicemail service at the state level for drug screening of physicians under contract with county medical society physician health and rehabilitation wellness committees, district coordinators, and hospital-based peer assistance committees (Committee on Physician Health and Rehabilitation Wellness, p 87, A-96; amended BOC Rep. 5-A-07).

**254.014 Physicians and Substance Use Disorder.** The Texas Medical Association adopted the following recommendations with regard to physicians and substance use disorder.

1. Adopt “substance use disorder” terminology instead of “addiction.”
2. Document aspects of disease management (treatment, maintenance therapy, monitoring, accountability, etc.) as part of TMA policy on SUD.
3. The TMA Committee on Physician Health and Rehabilitation Wellness to continue collegial communication and efforts with the Texas Medical Board, with an annual report back to the House of Delegates about progress.
4. Continue efforts to educate physicians regarding the distinct roles of PHRW, the Texas Physician Health Program (TXPHP), and TMB.

5. After an oversight and surveillance program (Texas Physician Health Program) that is satisfactory to TMA and TMB is prepared, funding must be identified.

6. Encourage county medical society-based PHRW committees to advise physicians subject to monitoring or intervention that TMB confidential rehabilitation orders TXPHP may be available to physicians who self-report. PHRW committee members should present the information to physicians in an objective manner so each one can make an informed decision as to whether to self-report.

7. Advise county medical society-based PHW committees that a report with the name of the physician, together with pertinent information relating to that impairment, to the TMB and any known health care entity in which the physician has clinical privileges, is required if the committee determines that, through the practice of medicine, a physician poses a continuing threat to the public welfare (CMPHR Rep 4-A-07).

**Recommendation:** Retain as amended.
REPORT OF COUNCIL ON CONSTITUTION AND BYLAWS

CCB Report 2-A-17

Subject: Board of Councilors Quorum and Voting Members

Presented by: Mark A. Casanova, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

The Council on Constitution and Bylaws recognizes that voting privileges for vice councilors historically have been extended whether the councilor representing the district is present or not, and the Board of Councilors approves of this arrangement. The following recommendation contains a housekeeping amendment intended to establish this practice clearly within the TMA Bylaws.

**Recommendation:** Amend Chapter 5, Board of Councilors, Section 5.60, Meetings, as follows:

**CHAPTER 5. BOARD OF COUNCILORS**

5.60 Meetings and quorums. The board shall hold such meetings as it may deem necessary, provided that at least one meeting is held during each annual session of the association, at which meeting any physician who has a proper grievance shall be allowed to appear and be heard by the board.

A majority of councilor districts being represented by either a councilor or a vice councilor voting at a meeting voting members shall be required to officially transact business.

Voting members include councilors, vice councilors, and Medical Student Section (MSS) and Resident and Fellow Section (RFS) special appointees.
Subject: Authority to Take Action Without a Meeting

Presented by: Mark A. Casanova, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

The TMA Office of the General Counsel examined the Texas Business and Organizations Code and recommends providing authority to take action without a meeting in the TMA Bylaws.

**Recommendation 1:** Amend Chapter 4, Board of Trustees, Section 4.60, Meetings, as follows:

CHAPTER 4. BOARD OF TRUSTEES

4.60 Meetings. The board shall hold regular meetings. Special meetings of the board may be called at any time by the chair, the TMA president, or by four members of the board upon written or personal notice at least five days before such meeting is to be held.

A majority of voting members shall be required to transact business.

A trustee vote on any matter may be conducted by mail, by facsimile transmission, by electronic message, or by a combination of those methods. Action may be taken without a meeting if a signed written consent stating the action to be taken is received from a majority of voting members.

**Recommendation 2:** Amend Chapter 5, Board of Councilors, Section 5.60, Meetings, as follows:

CHAPTER 5. BOARD OF COUNCILORS

5.60 Meetings. The board shall hold such meetings as it may deem necessary, provided that at least one meeting is held during each annual session of the association, at which meeting any physician who has a proper grievance shall be allowed to appear and be heard by the board.

A majority of voting members shall be required to transact business.

A councilor, vice councilor, or special appointee vote on any matter may be conducted by mail, by facsimile transmission, by electronic message, or by a combination of those methods. Action may be taken without a meeting if a signed written consent stating the action to be taken is received from a majority of voting members.

**Recommendation 3:** Amend Chapter 9, Councils, Section 9.40, Meetings, attendance, and quorums, as follows:

CHAPTER 9. COUNCILS

9.40 Meetings, attendance, and quorums. A council shall meet upon call of its chair, at least once a year.

If any member fails to attend two consecutive scheduled meetings, the position shall be declared vacant.
A majority of voting members to include medical student, Resident and Fellow Section (RFS), and Texas Medical Association Alliance (TMAA) special appointees, if present, (see Section 10.30), shall be required to officially transact business.

A council member vote on any matter may be conducted by mail, by facsimile transmission, by electronic message, or by a combination of those methods. Action may be taken without a meeting if a signed written consent stating the action to be taken is received from a majority of voting members.

Recommendation 4: Amend Chapter 10. Committees, Section 10.20, Classification of committees, Subsection 10.214, Meetings and quorums, as follows:

CHAPTER 10. COMMITTEES

10.20 Classification of committees

10.214 Meetings and quorums. Should any standing committee meet less than twice during the entire year between the end of one annual session and the end of the following annual session of the association, the committee shall be abolished.

A committee member vote on any matter may be conducted by mail, by facsimile transmission, by electronic message, or by a combination of those methods. Action may be taken without a meeting if a signed written consent stating the action to be taken is received from a majority of voting members.
The Board of Councilors (BOC) reviewed county medical society membership bylaw provisions and proposed that membership could be based on a home or work address. Additionally, the BOC suggested removal of a requirement that TMA members seek permission from their county medical society, or the BOC, prior to applying for membership in a contiguous county medical society.

The Council on Constitution and Bylaws considered the recommendations put forth by the BOC, and studied TMA Bylaws Chapter 1. Membership, Section 1.10, Admission, Subsection 1.11, General qualifications and Section 1.40, Membership in contiguous society.

**Recommendation 1:** Amend TMA Bylaws, Chapter 1. Membership, Section 1.10, Admission, Subsection 1.11, General Qualifications, as follows:

**CHAPTER 1. MEMBERSHIP**

1.10 Admission

1.11 General qualifications. The qualifications and requirements for membership shall be as stated in Article III, Sections 1 and 2, of the Constitution, and in this chapter.

Except as provided in 1.202, 1.210, and 1.211, the association’s membership shall comprise only members of county medical societies who have been reported to the office of the executive vice president and for whom the executive vice president has received the annual dues payment.

Each component county medical society shall judge the qualifications of its own members, but it shall have all due regard for the fact that, with the exceptions of at-large, associate, and affiliate members (see Sections 1.202, 1.210, and 1.211) only through a component county society may a physician, medical student, health science center president, or medical school dean become a member of the Texas Medical Association. 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.

Except as provided in Article III, Section 4, to apply for membership or to maintain membership in a county society or the Texas Medical Association, a physician must possess a license to practice medicine in the State of Texas. A license that has been permanently revoked, canceled, or permanently suspended shall not be deemed adequate.
A physician may apply and be eligible for membership in a component county society in the area in which the physician’s professional practice or residence is located or in a component county society contiguous to the area which the physician’s professional practice or residence is located.

Should a request for permission to apply for membership in a contiguous component county medical society be denied, the physician shall have the right of appeal to the Board of Councilors, which, on a majority vote, may permit the physician to apply for membership in a contiguous component county society.

A physician may not be a member of more than one component county medical society of the association simultaneously.

Recommendation 2: Amend TMA Bylaws, Chapter 1. Membership, Section 1.40, Membership in contiguous society, as follows:

CHAPTER 1. MEMBERSHIP

1.40 Membership in contiguous society. A component county medical society may grant permission for a physician under its jurisdiction to apply for membership in another contiguous component county medical society.

Permission for a physician to apply for membership in a contiguous component county medical society, and consideration of that application by the contiguous society, shall be denied only for (1) a violation of the constitution and bylaws of TMA or the component county medical society, (2) a violation of the AMA Principles of Medical Ethics, (3) criminal conduct, or (4) unprofessional conduct likely to deceive, defraud, or injure the public.

Should a request for permission to apply for membership in a contiguous component county medical society be denied, the physician shall have the right of appeal to the Board of Councilors, which, on a majority vote, may permit the physician to apply for membership in a contiguous component county society.

A physician may not be a member of more than one component county medical society of the association simultaneously.
The Speaker’s Advisory Committee (SPAC) has been updating the TMA Election Process and will submit a revised document for adoption by the House of Delegates. SPAC is composed of representatives from the Bexar, Dallas, Harris, Lone Star, Tarrant, and Travis caucuses as well as representatives from the Young Physician, Resident and Fellow, and Medical Student sections.

In late 2016, the speakers sought an interpretation of TMA Bylaws pertaining to floor nominations. At its 2016 TMA Fall Conference meeting, the Board of Councilors highlighted the point that the TMA Election Process document cannot contravene the TMA Bylaws and found the TMA Election Process to be in conflict with the TMA Bylaws concerning the allowance of nominations from the floor.

The following amendment to the TMA Bylaws would resolve any discrepancy between the TMA Bylaws and the TMA Election Process.

**Recommendation:** Amend TMA Bylaws, Chapter 7. Elections, Section 7.40, Method of Election, Subsection 7.41, Nominations, as follows:

**CHAPTER 7. ELECTIONS**

7.40 Method of Election

7.41 Nominations. Nominations shall be from the floor of the house and by members of the House of Delegates and shall be made in accordance with the TMA Election Process as adopted by the House of Delegates. Nominating speeches shall conform to protocols established by the Speaker of the House of Delegates.
REPORT OF COUNCIL ON LEGISLATION

COL Report 1-A-17

Subject: Policy Review

Presented by: G. Ray Callas, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

TMA periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness. The Council on Legislation’s analysis and recommendations for retention and deletion of policies are summarized in this report.

The following policy is recommended for deletion:

115.003 Indemnity for Charity Care: Knowing that many physicians would like to offer their services on a voluntary basis, the Texas Medical Association voted to work for expansion of the Charitable Immunity and Liability Act of 1987 to provide indemnification or other protections from medical malpractice liability for physicians who volunteer free medical service in a nonemergency setting (Amended Res. 28I, p 144, I-91; reaffirmed CL Rep. 2-A-03).

Recommendation 1: Delete.

The following policy is recommended for retention:

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).

Recommendation 2: Retain.
TMA periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness. The Patient-Physician Advocacy Committee’s recommendations for retention, deletion, or amendment are as follows:

The Patient-Physician Advocacy Committee recommends retention of the following policies:

**130.005 Arbitration Protocols in Smaller Institutions:** To facilitate arbitration of disputes concerning the quality of a physician’s care by other physicians, TMA approved the following ten-point set of protocols:

1. The hospital medical staff, the hospital’s governing body, and the physician whose care has been questioned must jointly request arbitration in writing.

2. The TMA Councilor and Vice Councilor must review each request for arbitration and determine that utilization of the protocols is appropriate.

3. The physician(s) being reviewed need not be members of TMA.

4. Physicians chosen from a panel of TMA members agreeing to participate in the arbitration process will perform the review.

5. The hospital requesting assistance will provide funding for the review.

6. The hospital from which the arbitration request originates must agree to indemnify the reviewing physicians for costs of defending lawsuits alleging defamation or other tortuous conduct.

7. The scope of review may include travel to review records of questioned treatment; interviews of those persons who question the physician’s care (patients, nurses, administrator, physician colleague(s), etc.; and interview of the physician whose treatment has been questioned.

8. The physicians conducting the arbitration must be appointed as members of an ad hoc committee of the hospital’s medical staff.

9. At least two physicians should be available to provide arbitration services for each request.

10. Physician arbitrators should be prepared to present their findings, recommendations, and conclusions within the following context: (a) verify a problem exists and that further investigation is warranted; (b) make specific comments in reference to specific charts and instances of care provided which may be discussed in subsequent hearings on hospital staff privileges; (c) be
available to testify at such a hearing if necessary; and (d) be available to testify or to be deposed
concerning their role in the arbitration process should a suit be filed by a physician adversely
affected by a decision on medical staff privileges (Hospital Medical Staff Section, p 151, A-93).

130.017 Physician Rights and Sham Peer Review: The Texas Medical Association condemns “sham peer
review” and manipulation of medical staff bylaws by hospitals attempting to silence physician
concerns for access to quality care at hospitals and advocates against “sham peer review,”
manipulation of medical staff bylaws and enforcement of such bylaws, and other tactics that chill
or inhibit the ability of staff physicians to advocate for their patients (Res. 401-A-07).

The Texas Medical Association will (1) work to assure that accused physicians are granted
reasonable rights and due process for peer review and quality assessment efforts; (2) solicit
member input and address issues related to misuse of peer review process or “disruptive
physicians” policies by health care facilities or peer review entities; (3) work to educate and
inform members about the potential misuse of peer review; and (4) work to end the use of
“disruptive physicians” policies which are extended to non-patient care issues, such as economic
credentialing, failure to support marketing or business plans of the hospital or health care facility,
or are used as a recourse because the physician has raised serious quality or patient safety issues
regarding the facility, and their practice (Res. 406-A-07).

160.001 Frivolous Suits: The Texas Medical Association will continue efforts to identify a suitable
countersuit test case involving a frivolous medical malpractice lawsuit that will stand the test of
appeals through the Supreme Court and agreed to be prepared to assist in such case in a manner
such as filing an amicus curiae brief (Amended Res. 28BB, p 174, A-91; reaffirmed CM-PL Rep.
1-I-01).

160.014 Principles for TMB Discipline in Expert Medical Testimony: The Texas Medical Association
adopted the following principles for Texas Medical Board (TMB) discipline in expert medical
testimony:

1. When a physician (doctor of medicine or osteopathy) testifies as an expert in a civil
proceeding regarding the applicable standard of medical care and whether the defendant has
breached that standard, the physician is subject to professional discipline by the TMB if the
testimony constitutes unprofessional conduct.
2. Knowingly providing false, misleading, spurious, or scientifically unfounded expert medical
testimony shall be considered unprofessional conduct.
3. TMB shall investigate physicians reported for such potential unprofessional conduct and
possess the full range of professional disciplinary measures for physicians who violate these
standards.
4. Physicians not licensed in Texas who are licensed and actively practicing in another state may
provide expert medical testimony in a Texas civil proceeding regarding the applicable
standard of medical care and whether the defendant has breached that care, provided they are
registered and possess a limited license from TMB for that sole purpose.
5. Registration and limited licensure with TMB for the sole purpose of providing expert medical
testimony in a Texas civil cause of action shall be through a simple registration document and
a nominal charge for annual registration.
6. This limited licensure shall not constitute the legal certification as an expert, which remains at
the discretion of the trial court. However, the court is obligated to verify the full or limited
licensure of physicians who testify before it for these purposes, prior to certification as an
expert.
7. Requirements for registration and limited licensure with TMB for the purpose noted above shall include but not be limited to a current unrestricted license in another state and an active clinical practice in that state.

8. Physicians who are not licensed, but are registered with limited licensure by TMB, shall be bound by the same ethical standards for professional conduct and disciplinary process as licensees of TMB.

9. When a physician (doctor of medicine or osteopathy) testifies as an expert in a civil proceeding regarding the applicable standard of medical care and whether the defendant has breached that standard, the physician shall not be held liable in a subsequent tort action brought by the adverse party (AHCM-TMB Rep. 1-I-04).

Recommendation 1: Retain.
The parliamentary authority for the Texas Medical Association referenced in the TMA Bylaws is *The Standard Code of Parliamentary Procedure* by Alice Sturgis. Many houses in organized medicine have adopted or are in the process of adopting the newer code, the *American Institute of Parliamentarians Standard Code of Parliamentary Procedure* (AIP).

Generally, differences between AIP and Sturgis are minor, with most changes dealing with terminology rather than actual procedures. The purpose of a parliamentary authority is to facilitate the orderly transaction of business and to promote cooperation and harmony. A parliamentary authority makes it easier for house members to work together effectively and should not cause difficulty in transacting business or compromise the efficiency or effectiveness of the house. Therefore, your TMA speakers of the House of Delegates and the Council on Constitution and Bylaws recommend adoption of AIP as parliamentary authority but with a few rules that vary slightly from AIP.

### The Importance of Debate on Both Sides of the Issue

An example of an important tradition employed by the TMA house is allowing both sides to be heard prior to closing debate on an issue. Although neither Sturgis nor the newer parliamentary authority, AIP, has such a requirement, this tradition has been and will be maintained at the TMA house.

### Motion to Table; Motion to Object to Consideration

The TMA house has always recognized the utmost importance of freedom of speech and protecting the rights of the minority to be heard. Yet there may be instances when debate (pro and con) may not be in the best interest of TMA. The open access of the TMA house for business items demands that there be some mechanism for the house to object to considering an item of business. Although the “motion to table” in AIP may be seen as a threat to free speech, the house should have a mechanism to exercise its collective right to determine its business. Under Sturgis, this motion serves to “postpone temporarily.” It has been the duty of the speaker to determine if the intent of the maker of a motion is to dispose of the motion without debate, and if so, require a two-thirds majority vote for passage.

Under AIP, the motion to table an item of business is in order from the point at which an item has been accepted as business of the house to the time the house has taken final action on that item. The motion to table, however, may not be recommended by a reference committee because it is not debatable.

An alternative approach to this issue, one which other houses in organized medicine have adopted recently, is adding a motion to “object to consideration.” This motion would serve to table a report or resolution that has not yet been referred to a reference committee. We recommend that the motion require a three-fourths supermajority vote of the house for passage. Debate would be limited to the merits of the “object to consideration” motion, with no debate permitted on the original item. The motion could not interrupt a speaker, would require a second, could not be amended, would take precedence over all subsidiary motions, and could not be renewed.
Motions to Refer

Sturgis and AIP both state that the maker of a motion to refer should include the provision that the body to which the item is referred would have the authority to act on behalf of the organization. Because all referrals from the TMA house are directed to the TMA Board of Trustees, the specific body being referred to is implicit in a motion to refer on the floor of the TMA house.

Under AIP, the motion to “refer to a committee” is present, but your speakers favor the historical usage and the distinct motions of “refer for report” and “refer for decision.” While AIP does not specify this distinction, it has served our house well and allows the will of the house to be clear. The motion to “refer for report” will continue to send the item to the board for study and report back. The motion to “refer for decision” will continue to be used to allow the board to determine the appropriate course of action, proceed with that action, and report back. Delegates may request a report back from the board but even without this request, it is tradition that the TMA board reports back to the house on the decision and the action taken. Your speakers will strive at all times to ensure that it is clear to the house as to whether a motion to refer is for report or decision.

In short, the separate motions to “refer for report” and “refer for decision” should be retained as a special rule during house meetings and “refer for decision” should have a higher order of precedence. Your TMA speakers will preside over motions to refer to make clear how the referral will be handled and ensure that the individual members of the house are not burdened with these parliamentary details.

Motion to Adopt in-Lieu-of

AIP also incorporates the motion to “adopt in-lieu-of.” The most straightforward application of the motion would arise in the case where a reference committee recommends the adoption of one item in lieu of additional items being considered during the same meeting. AIP also allows the motion to “adopt in-lieu-of” from a reference committee to dispose of one or more resolutions. The reference committee generally would propose a substitute resolution, and that substitute might be in place of a single resolution.

However, the motion to “adopt in-lieu-of” is not a substitute under AIP. Instead, the motion offers entirely new language to replace one or more items. Under AIP, the motion to “adopt in-lieu-of” is a main motion, and there may be both first- and second-order amendments. If the motion to “adopt in-lieu-of” is adopted, it enacts the motion and simultaneously defeats the underlying motion. If it is defeated, the original item does not automatically become business of the house. The original item becomes business of the house only if a member of the house moves adoption of one or more of the original items.

The most significant difference between AIP and Sturgis is that defeat of a motion to “adopt in-lieu-of” does not automatically bring an original item to the house floor. In the event of such an occurrence during a meeting, it is the duty of the speaker to invite a motion to consider a resolution that would have been addressed had the motion to “adopt in-lieu-of” not occurred.

Amendment by Substitution

The TMA house has many times dealt with substitute amendments without problem. The adoption of AIP allows an opportunity to codify a consistent practice for handling substitute amendments. An amendment by substitution is a first-order amendment, subject only to second-order amendments. When a reference committee proposes an amendment by substitution, further amendments must be dealt with as they arise before additional amendments can be proffered. A substitute proffered from the floor also is a first-order amendment.
Conclusion
The speakers of the House of Delegates and the Council on Constitution and Bylaws, after study of the new parliamentary authority AIP, put forward the following recommendations:

Recommendation 1: Adopt American Institute of Parliamentarians Standard Code of Parliamentary Procedure as TMA’s parliamentary authority, effective at the conclusion of the 2017 Annual Session.

Recommendation 2: Amend TMA Bylaws Chapter 3, House of Delegates, Section 3.70, Business and protocol, Subsection 3.73, Rules of conduct, as follows:

CHAPTER 3. HOUSE OF DELEGATES

3.70 Business and protocol

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

Recommendation 3: Amend TMA Bylaws Chapter 12, County Societies, Section 12.40, Structure, Subsection 12.411, Duties, as follows:

CHAPTER 12: COUNTY SOCIETIES

12.40 Structure

12.411 Duties. The executive board shall:

(1) Transact the routine business of the society;
(2) Receive and act upon applications for membership;
(3) Conduct disciplinary hearings as prescribed by the Hearings Procedures Manual of the Board of Councilors and render a decision;
(4) Refer to the county society questions of policy;
(5) Perform such other duties as may be required by the county society constitution and bylaws; and
(6) Conduct all meetings, in the absence of provisions to the contrary, under the procedures of Sturgis’ The Standard Code of Parliamentary Procedure, the American Institute of Parliamentarians Standard Code of Parliamentary Procedure.

Recommendation 4: Amend TMA Bylaws Chapter 14, Rules of Order, as follows:

CHAPTER 14. RULES OF ORDER

The American Institute of Parliamentarians Standard Code of Parliamentary Procedure shall govern the association in all cases to which it is applicable and is not inconsistent with this constitution and bylaws and standing rules of the association. The deliberations of the association shall be governed by parliamentary usages as contained in Sturgis’ The Standard Code of Parliamentary Procedure, unless otherwise provided by this Constitution and Bylaws.
**Recommendation 5:** Adopt the following standing rules for TMA House of Delegates’ parliamentary procedure in addition to the *American Institute of Parliamentarians Standard Code of Parliamentary Procedure*:

**A.** The motion to table a report or resolution that has not yet been referred to a reference committee will not be permitted and will be ruled out of order. A new motion is added to the procedures of the TMA house: “object to consideration.” If a delegate objects to consideration of an item of business by the house before it is referred to 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. The motion cannot interrupt a speaker, requires a second, cannot be amended, takes precedence over all subsidiary motions, and cannot be renewed.

**B.** The procedures of the house shall distinguish between a “motion to refer,” which is equivalent to a motion to refer for report, and a “motion to refer for decision,” in that the motion to refer for decision will be one step higher in precedence. Both motions will result in a report back to the house.

**C.** In proceedings of the house, both sides must have been heard before a motion to close debate is in order and, absent an express reference to “all pending matters,” the motion applies only to the matter under debate.

**D.** Adjournment of any meeting finalizes all matters considered at that meeting meaning that items from one meeting are not subject to recall from a committee, a motion to reconsider, or any other motion at a subsequent meeting.
JOINT REPORT OF COMMITTEE ON MEMBERSHIP AND COUNCIL ON CONSTITUTION AND BYLAWS

CM-M and CCB Report 2-A-17

Subject: TMA Bylaws Concerning Retired Member Classification

Presented by: Charles E. Cowles Jr., MD, MBA, Chair, Committee on Membership
Mark A. Casanova, MD, Chair, Council on Constitution and Bylaws

Referred to: Reference Committee on Financial and Organizational Affairs

Background
The House of Delegates at A-16 referred to the Committee on Membership and the Council on Constitution and Bylaws Resolution 101, TMA Bylaws Concerning Retired Member Classification (Travis County Medical Society). The resolution calls for the following:

That Texas Medical Association Committee on Membership and Council on Constitution and Bylaws review the category of retired membership and explore redefining the rights and privileges of retired membership to include the right to vote and hold elected positions, with report back at TexMed 2017.

Discussion
The Committee on Membership and Council on Constitution and Bylaws reviewed this matter and expressed appreciation for retired physicians’ interest in participating in TMA and for their longtime support. However, the members were concerned about recommending a change to the bylaws, specifically the right to vote and hold elected positions. Recent member survey research recommends that TMA put a focus on young physician needs and engagement efforts, especially in light of the finite number of leadership positions available. Practicing physicians are optimally positioned to understand the current practice environment and the challenges of practicing medicine in today’s environment, and they can use that knowledge to help craft and vote on TMA policies.

Additionally, the members recognized that the wealth of knowledge and experience possessed by physicians who have retired from the practice of medicine still can be brought to bear through consultant roles on TMA boards, councils, and committees. Further, a member who has retired from practice is not required to seek a change in membership status with the association and may retain his or her status as a fully active, voting member. Therefore, no amendments to the bylaws regarding this matter are proposed at this time.

Conclusion
Given the imperative to actively engage and promote new generations of Texas physicians, as well as the existing leadership opportunities for Texas physicians who have retired from the practice of medicine, the Committee on Membership and Council on Constitution and Bylaws recommend the following:

Recommendation: That Resolution 101-A-16, TMA Bylaws Concerning Retired Member Classification, not be adopted.
TEXAS MEDICAL ASSOCIATION HOUSE OF DElegates

Resolution 101
A-17

Subject: Election of TMA Board of Trustees Members, Filling Vacancies by Special Election

Introduced by: Lone Star Caucus

Referred to: Reference Committee on Financial and Organizational Affairs

Whereas, In 2008, the TMA House of Delegates altered the method by which vacancies in the Board of Trustees (BOT) were to be filled, combining regularly scheduled elections and vacancy elections into one ballot to inject “competition” into the voting process; and

Whereas, TMA Bylaws currently provide that “Nominees who receive (1) a vote of a majority of the legal ballots cast and (2) the highest majorities shall be elected to the vacancies to be filled. When there are varying lengths of position to be filled, those receiving the highest majorities shall be elected to the longer term;” and

Whereas, The current method does not allow candidates to know the length of term of office they may be given, which is inherently unfair to those seeking office; and

Whereas, Candidates seeking election, or even reelection, to the BOT spend maximum amounts of campaign money and efforts to run because their election may be thrown into an all-out floor vote simply by a vacancy on the board being created minutes before the election; and

Whereas, In nearly every representative body in our country, vacancies are filled by special elections held separately from general elections; and

Whereas, The experiment to determine if this voting method works has been tried for eight years, and it is generally agreed upon as being more chaotic and cumbersome to all candidates; and

Whereas, Establishing special elections for vacancies would allow for a smoother and fairer process for those candidates running in regularly scheduled elections; and

Whereas, Fairness, order, and simplification are hallmarks of the way TMA runs its House of Delegates, and the current method of filling BOT vacancies seems inconsistent with these values; therefore be it

RESOLVED, That the TMA House of Delegates amend the process of holding elections for the Board of Trustees, and that regularly scheduled elections be held on a different ballot from elections to fill board vacancies; and therefore be it also

RESOLVED, That the following amendment to TMA Bylaws, Chapter 4. Board of Trustees, Section 4.40, Term, tenure, and vacancies of at-large positions, be adopted:

CHAPTER 4. BOARD OF TRUSTEES

4.40 Term, tenure, and vacancies of at-large members
The term of service of at-large members of the Board of Trustees shall be three years. Tenure of service as an at-large member of the board, by election and by appointment, shall not exceed three terms, provided that serving as much as one year of the three-year term shall be considered serving a full term. The term of service of the young physician member on the Board of Trustees shall be two years and shall not be eligible for re-election. The two-year young physician term shall not count toward the lifetime service limit of 10 years on the Board of Trustees. Tenure of service as the young physician member on the board, by election, shall not exceed one term, provided that serving as much as half of the two-year term shall be considered serving a full term.

Total lifetime service on the Board of Trustees whether as an at-large or ex officio member shall not exceed 10 years excluding terms served as the young physician, resident, or student member.

The president shall fill vacancies in the offices of at-large members of the Board of Trustees until the next annual session of the House of Delegates, at which time election for the unexpired term shall be held. If, however, a vacancy occurs during the course of any House of Delegates meeting, it may be filled at that meeting by a separate special house election.

and therefore be it also

RESOLVED, That the following amendments to TMA Bylaws, Chapter 7. Elections, Section 7.42, Balloting, Subsections 7.421, First Ballot, and 7.422, Run-off ballot, be adopted:

CHAPTER 7. ELECTIONS

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, regardless of length of term. 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 of a majority of the legal ballots cast and (2) the highest majorities shall be elected to the vacancies to be filled. When there are varying lengths of position to be filled, those receiving the highest majorities shall be elected to the longer term. Elections to fill unexpired term vacancies shall be held on a separate ballot from regularly scheduled elections.

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, or, when necessary, to resolve any ties to determine which candidate(s) shall be elected to which term.

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.
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 103
A-17

Subject: Texas Medical Board License Renewal Notifications and Payment Processes

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Financial and Organizational Affairs

Whereas, The current procedure by which the Texas Medical Board (TMB) notifies Texas physicians of licensure expiration dates is a single U.S. Postal Service postcard delivery; and

Whereas, Such single postcards may be lost, overlooked, misdelivered, or otherwise misplaced prior to the assigned expiration date; and

Whereas, Such oversights may inflict significant economic, emotional, and professional hardships on physicians, patients, family, and staff by preventing physicians from practicing medicine, prescribing drugs, and caring for their patients, thus negating TMA’s vision, “To improve the health of all Texans”; and

Whereas, Corrective actions taken to resolve such oversights and to restore the physician’s license require significant time and expense, interfering with the physician’s and his or her staff’s duties to patients as well as creating extra work for the TMB staff; and

Whereas, Such obsolete procedures affect not only physicians but also physician assistants, surgical assistants, acupuncturists, medical radiological technologists, respiratory care practitioners, medical physicists, and perfusionists, as TMB regulates these health professionals, in addition to having an impact on pharmacists regulated by the Texas State Board of Pharmacy, thus affecting a broad array of health care professionals; and

Whereas, For example, the Texas Department of Motor Vehicles sends multiple email reminders before a vehicle registration expires; and

Whereas, TMB itself maintains an active website that includes a physician’s license status and also presently communicates with physicians by email; therefore be it

RESOLVED, That the Texas Medical Association request that the Texas Medical Board (TMB) take such action as to change and update its license renewal notification procedure and its license renewal payment processes; and be it further

RESOLVED, That TMA request that TMB:

1. Provide an electronic or email-based means to communicate routine license renewal information to licensed physicians, in addition to U.S. Postal Service mail;

2. Institute an electronic license renewal notification and an option for electronic auto-renewal payment; and

3. Provide for acceptance of credit card or bank electronic payment systems to convey payments for license renewals and fees.
Subject: Tort Reform Celebration Day

Introduced by: El Paso County Medical Society

Referred to: Reference Committee on Financial and Organizational Affairs

Whereas, The conditions to practice medicine in Texas have improved dramatically since tort reform; and

Whereas, The monetary damages have been capped to a reasonable amount; and

Whereas, The amount of professional liability litigation and number of malpractice lawsuits have decreased; and

Whereas, As a consequence, the costs of professional liability premiums have decreased considerably; and

Whereas, Texas since has been able to attract many more physicians, improving the ratio of patients per physician; and

Whereas, The law protects persons administering emergency care, unless there is willful and wanton negligence; and

Whereas, The law has special protection for charity hospitals and academic centers; and

Whereas, The people of Texas approved Proposition 12 on Sept. 13, 2003, granting the Texas Legislature the authority through a constitutional amendment to cap noneconomic damages in health care liability cases, ensuring that doctors and hospitals will be available if they are sick or injured; therefore be it

RESOLVED, That September 13 be recognized and celebrated annually as Tort Reform Day by Texas physicians and all U.S. physicians who share in the cause.
Subject: TMA Outreach to Displaced and Refugee Physicians

Introduced by: Harris County Medical Society

Whereas, The practice of medicine is both a science and an art, requiring advanced learning, years of practice, and high ethical principles; and

Whereas, Civil instability, wars, disruption in the economy, and a variety of other causes can force physicians in other countries voluntarily or involuntarily to leave their homes, their practices, their patients, and their families; and

Whereas, Displaced and refugee physicians from other countries are multilingual, highly productive, dedicated to helping society, and often trained in diseases not frequently seen in the United States; and

Whereas, Displaced and refugee physicians from other countries have lost a part of their identity, are cut off from professional connections and relationships, and have few resources to access the path to reestablishing their medical profession; and

Whereas, The British Medical Association recognizes the value displaced and refugee physicians can make to the delivery of health care services and has established a program to connect with, and provide support for, these physicians through professional medical associations; and

Whereas, The Texas Medical Association is the largest state medical association, in one of the most ethnically diverse and dynamic states in the United States; and

Whereas, Our association can benefit by offering displaced and refugee physicians the opportunity to connect with fellow physicians, supporting their efforts to reestablish their professional roles, and encouraging them in their journey to become Texas physicians and, ultimately, TMA members; and

Whereas, TMA currently has the International Medical Graduate Section, but this is open only to foreign medical graduates currently licensed to practice in Texas; therefore be it

RESOLVED, That the Texas Medical Association study the number of current displaced and refugee physicians in Texas; the role and impact TMA might offer to support and connect them with Texas colleagues; and the potential impact these individuals, as future TMA members, might have on the organization; and report back to the House of Delegates; and be it further

RESOLVED, That, if this study appears to be of benefit to TMA for residents of Texas who are displaced and refugee physicians, TMA consider moving this matter forward to the American Medical Association.

Fiscal Note: >$20,000
Relevant 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).

245.010 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 original or geographic location of medical school (Amended Res. 301-I-99; amended BOC Rep. 6-A-09).

Relevant AMA Policy:

Retraining Refugee Physicians H-200.950

Our AMA supports federal programs, and funding for such programs, that assist refugee physicians who wish to enter the US physician workforce, especially in specialties experiencing shortages and in underserved geographical areas in the US and its territories.

AMA Principles on International Medical Graduates H-255.988

Our AMA supports (only relevant policy included):

10. That special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.

15. The participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. The AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.

16. Support studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.

17. AMA membership outreach to IMGs, to include a) using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians; b) publicizing its many relevant resources to all physicians, especially to nonmember IMGs; c) identifying and publicizing AMA resources to respond to inquiries from IMGs; and d) expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.

18. Recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.

19. Its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.

21. Informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.

24. The Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.
01, A-16

References

- The British Medical Association has a program for health professionals:
- The Refugee Council (United Kingdom) has a link for health professionals:
  www.refugeecouncil.org.uk/what_we_do/refugee_services/refugees_into_jobs/refugee_health_profess
  ionals/services_and_links_for_r
Whereas, Certain rules and laws governing the practice of medicine may be impractical and result in hardship in a time of a disaster; and

Whereas, Disaster response teams are presented with unique circumstances that require timely clinical intervention to prevent patients who take scheduled medications for chronic illnesses from becoming ill; and

Whereas, Patients of chronic care facilities such as psychiatric care centers, nursing homes, and long-term acute care hospitals may be subject to a rapid evacuation without time to retrieve chronic care medications that are vital to the well-being of these patients; and

Whereas, Rescue workers and first responders may be dispatched to a disaster site for a period beyond which they had originally planned, resulting in these responders not being able to obtain refills for their personal prescription medications during the response; and

Whereas, Texas Administrative Code Title 22, Part 9, Chapter 165, requires documentation of every patient encounter regardless of circumstance or environment; and

Whereas, Texas Administrative Code Title 22, Part 9, Chapter 169, requires maintenance of records for the administration of drugs regardless of circumstance or environment; and

Whereas, Physicians recognize the need for rules governing telemedicine in routine circumstances and during normal business operations; therefore be it

RESOLVED, That the Texas Medical Association support reduced and alternative documentation and administrative requirements of the Texas Medical Board (TMB) and the Texas Administrative Code in the form of a policy related to specific requirements of medical documentation and record keeping during a declared disaster. Specifically, the policy would apply when the care provided is the continuation of currently prescribed medications and other necessary treatments for victims requiring disaster assistance, first responders, and other rescue workers during the declared disaster; and be it further

RESOLVED, That TMA urge TMB to adopt these reduced and alternative documentation and administrative requirements during times of declared disasters; and be it further

RESOLVED, That any waiver in requirements exist only in a time of declared disaster and not during normal business operations.

Relevant TMA Policy:

20.008 Minimum Disaster Preparedness Standards for Assisted Living: 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

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).
Whereas, Our Texas Medical Association’s vision is to improve the health of all Texans; and
Whereas, Our TMA advocates the use of the most current, best clinical research evidence in all
determinations and assessments of appropriate medical care; and
Whereas, Our TMA opposes policy that prohibits physicians from following best practice guidelines; and
Whereas, Our TMA opposes policy that hinders the autonomous clinical decisionmaking authority of a
physician or prevents a physician from providing evidence-based, empathic, and comprehensive treatment
options to a patient; and
Whereas, Physicians have become targets of legislation in Texas to criminalize the provision of legal,
evidence-based, safe, well-tolerated, and cost-efficient physician procedures; and
Whereas, Physicians have become targets of legislation in Texas to revoke licensure because of the
provision of legal, evidence-based, safe, well-tolerated, and cost-efficient medical care; and
Whereas, Our TMA mission is to stand up for Texas physicians’ provision of legal, evidence-based, safe,
well-tolerated, and cost-efficient medical care; therefore be it
RESOLVED, That TMA adopt policy opposing the criminalization of evidence-based medical care; and
be it further
RESOLVED, that TMA policy also oppose the revocation of a medical license for the provision of
evidence-based medical care; and be it further
RESOLVED, that TMA encourage TEXPAC to consider previous and planned actions to criminalize the
practice of medicine when deciding endorsements and allocation of funds.

Relevant TMA Policy:

**265.018 Evidence-Based Medicine.** Recognizing that the primary purpose of evidence-based
medicine and evidence-based guidelines is to improve patient care, the Texas Medical
Association advocates the use of the most current, best clinical research evidence in all
determinations and assessments of appropriate medical care. A strong source of evidence
must be documented in peer review journals and endorsed by specialty societies or nationally
recognized medical organizations. Evidence-based guidelines must be patient-centered,
recognizing that the integration of the physicians’ clinical skills and experience, along with
the patients’ unique needs and preferences, must be at the core of every clinical patient care
decision.¹
TMA recognizes there are many classifications of levels of evidence in the literature but supports the use of Class I/II, Level A/B, or an equivalent, as being the most clinically sound. Additionally, TMA maintains that observational studies generally should not be the foundation of evidence-based medicine.¹

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. Accordingly, TMA supports the American Medical Association-convened Physician Consortium for Performance Improvement through participation in workgroups and ongoing measure development review.

Recognizing that evidence-based medicine is continually evolving, measures should be evaluated and subject to regular review (1) at intervals in accordance with consortium standards, (2) whenever there is a major 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 AMA 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).


245.020 Physicians Retaining Autonomous Clinical Decision-Making Authority: The Texas Medical Association 1) opposes policy that prohibits physicians from following best practice guidelines as developed by their various specialty societies; 2) believes that a physician may lawfully administer Food and Drug Administration-approved drugs in doses other than the recommended dosage when such use is aligned with evidence-based practices; and 3) opposes any policy that hinders the autonomous clinical decision-making authority of a physician or prevents a physician from providing evidence-based, empathic, and comprehensive treatment options to a patient (Amended Res. 104-A-13).

References

- Kelly, T., Suddes, J., Howel, D., Hewison, J. and Robson, S. (2010), Comparing medical versus surgical termination of pregnancy at 13-20 weeks of gestation: a randomised controlled trial. BJOG:

Subject: Recognition of John R. Holcomb, MD

Introduced by: Bexar County Medical Society

Referred to: Reference Committee on Financial and Organizational Affairs

Whereas, John R. Holcomb, MD, recently retired from service as the chair of the Texas Medical Association Select Committee on Medicaid, CHIP, and the Uninsured, an ad hoc committee to which he devoted nearly two decades of service; and

Whereas, The work of the TMA Select Committee on Medicaid, CHIP, and the Uninsured played a critical role in the development of TMA policy and advocacy efforts to improve the health care safety net for vulnerable Texans, including advocating vigorously for competitive Medicaid payments; reforms to reduce physician practice costs by eliminating red tape; ensuring due process for physicians accused of waste, fraud, and abuse; and fighting for coverage for the nearly one million uninsured low-income Texans; and

Whereas, Dr. Holcomb dedicated countless hours to meeting with state officials and advocating TMA’s message, including testifying before numerous legislative committees and regulatory agencies, sometimes staying at hearings all night just to ensure lawmakers heard our message; and

Whereas, Dr. Holcomb’s leadership was instrumental in reforming Texas’ Office of the Inspector General, promoting simplification of children’s Medicaid and the Children’s Health Insurance Program, rescinding harmful cuts to Medicaid services and payments, and furthering efforts to seek federal dollars to improve coverage for low-income Texans; therefore be it

RESOLVED, That the Texas Medical Association commend John R. Holcomb, MD, for his outstanding service as chair of the TMA Select Committee on Medicaid, CHIP, and the Uninsured.
Subject: Transparency in Elections in the House of Delegates

Introduced by: Angelina County Medical Society

Referred to: Reference Committee on Financial and Organizational Affairs

Whereas, Vote counts in elections in the TMA House of Delegates, especially for elections for officers, Board of Trustees, and American Medical Association delegates and alternates, are known to some of the members of the House but not to others; and

Whereas, Vote counts for these elections are not now announced publicly; and

Whereas, AMA policy (Election Process G-610.030) is that final vote counts of all secret ballots shall be made public and be made a part of the official proceedings of the AMA House of Delegates; and

Whereas, The current electronic balloting system used in the TMA House of Delegates is capable of quickly producing these vote counts (as demonstrated by the fact that the vote counts are announced on secret ballots on policy issues); therefore be it

RESOLVED, That vote counts of all secret ballots taken in the TMA House of Delegates be announced publicly in the house at the time each election result is announced, and be it further

RESOLVED, That final vote counts of all secret ballots in the TMA House of Delegates be made public and made part of the official proceedings of the house.

Relevant TMA Policy:

295.013 Election Process (only relevant policy included): The Texas Medical Association recognizes the following election process:

Elections

TMA elections are held on the second day of the annual session at a time determined and published by the speakers in advance.

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

The house will hold a run-off election to fill any vacancy that cannot be filled because of a tie vote, or, when necessary, to resolve any ties to determine which candidate(s) shall be elected to which term(s).

With the exception of delegates and alternate delegates to the AMA, those candidates who are elected will assume office at the adjournment of the HOD meeting at the annual session. AMA
delegates and alternate delegates will assume office on January 1 of the year following their
election except those who are elected to fill vacancies in which case they will assume office at
the adjournment of the annual session (SPKR Rep. 1-A-12).

Relevant AMA Policy:
Election Process G-610.030
AMA guidelines on the election process are as follows: (1) AMA elections will be held on Tuesday at
each Annual Meeting; (2) Poll hours will not be extended beyond the times posted. All delegates eligible
to vote must be in line to vote at the time appointed for the close of polls; and (3) The final vote count of
all secret ballots of the House of Delegates shall be made public and part of the official proceedings of the
House.
Texas Medical Association House of Delegates

Resolution 110
A-17

Subject: Integrating Advance Directives Conversation to Maintain Autonomy

Introduced by: Medical Student Section

Referred to: Reference Committee on Financial and Organizational Affairs

Whereas, In 1990, Congress passed the Patient Self-Determination Act (PSDA), which requires all physicians, public hospitals, and health care providers to inform patients of their rights concerning their care; and

Whereas, As of January 2016, physicians can be paid for advance care planning conversations with Medicare beneficiaries; and

Whereas, Patients who are not chronically ill and are suddenly placed in a vegetative state due to an acute diagnosis might not previously have completed an advance directive; and

Whereas, Most people say they would prefer to die at home, yet only about one-third of adults have an advance directive expressing their wishes for end-of-life care; and

Whereas, A large group of stakeholders includes people who are at-risk for personal medical concerns but who also have aging parents. In this situation, stakeholders will benefit from a conversation among the physicians, the patients, and their families; and

Whereas, There is evidence that some physicians “fear future litigation from family members for withdrawing medical treatments [and] will push for continued, often aggressive, therapies”; and

Whereas, A 2011 study concluded that when health professionals know what the patient desires at the end of life, Medicare is saved “significant sums” and the patient is more likely to die at home, rather than in a hospital; and

Whereas, Patients with advance directives are more likely to choose to spend their final days in palliative care, refuse aggressive medical treatment, and save about $5,600 in medical expenses; therefore be it

RESOLVED, That the Texas Medical Association support primary care physicians discussing advance care planning with all of their patients; and be it further

RESOLVED, That TMA support the integration of advance directive patient-physician conversations into routine physical exams performed by a physician, physician assistant, or registered nurse and documented in the patients’ records.

Relevant TMA Policy:

85.002 Advance Directives Act Amendments: The Advance Directives Act should allow for the option of refusing specific life-sustaining procedures without being deemed to have accepted others by not specifically rejecting them. Additionally, it should establish
disincentives to deter plaintiffs from bringing a frivolous or bad faith suit to enjoin a physician or hospital from withholding or withdrawing life-sustaining treatment pursuant to a valid written directive.

With these concerns in mind, TMA asked that the following legislative changes be included: (1) provide that a patient may, in the written Directive to Physicians reject specific life-sustaining procedures without being deemed to have accepted any which have not been specifically rejected; and (2) provide that any person who brings a frivolous or bad faith suit to enjoin a physician or hospital from withholding or withdrawing life-sustaining treatment pursuant to a valid written Directive to Physicians would have to pay all defense costs, including court costs, attorney fees, and any damage incurred as a result of the frivolous action (Board of Councilors, p 31, I-90; amended BOC Rep. 7-A-08).

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).

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).

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).

References
Whereas, Untreated and undertreated mood disorders and mental conditions, and increased incidence of physician suicide result in 300 to 400 doctors committing suicide in the United States every year; and

Whereas, Physicians who committed suicide sought mental health treatment less often than non-physicians who committed suicide; and

Whereas, A meta-analysis of 54 studies demonstrated that an estimated 28.8 percent of medical residents experience a major depressive episode during their residency, compared with seven-eight percent of similarly aged individuals in the United States general population; and

Whereas, Texas Medical Board licensing requires disclosure of personal information such as medication and treatment plans if a physician has a diagnosis of a mental illness; and

Whereas, Evidence has suggested that major depressive disorder does not affect physicians’ job performance; and

Whereas, As of 2009, 42 out of 51 (50 states plus the District of Columbia) state applications for physician licensing, including licensing in Texas, ask about mental health, and this is considered “likely impermissible” or “impermissible” according to the Americans with Disabilities Act of 1990; and

Whereas, Broad questions regarding mental health by state licensing boards for physicians create barriers for affected physicians to seek appropriate treatment and increase the stigma of mental health disorders and treatment; and

Whereas, Nondisclosure and reluctance to self-disclose information regarding a mental health diagnosis or treatment among physicians may be primarily due to fear of stigma; and

Whereas, Nondisclosure is linked to improper treatment of mental illness and inadequate pursuit of interventions and treatment by those affected by mental illness, a trend that has become “increasingly negative” since 1968; therefore be it

RESOLVED, That the Texas Medical Association support the exclusion of questions regarding mental illness in the Texas Medical Board licensure process, specifically excluding questions related to major depressive disorder diagnoses; and be it further

RESOLVED, That TMA recognize that information regarding a physician’s mental health should be shared only between the physician-patient and his or her mental health physician or provider, including
psychiatrists, primary care physicians, counselors, and psychologists, and not a priority of state licensure boards; and be it further

RESOLVED, That TMA recognize the mental health physician’s or provider’s responsibility to make any disclosures regarding the mental health of a physician-patient necessary to maintain patient safety, instead of requiring these patients to disclose their own conditions to board licensure applications.

Relevant TMA Policy:

105.005 Physician Impairment as Medical Illness: The Texas Medical Association will pursue legislation that directs the Texas Medical Board to consider matters of substance use disorders, psychiatric disorders, and other potentially impairing conditions as medical illnesses rather than as a basis for disciplinary action (CM-PHR, p 51, A-93; amended BOC Rep. 3-A-03; amended BOC Rep. 6-A-13).

175.013 Major Depression and Physician Licensure: Decisions about licensure and credentialing/recredentialing of physicians who have major depression and seek treatment should be based on professional performance. These physicians should not have their medical licenses routinely called into question (Res. 301-A-05; reaffirmed CM-PHW Rep. 4-A-15).

130.020 Ensuring Physician Autonomy: The Texas Medical Association will (1) work with the Texas Legislature to ensure that all physicians, both employed and not employed, be subject to the same hospital standards and procedures for peer review, credentialing, quality of care, and privileges; and (2) develop model hospital staff bylaw provisions that do not favor or discriminate based on employment status and provide equivalent call opportunities and charity care obligations to all members of the hospital medical staff (Res. 407-A-11).


References:


Subject: Commendation of 2017 Texas Two-Step CPR: Save a Life Campaign

Introduced by: Arlo F. Weltge, MD, Harris County Medical Society
Carlos J. Cardenas, MD, Hidalgo-Starr County Medical Society
Douglas W. Curran, MD, Henderson County Medical Society
Diana L. Fite, MD, Harris County Medical Society
A. Tomas Garcia III, MD, Harris County Medical Society
Keith A. Bourgeois, MD, Harris County Medical Society
Kayla A. Riggs, Medical Student Section
Carrie E. de Moor, MD, Collin-Fannin County Medical Society
Laura Faye Gephart, MD, Bell County Medical Society
Don R. Read, MD, Dallas County Medical Society
Richard W. Snyder II, MD, Dallas County Medical Society
E. Linda Villarreal, MD, Hidalgo-Starr County Medical Society
David C. Fleeger, MD, Travis County Medical Society
Michelle A. Berger, MD, Travis County Medical Society
Dan K. McCoy, MD, Dallas County Medical Society
Gary F. Floyd, MD, Tarrant County Medical Society
David N. Henkes, MD, Bexar County Medical Society
Susan M. Strate, MD, Wichita-Archer-Baylor-Clay-Knox County Medical Society

Referred to: Reference Committee on Financial and Organizational Affairs

Whereas, The Texas Medical Association has proudly been a sponsor for the second year of the Texas Two-Step CPR: Save a Life Campaign – a free 5-minute training session in hands-only CPR designed to teach participants how to potentially save a life; and

Whereas, On Feb. 11-12, 2017, more than 750 medical students, at all 11 Texas medical schools, training over 6,500 Texans in life-saving hand-only CPR at 42 sites across 14 Texas cities, including Alamo, Amarillo, Austin, Brownsville, Corpus Christi, College Station, Dallas, El Paso, Fort Worth, Galveston, Houston, Lubbock, San Antonio and Waco; and

Whereas, The Texas Two Step CPR was a collaboration among medical students, cardiothoracic surgeon, Dr. Mehmet Oz, his national non-profit HealthCorps, American Heart Association, American College of Emergency Physicians, Emergency Medicine Residents' Association, Texas Medical Association, Texas Medical Association Foundation, Texas College of Emergency Physicians, leadership consulting firm MaveRx, and health law and consulting firm, The Spiers Group; and

Whereas, The Texas Two Step Save a Life Campaign offers medical students an opportunity to contribute to their communities by teaching lifesaving techniques to thousands of Texans; therefore be it

RESOLVED, That the Texas Medical Association House of Delegates recognize the 750 medical students and physician mentors involved in the 2017 Texas Two Step CPR: Save a Life Campaign; and be it further
RESOLVED, That the Texas Medical Association House of Delegates formally commend the Texas Two
Step Board of Directors for their efforts to promote the 2017 Texas Two Step CPR: Save a Life
Campaign.

Relevant TMA Policy: None.
Subject: HIPAA and Physician Rating Websites

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Financial and Organizational Affairs

Whereas, Physician internet-based rating sites are growing in popularity; and

Whereas, No standardization or regulation exists for rating sites’ content; and

Whereas, In this area, an unbalanced system exists between physicians and patients; and

Whereas, Other providers of goods or services to the public may respond legally to false or misleading information; and

Whereas, Physicians are highly regulated under HIPAA rules to maintain patient privacy; and

Whereas, A physician cannot respond to misinformation posted by patients, even if the patient is acknowledging the patient-physician relationship; therefore be it

RESOLVED, That the Texas Medical Association seek amendment of HIPAA rules to allow physicians to respond to incorrect information posted on the internet by patients, as long as physicians address only nonmedical care issues and do not disclose medical conditions or diagnoses the patient did not disclose; and be it further

RESOLVED, That if HIPAA rules cannot be amended to allow physicians to respond to incorrect information posted on the internet by patients, then TMA should seek amendment to HIPAA rules that develop guiding principles for entities with physician rating sites to promote fair and balanced restrictions on postings by physicians, patients, and others who post reviews.

Relevant TMA Policy

165.001 Health Care Policy Development: The Texas Medical Association favors legally mandated formal physician organization involvement in all areas of health care policy development in both the legislative and regulatory arenas (Res. 28YY, A-92; reaffirmed CSE Rep. 3-A-04; reaffirmed CSE Rep. 2-A-14).


195.032 Federal “Physician Compare Website”: That the Texas Medical Association will monitor Centers for Medicare & Medicaid Services’ development of the Physician Compare Website to ensure that physicians currently in clinical practice are involved in the development of the standards to evaluate physician performance, that the measures and methodology used for the website are transparent and valid, and that physicians are provided with an opportunity to challenge a rating through a fair process (CSE Rep. 3-A-11).
AGENDA
REFERENCE COMMITTEE ON MEDICAL EDUCATION
Friday, May 5, 2017
Marriott Marquis, Level 2, Liberty


2. Council on Medical Education Report 3 – Support for Exceptions to Medicare GME Cap-Setting Deadlines in Underserved Areas


4. Council on Medical Education Report 5 – Need for Continued Expansion of Graduate Medical Education Capacity


7. Committee on Physician Distribution and Health Care Access Report 1 – Long-Range State Health Care Workforce Study

8. Committee on Physician Distribution and Health Care Access Report 2 – Enhancements to State Physician Education Loan Repayment Program


10. Resolution 201 – Inclusion of Advocacy Education in Medical School Curricula (Harris County Medical Society)

11. Resolution 202 – Medical School Clinical Skills Exams (Medical Student Section)

12. Resolution 203 – Resolving the Impact of Travel and Immigration Bans on Health Care Provision (Medical Student Section)
The Council on Medical Education Report 3-A-16 Opposition to Medical School and Residency Program Curriculum Mandates was referred back to the council for reconsideration and a report back to the house. In this report, the council sought adoption of the following as new TMA policy:

1. TMA opposes mandates for curricular content for medical education and residency training by sources beyond the recognized national accreditation bodies, Liaison Committee for Medical Education, American Osteopathic Association, and Accreditation Council for Graduate Medical Education; and
2. TMA will work with medical school deans and other leaders in medical education and residency training to share tested curricular topics and/or innovations in medical education for broader implementation throughout the state.

The council submitted the proposed new policy based on the following findings:

- National accreditation bodies establish the core curriculum requirements for medical schools and residency programs. Each medical school and residency program is bound by these requirements.
- Beyond the core required curriculum, curriculum committees face an ongoing struggle to monitor and evaluate an exceptionally high volume and ever-increasing amount of new educational material for possible inclusion. Given this volume, the council does not expect it would be feasible for medical schools also to manage curricular mandates from TMA.
- The council strongly believes that medical students and residents need and deserve education and training that will prepare them adequately for the health care delivery system anticipated when they enter medical practice. This education should include timely topics relevant to a physician’s practice. However, medical education must be of a finite length, and it is not practical to add an unlimited amount of new material to the curriculum. Further, the council believes it is highly unlikely that a critically important curricular topic will escape the attention of the accreditation bodies or curriculum committees.

The council fully supports the ability of delegates to bring forth recommended curricular changes and the council embraces the role of articulating those recommendations to medical school leaders. The council does not, however, believe it is feasible to force changes to curricular content in the form of mandates.

In recommending that Council on Medical Education Report 3 be referred back to the council for a report, the reference committee cited the following as reasons for the referral:

- Since medical students and residents regularly submit resolutions seeking curriculum mandates to the house, the reference committee viewed this pattern as a potential indicator that inadequate avenues exist through other means for students and residents to make changes to curricular content.
- The House of Medicine should provide a communication line for medical students, residents, and other TMA members on topics of concern including preferences about curricular content in medical education and training.
The council recognizes the importance of facilitating discussions on topics related to medical education and training. The council is routinely composed of two special appointees from the TMA Resident and Fellow Section and the Medical Student Section. Their perspectives are highly valued and encouraged. There are opportunities for open communication with the state’s medical school deans and other leaders in medical education at the council’s three annual meetings. Further, the council welcomes input from TMA physician members.

Based on the direction provided by the Reference Committee on Medical Education at TexMed 2016, the council withdraws its recommendation for new policy in opposition to curricular mandates for medical schools and residency programs. This would then allow the house to continue to consider proposals for curricular mandates. This also will continue to present an opportunity for the council to express its views on the proposals. Lastly, the council will continue to provide opportunities for medical students, residents, and TMA physician members to bring forth needed curricular changes for evaluation and discussion at its three annual meetings.

Recommendation: That Council on Medical Education Report 3, Opposition to Medical School and Residency Program Curriculum Mandates not be adopted.
Subject: Support for Exceptions to Medicare GME Cap-Setting Deadlines in Underserved Areas

Presented by: Steven R. Hays, MD, Chair

Referred to: Reference Committee on Medical Education

Medicare is the single most important source of funding for graduate medical education (GME). When hospitals begin to sponsor GME and become recognized as eligible for Medicare GME funding, they have five years to establish their GME programs before the Medicare GME full-time-equivalency (FTE) funding cap is established by Medicare (Balanced Budget Act of 1997). The clock starts with the opening of the first residency program and stops at the end of that residency program’s fifth year of operation. The resident FTE funding cap then becomes effective on the first day of the sixth year of operation. The cap has a significant financial impact on a teaching hospital or program. Once the cap is set, it is basically permanent, with few exceptions. Under current federal policies, this FTE cap becomes the maximum number of resident FTE positions that Medicare will support for that institution.

To attain accreditation status, a new medical school must establish GME programs in all six of the core clerkships: family medicine, internal medicine, obstetrics-gynecology, pediatrics, psychiatry, and surgery. For new schools located in areas that are medically underserved and economically depressed, it can be particularly challenging to find eligible and willing teaching partners due to limited resources and a lack of infrastructure. In these cases, the council supports the granting of waivers by the Centers for Medicare & Medicaid Services to extend the five-year “cap-setting” deadline, thus allowing additional time for a school to establish the full complement of core GME programs. The council believes this waiver should be flexible, based on an area’s unique circumstances, but generally a maximum of seven to 10 years.

**Recommendation 1:** Adopt the following as TMA policy on Exceptions to Deadlines for Setting Medicare GME Funding Caps:

**Exceptions to Deadlines for Setting Medicare GME Funding Caps:** The Texas Medical Association believes medical schools and teaching hospitals located in areas that are medically underserved and economically depressed should be allowed exceptions to the five-year deadline for the setting of Medicare graduate medical education (GME) funding caps. Due to limited resources and the lack of infrastructure, teaching programs in underserved areas face additional challenges in establishing residency programs. TMA believes flexibility is needed to allow sufficient time for eligible teaching partners to be identified and for a full complement of residency programs to be established, in accordance with accreditation standards.

TMA supports flexibility in establishing the conditions for the waiver of the five-year time limit based on an area’s unique circumstances, but generally supports a time limit between seven and 10 years.

**Recommendation 2:** That the Texas Delegation to the American Medical Association take Council on Medical Education Report 3-A-17, Support for Exceptions to Medicare GME Cap-Setting Deadlines in Underserved Areas, to the AMA House of Delegates for consideration as new AMA policy.
Many rural communities experience a persistent shortage of physicians. Physician shortages are not limited to rural areas, but rural Texas has less than half the number of physicians per capita as urban areas, with a ratio of 84 patient care physicians per 100,000 population compared with 190 for urban areas. This trend is not expected to change with only 4 percent of a recent group of newly licensed physicians choosing to practice in a rural Texas county. Five hundred more primary care physicians are needed in Texas to remove all primary care health professional shortage area designations for the state. These 500 physicians would need to be added to specific areas of the state to achieve a population-to-primary care physician ratio below the national shortage threshold ratio of 3,500:1 in all 254 Texas counties.

Last session, the Texas Legislature made a substantial investment in graduate medical education by providing $53 million for residency training expansions in 2016-17. This initiative, however, did not have a specific rural component. Given the persistent shortage in practicing rural physicians in Texas, additional measures are required to increase physician access. The council is proposing TMA policy in support of a state grant program for rural training tracks (RTTs). This is intended to create additional incentives for the development of rural residency training opportunities to improve and preserve access to care in rural areas.

Rural Residency Training

Currently, the number of rural residency training opportunities is limited. Rural training can provide benefits at multiple levels: boosting a community’s physician supply and hospital staffing, providing practical training for residents to better prepare them for rural practice, facilitating urban/rural hospital partnerships, and enriching physician recruitment opportunities for rural communities. Some rural hospitals and community-based ambulatory health care facilities have the patient population to meet the accreditation requirements. Others can meet these requirements through partnerships with other training programs.

Rural Training Tracks

RTTs offer clinical training for residents in rural settings. Typically, the resident trains the first year in an urban setting followed by training in a rural program for portions of the second and third years. The length of training and curriculum for the rural component vary across programs. RTTs can be accredited on their own or as an integrated component of an accredited urban residency program. Many RTTs are in family medicine, but the program is not limited to this specialty. For example, there are programs in internal medicine in other states. The American College of Surgeons-South Texas Chapter has expressed strong interest in offering RTTs in general surgery. It is significant to note that RTTs can qualify for Medicare graduate medical education (GME) funding even at training facilities with Medicare GME funding caps, as described on the next page.

Texas Tech University Health Sciences Center School of Medicine at the Permian Basin currently offers family medicine RTTs in west Texas. In addition, The University of Texas Health Science Center at Tyler has a family medicine RTT in Tyler and Sulphur Springs. Previously, The University of Texas Medical Branch had a family medicine RTT in Weimar.
RTTs can better prepare physicians for rural practice, offering a blended training experience between urban and rural settings. Research studies have shown that physicians who train solely in tertiary care centers often feel ill prepared for practice in rural communities. Additional research demonstrated a high success rate for RTTs, such as a retention rate for RTT participants of 76 percent in rural practice. The ability to recruit new physicians is particularly important for rural areas where one of five physicians is of retirement age. Rural experts describe RTTs as a greatly underused strategy for ensuring an adequate rural physician workforce.

Special Medicare GME Funding Provisions for RTTs
Medicare limits the number of residents it will fund at training hospitals by means of a resident full-time equivalent (FTE) funding cap. Hospitals in both urban and rural hospitals that partner to offer RTTs can qualify for exceptions to that cap. The exception allows RTT positions to be added to the training facilities’ FTE funding cap. This is only applicable for new RTTs. To qualify an RTT for Medicare GME funding, the residents MUST train more than 50 percent of their time in the RTT during their second and third years of residency training. The Centers for Medicare & Medicaid Services allows urban hospitals three years to establish the Medicare GME FTE funding cap for RTT positions, and their rural hospital partners are allowed five years.

Need for State Grant Program to Incentivize RTT Development
To stimulate interest in RTTs and enhance the feasibility of creating new programs, the council believes there is a need for a state grant program to provide funding during the initial stages of development or at least until the Medicare GME funding cap is set (three years for urban hospitals and five years for rural). The amount of the individual grants would be dependent on estimated costs, but as an estimate, the average per-resident cost for Texas family medicine programs is approximately $150,000 per year. The Texas Higher Education Coordinating Board potentially could administer the RTT grant program as an addition to its GME expansion grant programs.

Recommendation: Adopt the following as TMA policy on Support of Rural Residency Training and State Grant Program for Promoting Rural Training Tracks:

Support of Rural Residency Training and State Grant Program for Promoting Rural Training Tracks: Texas needs more targeted programs to diminish the persistent shortage of physicians in rural areas. Recognizing the well-established linkage between where a resident trains and where he or she enters practice, it is important to institute residency training programs in rural areas with the resources to support such training. The Texas Medical Association recognizes the documented benefits of rural training track programs to rural communities and in preparing physicians for rural practice, as supported by research studies.

Accordingly, TMA supports legislative efforts to establish a state program to provide grants to incentivize the development of rural training tracks and other models of residency training designed for rural settings. To promote the success of the grant projects, TMA supports the use of eligibility criteria that take into account the likelihood a residency training program will be able to meet and maintain national graduate medical education accreditation standards and produce physicians who are well prepared for rural practice.

TMA will promote awareness of the grant opportunities among potential applicants.

TMA recognizes the stifling effect that Medicare graduate medical education (GME) funding policies have had on GME expansions. TMA strongly supports retention of
the current federal payment provision that allows urban and rural hospital sponsors of rural training tracks to qualify for an exception to their respective Medicare GME funding caps. It is important for this exception to continue to allow rural training tracks to qualify for both direct and indirect Medicare GME funding.
Subject: Need for Continued Expansion of Graduate Medical Education Capacity

Presented by: Steven R. Hays, MD, Chair

Referred to: Reference Committee on Medical Education

The addition of new medical schools in the state this decade will push the number of medical school graduates up by at least 20 percent by 2022. This represents a net gain of 343 graduates from 2016 to 2022. Unless the state’s graduate medical education (GME) capacity is expanded in a similar manner, more than 200 Texas medical school graduates likely will not have an opportunity to train in the state in 2022. There also are no guarantees they will be able to find a training position elsewhere because the shortage of entry-level GME positions is a national crisis. If training positions are not available, these graduates ultimately will be delayed in entering practice or in a worst case scenario, will be forced to forego a career in medicine.

Research has shown that about 40 percent of Texas medical school graduates who leave the state for postgraduate training fail to return to Texas to practice medicine. However, if both medical school training and postgraduate training occur in Texas, the retention rate rises to 82 percent, a greatly improved return on the state capital invested in educating medical students and a strong boost to the state’s physician workforce and economy.

TMA’s Council on Medical Education recognizes the:

- Importance of having an adequate number of GME positions to enable the training of the state’s medical school graduates and allow the state to recruit top graduates from other states, and
- Continued importance of educating and training more physicians to build a physician workforce that meets the state’s escalating needs for medical care.

The council is aware of the progress made in expanding the state’s GME capacity through the incentives offered by the state’s GME expansion grant program since 2014. Both the Senate and the House continue to show strong support for maintaining the state’s investment in growing GME in the initial state budget proposals for 2017-19. Unless the state continues this investment, the newly created positions will lose the grant funding needed to sustain them and then are likely to be terminated and subsequently lost to the state. Gone with them is not only the training opportunity for future medical school graduates but also the considerable time and expense of securing the initial state grant and accreditation status.

In addition to the state’s GME expansion grant program, the state GME formula funding process plays an important role in supporting existing GME positions. GME formula funding is intended to help medical schools pay the faculty costs related to training residents. These costs are not covered by other sources such as Medicare GME funding. The per-resident amount does not come close to actual costs and has been inconsistent since the process was initiated in 2006, ranging from $2,340 per resident/year in 2006-07 to a peak of $6,653 in 2010-11. In comparison, the estimated annual cost is $18,000 per resident. The initial Senate budget proposal for 2017-19 reduces the per-resident formula funding rate by 22.5 percent. The House makes a smaller cut of 7.1 percent. The cuts in funding could have a direct impact on the ability of medical schools to pay for the teaching costs related to GME.
Although GME funding is a high priority for the Council on Medical Education, it is also recognized that state budget makers have fewer available state dollars to work with in forming the next state budget and a plurality of pressing state needs.

In summary, the following areas are of chief concern to the Council on Medical Education in relation to GME funding:

1. The need for sustained state support for GME positions developed using GME expansion grant funds.

Approximately 700 GME positions received funding from the state’s GME expansion grant program since its start in 2014. Although the initial budget proposals by the Senate and the House for 2017-19 include additional funding for this program, neither provides enough funding to sustain the newly created positions. There may be funding to allow the initial resident to progress to a subsequent year of training, but there are not enough funds to allow the positions to be refilled with a new resident.

The Texas Higher Education Coordinating Board estimates an additional $18 million needs to be added to the Senate budget proposal for 2017-19, and an additional $32.2 million to the House proposal to provide enough funds to “refill” the residency positions created since 2014, after the initial resident completes training. The council recognizes the importance of adequate funding to allow the new positions to be sustained into the future. These positions help meet the current demand for residency training but the need for additional GME positions becomes even more critical when the projected number of graduates exceeds 2,000 beginning in 2021, as shown in the graphic below.

2. The gaps between the number of newly created GME positions since 2014 and number of additional positions needed to increase the state’s GME capacity in line with projected medical school graduates and also meet the state’s target ratio of 1.1 entry-level GME position per Texas medical school graduate.

The coordinating board projects a total of 1,777 first-year GME positions in Texas in 2017. In comparison, Texas medical schools are projected to graduate more than 2,000 students, beginning in 2021 as noted above, leaving a gap of more than 200. To reach the state target of 1.1 entry-level GME position per Texas medical school graduate in 2021, a total of 2,200 entry-level GME positions would be needed. That would require a net increase of more than 400 entry-level GME positions by 2021.

3. Proposed reductions to special item funding for medical schools and health-related institutions.

The initial Senate budget proposal includes the elimination of $800 million or 64 percent in special-item funding for all higher education programs. These cuts will have a direct impact on medical schools and health-related institutions. Many of the programs have been in operation for decades and are programs...
that typically do not fit into other state funding categories. This includes medical education programs such
as Texas A&M University’s Round Rock Medical School campus; GME programs at several medical
schools, such as primary care at The University of Texas (UT) Southwestern Medical Center and UT
Health Science Center at Tyler; and various types of residency programs at the Texas Tech University
Permian Basin Regional Academic Health Center. A long list of research programs at the medical schools
and health-related institutions also have lost all funding under this proposal. Much of this research is
collaborative and has resulted in translational programs that offer best practices for physicians in
community practice. This research, in critical areas such as Alzheimer’s disease, post-traumatic stress
disorder, and chronic diseases, plays a role in improving the health status of Texans. In short, these
programs improve and save lives.

The council supports a state assessment of the impact of the proposed elimination of special item funding
for programs sponsored by Texas health-related institutions. These programs encompass GME, medical
education, and medical research that translates into best practices for community physicians and improves
the health status of Texans.

Recommendation: Approval of the following as Texas Medical Association policy:

Building the Future Physician Workforce: To work to build the state’s physician
workforce to meet the state’s health care needs, the Texas Medical Association supports:

1. Continued state support, to the extent possible, to assist medical schools in paying
teaching costs related to residency training. This helps sustain existing graduate medical
education (GME) programs.

2. Continued efforts to sustain recent growth in and further expand the state’s GME
capacity in needed specialties so the growing number of Texas medical school graduates
can remain in the state for residency training and ultimately practice in the state. The
growth in GME capacity should correlate directly with the state’s physician workforce
needs.

3. Continued progress toward achieving the state target of 1.1 entry-level GME positions
per Texas medical school graduate.
REPORT OF COUNCIL ON MEDICAL EDUCATION

CME Report 6-A-17

Subject: Referral of Res. 201, Recognition of Alternative Recertification Boards (Harris County Medical Society) and Res. 207, Recognition of National Board of Physicians and Surgeons and National Board of Osteopathic Physicians and Surgeons (Ori Hampel, MD)

Presented by: Steven R. Hays, MD, Chair

Referred to: Reference Committee on Medical Education

Resolutions 201 and 207, relating to maintenance of certification (MOC), were referred to the Council on Medical Education in A-16. Resolution 201, Recognition of Alternative Recertification Boards (Harris County Medical Society) asks that:

1. TMA formally adopt standards by which it can (1) evaluate recertification programs that would be appropriate for Texas; (2) after adopting standards, begin the process of approving recertification programs offered by competing boards that meet TMA’s standards; and (3) publicize and advocate for the recognition of TMA-approved alternative recertification programs to hospitals throughout Texas.

Resolution 207, Recognition of National Board of Physicians and Surgeons and National Board of Osteopathic Physicians and Surgeons (Ori Hampel, MD), asks that:

1. TMA recognize that recertifications by the National Board of Physicians and Surgeons (NBPAS) and the National Board of Osteopathic Physicians and Surgeons (NBOPAS) are acceptable board recertifications for practicing physicians in the State of Texas for all purposes, including licensure, reimbursement, employment, and admitting privileges at a hospital.

MOC Versus Initial Board Certification

Physicians generally embrace initial board certification as an important achievement worthy of attainment, and this initial phase of certification is not a subject of scrutiny among physicians. In sharp contrast, some post-certification or MOC programs have resulted in varying degrees of frustration, opposition, mistrust, and resentment among physicians.

The council heard from a number of physicians who are satisfied with the MOC programs their individual specialty boards provide. But the degree of disagreement among others has been strong enough to motivate them to seek legislative action to prevent the use of MOC as a requirement for credentialing, employment, hospital staff membership, medical licensing, and payments for medical care. The TMA House of Delegates in 2016 adopted policy in support of such legislation in Texas. In response, Sen. Dawn Buckingham (R-Lakeway) filed Senate Bill 1148 on Feb. 27, 2017. Seven other senators are co-sponsors, including two physicians, Sen. Donna Campbell, MD (R-New Braunfels), and Sen. Charles Schwertner, MD (R-Georgetown). Oklahoma adopted similar legislation in 2016, and it is under consideration in other states.

The references to MOC in this report are intended to include the American Osteopathic Association’s Osteopathic Continuous Certification programs, as applicable.

Council Outreach

Because board certification is a national process, much of the scrutiny of MOC within organized medicine has been led by the American Medical Association’s Council on Medical Education, which has issued a
report on this topic for eight consecutive years. This report marks the first time the TMA council has conducted an in-depth assessment of physician perceptions and experiences with MOC.

Feedback provided to the council depicted a wide array of experiences with MOC, which is reflective of the fact that the American Board of Medical Specialties (ABMS) has 24 member boards with 37 specialties and 86 subspecialties. The varying physician experiences highlight the high degree of policy variation among member boards. Not only has this variation created frustration, but also it has prevented the health care community from receiving the full benefit of the original intent of MOC. The inconsistencies within MOC have left opportunity for improvement.

To better understand the differing views, the council met with the authors of the referred resolutions and solicited input from a cross section of physicians through various meetings held in conjunction with TMA conferences. The council began with a Round Table on MOC at 2016 TMA Fall Conference. Then, based on feedback, the council created a Workgroup on MOC Reform with representation across specialties, geographic areas, and membership groups within organized medicine. Workgroup members met at 2017 TMA Winter Conference. From these meetings, the council identified common principles, compiled specific areas of concerns, and narrowed the list of major conflicting views, as summarized below.

Common principles:

- Need for maintaining the public’s trust regarding maintenance of professional competency throughout a physician’s career,
- Need for action to maintain the privilege of self-governance and decrease the potential for governmental interference, and
- Service to diplomates, not generating revenues, as the goal of MOC programs.

Specific areas of concern:

- Amount of time away from medical practices and physicians’ families for MOC activities, including exams;
- Overall expense of MOC, particularly when expenses relate to activities inconsistent with maintenance of the public trust or improved professional competency;
- Limiting diplomates to continuing medical education (CME) offered by their specialty board, and the high cost of those courses;
- Excessively high revenues such as those generated previously by the American Board of Internal Medicine’s MOC programs;
- Limited availability of research on the benefits of MOC on physician competency;
- Slow response by some ABMS boards to diplomates’ concerns;
- Reaction from the public and hospitals to initiatives by organized medicine to seek legislation prohibiting the use of board recertification in credentialing processes;
- Impact of compounded MOC requirements on physicians with multiple board certifications/added qualifications; and
- Stringent security measures at some testing centers (e.g., banning facial tissues like Kleenex);

Major conflicting views:

- Whether ABMS member boards have been willing to respond to diplomate dissatisfaction by modifying MOC requirements and processes;
- Whether organized medicine should discontinue efforts to effect change at ABMS MOC programs and instead shift the focus to alternative MOC programs;
• Whether alternative MOC programs have demonstrated their relevance, merit, and rigor; and
• Whether involving government through legislation is the best method for addressing MOC concerns versus working with MOC programs to affect change.

In general, the council learned that physicians are seeking MOC processes that facilitate learning that is relevant, effective, timely, accessible, and at reasonable cost. Further, physicians want an MOC process that is meaningful and not onerous in terms of time and expense, and they want policies that convey a degree of mutual respect and trust.

Meetings With ABMS Leadership
Leadership from ABMS were invited to participate in three MOC-related events organized by the council at 2017 TMA Winter Conference: as guest speakers at the Council on Medical Education General Session, as special guests at the council’s Workgroup on MOC Reform meeting, and as featured speakers at the conference Dawn Duster on Future Directions of Continuing Certification: Innovations and Input. The latter was open to all physicians.

Lois Margaret Nora, MD, president and CEO of ABMS, and John C. Moorhead, MD, chair of the ABMS Board of Directors, represented ABMS at the various TMA meetings. They said the reason for their participation in the TMA meetings was to hear directly from Texas physicians about their concerns and personal experiences with MOC. Their visit to Texas was one of many to individual states to meet with physicians. They reported on steps taken in response to physician feedback and reassured TMA that ABMS will stay the course to make even more changes.

Highlights From Discussions With ABMS

Reminder of Physician’s Social Contract
Physicians have benefits and responsibilities under the three components of the social contract:

• Physicians have special knowledge and skills,
• Physicians place patients and society before self-interest, and
• Physicians have the privilege of substantial autonomy to self-regulate.

The social contract is based on trust and comes with a physician’s responsibility to patients, students, and colleagues. The privilege of professional self-regulation is unique; further, it is not guaranteed and could be lost.

Awareness of Need for Change
ABMS provided strong reassurance that its member boards are concerned about the impact of MOC on physicians and aware of the need to alleviate the burden. The boards have collaborated to explore how adult learning theories and emerging technologies can inform new approaches to the assessment of knowledge and skills with particular focus on changes to the high-stakes exam.

ABMS agrees:

• There is a need for diplomate engagement.
• Innovations and cross-pollination should be encouraged and facilitated across boards.
• Board requirements should be evidence-based, and there should be additional research on their merits.
• Exam should be “more practice-relevant, formative, and less burdensome.” Remote proctoring should be allowed, as well as open-book tests. Modular formats also should be used.
• MOC should have an enhanced focus on clinical decisionmaking and patient management.
Greater use of technology can be beneficial, as seen by the success of the American Board of Anesthesiologists’ MOCA Minute.

Board credentials must have meaning for the public and also sustain the medical profession’s ability to self-regulate.

There should be greater collaboration between MOC and programs such as the Medicare Access and CHIP Reauthorization Act, The Joint Commission Ongoing Professional Practice Evaluation, and Focused Professional Practice Evaluation, as well as the CME requirements of state medical boards.

ABMS appealed to Texas physicians to provide feedback to their individual specialty boards on changes they want to see, emphasizing that each ABMS member board is autonomous, and ABMS has limited influence on each. ABMS leaders also conveyed a strong commitment to work with diplomates toward the goal of enhancing the value of the credential to key stakeholders while making the program less costly, less burdensome, and more relevant to practicing physicians.

Alternative MOC Programs

Resolutions 201 and 207 both ask for TMA policy that supports MOC programs offered by boards that are not part of ABMS. The council agrees that physicians should evaluate alternative MOC programs, apply the same degree of scrutiny applied to ABMS-related MOC programs, and decide which program is the best fit for them individually. The council thoroughly evaluated both resolutions and offers the following analysis.

Res. 201

Asks TMA to: (1) formally adopt standards by which it can evaluate recertification programs that would be appropriate for Texas; (2) after adopting standards, begin the process of approving recertification programs offered by competing boards that meet TMA’s standards; and (3) publicize and advocate for the recognition of TMA-approved alternative recertification programs to hospitals throughout Texas.

Council Analysis of Res. 201

Res. 201 asks TMA to take on a significant new role in credentialing MOC programs. This would involve activities such as:

1. Approval from the TMA Board of Trustees of a new MOC credentialing program, new staff positions, and funding to operationalize such a program;
2. Securing any needed liability coverage;
3. Developing criteria for evaluating MOC programs in collaboration with all relevant medical specialty societies;
4. Securing needed staffing for evaluating, credentialing, and publicizing recognized MOC programs;
5. Establishing an application process, such as a web-based portal to allow MOC programs to apply for TMA recognition, and a process for informing applicants and Texas physicians of credentialing decisions;
6. Liaison activities with hospitals and other health care facilities to inform, publicize, and advocate for recognized MOC programs; and
7. A process for reevaluating credentialed MOC programs at appropriate time intervals.

The council has concerns about the appropriateness of adding an MOC credentialing process to TMA, both from the standpoint of the fit with TMA’s mission and the additional expense and responsibilities to TMA’s operations, including:

- Potential for liability and membership issues for TMA;
• Challenge of developing and maintaining credentialing criteria that meets the needs of each affected medical specialty;
• Establishing a state-level credentialing process for a national system; and
• Inability to generate sufficient fees for self-sufficiency, resulting in a long-term financial burden on TMA.

If the intention is state-level MOC credentialing programs in each state, such a goal would result in considerable cumulative cost and, with no plans for uniform credentialing, could result in considerable confusion among physicians and health care facilities as well as duplication of effort.

The council evaluated the potential for an external organization to assume this responsibility, such as the Texas Medical Foundation; however, no viable alternates were identified. The council also sought input from the AMA Council on Medical Education about a similar resolution the AMA house adopted in 2016. That council is conducting research and preparing a report for the 2017 AMA Annual Meeting in June on the following policy: That our AMA (1) examine the activities that medical specialty organizations have underway to review alternative pathways for board certification, and (2) determine if there is a need to establish criteria and construct a tool to evaluate if alternative methods for board certification are equivalent to established pathways. The council believes TMA should continue to monitor the work of the AMA Council on Medical Education in implementing this new policy and report outcomes to TMA members. This would prevent the potential duplication of effort by individual states, as previously described. Two members of the AMA council are Texas physicians, which better enables TMA to stay informed on this council’s progress.

Further, should SB 1148 pass the Texas Legislature this year, it would diminish the potential impact of the proposed TMA role specified in Res. 201.

Res. 207

Asks TMA to recognize that recertifications by the National Board of Physicians and Surgeons and the National Board of Osteopathic Physicians and Surgeons are acceptable board recertifications for practicing physicians in Texas for all purposes, including licensure, payment, employment, and admitting privileges at a hospital.

Council Analysis of Res. 207

This would require TMA to make an assessment of the rigor and merits of the MOC process offered by NBPAS and NBOPAS as it relates to the requirements for licensing (note: MOC is not currently required by the Texas Medical Board), payment, employment, and admitting privileges at hospitals.

• As previously noted, the AMA Council on Medical Education has begun a process that will accomplish the goals of Res. 207. The TMA Council on Medical Education will continue to monitor the progress of this activity closely and report outcomes to TMA members.
• Similar to Res. 201, if SB 1148 is passed this legislative session, it would reduce the potential impact of the TMA role called for in Res. 207.
• In evaluating the eligibility criteria for NBPAS and NBOPAS, the council believes these programs should undergo the same level of scrutiny as the ABMS or any other MOC program. These programs appear to place heavy reliance on competency assessments conducted by other entities, including ABMS and state licensing boards. Both ABMS certification and state medical licensure are a requirement for MOC credentialing by NBPAS and NBOPAS. In addition, applicants must complete a specified amount of CME, currently 50 hours over 24 months.
• CME requirements for these programs are only slightly above (two hours) the CME requirement for ALL licensed physicians in Texas, which is 48 hours over 24 months.
• The council recognizes the rigor of the initial ABMS board certification process and questions whether two additional hours of CME above the state’s licensure requirements are sufficient to qualify a physician for recertification. Further, the council did not find research studies that demonstrated that two additional hours of CME over a 24-month period is sufficient to distinguish a physician for recertification.

As of this writing, only 50 national entities are listed as recognizing MOC status from the NBPAS and NBOPAS. This is a fraction of the 5,600 hospitals in the United States. Of the 50 national entities that recognize these MOC programs, only three are in Texas. Two of the three Texas entities are hospitals, in comparison with a state total of more than 600 hospitals. There has been little increase in the number of entities that recognize these MOC programs.

Policy Recommendations
The council recommends adoption of the following four policy recommendations and the proposed initial guiding principles on MOC.

Recommendation 1: Approval of the following TMA policy on Initial Guiding Principles on Maintenance of Certification:

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 diplomat’s primary area of practice.

Recommendation 2: Adopt the following as TMA policy on Monitoring Maintenance of Certification Reforms:

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.

Sunset Review of 2007 TMA Policies

TMA Policies 175.006 and 175.018 relate to MOC and were last updated in 2007. The council recommends retention of Policy 175.006 as written and offers proposed changes to Policy 175.018.

175.006 Physician Licensure by Individual State Medical Boards: Individual state medical boards should judge the competency and qualifications of physicians. The TMA will monitor and respond to changes in federal law which would supersede state physician licensure law. TMA opposes proposals for post-licensure assessment as a condition for physician participation in the Medicare program. Further, TMA opposes the use of board certification as a requirement for reimbursement or licensure (CME, pp 98-99, I-93; amended CME Rep. 1-A-07).

Recommendation 3: Retain.

175.018 Maintenance of Certification: The maintenance of certification (MOC) process should become substantially more physician friendly, costing no more than $200 per year 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).

Recommendation 4: Retain as amended.
REPORT OF COUNCIL ON MEDICAL EDUCATION

Subject: Policy Review

Presented by: Steven R. Hays, MD, Chair

Referred to: Reference Committee on Medical Education

TMA periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness. The Council on Medical Education’s analysis and recommendations for retention, deletion, or amendments of policies due for review are summarized in this report.

The following policies are recommended for retention:


205.014 Medical Education Funding Through All Payer Approach: TMA supports the funding of medical education through an all payer approach and enhanced funding of medical research through existing mechanisms (Council on Medical Education, p 67, A-97; reaffirmed CME Rep. 1-A-07).

Recommendation 1: Retain.

The council reviewed the policies 150.003, 200.043, 200.044, and 200.045 for retention with amendments.

Upon review of policy 150.003, the council believes the policy should define clearly the reference to “parity” to prevent possible misinterpretation and confusion about TMA’s position. Further, the council believes the postgraduate training requirements currently in state law are reasonable and should be reflected clearly in TMA policy. The current requirement is one year of postgraduate training for U.S. and Canadian medical school graduates and two years of postgraduate training for international medical graduates.

150.003 Minimum Educational Requirement for Physician Licensure in Texas: TMA supports the following requirements for a full Texas medical license: one year of graduate medical education for graduates of U.S. and Canadian medical schools and two years of graduate medical education for international medical graduates. Parity in the length of graduate medical education required for state medical licensure by U.S. and International Medical Graduates.

TMA further recommends all physicians be allowed to submit their medical license application after successful completion of one year of graduate medical education. The requisite training should be accomplished in accordance with the standards established by the Accreditation Council for Graduate Medical Education- or American Osteopathic Association-accredited graduate medical education programs (Board of Trustees, p 20, A-96; amended CME Rep. 2-A-07).

Minor editing in the first sentence of the following policy was needed to reflect the fact that background checks for medical students have become standard practice:
200.043 Criminal Background Checks on Medical Students: TMA recognizes that the use of criminal background checks on medical students is becoming standard practice among many medical schools, teaching hospitals, and community-based training sites. The TMA applauds the cautious and thoughtful manner used by Texas medical educational institutions in establishing policies on this issue to date. When checks are conducted on medical students, it is recommended that strong consideration be given to: ongoing necessity for checks, prevention of duplication, collaboration, and consistency across educational and healthcare institutions, related financial burden on students, and consistent guidelines for the interpretation and storage of sensitive information, with confidentiality protections for students (CME Rep. 3-A-07).

The following proposed changes to 200.044 are intended strengthen TMA’s support for training and mentorship opportunities for medical students and residents at community-based physician practices:

200.044 Community-Based Physicians as Educators and Mentors: The TMA 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).

The council recommended changes to 200.045 for updating purposes. This policy was based on policy recommendations presented in the 2006 edition of Code Red — The Health of Texas, a publication that was superseded by a second edition in 2015. The majority of 200.045 is no longer relevant, particularly the numerical targets for increasing medical school graduates and residency positions, and the specific changes to the state’s physician education loan repayment program. All of these targets either have been met or replaced by new policy recommendations.

The council does not believe it is reasonable for TMA policy to assume there is the potential for medical schools to select applicants who are not adequately qualified during times of lower medical school application rates. The council has full faith in the medical school admissions’ committees and applicant screening processes and does not feel this policy statement is needed.

Lastly, the council does not believe the numerical target of adding 300 graduate medical education positions per year over the next decade is feasible and should be removed from TMA policy. However, the council believes the general policy in support of GME expansions is appropriate and relevant. The council recommends retention of this portion of the policy statement:

200.045 Needed Growth in Medical School Enrollments and Graduate Medical Education Programs, and Expansion of State Physician Education Loan Repayment Program: The TMA adopted recommendations by the Task Force on Access to Health Care in Texas in “Code Red—the Health of Texas, April 2006” as follows:

1. Texas should increase the number of physicians annually graduating from its medical schools by 20 percent over the next decade with special emphasis upon creating a workforce representative of the state population.
The TMA recognizes the recommendation for a 20 percent increase in medical school
enrollments over the next decade to be feasible and desirable for the state based on an
analysis of trends in medical school enrollments (actual and projected), graduate medical
education programs, and the state’s physician workforce needs. The recommended
growth rate should be periodically assessed for relevancy. The TMA believes it is prudent
to increase medical school enrollments to a level that recommends an increase that carries
a high risk of diminishing the quality of students accepted into Texas medical schools.
Based on recent and projected medical school growth, as well as the anticipated applicant
pool, it appears Texas medical schools could reasonably grow at least 20 percent by 2010
while maintaining the quality of the applicant pool. Should the applicant pool become
diminished, a greater effort should be made to recruit high-quality students. Further, there
is a need for growth in entry-level graduate medical education positions in the state
commensurate with medical school enrollment expansions.

2. Texas should expand medical school loan repayment programs for graduates of Texas
medical schools working in Texas to include up to 500 physicians per year. One third of
student debt up to $35,000 per year should be forgiven for each year of service in a public
hospital or in a clinic in which the patient population equals or exceeds 50 percent
Medicaid and uninsured patients.
The TMA endorses the concept of the recommendation with the goal of providing
$35,000 in loan repayment each year to 500 physicians who agree to practice at a public
hospital or health clinic with at least 50 percent patient population enrolled in Medicaid
or determined to be indigent. It is further recognized that the existing state physician
education loan repayment program also should continue to provide loan repayment to
physicians who practice in medically underserved areas of the state, including rural
communities.

3. State support of medical residency programs should allow an increase in residency
positions by 600 per biennium for the next decade.
The TMA supports the call for increases in graduate medical education positions and the
need to provide direct funding to residency programs. To prevent the loss of medical
graduates from the state as Texas medical school enrollments increase, there is the need
for concomitant growth in graduate medical education training slots sufficient to allow
for the retention of medical school graduates and a reasonable overage to allow other
graduates to train in Texas. Workforce trends should be monitored on a continuing basis
and periodically used to reassess needed growth in graduate medical education slots in
the state (CME Rep. 5-A-07).

Recommendation 2: Retain as amended.

Fellows are not eligible to bill for their services in programs that are accredited by the Accreditation
Council for Graduate Medical Education, even in cases where the fellow has a full medical license. On
this basis, the council believes the following policy cannot be implemented and recommends deletion:

235.020 Billing by Fellows: The TMA supports enabling fellows or their supervisors to bill for
services rendered to Medicare patients in cases where fellows who are the teaching
physicians for residents have a full medical license and are Medicare credentialed (Council

Recommendation 3: Deletion.
The Committee on Physician Distribution and Health Care Access is charged with monitoring the adequacy of the state’s health care workforce in relation to the demand for health care services. It has come to the committee’s attention that in 2016 the Texas Higher Education Coordinating Board submitted to the Texas Legislative Budget Board a recommendation for a long-range state health care workforce study to be included in the state’s 2017-19 biennial budget. The study is to focus on the current demand for health care workforce and a projection of future needs. The board referenced the state’s rapid population growth along with the state’s relatively poor ranking of health care professionals per capita as compelling reasons for conducting the study. The board is to undertake this effort in collaboration with other state agencies, institutions of higher education and health care, and other stakeholders. A report is to be issued on the results of the study for use during the 2019 Texas legislative session.

The committee believes it is fiscally appropriate for public funds to be allocated for medical education, graduate medical education, and other health professions’ training programs in alignment with the state’s health care workforce needs. On this basis, the committee supports the Texas Higher Education Coordinating Board’s recommendation for a long-range state health care workforce study.

**Recommendation:** Approval of the following as Texas Medical Association policy in support of a long-range state health care workforce study.

**Long-Range State Health Care Workforce Study:** The Texas Medical Association believes it is good state fiscal policy to align state funding for medical education, graduate medical education, and other health professions’ education/training programs with the state’s workforce needs. TMA supports a state health care workforce long-range study to be conducted by the Texas Higher Education Coordinating Board in conjunction with all other relevant agencies, boards, institutions, and programs. The study must be resourced adequately to produce credible results.
The State Physician Education Loan Repayment Program has been assisting physicians in paying their educational loans since 1986. The program is widely considered to be among the most effective tools for recruiting and retaining primary care physicians in underserved communities. Young physicians with high education-related debt are assisted in repaying their loans and underserved communities benefit from increased access to medical care. Notwithstanding this success, even more needs to be done to address physician shortages in Texas communities. The committee believes one way of accomplishing this goal is to make enhancements to the loan repayment program, as presented in this report.

To demonstrate the extent of the physician shortage, rural Texas has less than half the number of physicians per capita than urban. Rural Texas has a total ratio of 84 patient care physicians per 100,000 population compared to 190 for urban. Recruitment to rural areas is often challenging and only 4 percent of newly licensed physicians in 2013 chose rural practices. About 500 more primary care physicians, distributed in the right places, are needed to bring the ratio of population-per-primary care physicians below the national shortage threshold of 3,500:1, for all 254 Texas counties.

Although most urban areas have a lower ratio of people per doctor than rural areas, many urban areas are also in need of additional physicians. Public programs in urban and rural areas, such as Medicaid, CHIP, and the Healthy Texas Women’s Program, face ongoing challenges in recruiting sufficient numbers of participating physicians. The committee believes changes to the state’s physician loan repayment program are needed to specifically address these needs.

Eligibility Criteria
The Physician Education Loan Repayment Program is administered by the Texas Higher Education Coordinating Board. Physicians can qualify for a maximum repayment amount of $160,000 in return for four years of service in an underserved community. Payment is only made on an annual basis and after the completion of 12 months of service in an eligible area. The following prioritization criteria is used:

1) Primary care physicians practicing in primary care Health Professional Shortage Areas (HPSAs), and psychiatrists practicing in mental health HPSAs; and

2) Physicians in specialties other than primary care or psychiatry who are located in areas designated as primary care HPSAs;

If funds remain after eligible applicants have been funded under the first two categories, then repayment is available for:

3) Primary care physicians practicing anywhere in Texas who provide medical care to a minimum number of Medicaid patients or enrollees of the Healthy Texas Women’s Program, as established by HB 2550 (2013 Texas Legislature). This is similar, but far more limited, to a previous loan repayment program for Medicaid providers that had been established as part of the Texas Medicaid Frew lawsuit settlement. That program began in 2008 and concluded in 2011.
The Coordinating Board defines “primary care” for the purposes of the loan repayment program to include the following physician specialties:

- Family/general medicine
- Geriatrics
- Internal medicine
- Obstetrics/Gynecology
- Pediatrics
- Psychiatry

In the event funds are still remaining after this third group of eligible physicians receive funding, the unused monies are to be transferred to the Nursing Faculty Loan Repayment Assistance Program (HB 2099, 2013 Texas Legislature). In state Fiscal Year (FY) 2016, $1.3M was transferred for this purpose. Based on projected applicants, the Coordinating Board does not expect funds to be available for this type of transfer in FY 2017.

**Funding**

A total of $33.8 million was appropriated by the Texas Legislature for the program for the 2016-17 Biennium. The Coordinating Board projects that all funds will be committed in FY 2017 for an estimated 392 physicians in the first two categories of eligibility: physicians practicing in primary care or mental health HPSAs in 1) primary care; and 2) all other specialties. This would mean NO funds would be available for repayment for the 2,550 physicians projected for eligibility category three, primary care physicians in any location who meet the threshold for serving the number of Medicaid or Healthy Texas Women’s Program enrollees.

**Proposed TMA Policy**

The committee believes enhancements should be made to expand the benefits of the program. Three proposed changes are presented below and are recommended as new TMA policy.

When the committee developed the policy proposals, Texas Comptroller Hegar had not released his state revenue projections for 2018-19 and the committee was not aware of the projected funding shortfall for the next state budget. The committee recognizes that its recommendations for increased funding of the state physician loan repayment program must be balanced in relation to available funding. Should the funds not be available at this time, the committee believes it is important to have this policy in place when additional funding becomes available.

1. **Support for Increased Number of Loan Repayment Recipients in 2018-19**

   As noted above, no funds are expected to be available in the 2018-19 Biennium for loan repayment for the third group of eligible physicians, primary care physicians (in any location) who meet the threshold for serving the target number of Medicaid or Healthy Texas Women’s Program enrollees. The committee believes the loan repayment program should be expanded to allow an additional 50 physicians to receive loan repayment per year, beginning in FY 2018. To accomplish this goal, an additional $5.25M would be required in FY 2018 and $3M in FY 2019, for an additional biennial total of $8.25M above current funding.

2. **Support for Revised and Expanded Eligibility Criteria**

   In prior years, general surgeons in primary care HPSAs were included as a specialty qualifying in the first priority group for loan repayment. It is not known why surgeons were previously moved to the second priority group, but the committee believes general surgeons should be considered a first priority for loan repayment.
This proposal is in recognition of the critically important role of general surgeons in meeting health care needs. Surgeons augment the highly important role of primary care physicians. In rural areas, surgeons largely serve the needs of elderly Texans which prevents the need for elderly Texans to travel to urban centers for these services. Non-residents of rural areas can also potentially benefit from reasonable access to surgeons when urgent and emergency care is needed as a result of events such as car accidents for those traveling through rural areas.

3. Restoring Loan Repayment for Non-Primary Care Physicians Serving Medicaid/CHIP, and the Healthy Texas Women’s Program

The Coordinating Board predicts repayment monies will not be available in FY 2018-19 for physicians who are not located in HPSAs who provide services to Texans eligible for Medicaid or the Healthy Texas Women’s Program. The Texas Medicaid program faces serious challenges in recruiting and retaining physicians and loan repayment is a valuable incentive for addressing the challenge. TMA has policy in support of increases in Medicaid physician fees, however, achieving this goal in the next biennium will be unlikely given the state’s predicted budget challenges. It is important to be able to offer loan repayment to attract and retain physicians in the Medicaid program.

Under a provision adopted as part of the FREW lawsuit settlement, loan repayment was available to physicians in non-primary care specialties and subspecialties who participated in Medicaid. This ended in 2011. Specialist participation in Medicaid is an ongoing challenge in many areas of the state. For example, at this time there are reports of shortages of psychiatry, neurology, and gastroenterology. The ability to offer loan repayment can be a valuable tool in recruiting specialists to the Medicaid and CHIP programs. The committee believes it is important to restore these expanded loan repayment provisions.

To better manage the competition for available loan repayment monies that may result from this proposed expansion in eligibility, the expansion could focus on specialties with the highest level of shortages in the Medicaid program. It would be critically important for the Coordinating Board to continue collaborating with the Texas Health and Human Services Commission in identifying these specialties, possibly on an annual basis or as loan repayment funds become available.

TMA recommends physicians receiving loan repayment under this provision be required to contract with one or more Medicaid managed care plans in their community (90 percent of Medicaid enrollees are enrolled in managed care so to reach the population, physicians would need to join at least one HMO network), as appropriate, and also meet the threshold for serving a defined number of Medicaid and CHIP enrollees, or clients of the Healthy Texas Women’s Program, as applicable to the physician’s specialty.

The Texas Higher Education Coordinating Board should work with the Texas Health and Human Services Commission, TMA, and appropriate state medical specialty societies in defining the Medicaid-related loan repayment requirements. This is to include annual updates to the defined targets for the number of clients served by physicians receiving loan repayment and for setting eligibility priorities for physician specialties with the greatest shortages in the Medicaid program.

Recommendation 1: Adopt the following as TMA policy on Enhancing the State’s Physician Education Loan Repayment Program:

TMA urges expansion of the State Physician Education Loan Repayment Program to increase the number of physicians receiving repayment from 100 to 150 per year, beginning in State Fiscal Year 2018.

TMA supports expanding the first priority for eligible applicants for the State Physician Education Loan Repayment Program to include general surgeons practicing in primary care Health Professional Shortage
Areas (HPSAs). In addition to primary care physicians, general surgeons provide core medical services that are critical to the viability of hospitals.

TMA supports an expansion of the Medicaid-related eligibility provision in the State Physician Education Loan Repayment Program to include primary care physicians and physicians practicing in critically needed non-primary care specialties and subspecialties. This is for the purposes of improving access to physician services for Texans eligible for Medicaid, CHIP, and the Healthy Texas Women’s Program.

Amendment of TMA policy 205.021 is recommended because the number of repayments was reduced from five to four. This would bring the policy in line with current program operations:

205.021 **State Loan Repayment Program:** Recognizing the effectiveness of the State Physician Education Loan Repayment Program in recruiting and retaining physicians in underserved areas of the state, TMA supports increased state funding for this program to allow the state to maximize federal matching dollars, to maintain the five four-year escalating repayment levels as a retention aid for underserved areas, and to allow for annual growth in the number of physicians receiving loan repayment (CME Rep. 5-I-00).

Proposed changes to the title of 205.002 would better reflect the policy statement:

205.002 **Support for Federal Match for State Loan Repayment Program Student Loan Funds Repayment:** TMA recognizes the value of federal matching funds to the Texas Physician Education Loan Repayment Program in recruiting and retaining physicians for underserved areas of the state and supports the continued availability of federal matching funds (Supplemental Council on Medical Education, p 123, A-90; amended CME Rep. 5-I-00; reaffirmed CME Rep. 2-A-10).

Policy 185.017 remains relevant but is in need of updating in (1) and (2) to reflect the loan repayment program’s current procedures:

185.017 **Addressing the Threat to Primary Care in Texas:** TMA advocates the following to help alleviate the shortage of primary care physicians in Texas:

1. TMA should continue to work to identify ways to improve monitoring the impact of physician education loan repayment in the state, including repayment amounts that better correspond to current debt levels, which now average $131,000. Input from graduating medical students, residents, and practicing physicians should be considered in developing the new defining repayment levels.

2. Annual loan repayment amounts should be increased for each year a physician practices in an underserved community, within a defined cap, such as five four years.

3. Strong consideration should be given to expanding the state loan repayment program to include medical specialties experiencing shortages in addition to primary care.

4. Consideration should be given to offering higher repayment amounts for physicians who practice in areas of greatest need, including areas with longstanding physician shortages.

5. Reaffirmation of TMA Policy 185.013 that “encourages Texas medical schools with rural missions to periodically evaluate their student admission criteria to ensure that the most appropriate criteria are utilized for identifying students most likely to select careers in rural areas.”
medicine.” This would help prepare more physicians to meet the needs of rural, medically underserved areas.

(6) Reaffirmation of TMA Policy 185.001(1) that asks TMA to “continue to focus efforts on resolving the maldistribution of physicians by encouraging physicians to locate in underserved areas of the state.”

(7) In addition to loan repayment, state incentive and benefit programs for recruiting and retaining primary care physicians for medically underserved communities should be: (1) adequately funded and (2) sufficiently promoted among potential physician candidates to prevent available grants and stipends from going unspent.

(8) Efforts should be made to consolidate physician benefit and incentive programs for medically underserved communities at a single agency. The programs should be evaluated on a periodic basis to assess their effectiveness and net benefit to the state.

(9) TMA should take an active role in promoting awareness of the Physician Education Loan Repayment Program, in partnership with the Texas Higher Education Coordinating Board and Texas Medical Board.

(10) TMA also should promote greater awareness of other existing benefit and incentive programs for medically underserved communities through postings on the TMA website and promotion among TMA’s Medical Student and Resident and Fellow Sections (CME Rep. 3-A-08).

Recommendation 2: Retain as amended.

The following related TMA policies on physician education loan repayment are recommended for deletion.

Policy 205.034 is outdated and no longer relevant:

205.034 Reinstatement and Enhance Texas Physician Education Loan Repayment Program: TMA prioritizes efforts to fully reinstate the Texas Physician Education Loan Repayment Program as well as enhancing the program to ensure its viability through the remainder of the decade (Res. 207-A-12).

Policy 205.023 is no longer relevant and should be deleted because the two-percent tuition set-aside that is referenced in the policy statement was repealed through state legislative action in 2015:

205.023 Physician Education Loan Repayment Program: TMA supports a clearly defined auditing process to ensure that the legislatively mandated 2 percent medical school tuition set-aside is transferred in a timely and accurate manner by Texas medical schools to the Physician Education Loan Repayment Program (CME Rep. 6-A-03; reaffirmed CMS Rep. 1-A-13).

Recommendation 3: Delete.

¹Repayment can also be made for up to 10 physicians a year who serve patients in a Texas Juvenile Justice Department program or Texas Department of Criminal Justice facility. A separate state program, Loan Repayment Program for Mental Health Professionals, also offers loan repayment for psychiatrists. The total repayment is also
$160,000, but an additional year of service is required to qualify for the full repayment, five years versus the four years required for the Physician Education Loan Repayment Program.

To be eligible, a physician must provide medical services to a minimum of 200 unduplicated clients per year for all eligible specialties, except for the following specialties: Physicians specializing in geriatrics must provide services to a minimum of 25 clients/year; and psychiatrists must treat a minimum of 150 clients/year.
TMA periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness. The Committee on Physician Distribution and Health Care Access’ analysis of a policy item dated 2007 is summarized in this report.

Upon review of TMA policy 175.014, the committee recognized the importance of adding a reference in the policy statement to the state’s official definition of “border” areas. This designation is made by the Texas Department of State Health Services. It also is preferable not to single out a specific border area in the policy statement. The committee further recognizes that lower physician payment is an ongoing challenge to recruiting and retaining physicians in border areas.

The following policy is recommended for retention with changes:

175.014  Allowing Border Areas to Qualify for Expedited Medical Licensure: The Texas Medical Association supports the addition of border areas of the state, as defined by the Texas Department of State Health Services, to the list of geographic areas defined in state law as being eligible for expedited medical licensure. This is recommended in recognition of the chronic shortage of physicians in many border areas and longstanding difficulties in recruiting and paying physicians in these areas of the state (CM-PDHCA Rep. 3 A-07).

Recommendation: Retain as amended.
Whereas, Physician advocacy is a priority for the Texas Medical Association; and

Whereas, Current medical literature supports the inclusion of advocacy training in medical education and graduate medical education across multiple specialties, including but not limited to anesthesiology, dermatology, general surgery, and orthopedic surgery; and

Whereas, Advocacy is recognized as a component of professionalism; and

Whereas, While greater than 90 percent of trial lawyers contribute to their political action committee, generally speaking around 7 percent of colorectal surgeons, 14 percent of dermatologists, 5 percent of general surgeons, and 28 percent of orthopedic surgeons make such contributions; and

Whereas, The Texas Medical Association invests resources in educating member physicians about advocacy, with approximately 4,500 of the 50,000 members of TMA currently contributing to TEXPAC; and

Whereas, Advocacy on the part of TMA members is important in addressing issues such as Medicaid reform, Medicare Access and CHIP Reauthorization Act implementation, the Texas Medical Board sunset process, balance billing, and scope of practice, among others; and

Whereas, Advocacy education consistently has been included in the curriculum of physician extenders and allied health professionals; and

Whereas, Medical students previously may not be aware of the importance of advocacy; therefore be it

RESOLVED, That the Texas Medical Association support inclusion of at least two hours of didactic education per calendar year focused on advocacy education for every medical student in Texas; and be it further

RESOLVED, That the Texas Delegation to the American Medical Association submit a resolution at the 2017 AMA Annual Meeting that will call for the inclusion of at least two hours of didactic education per year in advocacy education for every medical student in the United States.

Relevant 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


Relevant AMA Policy:

Medical Student, Resident and Fellow Legislative Awareness H-295.953
1. The AMA strongly encourages the state medical associations to work in conjunction with medical schools to implement programs to educate medical students concerning legislative issues facing physicians and medical students.
2. Our AMA will advocate that political science classes which facilitate understanding of the legislative process be offered as an elective option in the medical school curriculum.
3. Our AMA will establish health policy and advocacy elective rotations based in Washington, DC for medical students, residents, and fellows.
4. Our AMA will support and encourage institutional, state, and specialty organizations to offer health policy and advocacy opportunities for medical students, residents, and fellows.


References
12. Texas Medical Association at www.texmed.org/getinvolved/.
Texas Medical Association House of Delegates

Resolution 202
A-17

Subject: Medical School Clinical Skills Exams

Introduced by: Medical Student Section

Referred to: Reference Committee on Medical Education

Whereas, The United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) examination was launched in 2004 to serve as a communication competency exam; and

Whereas, The Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2-Performance Examination (PE) was launched in 2005 for the same purpose; and

Whereas, Medical students from across the country must travel to one of only five standardized testing centers in the United States to take Step 2 CS; and

Whereas, The current registration fee for Step 2 CS is $1,280, plus the costs of travel and lodging; and

Whereas, In 2014-15, 20,252 medical students took Step 2 CS, amounting to $25,922,560 in exam fees alone; and

Whereas, Among U.S. medical students who graduated in 2016, approximately 76 percent had student loan debt, and median medical school debt was estimated to be around $180,000; and

Whereas, Students accrue more debt by paying for examinations with loans, leading to a more accurate estimate of $36.2 million as the total annual cost of the exam; and

Whereas, Step 2 CS evaluates medical students on three separate subcomponents, Communication and Interpersonal Skills, Spoken English Proficiency, and Integrated Clinical Encounter, skill areas that are evaluated repeatedly during medical school interviews, clinical rotations, and school-administered examinations; and

Whereas, In 2014-15, only 113 examinees failed Step 2 CS after two attempts, amounting to a cost of roughly $320,000 in exam fees spent by test-takers to identify just one under-skilled, double-failed student; and

Whereas, Studies have found weak correlations between Step 2 CS scores and end-of-year evaluations of internal medicine interns, while clinical skills scores added no additional predictive value beyond the written USMLE exams; and

Whereas, In a 2005 national survey of medical school curriculum deans, 84 percent of respondents reported administering an objective structured clinical examination or other comprehensive clinical skills assessment during the third or fourth year of medical school, and 70 percent of the schools represented required a passing score for graduation; and

Whereas, All 11 Texas medical schools offer clinical skills exams that are more rigorous than Step 2 CS or COMLEX Level 2-PE multiple times throughout the undergraduate medical education; and
Whereas, Each Texas medical school’s clinical skills requirement fulfills the guidelines outlined by the Liaison Committee on Medical Education (there is also the Texas College of Osteopathic Medicine in Fort Worth, which follows the guidelines of the Commission on Osteopathic College Accreditation); and

Whereas, According to a survey of 19 Texas medical school deans and administrators, all Texas medical schools require a passing grade for the school-administered clinical skills exam at the end of the third year of medical school as a graduation criterion; and

Whereas, All 19 Texas medical school deans and administrators who were surveyed cited cost of the exams as a concern, and 17 deans and administrators cited the inconvenience of the test as a concern; and

Whereas, Texas Medical Association Policy 200.038 states, “Clinical skills assessment is best performed using a rigorous and consistent examination administered by the medical school”; and

Whereas, No specific TMA policy exists concerning Step 2 CS or COMLEX Level 2-PE; and

Whereas, American Medical Association Policy H-275.956 states, “It is the policy of the AMA to recognize that clinical skills assessment is best performed using a rigorous and consistent examination administered by medical schools”; and

Whereas, AMA Policy D-295.988 states, “Our AMA will work … to pursue the transition from and replacement for the current USMLE Step 2 CS examination and the COMLEX Level 2-PE with a requirement to pass a Liaison Committee on Medical Education-accredited or Commission on Osteopathic College Accreditation-accredited medical school-administered, clinical skills examination”; therefore be it

RESOLVED, That the Texas Medical Association advocate for the Texas Medical Board to eliminate the United States Medical Licensing Examination Step 2 Clinical Skills examination and the Comprehensive Osteopathic Licensing Examination Level 2-Performance Examination licensure requirements for U.S. medical graduates who have passed a clinical skills examination administered by a Liaison Committee on Medical Education- or Commission on Osteopathic College Accreditation-accredited medical school.

Relevant TMA Policy:

200.038 Clinical Skills Assessment: Given the importance of assessing clinical competency, the Texas Medical Association joins the American Medical Association in strongly urging the Liaison Committee on Medical Education and the American Osteopathic Association to modify and enforce uniform accreditation standards as soon as possible to require that all medical schools rigorously and consistently assess clinical skills of all students as a requirement for advancement and graduation.

It is the policy of the Texas Medical Association to (1) support continued efforts to develop and validate methods for assessment of clinical skills; (2) support the American Medical Association’s participation in the development and testing of methods for clinical skills assessment; and (3) oppose the use of these methods in evaluation for licensure of graduates of Liaison Committee for Medical Education- and American Osteopathic Association-accredited medical schools, believing that clinical skills assessment is best performed using a rigorous and consistent examination administered by the medical school (CME Rep. 3-A-03; reaffirmed CMS Rep. 1-A-13).
Relevant AMA Policy:

D-295.988 Clinical Skills Assessment During Medical School

1. Our AMA will encourage its representatives to the Liaison Committee on Medical Education (LCME) to ask the LCME to determine and disseminate to medical schools a description of what constitutes appropriate compliance with the accreditation standard that schools should “develop a system of assessment” to assure that students have acquired and can demonstrate core clinical skills.

2. Our AMA will work with the Federation of State Medical Boards, National Board of Medical Examiners, state medical societies, state medical boards, and other key stakeholders to pursue the transition from and replacement for the current United States Medical Licensing Examination (USMLE) Step 2 Clinical Skills (CS) examination and the Comprehensive Osteopathic Medical Licensing Examination (COMLEX) Level 2-Performance Examination (PE) with a requirement to pass a Liaison Committee on Medical Education-accredited or Commission on Osteopathic College Accreditation-accredited medical school-administered, clinical skills examination.

3. Our AMA will work to: (a) ensure rapid yet carefully considered changes to the current examination process to reduce costs, including travel expenses, as well as time away from educational pursuits, through immediate steps by the Federation of State Medical Boards and National Board of Medical Examiners; (b) encourage a significant and expeditious increase in the number of available testing sites; (c) allow international students and graduates to take the same examination at any available testing site; (d) engage in a transparent evaluation of basing this examination within our nation’s medical schools, rather than administered by an external organization; and (e) include active participation by faculty leaders and assessment experts from U.S. medical schools, as they work to develop new and improved methods of assessing medical student competence for advancement into residency.

H-275.956 Demonstration of Clinical Competence

It is the policy of the AMA to (1) support continued efforts to develop and validate methods for assessment of clinical skills; (2) continue its participation in the development and testing of methods for clinical skills assessment; and (3) recognize that clinical skills assessment is best performed using a rigorous and consistent examination administered by medical schools and should not be used for licensure of graduates of Liaison Committee on Medical Education (LCME) - and American Osteopathic Association (AOA)-accredited medical schools or of Educational Commission for Foreign Medical Graduates (ECFMG)-certified physicians.

D-275.981 Potential Impact of the USMLE Step 2 CS and COMLEX-PE on Undergraduate and Graduate Medical Education

Our AMA will: (1) continue to closely monitor the USMLE Step 2 CS and the COMLEX Level 2-PE, collecting data on initial and final pass rates, delays in students starting residency training due to scheduling of examinations, economic impact on students, and the potential impact of ethnicity on passing rates; and (2) encourage residency program directors to proactively evaluate their access to resources needed to assist resident physicians who have not passed these examinations to remediate.

References

RESOLUTION 203
A-17

Subject: Resolving the Impact of Travel and Immigration Bans on Health Care Access

Introduced by: Medical Student Section

Referred to: Reference Committee on Medical Education

Whereas, Restrictions on entering the United States, such as the Jan. 27 executive order — Protecting the Nation from Foreign Terrorist Entry into the United States — and the March 6 executive order of the same name that took effect on March 16 may adversely impact physicians with a foreign affiliation; and

Whereas, Drs. Kamal Fadlalla and Suha Abushamma, both internal medicine residents of Sudanese descent, had well-publicized difficulties in returning to the United States from a trip abroad in January 2017; and

Whereas, American Medical Association CEO James Madara, MD, has stated that the "executive order is affecting both current and future physicians as well as medical students and residents who are providing much needed care to some of our most vulnerable patients"; and

Whereas, Baylor College of Medicine President and CEO Paul Klotman, MD, has pledged administrative support to foreign students, researchers, and physicians who are scheduled to leave the country on business; and

Whereas, There are more than 15,000 practicing physicians in the United States who are from the seven countries implicated in the Trump administration’s January executive order, with over a quarter of Texas physicians having received their medical education from outside the United States; and

Whereas, In 2013, 2,101 residency applicants were from 11 Muslim-majority countries; and

Whereas, The number of international medical graduates in the United States surpasses 240,000, approximately a quarter of all practicing physicians, with a large corresponding density in high-need rural and inner-city areas via the J-1 visa program; and

Whereas, Foreign residency applicants have approximately only 90 days after receiving a residency match to obtain a United States visa; and

Whereas, University of Texas Southwestern Program Director of Internal Medicine Residency Salahuddin Kazi, MD, has stated that delays in obtaining a visa experienced by residents in foreign countries for purposes of entering residency training in the United States may force current medical residents to give up vacation days and to work more shifts; therefore be it

RESOLVED, That the Texas Medical Association support the right of practicing physicians, residents in training, and medical students in Texas to return from travel abroad irrespective of a travel restriction; and it be further
RESOLVED, That TMA advocate for social and administrative support from medical centers and universities for current Texas medical residents or physicians who are non-United States citizens.

Relevant TMA Policy:

**185.021 Expanding J-1 Visa Waivers for Underserved Texas Communities:** The Texas Medical Association recognizes that a large number of small, isolated, rural communities continue to face serious challenges in recruiting and retaining sufficient numbers of physicians and that the lack of access to physician services has a detrimental impact on the health of Texans in these communities. TMA supports additional methods for helping underserved communities recruit physicians including the following improvements to the J-1 Visa Waiver program:

- Advocacy for reauthorization of the Conrad 30 program and for an increase in the annual waiver cap for Texas.
- Advocacy for expanding the U.S. Department of Health and Human Services’ J-1 Visa Waiver program to allow physicians in private practice and other practice settings in Texas to be eligible for waivers.
- Advocacy for funding the Southwest Border Commission and granting the status of “interested governmental agency” for the purposes of processing J-1 Visa Waivers for Texas, California, Arizona, and New Mexico. TMA should reach out to these three states to work together in advocating for these changes (IMGS Rep. 1-A-16).

References


AGENDA
REFERENCE COMMITTEE ON SCIENCE AND PUBLIC HEALTH
Friday, May 5, 2017
Marriott Marquis, Level 2, Houston Ballroom 2

2. Council on Science and Public Health Report 1 – All Hazards Disaster Planning
5. Committee on Child and Adolescent Health Report 1 – Policy Review
6. Committee on Infectious Diseases Report 1 – Policy Review
7. Committee on Reproductive, Women’s, and Perinatal Health Report 1 – Policy Review
8. Committee on Child and Adolescent Health and Committee on Reproductive, Women’s, and Perinatal Health Joint Report 3 – Resolution 310, Prevention of In-Hospital Newborn Falls
10. Committee on Infectious Diseases and Committee on Child and Adolescent Health Joint Report 5 – Preexposure Prophylaxis as HIV Prevention
11. Board of Councilors Report 3 – Resolution 307-A-16, Gender and Sex Options on Medical Paperwork (referral change from Reference Committee on Financial and Organizational Affairs)
12. Resolution 301 – Creating a Statewide Crisis Standards-of-Care Framework (Dallas County Medical Society)
13. Resolution 302 – Palliative Care (Larry Driver, MD)
14. Resolution 303 – Sudden Increase in Liability Claims for Wernicke’s Encephalopathy in Bariatric Surgery Patients (Harris County Medical Society)
15. Resolution 304 – Rejection of Discrimination (Young Physician Section, Resident and Fellow Section, and Medical Student Section)
16. Resolution 305 – Addressing the Diaper Gap (Medical Student Section)
17. Resolution 306 – Addressing the Need for Improved Water Supply Quality in Texas (Medical Student Section)
18. Resolution 307 – Reducing Errors in Pharmacy (Lubbock-Crosby-Garza County Medical Society)
19. Resolution 308 – Expansion of Next Generation 911 (Medical Student Section)
20. Resolution 309 – Addressing the Medical Inaccuracies of the Mandated “A Woman’s Right to Know” Booklet and Related Patient Information (Medical Student Section)

21. Resolution 310 – Healthy Food in Hospitals (Medical Student Section)

22. Resolution 311 – Addressing Access to Maternal Personal Protective Equipment from Radiation (Medical Student Section)

23. Resolution 312 – Implementing a Sugar-Sweetened Beverage Tax in Texas (Medical Student Section)

24. Resolution 313 – Improved Concussion Protocol to Reduce Psychological Morbidity in High School Athletes (Medical Student Section)

25. Resolution 314 – Promoting Increased Awareness and Research for Grade School Soccer-Related Head Injury (Medical Student Section)

26. Resolution 315 – Addressing the Expanding Habitats of Vectors of Infectious Disease (Medical Student Section)

27. Resolution 316 – Addressing Transgender Public Facility Use (Medical Student Section)

28. Resolution 317 – Precision Medicine in Refractory Cancer Treatment and Transparency in Compendia Used for Providing Coverage for Off-Label Cancer Drug Usage (Medical Student Section)

29. Resolution 318 – Access to Special Education Services (Medical Student Section)

30. Resolution 319 – Identification and Prevention of Adolescent Substance Abuse (Webb-Zapata-Jim Hogg County Medical Society)

31. Resolution 320 – Vitamin D3 Supplementation (Webb-Zapata-Jim Hogg County Medical Society)

32. Resolution 321 – Promoting Safe and Effective Disposal of Unused Medications (Webb-Zapata-Jim Hogg County Medical Society)
Every 10 years, TMA reviews its policies for relevance and appropriateness. The Council on Health Care Quality reviewed the following policy and offers one recommendation.

Upon review of policy 155.007 Cytology Proficiency Testing, the council recommends its retention.

155.007  Cytology Proficiency Testing: The Texas Medical Association supports allowing the up-to-date, scientifically proven, cytology proficiency testing as developed by the College of American Pathologists (CAP) or American Society for Clinical Pathology (ASCP) to satisfy the Clinical Laboratory Improvement Act of 1988 cytology proficiency testing requirement (Res. 401-A-05).

Recommendation 1: Retain.
Subject: All Hazards Disaster Planning

Presented by: David Lakey, MD, Chair

Referred to: Reference Committee on Science and Public Health

Background

The Council on Science and Public Health was charged with conducting a sunset review of TMA’s policy on all hazards preparedness. All hazards refers to natural hazards (hurricanes, floods, tornadoes, wildfires); man-made hazards (explosions, oil spills); bioterrorism or other security threats; and epidemics, pandemics, and other health threats. In Texas, all hazards planning and preparedness is outlined in the State of Texas Emergency Management Plan, which identifies the responsibilities and minimum functions of state agencies that support local planning and response to disasters and emergencies. The governor has authority to declare an emergency in a pandemic or in a more geographically widespread emergency, but Texas’ experience is that most hazards are local, involving only one or a few jurisdictions. That means disaster planning and response must be managed locally with support from regional, state, or federal agencies as requested. However, as most disasters have the potential for an adverse health impact, effective disaster planning involves physicians and the health care delivery system as partners during state and local or regional hazardous events.

The Division of Emergency Management (TDEM) in the Texas Department of Public Safety coordinates the state’s emergency management plan along with many state agencies that support and supplement local preparedness and disaster response. When a disaster like a hurricane is anticipated or when a disaster occurs, TDEM monitors local events and emergencies throughout the state and operates the state operations center for coordination during the disaster or emergency.

Texas is further organized into 24 disaster district committees (DDCs) made up of state agency personnel and volunteer organizations. The DDCs coordinate local and regional requests for use of state resources. State-level planning and preparedness for public health are the responsibility of the Department of State Health Services (DSHS). The agency is funded to support state and local planning, and response and recovery efforts.

The emergency management structure for all cities and counties is established in state law. Local officials (elected mayors or county judges) are responsible for developing a local operations plan to respond to local emergencies, and a local director of emergency management usually is designated. Local officials are responsible for assessing a hazard, declaring an emergency, allocating local resources, and requesting assistance as needed. A recent example was the 2014 Ebola case in Dallas, which was the responsibility of Dallas county officials but was supplemented with support and coordination of staff from DSHS and the Centers for Disease Control and Prevention.

Local emergency operations plans must provide direction on critical functions for any type of hazard or emergency that could endanger health (e.g., the use of local health and medical resources, sheltering and mass care, and communications). The plan must be based on planning and coordination with local public health officials, hospitals, emergency medical service and trauma centers, law enforcement, volunteer
organizations, and other support entities. Communities without a public health department are supported by the DSHS’ regional health department for their area.

**Policy Review and Discussion**

TMA’s policy 260.076 was adopted in 2006 in the context of multiple disasters such as hurricanes Claudette and Katrina, as well as floods and wildfires in various parts of Texas. Hundreds of physicians and TMA members were involved in responding to these disasters — sometimes for several days and weeks. The development of policy 260.076 reflected the growing concern for physician engagement in planning for all types of hazards. The American Medical Association adopted similar policies in the same period.

Over more than a decade of experience and information gained in significant disaster responses, our federal and state policymakers have continued to develop and strengthen disaster planning and response systems at the state and local level. Recognizing the many developments in the state and local preparedness systems, the council convened a workgroup to review policy 260.076. The workgroup agreed the policy needed updates, and it identified other topics for review such as the role of the county medical societies (CMSs) and local health departments, communications with physicians, and the need for information or education for physicians on all hazards planning. Other issues presented were physician involvement in regional advisory planning activities, an identification method for physicians when returning to a disaster area following evacuation, capacity to address emerging issues such as Zika or other public health emergencies, and support for continuation of the state’s initiative on crisis standards of care.

The council surveyed 77 county medical societies to assess how local planning is occurring, the role of the physician in preparedness and response, working with state and local public health officials, and the role of the CMS and its communications with physicians. The council sent 235 surveys; for many CMSs, both physician members and executive staff received a survey. While there were 20 responses, they represented 65.8 percent of TMA membership and had geographic diversity from urban CMSs to west and east Texas. About half of the surveys were completed by CMS executive staff and the others by CMS physician leadership. Results from the survey are summarized:

- Most of the CMSs (74 percent) have a point of contact and relationship with a local public health official or other public bodies involved in all hazards planning (e.g., the Regional Advisory Committee) and/or who responds to public health emergencies; however, only 26 percent of these were formal relationships. There is limited interaction with public health officials among other CMSs.
- Most (60 percent) had a designated physician or CMS staff contact responsible for disaster planning, and 58 percent had been involved in local disaster planning in their city/county.
- Half of the CMSs had provided education programs or shared information with their membership on disaster preparedness. This included programs on the distribution of scarce health resources in a disaster; training on chemical, biological, radiological, and nuclear defense/protective measures; and information on West Nile virus, Ebola, Zika, and other infectious diseases.
- Some noted that other stakeholders such as local hospitals are engaged in (and lead) local disaster planning and sponsor emergency drills; however, this typically may not include direct participation with the CMSs. Most CMSs have been involved in other preparedness exercises.
- Several CMSs participate in local planning activities that involve local public health and hospitals to promote planning.
- Half of the CMSs maintained a list of physicians who could volunteer during an emergency, and half did not. All encouraged physicians to register as volunteers either through the Texas Volunteer
Registry or the Emergency System for Advance Registration of Volunteer Health Professionals (ESAR-VHP), a federal system for health care volunteers.

- Almost all CMSs communicated recently to their membership about an emergency, but there appears to be no universal method for communications. Several used multiple methods with email the most common (50 percent).
- All would like to have access to more information for their members.

Conclusion and Recommendations

Federal and Texas laws have changed to address the growing awareness of the need for effective measures to prevent or reduce the physical and emotional health effects of a disaster. Each community must have an all hazards planning infrastructure that involves state and local public and private agencies and organizations including local and regional physicians and health care providers. While Texas has a highly regarded and tested infrastructure for planning and response to a wide spectrum of disasters, the responses to the council’s survey indicate physicians may not be involved in or informed about planning for and responding to events — even when these occur in their own communities. And while a CMS is the key physician association in every area of the state, some may not have the resources to work with public health and the local preparedness planning infrastructure to enable participation in local disaster planning. Yet physicians should be advised about the potential disaster concerns in their communities and the planning and resources for their community. As noted above, physicians can participate by signing up with the state volunteer registry or ESAR-VHP, or with Texas-based Medical Reserve Corps units. As recognized leaders in their communities, physicians must have the opportunity to advise public officials and to contribute to planning.

The workgroup also was interested in follow-up to DSHS’ 2014 Crisis Standards of Care Initiative. A 2010 report developed for DSHS provided an ethical framework for allocating scarce health resources in a disaster. The purpose was to support local decisionmaking when planning and managing health resources in a pandemic; such a public health emergency can severely strain resources, physicians, health care providers, and facilities for a long period. To building on the 2010 report, the 2014 DSHS initiative was created to bring together physicians, public officials, and others engaged in emergency planning and decisionmaking to create a Texas framework for developing local crisis standards of care.

Members of the workgroup noted the role of hospitals and hospital systems in developing medical standards of care for emergencies and that numerous CMSs have developed such standards. Yet local planning is now more difficult because these facilities often serve multiple jurisdictions, making it more complex for local CMSs to be engaged in their efforts. Members expressed support for the state’s initiative and recommended renewed efforts to follow through in developing a state framework for planning.

An issue not addressed in the CMS survey was the need for a strong physician identification system when a disaster occurs in an area to ensure efficiency and so that only qualified medical volunteers can return to their home or to get access a critical area. While physicians who are registered with a local and/or state/federal volunteer system will have such identification, there does not appear to be a uniform system for a physician who is evacuated from an area and needs to return to his or her location.

After careful review, the council agreed the existing policy needed substantial changes. The council drafted the following language to reflect changes in law, stress the important role of communications, and highlight opportunities for county medical societies. The council makes the following recommendations.
Recommendation 1: That TMA adopt the following as policy on Disaster Preparedness Planning and Response.

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 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
5. Monitor state laws governing practice and liability under these various disaster declarations and advocate for any needed legislative changes to address these issues.

Local Planning and Role of County Medical Societies
Because most disasters and emergencies are confined to a limited geographic area, planning and preparation must consider the local population, the local health care community, and available public health resources. CMSs can play an essential role in communicating with public health officials and with the health care community about planning and helping to coordinate a response when a local disaster occurs. TMA should help CMSs fulfill that role. TMA encourages CMSs to:

1. Improve physician awareness of state-required disease reporting, and state and local public health support systems;
2. Work with local public health departments to ensure physicians know how to have direct access to the local public health authority for guidance on confirmation and treatment of patients as needed during natural and biological disasters;
3. Educate their members on the essential aspects of terrorism and disaster medicine through continuing medical education programs at state society meetings and articles in state society journals and newsletters, with special focus given to training on incident command structure, basic and advanced disaster life support, and triage for physicians and health care providers;
4. Work with the local health department to compile and maintain a contact list of physicians (both member and nonmember) in the community and to ensure that physician-friendly reporting mechanisms are in place and that a two-way flow of information exists to provide incentives for physician collaboration, and maintain a database of volunteer physicians by promoting the state Texas Disaster Volunteer Registry and the federal Emergency System for Advance Registration of Volunteer Health Professionals, and tracking member participation in other disaster response organizations (e.g., local health facility response, Texas Medical Rangers, Medical Reserve Corps, Disaster Medical Assistance Teams, Texas National Guard);
5. Encourage local communities to identify a designated infection control practitioner who could provide basic infection control guidance to prevent exposure to or transmission of infectious diseases in the community and for special high-risk populations;

6. Maintain an ongoing relationship with their local or regional public health departments; CMSs should consider inviting the local or regional public health director to give a public health update to the society at least annually and to advocate for the local board of public health to appoint a CMS representative as a consultant to the board;

7. Provide a venue for physician education, work with local sponsors of continuing medical education, and identify members who are particularly interested and may become peer leaders and educators;

8. Participate in practice drills and exercises that involve local health departments and local emergency response.

Information for Physicians
As state and local disaster planning and preparedness evolve, physicians must have access to current information, particularly relating to public health emergencies involving bioterrorism and emerging infectious disease. TMA can assist with information that will:

1. Ensure that physicians understand the circumstances in which quarantine is appropriate and how to carry out complementary, previously determined roles in their practices regarding surveillance, health care, and public information;

2. Encourage medical educators at all levels to participate in training physicians in the essentials of disaster and terrorism medicine relevant to their practice and specialty;

3. Encourage physicians and their staff organizations to advocate for these disaster planning measures in their health care facilities;

4. Encourage DSHS and the Texas Department of Emergency Management to provide updates and information on resources for physicians for disaster planning; and

5. Encourage individual physicians to have a strategic plan for everything from evacuating their office building and protecting employees during a communicable disease outbreak to maintaining continuity of their practice and communication with their families, and provide templates and guidelines for these types of plans to physicians.

Recommendation 2: Delete TMA policies 260.076 All Hazards Disaster Planning and 260.067 Disaster Preparedness.

Recommendation 3: That TMA encourage the Department of State Health Services to proceed with its initiative to establish a state framework for crisis standards of care and to encourage local community development and active physician participation.

Related TMA policies:

100.17 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).

260.065 **Bioterrorism:** The Texas Medical Association asserts the importance of state level responsibility for public health preparedness, in ensuring an infrastructure capable of protecting the public health in the event of a terrorist strike, bioterrorist attack, or even natural disaster. TMA recommends appointment of a local health authority or a physician with public health experience and a strong background in infectious disease or bioterrorism to serve as the public health and medical operations director for any bioterrorism emergencies (CPH Rep. 3-I-01; amended CSPH Rep. 3-A-12).

20.008 **Minimum Disaster Preparedness Standards for Assisted Living:** 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).

**Related AMA policies:**

**All Hazards Disaster Preparedness and Response D-130.972**
Our AMA will work with: (1) subject matter experts at the national level to quickly produce a provider manual on state licensure and medical liability coverage for physicians during disasters; (2) appropriate medical, public health, disaster response and relief organizations to improve plans, protocols, and policies regarding the provision of health care in mass evacuation shelters; and (3) appropriate state and local organizations to develop templates for private practice/office continuity plans in CD-ROM or web-based format that can be stored in state medical association offices on a server in the event of a disaster.

**AMA Leadership in the Medical Response to Terrorism and Other Disasters H-130.946**
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.

Emergency Preparedness D-130.974
Our AMA (1) encourages state and local public health jurisdictions to develop and periodically update, with public and professional input, a comprehensive Public Health Disaster Plan specific to their locations. The plan should: (a) provide for special populations such as children, the indigent, and the disabled; (b) provide for anticipated public health needs of the affected and stranded communities including disparate, hospitalized and institutionalized populations; (c) provide for appropriate coordination and assignment of volunteer physicians; and (d) be deposited in a timely manner with the Federal Emergency Management Agency, the Public Health Service, the Department of Health and
Human Services, the Department of Homeland Security and other appropriate federal agencies; and (2) encourages the Federation of State Medical Boards to implement a clearinghouse for volunteer physicians (MDs and DOs) that would (a) validate licensure in any state, district or territory to provide medical services in another distressed jurisdiction where a federal emergency has been declared; and (b) support national legislation that gives qualified physician volunteers (MDs and DOs), automatic medical liability immunity in the event of a declared national disaster or federal emergency.

Physician Identification in Emergencies H-130.943

Our AMA, through the Center on Public Health Preparedness and Disaster Response, will continue to: (1) monitor the development of volunteer registration systems, such as Emergency System for Advanced Registration of Volunteer Health Professionals (ESAR-VHP), as well as volunteer organizations, such as the Medical Reserve Corps (MRC), and report back as appropriate; and (2) support the development of laws and policies such as license reciprocity and civil liability protections that encourage physicians to volunteer services during disasters.

References
Subject: Parental Leave

Presented by: David Lakey, MD, Chair

Referred to: Reference Committee on Science and Public Health

The Committee on Maternal and Perinatal Health (CMPH) submitted a report on parental leave to the 2016 House of Delegates. The report was referred to the Board of Trustees and the council for further study. CMPH made three recommendations on parental leave: that TMA (1) promote awareness and education for physicians, legislators, and the public on the importance of adequate parental leave, especially paid leave, in ensuring good maternal and infant health outcomes and promoting the health and well-being of the family; (2) advocate for state, local, and private adoption of parental leave policies that provide adequate time to give birth, recover, nurse new babies, and allow for parental bonding following the birth or adoption of a child; and (3) recommend at least 12 weeks of paid maternity leave and at least two weeks of paid paternity or partner leave following the birth or adoption of a child.

Background
Public awareness has increased regarding the availability of extended leave for parents caring for a newborn — particularly as more U.S. jurisdictions and countries are offering paid family and medical leave. Various studies have shown that strong family relationships in the early months of life support the development and well-being of children — and especially support breastfeeding initiation and continuation, which have been associated with a not quick return to work after childbirth. This has served as a compelling reason for breastfeeding workplace protections now in place in Texas and other states.

Authorized in 1993, the Family and Medical Leave Act (FMLA) ensures eligible workers have at least 12 weeks of job-protected leave. FMLA-covered employers include private businesses that have 50 or more employees, although many states have adopted more comprehensive FMLA requirements. More than half of U.S. employees work in covered workplaces and are eligible for the protections of the FMLA; however, only a fraction of all U.S. workplaces are covered by FMLA. Along with the growing public interest in paid parental leave have been multiple bills filed in Congress to provide paid medical and family-related leave.

U.S.-based studies on the outcomes for newborns or for parents with parental leave, and paid parental leave in particular, are not readily available. However, one study found that women who had at least 12 weeks of parental leave were five times more likely to return to work than those who had fewer than six weeks — regardless of whether leave was paid or unpaid for either group. Yet these benefits may not occur with children of employed single mothers or mothers without a college education, who are more likely to have limited income and other limits on resources.

Paid Leave
While FMLA and states ensure medical leave for qualified employees, neither federal law nor most states including Texas require a covered employer to pay for FMLA leave. The International Labour Organization reports that the United States is one of the few industrialized countries that do not mandate paid maternity leave (of 167 countries surveyed), although the length of leave (84-140 days) and amount of pay (60-100 percent) vary across countries. The duration of the paid period also may not cover the full maternity leave period.
A 2012 U.S. Department of Labor report noted that only 21 percent of those taking FMLA leave for their own illness took leave for pregnancy or a new child. The report also showed that most of those taking medical leave under FMLA receive some pay, although pay drops significantly when leave lasts longer than 10 days. The lack of payment is reported as a common reason for returning to work. And of those employees who were paid while on FMLA leave, 11.8 percent had maternity leave pay and 6.8 percent had paternity leave (i.e., not personal, sick, or vacation leave).

Today only four states (California, Rhode Island, New Jersey, and New York [effective 2018]) mandate some form of paid parental leave. Connecticut has a “temporary disability” insurance program for covered employees of either a private or a public employer who requires leave during a pregnancy or postpartum, a work-related illness, or to care for a family member who is ill. The insurance program offers up to two-thirds of the employee’s salary for up to six weeks.

Discussion and Recommendations

There is not a definition of parental leave in Texas law. In countries and states with parental leave, statutory language refers to the medical conditions and employment requirements for employers’ and employees’ use of parental leave. Yet the importance of parental leave is not controversial in the medical community. All can agree that a newborn or newly adopted child greatly benefits both developmentally and socially when a parent is present; developing a relationship through nurturing care, learning about the unique characteristics of the child and having regular interaction with the newborn’s physician all are particularly important in the early months of life. Where there is not clear guidance in relation to parental leave is the length of leave beneficial for child health, whether parental leave should be available to both mother and father, and the payment source and proportion of pay that should be ensured.

Intended to protect employment and maintenance of benefits for employees, the FMLA benefit is widely used by eligible employees for many qualifying events, including pregnancy and care of a newborn. The initial preamble of the 1993 FMLA legislation spoke to the importance of FMLA in supporting the participation of mothers and fathers to aid in the development and rearing of a child and to support the family unit. The provision of FMLA benefits remains one of the most significant benefits to U.S. employees, especially as the economy has expanded, with women representing a greater part of the paid labor force in all areas of our economy. Seventy percent of the U.S. female labor force has one or more young children under age 18, and in 40 percent of U.S. households, the mother is the primary or sole financial provider for the children.

Among the studies on the benefits of FMLA-parental leave, one notes that the greatest benefits from paid parental leave are to those who are low-income and with limited resources:

Children of poor, single and low-educated working mothers are a key vulnerable population that was not reached by the FMLA. However, these children and their families may benefit the most from policies that enable their mothers to take time off work during their early life without substantial losses in income. These mothers are often forced to work immediately after childbirth, and their newborn children are then placed in low-quality childcare. Their children already stand at a disadvantage for their later-life opportunities as they are born into low socio-economic status families, and lack of maternal time during their first few months of life may exacerbate this disadvantage.

There was wide support at the House of Delegates for parental leave, especially as it supports the initiation and extension of breastfeeding, about which TMA has strong policy. But there also was testimony on concerns with TMA endorsing paid parental leave — particularly regarding the financial
impact to small businesses such as medical practices, and also the a lack of evidence for a specific
timeframe beneficial to the child and the mother.

Regardless, the availability and health benefits of parental leave are clear, and paid parental leave
provides an obvious economic benefit. In spite of the fact that Texas is recognized as having a strong
economy, Texas also has a diverse working population, many of whom work in businesses without
benefits common for others such as covered leave for a medical event. This means many low-income
Texans simply cannot take advantage of the health and economic benefits of parental leave regardless of
the duration of the leave. The explosive population growth in Texas makes this issue even more
significant.

TMA must take a clear position on the benefits of parental leave but also seek to inform others of the
benefits of parental leave to the family and our economy. This requires a clear understanding of the
known benefits of parental leave so we can help guide the expansion of paid parental leave, especially for
families most in need of critical health and economic benefits — a growing component of our Texas
population. The council therefore recommends that in lieu of adopting the recommendations in the CMPH
report as submitted, that TMA adopt the following policy on parental leave.

**Recommendation 1:** That TMA 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.

**Recommendation 2:** That TMA 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.

**References**

1. Family and Medical Leave in 2012: Executive Summary, September 2013;
2. For example, the Family and Medical Leave Insurance Act (FAMILY); the Balancing Act, 2011; Healthy
3. Guendelman, el al., Work-Family Balance After Childbirth: The Association Between Employer-Offered Leave
   Characteristics and Maternity Leave Duration.
4. Maternity at Work, a review of national legislation, 2nd edition,
   www.ilo.org/wcmsp5/groups/public/@dgreports/@dcomm/@publ/documents/publication/wcms_124442.pdf;
6. Exhibit 5.3.5. Pay while on most recent leave in the past 12 months, by duration of leave, Family and Medical
8. Rossin, M, The Effects of Maternity Leave on Children’s Birth and Infant Health Outcomes in the United
9. TMA policy 140.008 endorses at least six months of breastfeeding for maternal and infant health and programs
   and policies that support initiation of breastfeeding.
TMA periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness. The Council on Science and Public Health’s analysis and recommendations for retention, deletion, or amendments of policies are summarized in this report.

The following policies are recommended for retention:

### 30.003 Laser Surgery:
Laser surgery should be performed only by individuals licensed to practice medicine and surgery or by those categories of practitioners currently licensed by the state to perform surgical services (Interspecialty Society Committee, p 22, I-91 reaffirmed CSA Rep. 2-A-02).

### 30.024 Electrologists Regulation and Licensing:
The Texas Medical Association supports establishment of guidelines for the regulation and licensing of electrologists and to define the scope of practice to be limited to “needle” and “tweezer” hair removal. In addition, TMA supports development of a formal requirement for education in the prevention of disease transmission during hair removal procedures (Resident Physician Section, p 136, A-97; reaffirmed CSA Rep. 4-A-07).

### 260.078 Mandated Patient Information:
The Texas Medical Association opposes state mandates dictating specific patient-physician communication without endorsement of the appropriate professional medical organization(s) (CM-MPH Rep. 2-A-07).

### 280.032 Definition of Surgery:
The Texas Medical Association adopts the following definition of surgery from American College of Surgeons Statement ST-11:

Surgery is performed for the purpose of structurally altering the human body by the incision or destruction of tissues and is part of the practice of medicine. Surgery also is the diagnostic or therapeutic treatment of conditions or disease processes by any instruments causing localized alteration or transposition of live human tissue which include lasers, ultrasound, ionizing radiation, scalpels, probes, and needles. The tissue can be cut, burned, vaporized, frozen, sutured, probed, or manipulated by closed reductions for major dislocations or fractures, or otherwise altered by mechanical, thermal, light-based, electromagnetic, or chemical means. Injection of diagnostic or therapeutic substances into body cavities, internal organs, joints, sensory organs, and the central nervous system also is considered to be surgery (this does not include the administration by nursing personnel of some injections, subcutaneous, intramuscular, and intravenous, when ordered by a physician). All of these surgical procedures are invasive, including those that are performed with lasers, and the risks of any surgical procedure are not eliminated by using a light knife or laser in place of a metal knife, or scalpel.
Patient safety and quality of care are paramount and, therefore, patients should be assured that individuals who perform these types of surgery are licensed physicians (defined as doctors of medicine or osteopathy) who meet appropriate professional standards (Amended Res. 306-A-07).

**Recommendation 1**: Retain

Council review of the following policies revealed that these are no longer relevant and are being recommended for deletion.

**260.027 Mobile Scanning Services**: Seven minimum standards of practice and five additional consultant responsibilities should provide physicians of Texas and the patient entrusted to their care the best available consultation by nuclear medicine physicians in every location where these consultations occur (These standards and responsibilities should not, however, be construed as an endorsement of the concept of mobile scanning service):)

1. The physician consultant will engage only in that practice in which he or she is qualified and properly licensed in Texas, including rendering an interpretation of the procedure.

2. The physician consultant will accept responsibility for, and assure the quality of, the technical aspects of the procedure.

3. The physician consultant will accept only those practice arrangements which will assure his or her supervision of the technical quality of the procedure.

4. The physician consultants’ interpretation will not be rendered in the absence of clinical information requisite to an optimal interpretation of the study.

5. The physician should make every attempt to assure that a reasonable professional fee, and a hospital charge when appropriate, will be rendered and properly identified.

6. The physician consultant will assure that all acts of the nuclear medicine procedure, including professional consultation, technical services, and radiation safety performed with a commercial operator at any location, are comparable to those which would prevail in the physician consultants private office, or in an institution in which he or she has staff privileges in nuclear medicine, including the standards of practice described in paragraphs (1)-(6).

7. The physician consultant will assure that images are stored either by the facility performing the study or by the patient/referring physician so as to be available for future comparison.

The nuclear physician consultant shall be wholly responsible for:

1. The choice and amount of radiopharmaceutical to be used.

2. The administration of that radiopharmaceutical. (If the radioactive substance is to be administered by another individual, the qualifications of that individual will be stipulated by the Texas Health and Human Services Commission and its appropriate agency councils.)
(3) The supervision of the performance of the procedure and the quality of the resultant data
and/or images.

(4) The submission of an oral and/or written consultation within an appropriate interval not to
exceed 24 hours. The nuclear medicine procedure will be of quality comparable to that
available in the hospital with its own nuclear medicine department and as if the mobile
services were unnecessary (Radiation Advisory Committee, p 138, A-94; amended CSA Rep.
3-A-05).

260.079 Coal Power Plant and Diesel Emissions in Texas: The Texas Medical Association urges
our state government leaders and legislators to act to reduce pollution from coal-fired power
plants and diesel engines. Steps might include:

• Requiring the immediate installation or retrofitting of technology highly efficient in
reducing all forms of air pollution, including ozone-causing pollutants, particulates,
carbon dioxide, and mercury on all existing and future coal-fired power plants;

• Ending state subsidies for polluting coal-fired power plants and levying a tax on coal,
equivalent to that on natural gas, sufficient to pay future federal levies on pollution
damage;

• Placing a moratorium on approval of old-technology coal-fired power plants; and

• Requiring an addition to the state diesel retrofit program to include particulate controls
(Res. 201-A-08).

Recommendation 2: Delete

Upon review of the following policies, council consensus was to update the language to read as follows:

10.002 Abortion: The Texas Medical Association guidelines recognizes abortion as a legal medical
procedure, for and the performance of abortion are must be based upon early and accurate
diagnosis of pregnancy; informed and nonjudgmental counseling; prompt referral; to skillful
and understanding personnel working in a good facility; reasonable cost; and professional
follow up (Remarks of Speaker, p 12, A-85; reaffirmed: Council on Public Health, p 105, I-
89; Res. 28WW, p 218-D, A-92; Res. 28J, p 168, A-94; and Council on Health Facilities, p

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 82(R) HR 15. To protect the integrity of the patient-physician
relationship, TMA urges the Texas Legislature to amend 82(R) HR 15 to allow the sonogram
requirement be waived based on physicians’ clinical judgment 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).
215.019 **Public Mental Health Care Funding:** Despite increases in funding from the Texas Legislature for the mental health care system, Texas still struggles to provide optimal psychiatric care for those in need. The Texas Medical Association therefore supports: (1) advocates state efforts to provide the public mental health system with funding adequate sufficient to for addressing the spectrum of such common to severe mental illnesses across the lifespan for all in need impacting the state; proper governance of these funds is necessary to ensure that funds serve as many people with mental illnesses as possible and that efficiencies are identified within the system to save dollars when possible; (2) state efforts to ensure that appropriated advocates prioritized state funding that will address the full spectrum of mental health addressing funding shortages, and increasing funding for crisis services are used to provide best practices for patients in a cost-efficient manner for taxpayers; (3) equity of reimbursement for primary care providers offering will work at state and federal levels to facilitate mental health authority and other behavioral health care in a primary care setting as a way of improving access to mental health care safety net providers in obtaining access to lower pharmaceutical prices through the existing 340 (b) drug program under the federal Office of Pharmacy Affairs; and (4) innovative and evidence-based approaches for the early detection and prevention of mental illness will work for legislation to assure that primary care providers are reimbursed for behavioral health care appropriately provided in a primary care setting (Res. 201-A-07).

260.077 **Clean Air in Texas:** The Texas Medical Association urges our state government leaders and legislators to take action and establish an energy policy that will stimulate energy savings, help to clean up the air, and encourage nonpolluting renewable energy sources. Steps might include: Physicians recognize that exposure to air pollution adversely affects the health of patients. We can advocate for clear principles and goals when it comes to clean air and support:

1. Reducing all forms of air pollution, including particulates, gases, toxicants, irritants, smog formers, and other biologically and chemically active pollutants;
2. Community-based efforts wherever air pollution is producing widespread environmental effects or physiological responses, particularly if a significant incidence of chronic respiratory diseases in the community accompanies these responses;
3. Prevention programs in areas where population and industrial trends can predict the above conditions;
4. Publicly funded resources and programs at the local, regional, or state level with jurisdiction over the respective sources of air pollution and the population and areas immediately affected, to bring about equitable and effective control;
5. National primary and secondary ambient air quality standards at the level necessary to protect the public health, including setting such standards at a level “allowing an adequate margin of safety,” as provided in current law, while supporting more scientific research on the health effects of standards the Environmental Protection Agency has set;
6. Protecting certain geographic areas (i.e., those with air quality better than the national standards) from significant quality deterioration by requiring strict, but reasonable, emission limitations for new sources;
7. A more effective hazardous pollutant program to allow for efficient control of serious health hazards that airborne toxic pollutants pose;
8. Research on the health effects of pollution and procedures to control pollution;
9. Setting a goal of meeting the national ambient air quality standards for nitrogen oxides and carbon monoxide for the long-term benefit of the public health;
10. Emission limitations for motor vehicles as a long-term goal;
11. Including physicians and county medical societies in regional and state decisionmaking regarding air pollution across Texas; and

12. The appointment of a TMA member with public health expertise as a commissioner to the Texas Commission on Environmental Quality, which would help the agency fulfill the mission statement of protecting the public’s health.

TMA will continue to promote education aimed at members and the general public to increase awareness of the health effects and cost of air pollution. Some other actions in Texas would be to:

- Requiring clean coal gasification technology for future coal-based power plants.
- Approving a tax on coal at least equal to the longtime tax on clean-burning natural gas.
- Require the immediate installation or retrofitting of technology highly efficient in reducing all forms of air pollution including ozone-causing pollutants, particulates, carbon dioxide, and mercury on all existing and future coal-fired power plants.
- End state subsidies for polluting coal-fired power plants.
- Require clean coal gasification technology for future coal-based power plants.
- Encouraging proposals to expand renewable energy sources, such as solar and wind, and to expand the grid expansion required to deliver the resulting renewable energy to our urban and rural markets.
- Offering incentives for power companies to provide businesses and consumers with hourly electricity pricing meters that will enable savings through shifting power usage to off-peak hours. New power plants are mainly needed mainly to supply peak demands on hot summer days; financial incentives to shift usage to off-peak hours can mitigate this need.
- Using energy tax revenues to extend attractive financial incentives to citizens for reducing energy consumption and investing in alternative home and business energy systems, such as solar and wind.
- Phasing-in strict gas mileage requirements for automobiles sold or licensed in the state.
- Scientifically evaluating and promoting energy conservation measures for homes, businesses, and public buildings to decrease Texas energy consumption.
- Bringing into compliance many of the chemical plants, refineries, and power generating stations with that have the highest pollution emissions which but are grandfathered and do not have to comply with Texas and EPA emission standards.
- Placing a moratorium on approval of old technology coal-based power plants.
- Require an addition to the state diesel retrofit program to include particulate controls.


**260.047 Low-Level Radioactive Waste Disposal:** The Texas Medical Association recognizes that many activities of society giving rise to low-level radioactive wastes are useful. Such activities include diagnosis and treatment of disease, research in science and medicine, and industrial uses such as generating electricity, detecting metal fatigue, and discovering oil supports development of a state of the art disposal facility operated by the Texas Low-Level Radioactive Waste Disposal Authority that will fully comply with applicable regulations and protect the health and environment of Texas. TMA therefore adopts the following guidance as stated in the policies of the American Medical Association on low-level radioactive disposal: (1) The rules and recommendations for radiation protection promulgated by the U.S. Nuclear Regulatory Commission, the U.S. Environmental Protection Agency, the National Council on Radiation Protection and Measurements, and the
International Commission on Radiological Protection ensure that disposal facilities for low-level radioactive wastes will be built and operated in a manner that protects the safety of workers and the public. (2) Physicians should inform their patients and help inform the public about the many beneficial uses of radioactive materials and about the measures and standards that are in place to reduce unnecessary exposures to these materials. (3) Physicians should minimize the diagnostic and therapeutic exposures of patients to ionizing radiation in accord with good medical practice.

In support of the management of low-level active radioactive waste, TMA also recommends that:

• Any site for the disposal of low-level radioactive waste be rejected by the Nuclear Regulatory Commission unless all applicable statutes and regulations are fully satisfied;

• Texas should be responsible for providing capacity within or outside the state for disposal of commercial, nonmilitary, low-level radioactive waste generated within its border — TMA urges Environmental Protection Agency action to ensure capacity for disposal of low-level radioactive waste — and, moreover, the Texas Department of State Health Services should develop the rules for storage of radioactive waste, while the Texas Commission on Environmental Quality is responsible for managing the licensure of disposal sites; and

• Texas reiterate its endorsement of the process now in place for dealing with the disposal of low-level radioactive wastes, which involves the formation of compacts among the 50 states and the construction of regional facilities. TMA encourages physicians to support and assist state agencies and others responsible for planning the safe disposal of low-level radioactive waste (Res. 290, p 160, A-97; Res 21-I-02; amended CSA Rep. 4-A-07).

260.048 Manganese in Gasoline: The Texas Medical Association is concerned that widespread use of manganese carbonyl (MMT) in the U.S. gasoline supply might have the potential for placing high-risk populations at special risk of manganese toxicity and joins the American Medical Association in supporting further federal research into its health effects (Committee on Environment, p 110, A-97; reaffirmed CPH Rep. 2-A-07).

270.004 Electromyography: Clinical diagnostic Electromyography (EMG) is a diagnostic procedure used to clinically diagnose a medical condition. This examinations involves the selection of the appropriate muscles to be studied, modifying the examination as the data unfolds, inserting the needle electrodes, recording and interpreting the data obtained, describing the findings, and rendering of a diagnostic opinion based upon an integration of the clinical history, physical examination features, other pertinent clinical data, and the electromyographic findings. As this constitutes the practice of medicine, EMG should be performed only by a physician fully licensed in Texas who is also qualified by reason of education, training, and experience in these procedures. When intraoperative EMG monitoring is performed, it should be supervised either directly or via remote real time telemetry by a physician fully licensed in Texas who also is qualified by reason of education, training, and experience in these procedures. TMA supports, as a patient safety component, the active enforcement of these physician credentialsing requirements (Committee on Rehabilitation, p 169, A-96; amended CSA Rep. 4-A-07).

280.021 Stroke Prevention Awareness: The Texas Medical Association recognizes that increasing public awareness of the early signs and symptoms of a stroke (“brain attack”) is essential to
prevention of death and disability from stroke. Early recognition of the warning signs of
stroke and immediate emergency medical attention can prevent death and reduce disability
from stroke. It favors collaboration with other concerned organizations, such as the American
Medical Association, National Institute of Neurological Disorders and Strokes, National
Stroke Association, American Academy of Neurologists, and American Health Association,
encouraging them to develop an effective media campaign to improve public awareness of
and response to stroke symptoms. TMA endorses coordinated state level data collection and
surveillance to improve prevention and care for stroke “brain attack” and myocardial
infarction “heart attack” (Medical Student Section, p 188, A-96; reaffirmed CSA Rep. 4-A-
07).

Recommendation 3: Retain as amended
TMA periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness. The Committee on Child and Adolescent Health reviewed the following policies and offers recommendations for retention, amendment, and deletion.

The following policy is recommended for retention:

55.051 Corporal Punishment in Schools: The Texas Medical Association supports the abolition of corporal punishment in schools and encourages teacher training that emphasizes alternative forms of discipline (CM-CAH Rep. 1-A-07).

Recommendation 1: Retain.

The committee recommends amending the following policies:

55.040 Child Abuse Reporting Laws: The Texas Medical Association supports beliefs in restoring child abuse reporting laws governing child abuse reporting that recognize the use and value allow for the use of professional judgment in determining when sexual activity by a minor represents abuse. TMA urges physicians to encourage their minor patients to talk to their parents regarding sexual activity but also recognizes the importance of confidential patient care. In the interest of ensuring access to confidential care for minors that protects their health, encourages minors to talk to their parents, encourages them to make responsible decisions regarding sexual activity, and detects and prevents child abuse (CM-MPH Rep. 2-I-04).

Recommendation 2: Retain as amended.

The committee recommends deleting the following policies:

55.025 Child and Health Safety: The Texas Medical Association supports educational efforts to increase knowledge about normal child development and age appropriate discipline, to be a part of educational curricula in middle school, high school and during medical school training. Components of the initiative include (1) increasing parental knowledge about the
emotional and developmental needs of children; (2) encouraging communication; (3) fostering healthy lifestyles by recommending regular medical checkups and one-on-one counseling; (4) teaching parents how to deal with stressors; and (5) providing community referrals (Council on Public Health, p 75, A-97; reaffirmed CM-CAH Rep 2-A-07).

Healthy Families Program: The Texas Medical Association supports increased state funding for the Healthy Families program (formerly called Healthy Start) (Committee on Child and Adolescent Health, p 107, A-97; reaffirmed CM-CAH Rep. 2-A-07).

Recommendation 3: Delete.
TMA periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness. The committee reviewed the following policies and offers recommendations for retention and amendment.

The following policy is recommended for retention:

**260.050 Hepatitis B Vaccine**: The Texas Medical Association supports prenatal screening for Hepatitis B and universal Hepatitis B vaccination of children and infants according to Advisory Committee on Immunization Practice (ACIP) recommendations (Committee on Child and Adolescent Health, p 84, I-97; amended CM-CAH Rep. 2-A-07).

**Recommendation 1**: Retain.

The committee recommends amending these policies as follows:

**135.009 Immunizations Pneumococcal Pneumonia 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’s Advisory Committee on Immunization Practices (Committee on Infectious Diseases, p 112, A-97; reaffirmed CM-ID Rep. 1-A-07).

**135.014 Adolescent Vaccines**: The Texas Medical Association supports the Centers for Disease Control and Prevention’s Advisory Committee on Immunization Practices’ recommendations schedule for adolescents that (1) 11- and 12-year-olds receive a vaccine against meningococcal disease. Catch-up vaccinations should be offered to those entering high school and to college students, especially freshmen; and (2) 12-year-olds receive a booster vaccine against pertussis. (CM-ID Rep. 2-A-06).

**Recommendation 2**: Retain as amended.
TMA periodically reviews House of Delegates policies in the association’s Policy Compendium for relevance and appropriateness. The Committee on Reproductive, Women’s, and Perinatal Health’s analysis and recommendations for retention, deletion, or amendments of policies are summarized in this report:

Upon review of the following policies, committee consensus was to update the language to read as follows:

**330.007 Folic Acid:** The Texas Medical Association supports the guidelines and recommendations of the Centers for Disease Control and Prevention and the American College of Obstetrics and Gynecology on folic acid consumption in women of childbearing age to reduce birth defects, encourages broad-based public education about the need for women with childbearing potential to consume an adequate level of folic acid (400 micrograms per day) through intake of a well-balanced diet and supplemental vitamins to reduce the risk of a child with a neural tube defect. Women with a prior history of pregnancy affected by a neural tube defect should consult closely with their physician on appropriate prevention steps before considering another pregnancy.

TMA encourages the Food and Drug Administration (FDA) to continue its rulemaking process expeditiously to require comprehensive fortification of all grains marketed for human consumption, including grains not carrying the "enriched" label, with folic acid at an appropriate level to reduce the risk of neural tube defects. Based on available data, TMA believes an appropriate fortification level for cereal grain products is 350 micrograms per 100 grams of cereal grain needed to achieve a reduction of neural tube defects. FDA is also encouraged to require food, food supplement, and vitamin labeling to specify milligram content, as well as RDA levels, for critical nutrients, which vary by age, gender, and hormonal status (including anticipated pregnancy).

TMA encourages the Centers for Disease Control and Prevention and the Texas Department of State Health Services’ ongoing surveillance of folic acid-related birth defects and urges this data be used as a tool for preventing reoccurrence of birth defects that could possibly be averted by folic acid consumption by women during pregnancy, give priority to establishing monitoring programs to assess implementation and effect of the neural tube defect prevention programs.

TMA supports safe, evidence-based approaches, including educational opportunities, for improving adherence to folic acid consumption recommendations that affect the general population such as folic acid fortification in all grain products. TMA encourages Texas-serving grain product manufacturers to comply with the U.S. Food and Drug Administration’s minimum requirements for folic acid enrichment in all grain products.
TMA encourages the National Institutes of Health and Centers for Disease Control and Prevention to fund basic research, epidemiologic studies, and clinical trials to assess expeditiously the causal and metabolic relationships among homocysteine, vitamins B12 and B6, and folic acid, so as to reduce the risks for and incidence of associated diseases and deficiency states, such as low birth weight babies associated with reduced levels of folate in red blood cells. TMA also encourages research efforts to identify and monitor those populations potentially at risk for masking vitamin B12 deficiency through routine folic acid supplementation of enriched food products (Council on Scientific Affairs, p 160, A-96; amended CSA Rep. 5-A-07).

Recommendation 1: Retain as amended.

330.001 **Folic Acid Supplementation**: The Texas Medical Association supports tracking neural tube defects using the Texas Department of State Health Services' birth defects registry and the state's continued efforts to inform practicing physicians and women of child-bearing age of the Centers for Disease Control and Prevention's recommendations for folic acid supplementation as a means to help reduce the incidence of neural tube defects (Committee on Maternal and Child Health, p 134, A-92; amended CSE Rep. 1-A-10).

Recommendation 2: Delete
Resolution 310, introduced by the Medical Student Section at A-16, recommended that the Texas Medical Association: (1) work with the Texas Department of State Health Services (DSHS) and other stakeholders to support increased research on newborn falls, (2) encourage education of parents and health care professionals on risk factors and prevention of newborn falls in Texas hospitals, and (3) support implementation of newborn fall prevention plans and post-fall care protocol in Texas hospitals. The resolution was referred with report back to the House of Delegates at the 2017 Annual session.

Testimony in reference committee favored referral, in part as an opportunity to better understand the issue and any related issues.

The Committee on Child and Adolescent Health (CCAH) and the Committee on Reproductive, Women’s, and Perinatal Health (CRWPH) created a workgroup to review the data and study the topic. The committees looked at the evidence and identified opportunities to continue to investigate this topic.

There are few published studies on the topic either estimating the size of the problem or identifying risk factors related to newborn falls. However, a few studies of hospital systems have estimated 600-1,600 newborn falls occur each year in U.S. hospitals. In a nine-year analysis of Pennsylvania patient safety data by that state’s patient safety agency, newborn falls were the most common events related to the safety of newborns while in the care of their families. The rate of newborn falls in the Pennsylvania study increased over the nine years from 0.4 to 3.8 in-hospital newborn falls per 10,000 births.

The Institute of Medicine and The Joint Commission have identified patient falls as a prevalent patient safety problem. The reporting of fall rates among adult and elderly patient populations is an important part of patient quality and safety programs. Falls are the leading cause of nonfatal injury among pediatric patients under age 19 years. However, there is no widely accepted national quality measure associated with newborn falls.

The American Nurses Association’s National Database of Nursing Quality Indicators incorporates a definition of newborn fall or drop: “A fall in which a newborn, infant, or child being held or carried by a healthcare professional, parent, family member, or visitor falls, or slips from that person’s hands, arms, lap.” Falls can occur during delivery, during transport, or during the postpartum period with the mother or another caregiver.

The American Academy of Pediatrics (AAP) does consider infant falls a possible safety concern during the practice of skin-to-skin care immediately after birth. Further, AAP points to falls as a possible risk during the practice of rooming-in, whereby the newborn stays in the hospital room with the mother, especially if a mother falls asleep while holding the infant. The literature suggests some common factors contributing to falls are fatigue, breastfeeding or bottle feeding, cesarean birth, and pain medication.
Currently, no ICD-10 code specifically addresses in-hospital newborn falls, which allows these incidents to go unseen in claims data and other reporting measures. Attending clinical staff report anecdotally that infant family members commonly fail to report an in-hospital newborn fall because of guilt or no perceived injury. Hospitals have begun monitoring the issue and collecting data internally but are not required to report these statistics to a state entity, e.g., the Texas Department of State Health Services (DSHS). In Texas, hospitals are required to report preventable adverse events, including falls, but only if they are associated with death or severe harm.

Hospitals in multiple states have initiatives that include newborn falls as part of a comprehensive fall prevention strategy or newborn safety program. However, little published material provides evidence-based recommendations on interventions. Some of the initiatives include patient and nurse education, increased supervision, risk assessments, and policy changes. Some Texas hospital systems have started examining in-hospital newborn falls and are in different stages of investigating or implementing initiatives related to newborn falls.

Texas Department of Family and Protective Services (DFPS) and Department of State Health Services

Texas state-led initiatives, such as Healthy Texas Babies and Safe Sleep for Babies: A Community Training, are aimed at reducing infant mortality, morbidity, and hospitalization, yet in-hospital newborn fall incidence and relevance remains an elusive occurrence. While unintentional falls are the top cause for hospitalization for pediatric patients in Texas, DSHS does not publish data specific to in-hospital falls for newborns as part of the injury surveillance program.

The statewide Healthy Texas Babies initiative is aimed at decreasing infant mortality; however, it has not addressed newborn falls. DFPS and DSHS offer free training modules on safe sleep that cover safe sleeping positions, bed-sharing, and crib safety.

Related Policy

TMA Policy 140.008 Breastfeeding and Human Milk supports breastfeeding initiatives such as baby-friendly hospital programs, which include the practices of rooming-in. AAP’s Safe Sleeping Recommendations include room-sharing with infants sleeping on a separate surface. The policy also recommends health care providers endorse and model the recommendations in the hospital setting. In a recent clinical report on safer sleep during skin-to-skin contact, AAP recommends several strategies, including publicizing information about preventing falls throughout the hospital and implementing fall risk assessment tools.

In November, the American Medical Association adopted the following policy put forward by the AMA Medical Student Section: That AMA support implementation of newborn fall prevention plans and post-fall procedures through clinically proven, high-quality, and cost-effective approaches.

Discussion and Conclusion

The TMA workgroup commends the TMA Medical Student Section for drafting the resolution on newborn falls. The resolution identified an emerging topic not previously discussed by TMA. The workgroup agreed not to put forward any relevant policy recommendations to the TMA House of Delegates at this time. However, the workgroup outlined some strategies for uncovering more data, studying Texas-based efforts underway, and identifying opportunities for physicians. TMA’s CAH and RWPH committees, along with TMA staff, will continue to look at this issue and follow up with other stakeholders, including DSHS and the Texas Hospital Association.
Recommendation: That Resolution 310, Prevention of In-Hospital Newborn Falls, not be adopted.

References

Resolution 311, Sexual Orientation Change Efforts in Minors, introduced by the Medical Student Section at A-16, was referred to the Committee on Child and Adolescent Health for further consideration.

The resolution (1) called for TMA to (a) advocate for legislation banning conversion therapy for patients under 18 years of age in Texas on the basis that they are minors, and (b) support prohibiting state-licensed therapists from engaging in these scientifically discredited practices; and (2) held that regulated practices do not include therapies that provide support for youth or the facilitation of youth’s coping and identity exploration and development, including sexual orientation-neutral efforts to prevent or address unlawful conduct or unsafe sexual practices, or therapy that is designed to aid a person in a transition from one gender to another.

Testimony at the TMA meeting generally was supportive of the resolution’s intent. However, members stated that seeking legislation would be a concern for the association, as the topic would be so politically controversial that it would undermine other TMA efforts.

Discussion
Sexual orientation change efforts are commonly referred to as “conversion therapy” or “reparative therapy.” They include a variety of practices (including psychotherapy or other treatment) aimed at changing a person’s sexual orientation, gender identity, or expression.

In 2015, the American Psychology Association and the Substance Abuse and Mental Health Services Administration convened an expert panel to review the literature and provide information on therapies related to children’s sexual orientation and gender identity. The summary report affirms the following findings:

- Same-gender sexual orientation and variations in gender identity and expression are a part of the normal spectrum of human diversity. These variations are not mental disorders.
- Existing research does not support the notion that mental or behavioral health interventions can alter gender identity or sexual orientation.
- Interventions aimed at changing gender identity or expression, or sexual orientation should not be considered behavioral health treatment but are considered coercive and can be harmful.

More data are needed to further understand the health status and needs of lesbian, gay, bisexual, transgender, and questioning populations (LGBTQ). However, physicians recognize that discrimination and stigmatization, as well as other legal and social factors such as homophobia, contribute to health disparities among LGBTQ patients. In addition, youth face unique barriers and risks related to health, and it is understood that LGBTQ youth are at higher risk for suicide, sexual transmitted infections, and
substance use. Associations, including the American Academy of Pediatrics, recommend that health care for sexually minority youth be rooted in acceptance and support of the individual’s identity, and provide accurate information on the developing of sexual orientation and gender identity.

The frequency of use of conversion therapies in Texas or the United States is not well understood. Therapists do advertise services in Texas. Medicaid has no specific prohibition against these services. However, Medicaid services also must be considered medically necessary. Because evidence does not support conversion therapy, it is not clear how the state or Medicaid managed care organizations handle claims for these services. At least six other states and the District of Columbia, through statute or regulation, prohibit mental health practitioners from engaging in conversion therapy with a patient younger than 18 years old.

House Bill 569, introduced in Texas in 2017, would define an effort to change a child’s sexual orientation or gender identity as unprofessional conduct for mental health practitioners. The same bill was filed in 2015 in Texas but did not receive a hearing.

Summary and Conclusions
Both the Committee on Child and Adolescent Health and the Task Force on Behavioral Health reviewed the resolution and agreed to recommend TMA policy that condemns conversion therapy for minors and supports only evidence-based therapies. Members also agreed to amend an existing TMA policy addressing adolescent sexual activity to highlight a call for education on gender identity and sexual orientation. The recommended amendments to TMA policy 55.004 incorporate language from both the American Medical Association’s H-160.0991 Health Care Needs of Lesbian Gay Bisexual and Transgender Populations, and AAP’s Office-based Care for Lesbian, Gay, Bisexual, Transgender, and Questioning Youth.

The committee and task force make the following recommendations in lieu of Res. 311:

Recommendation 1: That TMA adopt the following as policy on sexual orientation change efforts in minors:

**Sexual Orientation Change Efforts in Minors**

1. The Texas Medical Association supports treatment and therapies rooted in acceptance and support regarding an individual’s sexual orientation and gender identification and therefore opposes practices aimed at changing an individual’s sexual orientation, including conversion therapy.

2. TMA supports the prohibition of any person licensed to provide mental health counseling from engaging in sexual orientation change efforts with patients younger than 18 years of age. TMA supports the practice of evidence-based therapies and will aggressively oppose the use of potentially harmful, unproven therapies for children. In addition, the association supports any regulatory changes to prohibit coverage for conversion therapy under the state’s Medicaid program as well as any health insurers in the state.

3. TMA encourages physicians to stay informed on the potential harms associated with sexual orientation change efforts.

Recommendation 2: That TMA amend existing policy as follows:

55.004  **Adolescent Sexual Activity** (1) The role of the physician — Physicians who treat adolescents have a responsibility to address or refer a patient with concerns related to
sexual identity and positive self-image. Comprehensive health care for adolescents must address issues related to reproductive history and sexual activity. Physician offices should be welcoming to all adolescents, regardless of sexual orientation or gender identity.

The following general principles should be considered by physicians in their discussions with adolescents and their families when appropriate.

Sexuality education. Physicians should help prepare parents to be effective sexuality educators for their children, encouraging them to communicate factual knowledge, family values, and behavioral expectations throughout childhood, especially during the critical transition years into early adolescence.

Confidentiality and consent. Physicians should be familiar with Texas laws regarding the adolescent’s right to reproductive health, assessment, and treatment for sexually related issues. Physicians also should be aware, in general, that the adolescent’s right to reproductive health has been upheld consistently in court either through specific statutes or the “mature minor” doctrine.

Adolescent reproductive health choices for sexually active teens. The healthiest and most effective way to prevent pregnancy and sexually transmitted infections in unmarried adolescents is abstinence. There is no ideal contraceptive method that is 100 percent effective in preventing both pregnancy and infection, or is free of side effects. However, there are methods suitable for use by teenagers. Physicians caring for adolescents should be familiar with the most suitable contraceptive choices or be willing to refer to others who are.

Medical/lifestyle history. A thorough history is critical, as all sexually active adolescents are at risk for sexually transmitted diseases and unplanned pregnancies.

Sexual decision making with implications for self-esteem. As teenagers become interested in relationships, they need an opportunity to discuss sexual pressures, values, expectations, options, and consequences.

Sexual responsibility. Without being morally judgmental, the physician can help adolescents identify their own goals for safe and responsible sexual behavior. 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.

Standards of practice. Physicians who treat adolescents should provide counseling and treatment or a referral for adolescent patients with respect to sexual development, sexually transmitted disease, birth control, and pregnancy. Adolescents should have a confidential adolescent psychosocial history. Verbal histories and/or written questionnaires should use a gender-neutral approach. Screening and referral for depression, suicidality, other mood disorders, substance abuse, and eating disorders should be included.

(2) The role of the Texas Medical Association — TMA can contribute substantially to the promotion of adolescent health by (a) Sponsoring continuing medical education for physicians and health care providers at annual sessions and preparing reports and
facilitating formal presentations concerning adolescent sexual activity; (b) Encouraging medical schools in the state to engage in research and training in all aspects of adolescent health, including adolescent sexuality; (c) Promoting interdisciplinary dialogue and networking on public health and public affairs issues involving the promotion of improved care for adolescents and comprehensive health education; (d) Utilizing *Texas Medicine* and other media as a forum for the promotion and discussion of all adolescent health issues including, but not exclusively concerned with, adolescent sexuality; and (e) Developing educational materials (i.e., anticipatory guidance/discussion with parents); (f) Serving as a resource to public schools and agencies creating programs and strategies to educate our youth; and (g) 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; and (h) Educating physicians on the health disparities that exist for sexual minority youth.

(3) Legislative initiatives — TMA should advocate for; (a) Local school districts should provide instruction on family life, human sexuality, and comprehensive health education for grades kindergarten through college level. Education should be age appropriate and should be taught by teachers who have received training in family life, human sexuality, and comprehensive health education; (b) The State of Texas should adoption in statutory form of the “mature minor” doctrine and elimination of other statutory barriers to adolescents accessing health care; (c) the Texas Medical Association should support the following principles regarding adolescent pregnancy when it is the subject of legislation: (1) access to early and accurate diagnosis of pregnancy; (2) professional counseling describing the gestational alternatives; and (3) support of already existing TMA guidelines regarding abortion, which base its performance on early and accurate diagnosis of pregnancy, informed and nonjudgmental counseling, prompt referrals, skillful and understanding personnel working in a good facility, reasonable costs, and professional follow-up; (d) Funding at the state and local levels should be established for student-oriented primary care clinics and/or school-linked comprehensive health care for adolescents; and (e) Funding should be established for STD and AIDS research, treatment, and support services for adolescents. (Council on Public Health, p 76, I-91; amended Res. 304-, 305-, and 306-A-01; amended CCAH Rep. 4-A-10).

References


We have seen great advances over the last 30 years in the health of Texans regarding the HIV epidemic. We have seen HIV infection shift from a serious deadly disease to a treatable chronic condition. We have made great strides in controlling the spread of HIV through the work of public health officials, physicians, and health care providers. HIV infection should be decreasing with increased public awareness of the risks of sexually transmitted infections (STIs), STI prevention education, routine STI and HIV screening, HIV treatment, and HIV prophylaxis. However, we have not eliminated HIV and have ongoing new acquisition of HIV despite our advances. In 2015, 4,486 people in Texas were diagnosed with HIV, and an estimated 20 percent of Texans infected with HIV have not yet been diagnosed. Overall, the rate of new HIV diagnoses in Texas has remained stable over the past decade, and there have been increasing numbers of new infections in young adult men who have sex with men (MSM). The most common mode of exposure reported in Texans newly diagnosed was male-male sexual contact. According to Texas data:

- Fifty-nine percent of individuals living with HIV in Texas in 2015 are gay men or other men who have sex with men, and about 11 percent acquired it via injection drug use.
- Thirty-seven percent of newly diagnosed cases are black Texans, though they account for 12 percent of the state’s population.
- While HIV has been declining in individuals aged 35-44 years, HIV has been increasing among people aged 15-34 years.

Prescribing to prevent

Truvada® was approved as preexposure prophylaxis (PrEP) by the Food and Drug Administration (FDA) in 2012 and is a combination of the HIV medications tenofovir and emtricitabine. The medication became the first and only medication approved for HIV prevention.

The approval followed the first randomized controlled trial of PrEP in 2010, from the Preexposure Prophylaxis Initiative. The trial demonstrated that the HIV infection rate among HIV-negative men and transwomen who were given the antiretroviral daily was reduced by 44 percent, and by 73 percent among those who took the medication more than 90 percent of the time. Further, an estimated 92-percent efficacy was expected for participants who took the medication every day. Additional studies demonstrated even higher efficacy rates and included both men and women. According to other studies, the pill must be taken daily for effectiveness.

The drug is a valuable addition to other HIV prevention efforts in persons with high risk or ongoing significant risk of new HIV infection. It is indicated for anyone at risk of contracting HIV. Target populations are individuals at substantial risk of acquiring HIV and may be sexually active adult MSM; heterosexually active adult men and women; adult injection drug users; or individuals who are in a sexual
A relationship with a partner living with HIV, have a high number of sexual partners, or are engaged in commercial sex work. This is according to the Centers for Disease Control and Prevention’s (CDC’s) clinical practice guidelines, which offer comprehensive recommendations. When the guidelines were drafted, there was insufficient evidence related to PrEP and adolescents. The guidelines recommend a sexual history as a first step in identifying patients who would be candidates for the medication and medication to be used along with safe-sex behaviors. The drug should not be used in someone who is not infected with HIV.

The data from the trials indicated no serious adverse events. A decrease in bone mineral density and kidney problems were reported among users. CDC guidelines identify persons NOT recommended for PrEP, and this includes individuals with unknown HIV status, decreased kidney function, and unknown hepatitis B status.

The cost of the drug without insurance is about $1,500 per month. There are patient assistance programs for patients who are not insured.

**Adolescents**

The number of new HIV infections continues to increase among gay and bisexual men, particularly young minority men. The initial clinical studies did not include data on adolescent use, and the FDA labeling specifies the drug is for use by “adults,” though it does not identify an age. National guidelines do not incorporate any recommendations for young patients. Currently, a clinical trial, Project Prepare, has focused on teens and young adult participants.

Texas has no law explicitly prohibiting a minor’s access to PrEP, but Texas law allows for some conditions or situations under which minors may consent to their own medical care. This includes the ability to consent to treatment of an infectious, contagious, or communicable diseases that is required to be reported to a local health officer.

In addition to legal issues related to consent, insurance and billing practices may affect a minor’s access to confidential care, especially if the minor accesses care through a parent’s health plan. An explanation of benefits (EOB) or other communication may reveal potential information the minor intends to keep confidential.

**Other populations**

The U.S. Preventive Services Task Force guidelines for use of antiretroviral drugs in pregnant women suggest that PrEP may offer additional support to minimizing the risk of transmission for serodiscordant couples. Importantly, once serodiscordant couples conceive, the risk of HIV acquisition continues, and a few studies indicate it may increase during pregnancy. PrEP is an adjunctive method of decreasing HIV transmission and maternal-to-child transmission during pregnancy and breastfeeding. While there are no randomized controlled studies of PrEP for pregnant women or those breastfeeding, there is a growing body of literature examining PrEP during conception. In 2014, the American College of Obstetricians and Gynecologists issued guidance for PrEP for women at high risk of acquiring HIV infection and stated there is limited study among women who are pregnant or lactating. However, limited studies of HIV-positive women receiving tenofovir exist and do not demonstrate significant adverse outcomes for mothers or infants.

**Other states**

New York Gov. Andrew Cuomo established a plan in 2014 aimed at reducing the number of newly diagnosed cases of HIV infection. The initiatives include improving access to PrEP by creating a toolkit for physicians and health care providers, increasing access through Medicaid, and maintaining an online
directory of physicians and providers offering PrEP. An analysis of the claims data from 2012 to 2015 showed the number of Medicaid recipients initiating PrEP increased more than fourfold (from 259 recipients to 1,330 recipients).

Several states have implemented laws aimed at increased medical privacy for dependents. This includes prohibiting release of a minor’s EOB unless the minor consents and requiring health plans to keep communication confidential upon request. Several states allow minors to consent to confidential medical services for the prevention of sexually transmitted diseases including HIV.

Summary
HIV PrEP is a resource for preventing new HIV infection that is safe and effective. We are not advocating HIV PrEP for everyone but want to alert Texans that this will help a select group avoid new HIV infection. This is a means to save health care resources. Despite the national recommendations, health plan coverage, and patient assistance programs, gaps remain for uptake. According to a CDC analysis, about 25 percent of adult MSM aged 18-59 who report sexual activity in the past year have indications for PrEP. Patients have expressed willingness. An analysis of data from the 2014 national HIV Behavioral Surveillance system revealed more than half of MSM reported they were willing to take PrEP, but only about 4 percent reported using PrEP, as access to HIV PrEP is limited.

In an assessment of physicians in Massachusetts, the authors found that participants did express a willingness to prescribe PrEP to populations for which efficacy data exists, but participants also misinterpreted the results of PrEP efficacy data and indicated concerns regarding efficacy and safety. Physicians play a critical role in how PrEP can be a tool in reducing the spread of HIV. More information is needed not only on how to best address barriers to prescribing but also on how to address barriers for patients. More information is needed on what influences adherence and how to identify patients at substantial risk for HIV.

After reviewing the available evidence, the committees make the following recommendation for adoption as TMA policy to better serve our adolescent and adult patients:

Recommendation: That TMA promote awareness among physicians on preexposure prophylaxis (PrEP) as a tool for HIV infection prevention. Efforts should include: (1) informing physicians about trends in HIV infection, PrEP as prevention, PrEP research and guidelines, PrEP clinical program structure, and access issues; (2) identifying resources and referral locations regarding HIV infection prevention for physicians who treat adult and adolescent patients; and (3) working with the Texas Department of State Health Services and other stakeholders to identify opportunities to promote PrEP and reduce barriers to access, including legal and confidentiality barriers that may affect younger patients.

References

8. Texas Family Code. Section 32.003 Consent to Treatment by Child.


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Subject: Resolution 307-A-16, Gender and Sex Options on Medical Paperwork

Presented by: Dan L. Locker, MD, Chair

Referred to: Reference Committee on Science and Public Health

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**Background**

At TexMed 2016, the Medical Student Section filed Resolution 307 relating to gender and sex options on medical paperwork. The resolution states that (1) adding more gender and sex options to patient paperwork will prevent medical errors by encouraging more complete patient disclosure, (2) accurate gender information will help physicians screen for gender and lifestyle-specific disease, and (3) the lack of data on nonbinary gender identities in health care limits the performance of quality health care research on these criteria.

The resolution asks that the Texas Medical Association (1) recognize the importance of delineating gender identities in patients to promote the delivery of thorough medical care and support the addition of gender and sex options on patients’ medical records, and (2) support patient data collection inclusive of nonbinary gender identities, as it will allow for relevant medical research.

The House of Delegates referred the resolution to the Reference Committee on Science and Public Health. The reference committee heard largely supportive testimony; however, members raised concerns regarding the scope of the policy and whether the recommendations should be expanded to address related issues, including how physician offices can ensure an inclusive and welcoming environment for patients. The resolution ultimately was referred and later assigned to the TMA Board of Councilors.

**Discussion**

TMA currently does not have any policy in this area. The American Medical Association has no direct policy but maintains several policies concerning gender identity, sexual orientation, and human rights. The Board of Councilors reviewed and discussed the resolution and accompanying documents. Members were supportive of the recommendations in the resolution. The board moved that TMA should adopt policy on gender and sex identity to improve quality of care and increase medical research in this area.

**Conclusion**

The Board of Councilors discussed the importance of gender and sex identity information being part of medical records and recommends the following:

**Recommendation:** That the Council on Science and Public Health develop policy on the topic of patient gender and sex identity for consideration by the House of Delegates at the 2018 annual session.

**Related TMA Policy:** None

**Related AMA Policy:**

AMA Policy H-65.976 Nondiscriminatory Policy for the Health Care Needs of LGBT Populations
Our AMA encourages physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, health care workers, or employees to include “sexual orientation, sex, or gender identity” in any nondiscrimination statement. (Res. 414, A-04; Modified: BOT Rep. 11, A-07; Modified: Res. 08, A-16).

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. (CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-9; 1 CSA Rep. 8 - I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmation A-12; Modified: Res. 08, A-16).

AMA Policy H-65.965 Support of Human Rights and Freedom
Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its longstanding policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual’s sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual’s sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate
crimes prevention legislation in accordance with our AMA’s policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States. (CCB/CLRDP Rep. 3, A-14).

AMA Policy H-65.967 Conforming Birth Certificate Policies to Current Medical Standards for Transgender Patients
1. Our AMA supports policies that allow for a change of sex designation on birth certificates for transgender individuals based upon verification by a physician (MD or DO) that the individual has undergone gender transition according to applicable medical standards of care.
2. Our AMA: (a) supports elimination of any requirement that individuals undergo gender affirmation surgery in order to change their sex designation on birth certificates and supports modernizing state vital statistics statutes to ensure accurate gender markers on birth certificates; and (b) supports that any change of sex designation on an individual’s birth certificate not hinder access to medically appropriate preventive care. (Res. 4, A-13; Appended: BOT Rep. 26, A-14).

AMA Policy H-185.950 Removing Financial Barriers to Care for Transgender Patients
Our AMA supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient’s physician. (Res. 122 A-08; Modified: Res. 05, A-16).

AMA Policy H-525.988 Sex and Gender Differences in Medical Research
Our AMA: (1) reaffirms that gender exclusion in broad medical studies questions the validity of the studies’ impact on the health care of society at large; (2) affirms the need to include both genders in studies that involve the health of society at large and publicize its policies; (3) supports increased funding into areas of women’s health research; (4) supports increased research on women’s health and participation of women in clinical trials, the results of which will permit development of evidence-based prevention and treatment strategies for all women from diverse cultural and ethnic groups, geographic locations, and socioeconomic status; and (5) recommends that all medical/scientific journal editors require, where appropriate, a sex-based analysis of data, even if such comparisons are negative. (Res. 80, A-91; Appended: CSA Rep. 4, I-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 05, A-16).

AMA Policy H-185.927 Clarification of Medical Necessity for Treatment of Gender Dysphoria
Our AMA: (1) recognizes that medical and surgical treatments for gender dysphoria, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice; and (2) will advocate for federal, state, and local policies to provide medically necessary care for gender dysphoria. (Res. 05, A-16).

AMA Policy H-295.878 Eliminating Health Disparities - Promoting Awareness and Education of Lesbian, Gay, Bisexual, and Transgender (LGBT) 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, and Transgender 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 LGBT 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 LGBT patients. (Res. 323, A-05; Modified in lieu of Res. 906, I-10;
Reaffirmation A-11; Reaffirmation A-12; Reaffirmation A-16).

AMA Policy D-65.996 Nondiscriminatory Policy for the Health Care Needs of LGBT
Populations
Our AMA will encourage and work with state medical societies to provide a sample printed
nondiscrimination policy suitable for framing, and encourage individual physicians to display for
patient and staff awareness-as one example: “This office appreciates the diversity of human
beings and does not discriminate based on race, age, religion, ability, marital status, sexual
orientation, sex, or gender identity.” (Res. 414, A-04; Modified: BOT Rep. 11, A-07; Modified:
Res. 08, A-16).

AMA Policy H-180.980 Sexual Orientation and/or Gender Identity as Health Insurance
Criteria
The AMA opposes the denial of health insurance on the basis of sexual orientation or gender
Whereas, During the 2009 influenza H1N1 pandemic, the Texas Department of State Health Services (DSHS) assembled a multidisciplinary group of stakeholders, including physicians, whose goal was to provide guidance and recommendations for the allocation of state-owned medical resources during a pandemic event; and

Whereas, In this 2009 workgroup meeting, it was recognized that the state did not maintain a plan for allocation of scarce medical resources not owned directly by the state, constituting the vast majority of medical resources; and

Whereas, In 2010, the Dallas County Medical Society helped form the North Texas Task Force on Crisis Standards of Care, which created a communitywide triage framework for guiding medical decisions during a public health emergency that exceeds available medical resources; and

Whereas, In 2012, the Institute of Medicine (now the National Academy of Medicine) issued a follow-up to its 2009 report, which established a national framework for ensuring that the largest number of people receive the best possible care during a public health emergency, while ensuring everyone receives fair and equitable care; and

Whereas, In 2012, a multidisciplinary task force led by the Harris County Public Health Department developed a crisis standards-of-care framework for Harris County; and

Whereas, In 2013, DSHS assembled a task force with the intent of creating a statewide crisis standards-of-care framework, but work has stalled; and

Whereas, Most hospital systems and health care entities operate beyond local jurisdictional boundaries, preventing effective implementation of locally developed crisis frameworks; and

Whereas, The authority for declaring a public health emergency rests with the DSHS commissioner; therefore be it

RESOLVED, That the Texas Medical Association work closely with the Texas Department of State Health Services commissioner to ensure the reinvigoration of a task force charged with creating a statewide crisis standards-of-care framework; and be it further

RESOLVED, That TMA support legislative efforts that promote physician-led decisionmaking during public health emergencies, using nationally recognized guidelines; and be it further
RESOLVED, That TMA help identify any legal barriers that would prohibit the implementation of a crisis standards-of-care framework during a declared public health emergency.

Relevant TMA Policy

260.067 Disaster Preparedness: In response to floods in Houston in 2001, the Texas Medical Association encourages the Texas Department of State Health Services to lead the development of a more proactive disaster preparedness plan for Texas health care facilities (CHSO Rep. 2-A-02; reaffirmed CHSO Rep. 2-A-12).

260.076 All Hazards Disaster Planning: The Texas Medical Association adopted the following recommendations:

(1) Ask our American Medical Association to work with subject matter experts at the national level to produce a provider manual on medical liability and coverage during disasters;

(2) Ask our AMA to work with the American Red Cross to improve plans, protocols, and policies regarding the provision of health care in mass casualty shelters;

(3) Request our AMA to develop templates for private practice/office continuity plans in CD-Rom or web-based format with backups to be stored at the state medical association offices;

(4) Work closely with the Texas Department of State Health Services (DSHS) in statewide disaster planning efforts and advocate for stronger roles for county medical societies in local disaster planning efforts, drills, and other activities;

(5) Establish a liaison to both the Commissioner of Health and the state's emergency coordinator to explore medical needs during terrorism and natural disasters;

(6) Work closely with DSHS to establish state-level communications through the Health Alert Network (HAN) and assist local health departments or other appropriate agencies in expanding the mechanism for informing physicians of essential information on a newly recognized outbreaks;

(7) Work [with] DSHS to improve physician reporting and consultation systems at the state and local levels;

(8) Work with DSHS to establish standards for local public health departments to ensure that reporting physicians have immediate or rapid access to a public health authority who can provide additional guidance on confirmation and treatment of patients, especially during natural and biological disasters;

(9) Work closely 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;

(10) Maintain a database of volunteer physicians, coordinating with state ESAR-VHP efforts, and including tracking of member participation in other disaster response organizations (e.g., local health facility response, Texas Medical Rangers, Medical Reserve Corps, DMATs, Texas National Guard);
(11) Work with DSHS to define when it will be appropriate to contact area physicians and ensure that potential volunteers understand the commitment they are making, including information on liability, travel expenses, job protection, and personal and family safety;

(12) Examine state laws governing practice and liability under these various disaster declarations and advocate for any needed legislative changes to address these issues;

(13) Work with DSHS to identify specific needs and to deploy physicians and special services to assist with the medical needs of shelter evacuees during a disaster;

(14) Recruit physicians in advance of a disaster with particular emphasis on assuring sufficient pediatric and other specialists, including mental health counselors with special efforts to address the specific needs of patients with mental illness, Alzheimer’s, infectious diseases, long-term care residents, and pregnant women;

(15) Encourage local communities to identify, prior to an event, a designated infection control practitioner to provide basic infection control guidance to prevent exposure to or transmission of infectious diseases in temporary community evacuation centers;

(16) Educate its members on the essential aspects of terrorism and disaster medicine through CME programs at state society meetings and by articles in state society journals and newsletters with special focus given to training on Incident Command Structure, Basic and Advanced Disaster Life Support, and triage for health care providers;

(17) Ensure that physicians understand the circumstances in which quarantine is appropriate and utilized and how to carry out complementary, previously determined roles in their practices regarding surveillance, health care, and public information;

(18) Promote the Texas Medical Rangers and the Medical Reserve Corp to physician members;

(19) Encourage medical educators at all levels to participate in training physicians in the essentials of disaster and terrorism medicine relevant to their practice and specialty;

(20) Encourage our county medical societies to appoint a staff member or member physician to coordinate the society's participation in disaster preparedness and to participate in community disaster drills that test these plans;

(21) Encourage our county medical societies to maintain an ongoing relationship with their local or regional public health departments and to consider appointing the local or regional public health director to the board of the county medical society as a consultant;

(22) Encourage our county medical societies to work with the local health department to compile and maintain a contact list of physicians (both member and nonmember) in the community and to ensure that physician-friendly reporting mechanisms are in place, and that a two-way flow of information exists to provide incentives for physician collaboration;
(23) Encourage our county medical societies to provide a venue for physician education, work with sponsors of local CME efforts, and identify members who are particularly interested and may become peer leaders and educators;

(24) Encourage our county medical societies to participate in practice drills and exercises that involve local health departments and local emergency response units;

(25) Encourage physicians and their staff organizations to advocate for these disaster planning measures in their health care facilities;

(26) Encourage individual physicians to have a strategic plan for everything from evacuating their office building, protecting employees during a communicable disease outbreak, maintaining continuity of their practice and maintaining communication with their families, and provide templates and guidelines for these types of plans to physicians; and

(27) That the Board of Trustees create an ad hoc committee on disaster preparedness and response to provide guidance to the association on how to implement policy and establish guidelines for a statewide medical disaster system that integrates with other emergency response providers in Texas (Amended CPH Rep. 1-A-06).
Resolution 302
A-17

Subject: Palliative Care

Introduced by: Larry Driver, MD

Referred to: Reference Committee on Science and Public Health

Whereas, The 84th Texas Legislature, in House Bill 1874 (by State Rep. John Zerwas, MD) found that palliative care is care that is patient-centered and family-focused, and provides relief from the symptoms, pain, and stress of serious illness; is provided by an interdisciplinary team adding another layer of support for a patient during the treatment of a serious illness; is appropriate for a patient of any age and at any stage of a serious illness; can help a patient recover from a serious illness and potentially can reduce medical costs for patients and our health care system; and

Whereas, HB 1874 created the Texas Health and Human Services Commission (HHSC) Palliative Care Interdisciplinary Advisory Council (PCIAC), whose initial 18 voting members include eight physicians who are members of the Texas Medical Association: Drs. James Castillo II, Larry Driver, Robert Fine, Erin Fleener, Hattie Henderson, Craig Hurwitz, Amy Moss, and Michael Ragain, with Dr. Driver serving as chair; and

Whereas, HB 1874 charged PCIAC with submitting to the legislature a biennial report on the availability of and access to palliative care services in Texas; an overview of relevant policies, practices, and protocols in Texas; and development of professional and consumer information and education program strategies such as a website clearinghouse of information and resources; and

Whereas, PCIAC in November 2016 submitted its first report on palliative care in Texas advising the governor, the HHSC commissioner, and the legislature with recommendations to (1) clarify what palliative care is, (2) establish how it is best delivered with the highest standards for quality, (3) devise strategies for expansion of training and education opportunities for all Texas health care professionals, (4) create model policies and protocols for palliative care programs, and (5) develop a consensus statement on patient rights related to palliative care information; and

Whereas, PCIAC continues its prescribed work toward fulfillment of its charges and implementation of its recommendations; therefore be it

RESOLVED, That the Texas Medical Association recognize and commend the Palliative Care Interdisciplinary Advisory Council for establishing the framework for advancing palliative care in Texas that will improve availability of and access to the highest quality of evidence-informed palliative care, delivered by expert interdisciplinary teams led by Texas physicians who receive the best available education and training in the field based upon leading-edge research, and that establishes Texas as a model of palliative care for the rest of the nation; and be it further

RESOLVED, That TMA will recommend as appropriate the tangible results of PCIAC’s work in conceiving, developing, and implementing clinical, educational, public awareness, advocacy, and research activities that promote and enhance the provision of the best possible supportive palliative care and hospice palliative care in Texas.
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 303
A-17

Subject: Sudden Increase in Liability Claims for Wernicke’s Encephalopathy in Bariatric Surgery Patients

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Science and Public Health

Whereas, Bariatric surgical procedures are the most commonly performed gastrointestinal operations today; and

Whereas, Multiple types of bariatric surgical procedures exist, some regarded as restrictive, some malabsorptive, and some mixed, but all can be related to potential vitamin deficiencies; and

Whereas, Other causes of potential vitamin deficiencies after bariatric surgery include post-operative decreased food intake, inadequate diet, vomiting, and the use of 5-percent dextrose intravenous solution to treat vomiting; and

Whereas, Wernicke’s encephalopathy is an acute neurological disorder caused by deficiency of vitamin B1; and

Whereas, Wernicke’s encephalopathy is characterized by the triad of ophthalmoplegia and nystagmus, motor ataxia, and confusion, but only the minority of cases present with all three symptoms at the same time; and

Whereas, Wernicke’s encephalopathy has a 20-percent mortality rate if untreated or undertreated; and

Whereas, A thiamine level may take several days to return when ordered, but treatment of the condition should not be delayed; and

Whereas, The Texas Medical Liability Trust has reported to policyholders that it is seeing a sudden surge in claims being filed related to Wernicke’s encephalopathy being missed or delayed in diagnosing in bariatric surgery cases, particularly involving general surgeons, emergency physicians, internists, and gastroenterologists; therefore be it

RESOLVED, That the appropriate Texas Medical Association council or committee review existing evidence regarding the prevalence and presentation of Wernicke’s encephalopathy after bariatric procedures, and if appropriate, provide information to all Texas physicians regarding the recent phenomenon of vitamin B1 deficiency causing Wernicke’s encephalopathy in certain bariatric surgery patients, given the potential for death or permanent disability.

Reference
Whereas, Our Texas Medical Association’s vision is to improve the health of all Texans; and
Whereas, Doctors are called to care and advocate for those most vulnerable in the population; and
Whereas, Lesbian, gay, bisexual, transgender, and questioning (LGBTQ) individuals are at increased risk of disease including psychiatric disorders, substance abuse, and suicide, and transgender individuals specifically have significantly increased prevalence of sexually transmitted infections, victimization, mental health diagnoses, suicide, and lack of insurance compared with heterosexual, homosexual, or bisexual individuals; and
Whereas, LGBTQ youth are at particular risk of adverse health outcomes, including homelessness and a two-to-three-fold increase in suicide attempts; and
Whereas, Parental rejection increases the likelihood that a lesbian, gay, or bisexual youth will suffer from depression, attempt suicide, use illegal drugs, and/or engage in risky sexual behaviors; and
Whereas, Sexual and gender minorities experience worse physical health compared with their heterosexual and nontransgender counterparts; and
Whereas, The LGBTQ population experiences increased barriers to care including gaps in coverage, cost-related hurdles, and poor treatment from some physicians and health care providers; and
Whereas, Safe schools and housing; access to recreation facilities, activities, and health services; and the availability of safe meeting places all contribute to the health of LGBTQ individuals; and
Whereas, LGBTQ individuals have been targets of discriminatory legislation across the United States; therefore be it
RESOLVED, That TMA adopt policy opposing any discrimination based on an individual’s sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin, or age; and be it further
RESOLVED, That TMA policy on this issue also call for TMA to work with other organizations, both public and private, to identify and make resources available to assist physicians’(1) self-education regarding care for the LGBTQ population, (2) provision of support to families in developing healthy relationships with their youth regardless of sexual orientation, and (3) discussion of consequences and health risks of varying levels of acceptance and rejection of LGBTQ youth; and be it further
RESOLVED, That TMA policy direct TMA to work with public and private organizations to reduce
suicide and improve health in all Texans, with care to include LBGTQ individuals and at-risk youth; and
be it further

RESOLVED, That the TMA Speakers and TMA Board of Trustees consider the formation of an LGBTQ
committee or interest group to continue to guide TMA regarding the issues of this unique, at-risk
population; and be it further

RESOLVED, That TMA encourage TEXPAC to consider proposed or past actions’ discriminatory impact
on vulnerable populations when deciding endorsements and allocation of funds.

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Whereas, There are over 1 million children under three years of age in Texas; and
Whereas, Twenty-five percent of Texas families earn less than the federal poverty level; and
Whereas, Eleven percent of the Texas population over 65 years of age are living in poverty; and
Whereas, The national average monthly cost of diapers is $80, equating to annual expenditures of $936 for a family with a diaper-wearing individual; and
Whereas, The economic impact of diaper purchases continues to affect more individuals and families as sales of adult incontinence products and baby diapers are projected to increase 48 percent and 2.6 percent respectively by 2020; and
Whereas, While mothers living below the poverty line are more likely to experience diaper need, diaper need is widespread, affecting mothers of all ethnicities and economic statuses; and
Whereas, Texas Temporary Assistance for Needy Families, the only federal assistance program covering diapers, is intended to cover many expenses, leaving only a small portion of remaining funds for diapers; and
Whereas, Diaper need was found to occur more frequently in children with mothers who have mental health needs, contributing to increased parenting stress and depression in addition to preexisting mental health illnesses; and
Whereas, Parental stress and depression have been known to present a greater risk for future behavioral, social, and emotional problems for the child; and
Whereas, Efforts by parents to ease the financial strain have resulted in attempts to accelerate meeting the child’s developmental milestones, like early potty training, which are inconsistent with current child development recommendations; and
Whereas, Lack of diapers or prolonged use of soiled diapers can lead to health problems, including recurrent urinary tract infections, diaper dermatitis, or exacerbation of eczema leading to an increase in physician’s office and emergency department visits; and
Whereas, Cloth diapers have been shown to increase the incidence of sepsis and costs in a neonatal intensive care unit, making them a less hygienic choice of diaper and a possible strain in family budgets for laundering and additional medical care; and
Whereas, Child care facilities are increasingly requiring parents to provide disposable, not cloth, diapers as a prerequisite for attendance; and
Whereas, Several state legislatures including those of Connecticut, Illinois, and California, have proposed bills to address the diaper gap; therefore be it

RESOLVED, That the Texas Medical Association advocate for elimination or reduction of taxes imposed on infant and adult diapers; and be it further

RESOLVED, That the Texas Delegation forward this resolution immediately to the American Medical Association House of Delegates.

Relevant TMA Policy:


140.002 Prenatal and Perinatal Care: The Texas Medical Association supports a system to meet the needs of low- and high-risk perinatal and prenatal care in both the private and public sections based on the coordinated efforts of private physicians; medical schools; federal, state, and local health agencies; and other available resources (Committee on Maternal and Child Health, p 114, A-91; reaffirmed CM-MPH Rep. 3-A-01; reaffirmed CM-MPH Rep. 1-A-11).

190.022 Medicaid and CHIP Funding and Access to Care for Children: The Texas Medical Association will work toward improving access to care for Texas children by opposing legislative proposals for Medicaid and CHIP funding cuts and supporting increased reimbursement for Medicaid and CHIP; by educating communities and taxpayers about the negative impact of shifting costs from the state budget to local economies; and by emphasizing that physicians and providers of health care for children under Medicaid and CHIP must receive reimbursement parity with Medicare (Amended Res. 406-A-03; reaffirmed CSE Rep. 1-A-13).

Relevant AMA Policy:

Provision of Health Care and Parenting Classes to Adolescent Parents H-60.973

1. It is the policy of the AMA (A) to encourage state medical and specialty societies to seek to increase the number of adolescent parenting programs within school settings which provide health care for infant and mother, and child development classes in addition to current high school courses and (B) to support programs directed toward increasing high school graduation rates, improving parenting skills and decreasing future social service dependence of teenage parents.

2. Our AMA will actively provide information underscoring the increased risk of poverty after adolescent pregnancy without marriage when combined with failure to complete high school.

Insurance Coverage for Complete Maternity Care H-185.997

Our AMA (1) reaffirms its policy of encouraging health insurance coverage for care of the newborn from the moment of birth; (2) urges the health insurance industry and government to include in their plans, which provide maternity benefits, coverage for normal obstetrical care, and all obstetrical complications including necessary intrauterine evaluation and care of the unborn infant; (3) urges the health insurance industry to offer such plans on the broadest possible basis; (4) urges the health insurance industry to make available, on an optional basis, coverage for treatment associated with voluntary control of reproduction;
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(5) will advocate for expanding coverage of maternity care to dependent women under the age of 26 on their parents’ large group plans; and
(6) will advocate that individual, small and large group health plans provide 60 days of newborn coverage for all newborns born to participants in the plan.

Opposition to Proposed Budget Cuts in WIC and Head Start H-245.979
The AMA opposes reductions in funding for WIC and Head Start and other programs that significantly impact child and infant health and education.

Expanding Enrollment for the State Children's Health Insurance Program (SCHIP) H-290.971
Our AMA continues to support:
a. health insurance coverage of all children as a strategic priority;
b. efforts to expand coverage to uninsured children who are eligible for the State Children’s Health Insurance Program (SCHIP) and Medicaid through improved and streamlined enrollment mechanisms;
c. the reauthorization of SCHIP in 2007; and
d. supports the use of enrollment information for participation in the Special Supplemental Nutrition Program for Women, Infants, and Children (WIC) and/or the federal school lunch assistance program as documentation for SCHIP eligibility in order to allow families to avoid duplication and the cumbersome process of re-documenting income for child health coverage.

Adequate Funding of the WIC Program H-245.989
Our AMA urges the U.S. Congress to investigate recent increases in the cost of infant formula, as well as insure that WIC programs receive adequate funds to provide infant formula and foods for eligible children.

Tax Exemptions for Feminine Hygiene Products H-270.953
Our AMA supports legislation to remove all sales tax on feminine hygiene products.

Dignity and Self Respect H-25.997
The AMA believes that medical care should be available to all our citizens, regardless of age or ability to pay, and believes ardently in helping those who need help to finance their medical care costs. But the AMA does not believe that tax dollars of the working people of America should be used to finance medical care for any person who is financially able to pay for it. Furthermore, the AMA believes in preserving dignity and self-respect of all individuals at all ages and believes that people should not be set apart or isolated on the basis of age. The AMA believes that the experience, perspective, wisdom and skill of individuals of all ages should be utilized to the fullest.

References


Whereas, Arsenic is a known carcinogen also known to cause skin and circulatory problems; and

Whereas, Evidence indicates that long-term exposure to low levels (≥0.005 milligrams/liter) of arsenic from drinking water may result in lower IQ scores in children; and

Whereas, Under the 2006 federal Safe Drinking Water Act, the Environmental Protection Agency (EPA) determined the arsenic limit for safe drinking water, at which no adverse health effects are likely to occur, to be 10 parts per billion (ppb) and in 2010 warned of 10 ppb of arsenic being 17 times as harmful as reported previously; and

Whereas, 65 Texas communities have reported levels of arsenic that surpass the EPA-recommended level (10 ppb), the highest being in Bruni, a community in South Texas that reported arsenic levels at 80 ppb; and

Whereas, The Environmental Integrity Project reported that 51,000 Texans in 34 Texas communities have had annual arsenic levels in their water greater than 10 ppb consistently for more than 10 years; and

Whereas, Chromium-6, another known carcinogen, has been shown in animal studies to cause congenital deformities of the skeletal system, low birth weight, and increased stillbirths in rat newborns, as well as lung cancer, oral cancer, and cancer of the small intestine in adult rats; and

Whereas, In California, the Office of Environmental Health Hazard Assessment indicates cancer rates start to rise at a chromium-6 concentration of 0.02 ppb; and

Whereas, Data from a 2015 EPA report show that Houston, Dallas, and San Antonio are among the top 12 American cities with the highest levels of chromium-6, with average measured levels of 0.747, 0.274, and 0.136 ppb of chromium-6 respectively; and

Whereas, Texas has no published policy on safe levels of chromium-6; and

Whereas, The Texas Commission on Environmental Quality (TCEQ) requires public water systems to notify users when the system’s water violates the 2006 Safe Drinking Water Act, but the notification language TCEQ mandates for public notices about arsenic violations also requires the systems to state “this is not an emergency” and “you do not need to use an alternative water supply;” therefore be it

RESOLVED, That the Texas Medical Association advocate for regulatory action to support public health or infrastructural measures to lower carcinogenic chemicals in community water systems; and be it further
RESOLVED, That TMA promote awareness among physicians regarding safe drinking water.

**Relevant TMA Policy:**

**260.087 Natural Gas Fracking in Texas:** The Texas Medical Association believes that the Texas Legislature, while encouraging natural gas production, should protect our water from the risk of fracking by requiring disclosure of fracking fluid components. This would include the removal of exemption from the Emergency Planning and Community Right-to-Know Act and the removal of a special exemption from the Safe Drinking Water Act; Clean Water Act; Clean Air Act; Resource Conservation and Recovery Act; Comprehensive Environmental Response, Compensation, and Liability Act; and National Environmental Policy Act for all companies engaged in this process (Res. 203-A-11; amended Res. 306-A-14).

**50.007 Cancer Diagnosis, Treatment, and Follow-Up:** To ensure all Texans with a suspected or proven diagnosis of cancer receive appropriate, comprehensive, and evidenced-based care, TMA recommends that physicians involved in a cancer program follow the latest Program Standards of the American College of Surgeons Commission on Cancer, and that all patients should have access to, as a minimum: (1) an accurate diagnosis obtained through the most minimally invasive biopsy, resection, or test necessary to provide an accurate cancer diagnosis; (2) a proper workup and staging performed in accordance with the American Joint Committee on Cancer staging system or other appropriate staging system; (3) a treatment plan developed by a multidisciplinary cancer conference, with recommended representation in the areas of genetic testing and counseling, palliative care, psychosocial care, and rehabilitation services; (4) appropriate management of pain and non-pain symptoms, screening and care for psychosocial distress, and support for health-related quality of life, including palliative care from diagnosis through end of life; (5) provision of a Treatment Summary and Survivorship Care Plan that reflects the treatment the patient received and addresses post-treatment needs and follow-up care; and (6) appropriate long-term follow up to monitor cancer recurrence and evaluate outcomes of cancer care. TMA will continue to educate physicians on the latest recommendations related to the care of cancer patients throughout their life span and advocate for state programs and policies that promote access to cancer prevention, early detection, and cancer treatment and supportive services for all Texans (Amended CM-C Rep. 3-A-06; amended CM-C Rep. 1-A-16).

**260.077 Clean Air in Texas:** The Texas Medical Association urges our state government leaders and legislators to take action and establish an energy policy that will stimulate energy savings, help to clean up the air, and encourage nonpolluting renewable energy sources. Steps might include:

- Requiring clean coal gasification technology for future coal-based power plants.
- Approving a tax on coal at least equal to the longtime tax on clean-burning natural gas.
- Encouraging proposals to expand renewable energy sources, such as solar and wind, and the grid expansion required to deliver the resulting renewable energy to our urban and rural markets.
- Offering incentives for power companies to provide businesses and consumers with hourly electricity pricing meters, to allow savings through shifting power usage to off-peak hours. New power plants are mainly needed to supply peak demands on hot summer days; financial incentives to shift usage to off-peak hours can mitigate this need.
• Using energy tax revenues to extend attractive financial incentives to citizens for reducing energy consumption and investing in alternative home and business energy systems, such as solar and wind.

• Phasing-in strict gas mileage requirements for automobiles sold or licensed in the state.

• Scientifically evaluating and promoting energy conservation measures for homes, businesses, and public buildings to decrease Texas energy consumption.

• Bringing into compliance many of the chemical plants, refineries, and power generating stations with the highest pollution emissions which are grandfathered and do not have to comply with Texas and EPA emission standards.

• Placing a moratorium on approval of old technology coal-based power plants (CPH Rep. 1-A-07).

References


TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 307
A-17

Subject: Reducing Errors in Pharmacy

Introduced by: Lubbock-Crosby-Garza County Medical Society

Referred to: Reference Committee on Science and Public Health

Whereas, An attempt has been made to reduce errors in prescriptions written by physicians by switching to e-prescriptions; and

Whereas, The rate of errors has not been reduced even though prescriptions have become more legible, resulting in errors rates ranging from 0.23 percent to 11 percent; and

Whereas, Medication errors were estimated to have caused 7,000 deaths per year in the United States in 1999; and

Whereas, This is an important patient safety issue; and

Whereas, There is a need to study at greater depth what errors are peculiar to e-prescribing compared with the manual form of prescribing; therefore be it

RESOLVED, That the Texas Medical Association study the causes of errors in e-prescribing in pharmacies and suggest ways to reduce these errors.

Relevant TMA policy:

265.020 Comprehensive Analysis of Potential Errors Facilitated by the Implementation of Computerized Physician Order Entry Systems: The Texas Medical Association (1) monitors the potential increase in errors incurred by computerized physician order entry (CPOE) adoption in hospitals and ambulatory clinics and suggest suitable solutions or alternatives including CPOE standardization; (2) works with patient safety organizations that are willing to develop mechanisms for physicians to report safety-related issues regarding medical records and other health information technology for the purpose of aggregating these issues and developing recommendations to drive changes for best practices for the improvement of patient safety; and (3) the Texas Delegation to the AMA will carry a resolution to the AMA House of Delegates asking AMA to conduct a comprehensive study of the impact of computerized CPOE adoption on errors in hospitals and ambulatory clinics and suggest suitable solutions or alternatives such as CPOE standardization within different EHR systems (Res. 415-A-12).

95.008 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 (CSA, p 139, I-93; reaffirmed CSA Rep. 2-A-03; amended CSPH Rep. 1-A-13).
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).

Health Information Technology and Health Information Exchange: 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 Medical Record Adoption

The Texas Medical Association:
1. Supports legislation and other appropriate initiatives that provide positive incentives for physicians to acquire 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 electronic medical records (EMRs) when it does not unreasonably constrain the physician’s choice of which ambulatory HIT 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 EMRs 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 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.

Health Information Exchange

1. Patient safety, privacy, and quality of care are the guiding principles of all health information exchange (HIE) efforts; cost reduction and efficiency are expected byproducts.
2. The Texas Medical Association 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 should be the default. Participants should be able to withdraw upon reasonable notice.

8. HIE will strive to provide complete, timely, and relevant patient-focused information as part of the physician’s workflow, at the point of care, 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 providing HIT incentives to physicians 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 must 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 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 de-identified unless informed consent has been obtained and can be documented.

12. The HIE 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 (children, disabled, uninsured, homeless, aged, etc.).

13. The patient’s Social Security number will not be used as the de facto unique patient identifier.

14. Patient data must be transmitted over a secure network, with provisions for authentication and encryption in accordance with eRisk, HIPAA, and other appropriate guidelines. Standard e-mail 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 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 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.

20. TMA physicians should support partnerships 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 (CPMS Rep. 3-A-07).

21. TMA supports national health information standards such as Nationwide Health Information Network (NHIN), HL7, Continuity of Care Record (CCR)/Continuity of Care Document (CCD), and other standards adopted by Centers for Medicare & Medicaid Services (CMS). In addition to the CCR/CCD contents, HIE participants’ data should also include: labs, radiology results (text), history and physical, discharge summaries, progress, and other notes.

22. TMA supports HIE participation of the United States Department of Veterans Affairs, United States Department of Defense, the uninsured, and other populations that may have medical records inadequately integrated in 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 is breached due to the actions or inactions of the HIE, another HIE participant, or any other person. Each participating individual or entity should only be responsible for their own actions or inactions as it relates to a possible breach of protected health information provided to an HIE.

Electronic Prescribing

TMA supports initiatives that increase appropriate utilization of electronic prescribing (e-prescribing) such as:

1. Further development of physician and patient controls of e-prescribing and e-refills including patient health records and patient portals to manage prescriptions.
2. Positive incentives for the adoption of e-prescribing. TMA opposes physician penalties where e-prescribing is not practical, possible, or desired by patients.
3. Legislative and regulatory efforts to ensure universal acceptance by pharmacies of electronically transmitted prescriptions.
4. Development of patient and condition specific e-prescribing tools, for example, appropriate rounding of weight-based doses in pediatrics.
5. The use of standardized plug-in applications or Web-based tools to standardize and simplify e-prescribing.
6. Cost-free access to patient-specific medication-related information such as formulary, eligibility, and fill history.

TMA strongly supports removing barriers to electronic prescribing by pursuing legislative and regulatory changes through its activities in the federation, including advocating for:

1. Removal of the Medicaid requirement that physicians write, in their own hand, “brand medically necessary” on a paper prescription form; and
2. Removal of restrictions on e-prescribing of Schedule II through V medications in a manner friendly to physician workflow.
Data Warehouses: Principles for the Collection, Use, and Warehousing of EMRs and Claims Data

The Texas Medical Association supports policy that any payer, clearinghouse, vendor, or other entity that collects, warehouses, and uses EMRs 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. EMRs and claims data transmitted for any purpose to a third party must contain the minimum information necessary 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 patient must be informed of and provide permission for third-party analyses undertaken with his or her EMRs 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 EMRs and claims data must be provided to the physician or an independent third party so that re-analysis 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 EMRs 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. EMR 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 EMRs 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.

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 EMRs. There is a degree of precision in EMRs that does not exist with the use of paper records. Physicians should not be held liable for innocent inconsistencies that occur within the EMR 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 EMRs 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.

Relevant AMA policy:

H-35.999 Medicine and Pharmacy Relations
(1) The contribution of pharmacy as an independent profession in assisting physicians toward the constant goal of improved patient care is recognized and commended; and (2) The AMA urges physicians to encourage and support the continued growth of pharmacy as a valuable and necessary member of the health team. (Res. 96, A-66; Reaffirmed: CLRPD Rep. C, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: CSAPH Rep. 2, A-08)

H-120.963 Epidemiology of Drug Errors
The AMA will continue its collaborations with the Food and Drug Administration and the US Pharmacopoeial Convention, Inc., along with its own ongoing initiatives, to identify and eliminate causes of medication errors. (Sub. Res. 519, I-96; Reaffirmed: CSAPH Rep. 3, A-06; Reaffirmed: CSAPH Rep. 01, A-16)

H-120.965 Medication Errors
The AMA reaffirms its long-standing supportive efforts to curtail the problems of medication errors; and encourages physicians to add a brief notation of purpose (e.g., for cough, for constipation) on prescriptions, where appropriate, to avoid confusion on the part of either the pharmacists or the patients. (Res. 515, I-95; Reaffirmed: CSA Rep. 8, A-05; Modified: CSAPH Rep. 1, A-15)
D-35.981 AMA Response to Pharmacy Intrusion Into Medical Practice
1. Our AMA deems inappropriate inquiries from pharmacies to verify the medical rationale behind
prescriptions, diagnoses and treatment plans to be an interference with the practice of medicine and
unwarranted. 2. Our AMA will work with pharmacy associations such as the National Association of
Chain Drug Stores to engage with the Drug Enforcement Administration, the federal Department of
Justice, and other involved federal regulators and stakeholders, for the benefit of patients, to develop
appropriate policy for pharmacists to work with physicians in order to reduce the incidence of drug
diversion and inappropriate dispensing. 3. If the inappropriate pharmacist prescription verification
requirements and inquiry issues are not resolved promptly, our AMA will advocate for legislative and
regulatory solutions to prohibit pharmacies and pharmacists from denying medically necessary and
legitimate therapeutic treatments to patients. (Res. 218, A-13)

H-120.973 DEA, Diagnosis and ICD-9-CM Codes on Prescriptions
Our AMA, in order to protect patient confidentiality and to minimize administrative burdens on
physicians, opposes requirements by pharmacies, prescription services, and insurance plans to include
such information as ICD-9-CM codes and diagnoses on prescriptions. (Sub. Res. 518, A-93;
Reaffirmation A-97; Reaffirmed by Sub. Res. 205, A-98; Reaffirmed: Res. 523, A-00; Amended: Res.
527, A-02; Modified: CSAPH Rep. 1, A-12)

H-100.971 Preserving the Doctor-Patient Relationship
The AMA and interested physicians will continue to work with the Food and Drug Administration to
prevent the unnecessary intrusion of the government and other regulatory bodies into the doctor-patient
relationship, especially as it concerns the prescription of medication. (Sub. Res. 510, I-95; Reaffirmed:

D-120.956 Electronic Prescribing and Conflicting Federal Guidelines
Our American Medical Association will address with the Centers for Medicare & Medicaid Services and
the Drug Enforcement Administration the contradictory guidance, issued respectively by those two
federal agencies, relating to electronic transmission of physicians’ prescriptions to pharmacies —
commonly referred to as “e-prescribing” — for Schedules III, IV and V drugs, as those current guidelines
add rather than reduce administrative paperwork and defeat the purpose of electronic handling of
prescriptions. (Res. 210, I-09 I-16)

D-120.984 Streamlining the Process for Prescription Refills
Our AMA will work with the American Pharmacists Association, the National Community Pharmacists
Association, and the National Association of Chain Drug Stores to streamline the process for prescription
refills in order to reduce administrative burdens on physicians and pharmacists and to improve patient
safety. (Sub Res. 522, A-03; Reaffirmed: BOT Rep. 8, A-11)

H-120.958 Supporting Safe Medical Products as a Priority Public Health Initiative
Our AMA will: (1) work through the United States Adopted Names (USAN) Council to adopt
methodology to help prevent “look alike-sound alike” errors in giving new drugs generic names; (2)
continue participation in the National Patient Safety Foundation’s efforts to advance the science of safety
in the medication use process and likewise work with the National Coordinating Council for Medication
Error Reporting and Prevention; (3) support the FDA’s Medwatch program by working to improve
physicians’ knowledge and awareness of the program and encouraging proper reporting of adverse events;
(4) vigorously work to support and encourage efforts to create and expeditiously implement a national
machine-readable coding system for prescription medicine packaging in an effort to improve patient
safety; (5) participate in and report on the work of the Healthy People 2010 initiative in the area of safe
medical products especially as it relates to existing AMA policy; and (6) seek opportunities to work
collaboratively within the Medicine-Public Health initiative (H-440.991) and with the Food and Drug
Administration (FDA), National Institutes of Health (NIH), United States Pharmacopoeia (USP) and
Centers for Disease Control and Prevention (CDC) the Agency for Health Care Policy and Research (AHCPR) and the Centers for Medicare & Medicaid Services (CMS) to provide information to individual physicians and state medical societies on the need for public health infrastructure and local consortiums to work on problems related to medical product safety. (Res. 416, A-99; Appended: Res. 504, I-01; Reaffirmation A-10)

D-120.965 Pharmacy Review of First Dose Medication
1. Our AMA supports medication reconciliation as a means to improve patient safety. 2. It is AMA policy that (a) systems be established to support physicians in medication reconciliation, and (b) medication reconciliation requirements should be at a level appropriate for a particular episode of care and setting. (BOT Action in response to referred for decision Res. 808, I-06; Reaffirmation A-10; Reaffirmation A-15)

D-120.958 Federal Roadblocks to E-Prescribing
1. Our AMA will initiate discussions with the Centers for Medicare and Medicaid Services and state Medicaid directors to remove barriers to electronic prescribing including removal of the Medicaid requirement that physicians write, in their own hand, “brand medically necessary” on a paper prescription form. 2. Our AMA will initiate discussions with the Drug Enforcement Administration to allow electronic prescribing of Schedule II prescription drugs. 3. It is AMA policy that physician Medicare or Medicaid payments not be reduced for non-adoption of E-prescribing. 4. Our AMA will work with federal and private entities to ensure universal acceptance by pharmacies of electronically transmitted prescriptions. 5. Our AMA will advocate for appropriate financial and other incentives to physicians to facilitate electronic prescribing adoption. 6. Our AMA will: (A) investigate regulatory barriers to electronic prescription of controlled substances so that physicians may successfully submit electronic prescriptions for controlled substances; and (B) work with the Centers for Medicare & Medicaid Services to eliminate from any program (e.g., the Physician Quality Reporting System, meaningful use, and e-Prescribing) the requirement to electronically prescribe controlled substances, until such time that the necessary protocols are in place for electronic prescribing software vendors and pharmacy systems to comply. 7. Our AMA will work with representatives of pharmacies, pharmacy benefits managers, and software vendors to expand the ability to electronically prescribe all medications. 8. Our AMA will petition the Centers for Medicare & Medicaid Services and the federal government to have all pharmacies, including government pharmacies, accept e-prescriptions or to temporarily halt the e-prescribing requirements of meaningful use until this is accomplished. (Res. 230, A-08; Reaffirmed in lieu of Res. 215, I-08; Reaffirmation A-09; Reaffirmation A-10; Appended: Res. 244, A-12; Appended: Res. 714, A-13; Appended: Res. 203, A-14)

D-120.944 Improvement of Electronic Prescription Software
Our AMA will: (1) advocate for changing the national standards for controlled substance prescriptions so that prescriptions for controlled substances can be transmitted electronically directly to the pharmacy in a secure manner; and (2) work with pharmacies, vendors, and other appropriate entities to encourage the use of standards that would allow the transmission of short messages regarding prescriptions so that both physicians and pharmacists could communicate directly with each other within the secure health records systems that they are already using. (Res. 209, A-14; A-16)

H-335.965 Patient Safety
Our AMA: (1) continues its advocacy efforts in the area of patient safety and work to promote a meaningful long-term approach to ensure greater patient safety in the delivery of health care in our nation; and (2) continues to advance non-punitive, evidenced-based health systems error data collection as well as strong legal protections for participants in safety programs. At a minimum, these protections must ensure that all information reported or otherwise gathered in the process of patient safety and error reporting programs (including any data, report, memorandum, analysis, statement, or other communication) intended either for internal use, or to be shared with others solely for the same purposes, remain confidential and not be subject to discovery in legal proceedings. Such protections must extend
from the time of reporting to post-incident review activities and with regard to the repositories of
identifiable data from such reporting programs. (Sub. Res. 202, A-00; Reaffirmed: BOT Rep. 13, I-00;
Reaffirmation A-01; Reaffirmation I-03; Reaffirmation A-05; Modified: CSAPH Rep. 1, A-15)

D-478.995 National Health Information Technology
1. Our AMA will closely coordinate with the newly formed Office of the National Health Information
Technology Coordinator all efforts necessary to expedite the implementation of an interoperable health
information technology infrastructure, while minimizing the financial burden to the physician and
maintaining the art of medicine without compromising patient care. 2. Our AMA: (A) advocates for
standardization of key elements of electronic health record (EHR) and computerized physician order entry
(CPOE) user interface design during the ongoing development of this technology; (B) advocates that
medical facilities and health systems work toward standardized login procedures and parameters to reduce
user login fatigue; and (C) advocates for continued research and physician education on EHR and CPOE
user interface design specifically concerning key design principles and features that can improve the
quality, safety, and efficiency of health care.; and (D) advocates for more research on EHR, CPOE and
clinical decision support systems and vendor accountability for the efficacy, effectiveness, and safety of
these systems. 3. Our AMA will request that the Centers for Medicare & Medicaid Services: (A) support
an external, independent evaluation of the effect of Electronic Medical Record (EMR) implementation on
patient safety and on the productivity and financial solvency of hospitals and physicians’ practices; and
(b) develop minimum standards to be applied to outcome-based initiatives measured during this rapid
implementation phase of EMRs. 4. Our AMA will (A) seek legislation or regulation to require all EHR
vendors to utilize standard and interoperable software technology components to enable cost efficient use
of electronic health records across all health care delivery systems including institutional and community
based settings of care delivery; and (B) work with CMS to incentivize hospitals and health systems to
achieve interconnectivity and interoperability of electronic health records systems with independent
physician practices to enable the efficient and cost effective use and sharing of electronic health records
across all settings of care delivery. 5. Our AMA will seek to incorporate incremental steps to achieve
electronic health record (EHR) data portability as part of the Office of the National Coordinator for
Health Information Technology's (ONC) certification process. 6. Our AMA will collaborate with EHR
vendors and other stakeholders to enhance transparency and establish processes to achieve data
portability. 7. Our AMA will directly engage the EHR vendor community to promote improvements in
EHR usability. (Res. 730, I-04 Reaffirmed in lieu of Res. 818, I-07; Reaffirmed in lieu of Res. 726, A-
08; Reaffirmation A-10; Reaffirmed: BOT Rep. 16, A-11; Modified: BOT Rep. 16, A-11; Modified: BOT
Rep. 17, A-12; Reaffirmed in lieu of Res. 714, A-12; Reaffirmed in lieu of Res. 715, A-12; Reaffirmed:
of Res. 208, A-15; Reaffirmed in lieu of Res. 223, A-15; Reaffirmation I-15; Reaffirmed: CMS Rep. 07,
I-16; Reaffirmed: BOT Rep. 05, I-16)

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Subject: Expansion of Next Generation 9-1-1

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, Next Generation 9-1-1 networks replace the existing narrowband, circuit-switched 9-1-1 networks that carry only voice and very limited data; and

Whereas, Texting 9-1-1 could be valuable in emergencies such as mass shooting situations or a domestic violence incident, where it is unsafe to make a call; and

Whereas, Texting 9-1-1 would allow emergency dispatchers to better serve people who are deaf or have speech impairment; and

Whereas, The Federal Communications Commission advises use of voice calls over texting to contact 9-1-1 during an emergency whenever possible due to the lack of widespread ability for emergency dispatch to receive text messages; and

Whereas, In Texas, only 150 public safety answering points (PSAPs) are ready to receive text-to-9-1-1 messages out of nearly 600 PSAPs statewide; therefore be it

RESOLVED, That our Texas Medical Association support the expansion of ongoing updates to the 9-1-1 service infrastructure throughout the state of Texas; and be it further

RESOLVED, That our TMA expand public education on the usage, availability, and benefits of Next Generation 9-1-1.

Relevant TMA Policy:

100.008 Statewide Emergency Telephone System: Texas should maintain a robust and adequately funded statewide 911 telephone system and, as part of that effort, county medical societies should assist in advocating needed resources to support their local 911 emergency systems (CPH, p 91, A-95, amended CPH Rep. 3-A-10).

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).

Relevant AMA Policy:
Cellular Phone Location of 911 Emergency Calls H-440.913
The AMA encourages the development of 911 emergency cellular phone service locating systems; encourages that such locating systems be made available to the purchaser of a cellular phone for the benefit of the consumer; and urges appropriate state and federal agencies (e.g., the FCC) to facilitate universal access to 911 services via cellular telephones.

References
Subject: Addressing the Medical Inaccuracies of the Mandated A Woman’s Right to Know Booklet and Related Patient Misinformation

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, In Texas, a woman can give voluntary and informed consent to an abortion only if the physician who is to perform the abortion or the physician’s agent provides the woman with or access to the printed or online materials from the Department of State Health Services (DSHS); and

Whereas, DSHS is to use information from the American Congress of Obstetricians and Gynecologists (ACOG) as a resource for the materials physicians are required to provide; and

Whereas, ACOG is committed to encouraging and upholding policies that ensure women have the right to evidence-based health care, including health and sexuality education; and

Whereas, ACOG is committed to encouraging and upholding policies that ensure women have the right to autonomous decisionmaking and informed consent, including the right to decide whether to have children and the number and spacing of their children, and to have the information, education, and access to health services to make these choices; and

Whereas, Our Texas Medical Association already “urges DSHS to distribute printed materials 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”; and

Whereas, Our 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”; and

Whereas, Informed consent is a fundamental aspect of medical ethics that requires patients be given complete and accurate medical information so they can make reasoned decisions and considers giving patients the right to complete and accurate medical information imperative for patients to make reasoned decisions; and

Whereas, Mandating the transmission of misinformation violates the accepted principles of informed consent, physician autonomy, and the physician’s fiduciary duty to the patient; and

Whereas, A breach in these accepted principles can detract from the patient’s long-term trust in the health care system; and

Whereas, State-mandated informed consent scripts, when containing inaccurate information, have been shown to result in a decrease in patient knowledge about abortion and endorsement of inaccurate information as facts; and
Whereas, The patient-physician fiduciary relationship requires the physician to make decisions based on
scientific evidence, well-documented outcomes, and open and honest communication; and
Whereas, The use of the word “baby” is biased, when the medically accurate terminology is “embryo” or
“fetus”; and
Whereas, The booklet uses the term “baby” 120 times, and the “word” fetus twice; and
Whereas, The A Woman’s Right to Know booklet incorrectly cites an article about spontaneous abortion,
or miscarriage, when discussing elective abortive procedures; and
Whereas, Women with one or more spontaneous abortions did not have an overall increased relative risk
for breast cancer with a relative risk of 0.98 (95% CI 0.92–1.04, p=0.5); and
Whereas, The corresponding relative risk of breast cancer for induced abortion was 0.93 (95% CI 0.89–
0.96, p=0.0002); and
Whereas, The relative breast cancer risk relies on the presumption that the state of pregnancy decreases
the risk of breast cancer, misleadingly implying anytime a woman is not pregnant, her relative risk is
increasing; and
Whereas, From 1998 to 2010, of approximately 16.1 million abortion procedures, 108 women died, for a
mortality rate of 0.7 deaths per 100,000 procedures overall, 0.4 deaths for non-Hispanic white women, 0.5
deaths for Hispanic women, and 1.1 deaths for black women; and
Whereas, In 2008, 12 patients died from legally induced abortive procedures in the United States; and
Whereas, In 2008, 15.5 patients per 100,000 died from live birth; and
Whereas, According to a 2005 systematic review published in the Journal of the American Medical
Association, the capacity for conscious perception of pain can arise only after the thalamocortical
pathways start to function, which may happen in the third trimester around 29 to 30 weeks of gestation,
which contradicts the material in the booklet that states capacity for fetal pain is considered to begin at 20
weeks; and
Whereas, The literature cited regarding fetal pain in A Woman’s Right to Know states there is
inconclusive evidence regarding the gestational age a fetus feels pain, which does not reflect the
statements made in the booklet; and
Whereas, A five-year prospective, longitudinal cohort study demonstrated that women who received an
elective abortion reported similar or better mental health compared with women denied an elective
abortion; and
Whereas, Women report elevated anxiety levels, and decreased self-esteem and life satisfaction after
being denied an abortion; therefore be it
RESOLVED, That the Texas Medical Association support providing medically accurate information to
patients in regards to reproductive health; and be it further
RESOLVED, That TMA support a thorough update using evidence-based medicine to the *A Woman’s Right to Know* booklet and related materials to prevent breaches in the patient-physician relationship.

**Relevant TMA Policy:**

**10.002 Abortion:** The Texas Medical Association guidelines for performance of abortion are based upon early and accurate diagnosis of pregnancy; informed and nonjudgmental counseling; prompt referral; skillful and understanding personnel working in a good facility; reasonable cost; and professional follow up (Remarks of Speaker, p 12, A-85; reaffirmed: Council on Public Health, p 105, I-89; Res. 28WW, p 218-D, A-92; Res. 28J, p 168, A-94; and Council on Health Facilities, p 64, A-97; reaffirmed CPH Rep. 2-A-07).

**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 82(R) HR 15. To protect the integrity of the patient-physician relationship, TMA urges the Texas Legislature to amend 82(R) HR 15 to allow the sonogram requirement be waived based on physicians’ clinical judgment (Amended Res. 306-A-12).

**330.009 Preconception and Inter-gestational Health and Care:** The Texas Medical Association recognizes that preconception and inter-gestational care are components of a larger health care goal of optimizing the health of every woman. Reproductive capacity spans almost four decades for most women. Optimizing women’s health before and between pregnancies is an ongoing process that requires access to and the full participation of all segments of the health care system.

TMA believes that all women in Texas should have the opportunity to benefit from preconception and inter-gestational care. TMA supports efforts to assure that every pregnancy is a planned pregnancy and that all women in Texas have access to contraception counseling and affordable options when pregnancy is not desired. This includes counseling and assistance with pregnancy spacing to achieve the best possible health outcomes for mother and baby.

Further, TMA supports improving access to care for women of reproductive age in order to be able to: (1) screen for and optimize management of chronic medical conditions prior to pregnancy; (2) use medications that are safe in pregnancy; (3) assess family history and genetic risk; (4) address tobacco and substance use; (5) address nutritional issues and weight management; (6) assess occupational and environmental exposures and; (7) screen for and address mental health issues.

All annual exams for women of reproductive age should address pregnancy status and planning. In addition, clinicians providing reproductive care to women should encourage their patients to formulate a reproductive health plan and should discuss it in a culturally sensitive, nondirective way at each visit. TMA will work to provide and promote resources that can help physicians discuss these plans with their patients.

Relevant AMA Policy:

H-5.989 Freedom of Communication Between Physicians and Patients; Topic: Abortion

It is the policy of the AMA: (1) to strongly condemn any interference by the government or other third parties that causes a physician to compromise his or her medical judgment as to what information or treatment is in the best interest of the patient; (2) working with other organizations as appropriate, to vigorously pursue legislative relief from regulations or statutes that prevent physicians from freely discussing with or providing information to patients about medical care and procedures or which interfere with the physician-patient relationship; (3) to communicate to HHS its continued opposition to any regulation that proposes restrictions on physician-patient communications; and (4) to inform the American public as to the dangers inherent in regulations or statutes restricting communication between physicians and their patients.

H-5.993 Right to Privacy in Termination of Pregnancy

Our AMA reaffirms existing policy that (1) abortion is a medical procedure and should be performed only by a duly licensed physician in conformance with standards of good medical practice and the laws of the state; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment or 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. The AMA further supports the position that the early termination of pregnancy is a medical matter between the patient and the physician, subject to the physician's clinical judgment, the patient's informed consent, and the availability of appropriate facilities.

H-5.995 Abortion

Our AMA reaffirms existing policy that (1) abortion is a medical procedure and should be performed only by a duly licensed physician in conformance with standards of good medical practice and the laws of the state; and (2) no physician or other professional personnel shall be required to perform an act violative of good medical judgment or 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. The AMA further supports the position that the early termination of pregnancy is a medical matter between the patient and the physician, subject to the physician's clinical judgment, the patient's informed consent, and the availability of appropriate facilities.

References

3. Texas Medical Association, 10.003 Patient Autonomy and Accuracy of Information in Informed Consent for Abortion.


Resolution 310
A-17

Subject: Healthy Food in Hospitals

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, Obesity is linked directly to poor diet and serious diseases, including a 53-percent increased risk of mortality due to heart disease; a 55-percent increased risk of depression; a seven- to 12-fold higher risk of type 2 diabetes; a 22-percent increased risk of stroke; and higher susceptibility to other diseases like cancer, obstructive sleep apnea, kidney disease, and liver disease; and

Whereas, Between 1987 and 2001, an estimated 27 percent of the rise in per-capita health care spending was associated with “obesity-attributable” factors, with obese employees costing American private companies $45 billion per year in medical expenditures and related productivity losses; and

Whereas, Between 1995 and 2010, the obesity rates in Texas doubled for adults and tripled for children, with Texas ranking 10th highest among states for percentage of obese citizens; and

Whereas, The Texas Department of State Health Services (DSHS) identified obesity as a tier-one priority in 2008, and the DSHS Obesity Workgroup was formed to enhance efforts towards obesity prevention; and

Whereas, Consumption of fast food has been linked to weight gain in adults and to higher caloric intake and poorer diet quality in children and adolescents; and

Whereas, A 2009 study by the University of California at Berkeley showed that when normalized against schools with fast food restaurants located at least one-fourth mile away, schools with fast food restaurants located within one-tenth mile were associated with a 5.2-percent increase in obesity incidence rates among ninth-grade children, suggesting that proximity and convenience to fast food are linked with obesity; and

Whereas, In a 2015 survey of 200 U.S. hospitals, the Physicians Committee for Responsible Medicine reported that Texas is one of only 15 states still allowing fast food franchises, such as McDonald’s, Wendy’s, and Chick-fil-A, on hospital campuses; and

Whereas, A May 2011 Physicians Committee for Responsible Medicine report determined that the CHI St. Luke’s Health/Texas Heart Institute/Texas Children’s Hospital complex in Houston’s Texas Medical Center, the largest medical complex in the world with 10 million patients a year and more than 106,000 employees, had one of the five worst hospital food environments in the United States; and

Whereas, A 2006 study published by the American Academy of Pediatrics reported that compared with outpatients at a hospital with no McDonald’s, outpatients at a hospital with an on-site McDonald’s rated the restaurant’s food higher on a health scale and were four times more likely to have purchased its food during their visit; and
Whereas, As institutions that serve as both health care and food service environments, hospitals have the opportunity to positively influence dietary patterns of patients, their family members, and health care professionals towards increased fruits and vegetables and decreased added sugar, saturated fats, and sodium consumption as recommended by the Food and Drug Administration Dietary Guidelines for Americans 2015-2020; and

Whereas, Current TMA policy supports “educating the general public on the benefits of maintaining a proper diet,” and physicians and providers who counsel patients based on their own healthy practices are perceived as more credible by patients, especially on the topics of diet and exercise; and

Whereas, Current American Medical Association policy “encourages healthy food options be available, at reasonable prices, and easily accessible on hospital premises;” therefore be it

RESOLVED, That our Texas Medical Association encourage hospitals to offer and promote healthy, reasonably priced, and easily accessible food options; and be it further

RESOLVED, That our TMA encourage hospitals to 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.

Relevant TMA Policy:

**260.083 Promotion of Healthy Lifestyles — Reducing the Population Burden of Cardiovascular Disease by Reducing Sodium Intake:** 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) To assist in achieving the Healthy People 2010 goal for sodium consumption, 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 about the benefits of long-term, moderate reductions in sodium intake. (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 label markings 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 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.

TMA will promote educational efforts for members and consumers about the risks of dietary sodium and ways to reduce consumption (CSA Rep. 2-A-09).

**260.007 Obesity:** The Texas Medical Association recognizes obesity as a serious public health problem. Approximately 66 percent of Texans are either overweight or obese, and nearly one-quarter of adolescents and children are overweight or obese. Obesity is a risk factor
for heart disease, stroke, hypertension, diabetes, and some cancers. Obesity and the
associated medical complications increase health care spending and patient morbidity and
mortality.

Texas children now are in a health crisis, with the highest percentage of students with
type 2 diabetes, obesity, and heart disease in the history of our state. Obesity in childhood
increases the risk of obesity in adulthood. Obesity is the second most preventable cause
disease behind tobacco use.

TMA encourages physicians to become educated and empowered to conduct appropriate
assessment and treatment of overweight patients and obesity in their practices and to
serve as leaders in their communities and in the policymaking process to improve healthy
eating and increased physical activity among our state’s children. The crisis results from
a multitude of factors, including lack of physical activity, poor nutritional habits, and
personal and societal responsibility. These issues require a multipronged response. TMA
will monitor and encourages research on the medical, psychological, and social issues
related to obesity to be best informed when making recommendations on prevention and
treatment.

Public Education
(1) TMA supports educating the general public on the benefits of maintaining a proper
diet and adopting a schedule of daily physical activity. This includes targeted messages to
specific audiences including pregnant women, parents, and preschool and day-care
employees, and mid-life and older adults.

Physician Education
(19) Medical schools should be encouraged to teach medical students the etiologies of
obesity including nutritional choices and social circumstances, and the pathophysiology
of the possible sequelae of obesity such as diabetes and metabolic syndrome, and be
couraged to teach students the prevention and management of obesity, including the
value of healthy nutrition and the importance of maintaining an ideal body weight
through proper dietary intake and regular physical activity. Physicians should be the
model of appropriate weight and health.

260.095 Eligibility of Sugar-Sweetened Beverages for the Supplemental Nutrition
Assistance Program: The Texas Medical Association 1) will publish an educational
brief educating physicians about the effects of sugar-sweetened beverages (SSBs) on
obesity and overall health, and encourage them to educate their patients in turn; 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 3) will
work with both the Texas Legislature and the HHSC to remove SSBs from SNAP

References
prevention-source/obesity-consequences/health-effects/.


Subject: Addressing Access to Maternal Personal Protective Equipment From Radiation

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, Guidelines enforcing the use of personal protective equipment for pregnant health care workers are insufficient; and

Whereas, Multiple studies have shown that adequate maternal personal protective equipment against radiation for pregnant health care workers exists on the market but this population does not use it properly; and

Whereas, Some health care workers feel pressure to withhold the announcement of their pregnancy to their employer due to the potential for discrimination, where 24 percent of pregnancy discrimination charges filed with the Equal Employment Opportunity Commission between 2011 and 2015 originated from within health care and social assistance industries; and

Whereas, Having maternal lead suits readily available without requiring institutional approval is essential for protecting health care workers from radiation and to avoid discrimination; and

Whereas, Societies such as the Cardiovascular and Interventional Society of Europe call for properly fitted protective equipment that is both adequate and comfortable and accommodates pregnancy-related anatomical changes to reduce the risk for musculoskeletal/back injuries; and

Whereas, American College of Radiology and the American Association of Physicists in Medicine safety standards hold that declared pregnant women should monitor radiation exposure in the workplace on a monthly basis with two abdominal dosimeters versus the single collar dosimeter used for nonpregnant health care staff; and

Whereas, Although the national average for percentage of women in medical school is 46 percent, the number of female radiologists and interventional radiologists has been stagnant for decades, potentially due to fears of conceptus exposure to radiation; therefore be it

RESOLVED, That the Texas Medical Association support the revision of the current national guidelines, set forth by the National Council on Radiation Protection, to provide explicit instructions regarding personal protective equipment against radiation for pregnant health care workers in all specialties; and be it further

RESOLVED, That TMA support the provision of readily available maternal/fetal lead suits for pregnant health care workers without individual approval from the institution; and be it further

RESOLVED, That TMA support the use of appropriately fitting and ergonomic protective equipment, especially for pregnant health care workers, to prevent injury and accidents; and be it further
RESOLVED, That TMA support policies that require two abdominal dosimeters to be worn under the maternal lead suit for pregnant health care workers; and be it further

RESOLVED, That our TMA Delegation to the American Medical Association forward this resolution to the AMA House of Delegates.

Relevant AMA Policy:

H-455.994: Risks of Nuclear Energy and Low-Level Ionizing Radiation

Our AMA supports the following policy on nuclear energy and low-level ionizing radiation:

(5) Occupational Safety: The philosophy of maintaining exposures of workers at levels “as low as reasonably achievable (ALARA)” is commended. The present federal standards for occupational exposure to ionizing radiation are adequate. The responsibilities of the various federal agencies regarding workers in the nuclear energy industry should be clarified; these agencies include the Departments of Energy, Defense, HHS, Labor and Transportation; and the NRC, VA and EPA.

References

13. Chaudry, Humaira; Karcich, Jenika; Thomas, Prashant; Baker S. Women as Radiologists a Decade Later: Are There Still Barriers to Entry and Advancement? Am Coll Radiol. 2015;Abstract N.

Subject: Implementing a Sugar-Sweetened Beverage Tax in Texas

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, Sixty-six percent of adult Texans are obese or overweight, with 29.5 percent being obese as of 2009; and

Whereas, Twenty percent of Texas children aged 10-17 are obese; and

Whereas, U.S. annual health care costs due to obesity have doubled in less than a decade to 9.1 percent of total health costs, or $147 billion a year; and

Whereas, Texas businesses spent $9.5 billion in 2009 due to obesity-related health care, absenteeism, disability, and decreased productivity; and

Whereas, The 82nd Texas Legislature ordered a report on the direct and indirect costs of type II diabetes in Texas, which estimated the total costs at $18.5 billion a year; and

Whereas, Multiple rigorous studies over the past 10 years have found a significant association between sugar-sweetened beverages (SSBs) and the development of type II diabetes; and

Whereas, Substituting one serving a day of water or unsweetened tea/coffee for sugar-sweetened beverages has been found to lower the incidence of type II diabetes by 14-25 percent; and

Whereas, A comprehensive 2015 meta-analysis using data from 17 cohort studies estimated that every decade 1.8 million new cases of type II diabetes in the United States are attributable to SSB consumption; and

Whereas, Certain American cities such as Berkeley, Calif., and Philadelphia, Pa., already have successfully implemented a tax on SSBs, which has led to a sustained fall in consumption of sugar-sweetened beverages in these cities; and

Whereas, A 2016 public health study that measured the impact of the new 2014 SSB tax in Berkeley, Calif., found that SSB consumption fell by 21 percent in low-income neighborhoods; and

Whereas, Low-income residents are more likely to consume SSBs, and also are more likely to suffer from obesity/diabetes related-health issues; and

Whereas, Recent shifts in federal policy, such as the alignment of Women, Infants, and Children food packages with the Dietary Guidelines for Americans and the Let’s Move! public health campaign, have
been cited as a key reason for the recent decrease in childhood obesity prevalence in low-income preschoolers, a vulnerable population; and

Whereas, A country-wide 10-percent excise tax on sugar-sweetened beverages in Mexico has been in effect since 2014, and the country saw a decrease in consumption of said beverages of approximately 10 percent; and

Whereas, A 2016 epidemiological study through the Mexican National Institute of Public Health has modeled that if Mexico’s 10-percent drop in consumption of SSBs is sustained, Mexico would see 189,300 fewer type II diabetes cases, 20,400 fewer strokes and myocardial infarctions, 18,900 fewer deaths, and health care savings of $983 million U.S. dollars from 2013 to 2022; and

Whereas, TMA actively encourages policymakers to craft evidence-based public health legislation that will strengthen obesity/diabetes prevention and interventions in the state of Texas; therefore be it

RESOLVED, That our Texas Medical Association support the incorporation of a Texas-wide sugar-sweetened beverage tax.

Relevant TMA Policy:

260.095 Eligibility of Sugar-Sweetened Beverages for the Supplemental Nutrition Assistance Program: The Texas Medical Association 1) will publish an educational brief educating physicians about the effects of sugar-sweetened beverages (SSBs) on obesity and overall health, and encourage them to educate their patients in turn; 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 3) will work with both the Texas Legislature and the HHSC to remove SSBs from SNAP (Amended Res. 302-A-13).

260.007 Obesity: The Texas Medical Association recognizes obesity as a serious public health problem. Approximately 66 percent of Texans are either overweight or obese, and nearly one-quarter of adolescents and children are overweight or obese. Obesity is a risk factor for heart disease, stroke, hypertension, diabetes, and some cancers. Obesity and the associated medical complications increase health care spending and patient morbidity and mortality.

Texas children now are in a health crisis, with the highest percentage of students with type 2 diabetes, obesity, and heart disease in the history of our state. Obesity in childhood increases the risk of obesity in adulthood. Obesity is the second most preventable cause of disease behind tobacco use.

TMA encourages physicians to become educated and empowered to conduct appropriate assessment and treatment of overweight patients and obesity in their practices and to serve as leaders in their communities and in the policymaking process to improve healthy eating and increased physical activity among our state's children. The crisis results from a multitude of factors, including lack of physical activity, poor nutritional habits, and personal and societal responsibility. These issues require a multipronged response. TMA will monitor and encourages research on the medical, psychological, and social issues related to obesity to be best informed when making recommendations on prevention and treatment.
TMA supports the need to educate Texas adults and children on the importance of proper diet, nutrition, and physical activity in the prevention and management of obesity. Specifically, TMA makes the following recommendations:

Public Policy Initiatives:
(8) TMA supports making physical activity an integral part of life and local community initiatives that promote a built environment that encourages safe physical activity for all, such as lighting parks and sports fields, promoting walking in the mall, cycling lanes, and so forth.
(9) TMA encourages physicians to participate in broad-based coalitions that are engaged in obesity prevention and fitness interventions through community health improvement processes and evidence-based programs and policies that reflect the recommendations of the U.S. Community Preventive Services Task Force.
(10) TMA should work to support physicians by providing information on potential public state and federal funding for obesity awareness, education and technology, and preventive obesity care.
   a) TMA should actively seek to collaborate with the food and restaurant industry to increase menu labeling in Texas, and work to advance this initiative nationally through the American Medical Association.
(11) TMA supports an increased role for health plans, policy makers, and employers when it comes to obesity prevention and intervention. TMA should work with health plans to recognize obesity as a primary diagnosis and develop payment codes for physicians for prevention and treatment of obesity.
(12) Physicians should actively participate in their local school health advisory committees (SHACs). SHACs provide an opportunity to promote nutrition and other health standards as well as guide health policy for school districts.

Relevant AMA Policy:
Eligibility of Sugar-Sweetened Beverages for SNAP D-150.975
Our AMA will: (1) publish an educational brief to educate physicians about the effects of sugar-sweetened beverages (SSBs) on obesity and overall health, and encourage them to educate their patients in turn, (2) encourage state health agencies 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 (3) work to remove SSBs from SNAP.

Addition of Alternatives to Soft Drinks in Schools D-150.987
Our AMA will seek to promote the consumption and availability of nutritious beverages as a healthy alternative to high-calorie, low nutritional-content beverages (such as carbonated sodas and sugar-added juices) in schools.

Support for Nutrition Label Revision and FDA Review of Added Sugars D-150.974
1. Our AMA will issue a statement of support for the newly proposed nutrition labeling by the Food and Drug Administration (FDA) during the public comment period.
2. Our AMA will recommend that the FDA further establish a recommended daily value (%DV) for the new added sugars listing on the revised nutrition labels based on previous recommendations from the WHO and AHA.
3. Our AMA will encourage further research into studies of sugars as addictive through epidemiological, observational, and clinical studies in humans.
1. Our AMA will: (a) assume a leadership role in collaborating with other interested organizations, including national medical specialty societies, the American Public Health Association, the Center for Science in the Public Interest, and the AMA Alliance, to discuss ways to finance a comprehensive national program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; (b) encourage state medical societies to collaborate with interested state and local organizations to discuss ways to finance a comprehensive program for the study, prevention, and treatment of obesity, as well as public health and medical programs that serve vulnerable populations; and (c) continue to monitor and support state and national policies and regulations that encourage healthy lifestyles and promote obesity prevention.

2. Our AMA, consistent with H-440.842, Recognition of Obesity as a Disease, will work with national specialty and state medical societies to advocate for patient access to and physician payment for the full continuum of evidence-based obesity treatment modalities (such as behavioral, pharmaceutical, psychosocial, nutritional, and surgical interventions).

Obesity as a Major Health Concern H-440.902

The AMA: (1) recognizes obesity in children and adults as a major public health problem; (2) will study the medical, psychological and socioeconomic issues associated with obesity, including reimbursement for evaluation and management of obese patients; (3) will work with other professional medical organizations, and other public and private organizations to develop evidence-based recommendations regarding education, prevention, and treatment of obesity; (4) recognizes that racial and ethnic disparities exist in the prevalence of obesity and diet-related diseases such as coronary heart disease, cancer, stroke, and diabetes and recommends that physicians use culturally responsive care to improve the treatment and management of obesity and diet-related diseases in minority populations; and (5) supports the use of cultural and socioeconomic considerations in all nutritional and dietary research and guidelines in order to treat overweight and obese patients.

References


Whereas, Participation in contact sports can lead to a higher incidence of cerebral concussions; and
Whereas, Nine percent of high school football players may receive a sports-related-concussion; and
Whereas, Four to 5 million concussions in athletes occur annually, with rising numbers among middle school athletes; and
Whereas, Forty percent of high school athletes with an initial concussion will incur a second concussion; and
Whereas, Thirty-three percent of high school athletes who have a sports concussion report two or more in the same year; and
Whereas, Research indicates that concussions in high school athletes are frequent but underreported; and
Whereas, Possible concussive injuries often receive inadequate attention, as evidenced by the return-to-play guidelines, and such inattention can lead to damaging long-term injuries; and
Whereas, Concussed high school and college athletes display significantly higher depression scores more than two weeks post-concussion; and
Whereas, Adolescent patients who report sleep disruption after sports-related concussions report a greater number of concussion symptoms during their recovery; and
Whereas, High school athletes with a history of two or more concussions have been shown to have significant prolonged neuropsychological effects; and
Whereas, Evidence links concussions in adults with long-term risk of suicide, up to three times the population norm; and
Whereas, Compared with retired players with no history of concussion, retired players reporting three or more previous concussions (24.4 percent) were three times more likely to be diagnosed with depression; those with a history of one or two concussions (36.3 percent) were 1.5 times more likely to be diagnosed with depression; and
Whereas, Data suggest cognitive behavioral therapy can improve adaptive coping in traumatic brain injury and Hamilton Depression Rating scores in general cases of depression; therefore be it
RESOLVED, That the Texas Medical Association support legislation that implements standardized assessments for or diagnostic testing of neurological and psychological manifestations of concussions for high school athletes post-concussion; and be it further

RESOLVED, That TMA support legislation that recommends that athletes who have had a concussion receive information about psychiatric support; and be it further

RESOLVED, That TMA support legislation that recommends psychiatric or neuropsychiatric consultation for high school athletes who have had a concussion; and be it further

RESOLVED, That TMA support legislation increasing awareness protocol for concussions across all sports; and be it further

RESOLVED, That the Texas Delegation forward this resolution to the American Medical Association for consideration at the House of Delegates.

References


Subject: Promoting Increased Awareness and Research for Grade School Soccer Related Head Injury

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, The sport of soccer involves the routine use of the head as a medium to strike the ball; and

Whereas, Recent studies have indicated that heading a soccer ball can lead to transient electrophysiological changes in the brain and consequent cognitive impairment, leading to many different chronic neurological injuries, such as chronic traumatic encephalopathy, of which the prevalence as a result of head trauma is unknown and difficult to diagnose in vivo; and

Whereas, Recent studies of soccer players indicate deficits in a wide range of categories of cognitive function, such as “attention, concentration, memory, and judgment,” decreased conceptual thinking when compared to swimmers, decreased performance on “verbal and visual memory, planning, and visuoperceptual processing tasks,” as well as “verbal learning, planning and attention, and information processing speed” related to number of “headings;” and

Whereas, The Texas Medical Association has demonstrated a commitment to student participation in sporting activities and seeks to “promote understanding of special issues related to athletes including concussion management;” and

Whereas, The Texas Medical Association has demonstrated a commitment to monitoring dangerous practices related to head use in sports and surveillance for head injuries in both contact and non-contact sports, such as football and cheerleading; therefore be it

RESOLVED, That TMA support measures to increase public education regarding the signs, symptoms, and effects of concussive and subconcussive head injuries among student soccer athletes; and be it further

RESOLVED, That TMA promote awareness among physicians of research in both the acute and long-term complications of head trauma related to soccer, specifically regarding the use of the head as a medium for striking the soccer ball.

Related TMA Policy:

260.094 Cheerleading Head Injuries and Concussion: The Texas Medical Association 1) advocates for stronger University Interscholastic League (UIL) oversight of cheer programs in Texas. Oversight should include requirements for safety training and certification for coaches and safety and technique training for cheerleaders in line with national guidelines; 2) will work with external groups, including UIL, to strengthen injury surveillance in Texas including monitoring cheerleading injuries and identify high-risk activities; 3) promotes educational programming for students, coaches, and
physicians on concussions and injury prevention; and 4) encourages physicians to get
involved in local development of policies and strategies focusing on injury prevention
through the school health advisory councils (CCAH and CSPH Joint Rep. 2-A-13).

260.026 Football Helmet Use: Coaching techniques which call for players to use the head as the
contact point and the helmet as an offensive weapon represent a danger to the players and
should be discontinued (Committee on Sports Medicine, p 126, A-94; reaffirmed CPH
Rep. 3-A-10).

55.056 Physician Examinations for Young Athletes: The Texas Medical Association (1)
supports the promotion of student involvement in sports and other physical activities and
supports elimination of barriers that prevent students from participating; (2) supports
changes in the Texas Education Code that would require that athletic pre-participation
physical examinations for school-age children be conducted only by licensed allopathic
or osteopathic physicians, or appropriately supervised physician assistants or advanced
practice nurses licensed in the State of Texas; (3) endorses the standardized screening
procedures as outlined in the pre-participation physical evaluation form developed by the
American Academy of Family Physicians, American Academy of Pediatrics, American
Society for Sports Medicine, American Orthopaedic Society for Sports Medicine, and
American Osteopathic Academy of Sports Medicine. TMA also recognizes the
importance of reviewing these national guidelines on a regular basis to monitor emerging
science and evidence-based guidelines; and (4) will work with the University
Interscholastic League and other groups, including county medical societies, to support
evidence-based efforts to promote health and safety among young Texans engaged in
sports and physical activity. In addition, TMA will work to provide resources to
physicians to raise awareness on screening guidelines for pre-participation exams and to
promote understanding of special issues related to athletes including concussion

References
1. Virgilio, Thomas G. Di, Angus Hunter, Lindsay Wilson, William Stewart, Stuart Goodall, Glyn
Howatson, David I. Donaldson, and Magdalena Ietswaart. "Evidence for Acute
Electrophysiological and Cognitive Changes Following Routine Soccer Heading." EBioMedicine
3. Tysvaer, Alf T., and Einar A. LÅ.chen. "Soccer Injuries to the Brain." The American Journal of
of Cognitive Dysfunction after Soccer Playing with Ball Heading Using a Novel Tablet-Based
Subject: Addressing the Expanding Habitats of Vectors of Infectious Disease

Whereas, Vector-borne diseases, such as West Nile Virus, Zika Virus, etc., continue to be a threat in Texas; and

Whereas, The incidence of vector-borne diseases is largely determined by the abundance of vectors and by the size of the vector’s available habitat; and

Whereas, Flooding and warm temperatures contribute to increased vector and rodent-borne infectious diseases such as the West Nile and Zika viruses; and

Whereas, There was an increase in confirmed instances of local mosquito-borne West Nile Virus in Texas from 487 instances in 2013 to 2,032 instances in 2014; and

Whereas, From January 1, 2015 through February 15, 2017, the United States confirmed 220 cases of local-transmitted mosquito-borne Zika Virus; and

Whereas, Prior to 2016 there were no reported instances of locally transmitted Zika Virus in Texas, during 2016 there were six instances of locally acquired Zika Virus reported in Texas; and

Whereas, In January 2017, Texas saw its first incidence of a locally acquired Zika Virus infection in a pregnant woman; and

Whereas, Texans are also being affected by increased incidence and distribution of vector-borne diseases in other countries because of high rates of travel to subtropical and tropical countries, as there was an increase in confirmed instances of Zika Virus in Texans traveling to foreign countries from eight instances in 2015 to 302 instances in 2016; and

Whereas, Studies suggest that increasing average annual temperatures and altered precipitation patterns, could continue to alter the global range of the Aedes aegypti mosquito resulting in a northern expansion from its present habitat; therefore be it

RESOLVED, That the Texas Medical Association promote awareness for physicians and patients on infectious disease vectors, including the factors that affect the presence of vectors and disease; and be it further

RESOLVED, That TMA work with like-minded organizations and individuals to support legislation regarding both the study of the expanding habitats of the Aedes aegypti and Culex mosquitoes, as well as the preparation for and prevention of the spread of the Zika and West Nile Viruses.
Relevant 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).

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 (CPH, p 125A, I-96; amended CPH Rep. 2-A-09; amended CSPH Rep. 3-A-13).

Relevant AMA Policy:

H-135.938 Global Climate Change and Human Health

Our AMA:

1. Supports the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor.

2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.

3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.

4. Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.

5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort.

6. Supports epidemiological, translational, clinical and basic science research necessary for evidence-based global climate change policy decisions related to health care and treatment

Enhanced Zika Virus Public Health Action - Now D-440.930

1. Our AMA urges Congress to enact legislation, without further delay, to provide increased and sufficient funding for research, prevention, control, and treatment of illnesses associated with the Zika
virus, commensurate with the public health emergency that the virus poses, without diverting resources from other essential health initiatives.

2. Our AMA will work with experts in all relevant disciplines, and convene expert workgroups when appropriate, to help develop needed United States and global strategies and limit the spread and impact of this virus.

3. Our AMA will consider collaboration with other educational and promotional entities (e.g., the AMA Alliance) to promote family-directed and community-directed strategies that minimize the transmission of Zika virus to potentially pregnant women.

Next Generation Infectious Disease Diagnostics H 440.834

1. Our AMA supports strong federal efforts to stimulate early research and development of emerging rapid ID (infectious disease) diagnostic technologies through increased funding for appropriate agencies.

2. Our AMA supports the reduction of regulatory barriers to allow for safe and effective emerging rapid diagnostic tests, particularly those that address unmet medical needs, to more rapidly reach laboratories for use in patient care.

3. Our AMA supports improving the clinical integration of new diagnostic technologies into patient care through outcomes research that demonstrates the impact of diagnostics on patient care and outcomes, educational programs and clinical practice guidelines for health care providers on the appropriate use of diagnostics, and integration of diagnostic tests results into electronic medical records.

4. Our AMA supports efforts to overcome reimbursement barriers to ensure coverage of the cost of emerging diagnostics.

References:

5. Center for Disease Control and Prevention. (2017). Zika Virus Case Counts in the US. Atlanta, GA.
6. Texas Department of State Health Services Infectious Disease Control Unit Zoonosis Control Branch. (2017) Zika in Texas. Austin, TX.
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 316
A-17

Subject: Addressing Transgender Public Facility Use

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, A person’s gender identification as a man, woman, or something else may or may not correspond to the person’s external body or assigned sex at birth; and

Whereas, A 2010 study demonstrated a 36.6-percent increase in diagnosed mood disorders, 248.2-percent increase in generalized anxiety disorders, 60.8-percent increase in panic disorders, and 41.9-percent increase in alcohol related disorders among lesbian, gay, bisexual, transgender, and queer populations following implementation of a discriminatory policy; and

Whereas, Seventy-five percent of transgender high school students report feeling unsafe at school, compared with less than one-third of their nontransgender classmates; and

Whereas, Even without being barred legally from sex-segregated spaces, 63.4 percent of transgender high school students avoid using the bathrooms and locker rooms at their school because they feel unsafe or uncomfortable; and

Whereas, Fifty-nine percent of transgender adults report avoiding the use of bathrooms at work and other public places for fear of confrontation; and

Whereas, Thirty-one percent of transgender people forgo drinking or eating to avoid restroom use, resulting in a decrease of urine output and posing a risk to renal health; and

Whereas, Normal urine output is needed to minimize or prevent nephrolithiasis, or kidney stones; and

Whereas, Individuals who face inadequate bathroom access suffer from “taxi cab syndrome,” resulting in “more voiding dysfunction, infertility, urolithiasis, bladder cancer, and urinary infections” compared with individuals with adequate access to bathrooms; and

Whereas, Fifty-four percent of people who forgo using public restrooms report experiencing some form of physical distress such as dehydration, kidney infection, and urinary tract infections; and

Whereas, Thirty to 50 percent of individuals with kidney stones, or nephrolithiasis, experience a recurrence of stones after five years; and

Whereas, The real-life experience is a medically indicated treatment modality for a transgender individual living fully as his or her authentic identified gender in society and is considered essential to adequately treat gender dysphoria; and
Whereas, The real-life experience includes using the public facilities of the gender with which the individual identifies; therefore be it

RESOLVED, That the Texas Medical Association recognize and inform physicians about the medical issues related to transgender individuals not being able to use public facilities that correspond to their current gender identity; and be further it

RESOLVED, That TMA study how to promote transgender health care and report on it; and be it further

RESOLVED, That TMA advocate for transgender health care based upon these findings.

Relevant TMA Policy:

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 insuring 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).

Relevant AMA Policy:

H-185.927 Clarification of Medical Necessity for Treatment of Gender Dysphoria

Our AMA: (1) recognizes that medical and surgical treatments for gender dysphoria, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice; and (2) will advocate for federal, state, and local policies to provide medically necessary care for gender dysphoria.

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.

References

Whereas, As many as 575,000 people die from cancer in the United States each year, and this number is expected to increase to 630,000 by the year 2020, while in Texas, approximately 100 Texans die from cancer each day; and

Whereas, Most patients with metastatic or refractory cancer will exhaust all conventional therapy options; and

Whereas, Molecular profiling-based personalized medicine trials conducted at multiple sites, including leading cancer treatment facilities, have demonstrated increased progression-free survival rates with molecular profiling-suggested regimens using “off-label” cancer drugs; and

Whereas, Precision medicine is shifting cancer treatment strategies from a histology-based model to a molecular-based model, allowing for the identification of off-label medications to be used effectively in the treatment of refractory cancer; and

Whereas, Oncologists prescribing an off-label cancer medication frequently will find themselves challenged with the dilemma of a patient’s insurance company not approving the financial coverage for the off-label treatment; and

Whereas, State statutes have been set in place to allow for coverage of off-label usage in specific cancers; however, the coverage is regularly based upon compendia listings that either are not up to date or are not readily available unless the user is a paid subscriber to the compendia; and

Whereas, The Journal of the American Medical Association has addressed this matter, highlighting that the Centers for Medicare & Medicaid Services uses third-party compendia, which are privately owned, to inform coverage decisions for off-label cancer drug therapies in the United States. These compendia have a significant influential role in both cancer medication pricing and coverage decisions based upon the 1993 Omnibus Budget Reconciliation Act, which mandates that coverage be provided when indication for usage of an off-label drug is supported by at least one compendium. Furthermore, there is limited transparency about the framework to these compendia and any conflicts of interest present on the part of the contributors to the compendia; and

Whereas, A meta-analysis conducted to assess the impact of using molecular profiling in designing a personalized cancer treatment strategy from 1998-2003 demonstrated a positive association between using molecular profiling and improved efficacy outcomes in Food and Drug Administration-approved anticancer agents; and
Whereas, The technology for advancing personalized medicine in cancer therapy is developing at a rapid pace, and proving effective; however, the issue of patients with refractory cancers receiving paid coverage for identified precision therapies considered off-label remains; therefore be it

RESOLVED, That the Texas Medical Association support measures that increase transparency regarding compendia used by insurers to provide coverage for “off-label” usage in refractory cancer treatment; and be it further

RESOLVED, That TMA support the autonomous clinical decisionmaking authority of a physician and a physician’s ability to use a Food and Drug Administration-approved therapeutic agent lawfully for an off-label indication in treating refractory cancer when such use is based upon reasonable scientific evidence or sound medical opinion; and be it further

RESOLVED, That TMA affirm the position that when the prescription of a drug represents safe and effective therapy, third-party payers, including Medicare, should consider the intervention as clinically appropriate medical care, irrespective of labeling, and should fulfill their obligation to their beneficiaries by covering such therapy.

Relevant TMA Policy:

50.003 Unorthodox Treatment of Cancer: The Texas Medical Association recognizes the dangers to the health of Texans by treatments for cancer with unorthodox methods that lack a proven scientific basis for effectiveness particularly when these treatments are offered as an alternative to proven, conventional treatments. TMA strongly advises that patients with cancer receive treatment that has withstood scientific scrutiny or is part of a science-based clinical trial (Committee on Cancer, p 132, A-94; amended CM-C Rep. 2-A-10).

50.007 Cancer Diagnosis, Treatment, and Follow-Up: To ensure all Texans with a suspected or proven diagnosis of cancer receive appropriate, comprehensive, and evidenced-based care, TMA recommends that physicians involved in a cancer program follow the latest Program Standards of the American College of Surgeons Commission on Cancer, and that all patients should have access to, as a minimum: (1) an accurate diagnosis obtained through the most minimally invasive biopsy, resection, or test necessary to provide an accurate cancer diagnosis; (2) a proper workup and staging performed in accordance with the American Joint Committee on Cancer staging system or other appropriate staging system; (3) a treatment plan developed by a multidisciplinary cancer conference, with recommended representation in the areas of genetic testing and counseling, palliative care, psychosocial care, and rehabilitation services; (4) appropriate management of pain and non-pain symptoms, screening and care for psychosocial distress, and support for health-related quality of life, including palliative care from diagnosis through end of life; (5) provision of a Treatment Summary and Survivorship Care Plan that reflects the treatment the patient received and addresses post-treatment needs and follow-up care; and (6) appropriate long-term follow up to monitor cancer recurrence and evaluate outcomes of cancer care. TMA will continue to educate physicians on the latest recommendations related to the care of cancer patients throughout their life span and advocate for state programs and policies that promote access to cancer prevention, early detection, and cancer treatment and supportive services for all Texans (Amended CM-C Rep. 3-A-06; amended CM-C Rep. 1-A-16).
Relevant AMA Policy:

**H-120.988 Patient Access to Treatments Prescribed by Their Physicians**

1. Our AMA confirms its strong support for the autonomous clinical decision-making authority of a physician and that a physician may lawfully use an FDA approved drug product or medical device for an off-label indication when such use is based upon sound scientific evidence or sound medical opinion; and affirms the position that, when the prescription of a drug or use of a device represents safe and effective therapy, third party payers, including Medicare, should consider the intervention as clinically appropriate medical care, irrespective of labeling, should fulfill their obligation to their beneficiaries by covering such therapy, and be required to cover appropriate 'off-label' uses of drugs on their formulary. 2. Our AMA strongly supports the important need for physicians to have access to accurate and unbiased information about off-label uses of drugs and devices, while ensuring that manufacturer-sponsored promotions remain under FDA regulation. 3. Our AMA supports the dissemination of generally available information about off-label uses by manufacturers to physicians. Such information should be independently derived, peer reviewed, scientifically sound, and truthful and not misleading. The information should be provided in its entirety, not be edited or altered by the manufacturer, and be clearly distinguished and not appended to manufacturer-sponsored materials. Such information may comprise journal articles, books, book chapters, or clinical practice guidelines. Books or book chapters should not focus on any particular drug. Dissemination of information by manufacturers to physicians about off-label uses should be accompanied by the approved product labeling and disclosures regarding the lack of FDA approval for such uses, and disclosure of the source of any financial support or author financial conflicts. 4. Physicians have the responsibility to interpret and put into context information received from any source, including pharmaceutical manufacturers, before making clinical decisions (e.g., prescribing a drug for an off-label use). 5. Our AMA strongly supports the addition to FDA-approved labeling those uses of drugs for which safety and efficacy have been demonstrated. 6. Our AMA supports the continued authorization, implementation, and coordination of the Best Pharmaceuticals for Children Act and the Pediatric Research Equity Act.

**References**

Resolution 318
A-17

Subject: Access to Special Education Services

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

Whereas, An estimated 15 percent of children in the United States have a disability; and

Whereas, Some recent evidence has pointed to an 8.5 percent cap placed in 2004 by the Texas Education Agency (TEA) on special education utilization in Texas; and

Whereas, The national average percentage of students receiving special education has remained steady at approximately 13 percent between 2004 and 2014; and

Whereas, “free appropriate public education,” guaranteed under national policy in the Individuals with Disabilities Education Act, states that students with disabilities must have access to free and appropriate public education, which includes costs of the “tuition … psychological and medical services necessary for diagnostic and evaluative purposes, and adequate transportation”; and

Whereas, The American Academy of Pediatrics advocates for appropriate and timely services to meet a child’s or adolescent’s needs, with payment as a secondary concern, in maintaining an appropriate educational environment; and

Whereas, While the Substance Abuse and Mental Health Services Administration estimates there are approximately 519,368 Texas youth, 17 years and younger, with severe emotional disturbance defined as a diagnosable mental, behavior, or emotional disorder that causes serious functional impairment, only 30,034 students with serious mental illness receive special education services; and

Whereas, Districts that have sharply cut funding to special education programs have seen the largest increase in percentage of public school withdrawal, suggesting a strong association between special education access and public school withdrawal; and

Whereas, Inaccessibility to special education accommodations have resulted in academic disruptions and relocation of families; and

Whereas, Individual education programs placing students in the least restrictive environment are critical for children with a disability or chronic health condition; and

Whereas, In December the US Department of Education held statewide listening tours to hear public concerns about the issues and are currently investigating special education services in twelve Texas school districts; and

Whereas, Advocating for special education is in line with physicians’ roles and the Texas Medical Association’s vision “to improve the health of all Texans”; therefore be it
RESOLVED, That the Texas Medical Association closely follow state and federal activities regarding special education services in Texas including but not limited to investigations and legislation restricting the provision of special education; and be it further

RESOLVED, That TMA advocate for eliminating barriers to identification of and intervention in children who need special education services.

Relevant TMA Policy:

55.008 Early Childhood Intervention Program: Believing early medical intervention in childhood disabilities is often essential for children who have the potential to lead normal, productive lives and that it may significantly improve the quality of life for disabled children, the Texas Medical Association endorses the continuation of the Early Childhood Intervention program (Committee on Rehabilitation, p 140, A-93; reaffirmed Council on Scientific Affairs, p 129, A-94; reaffirmed CM-R Rep. 3-A-04; reaffirmed CM-CAH Rep. 1-A-14).

90.001 Funding of Services for Disabled Persons: The Texas Medical Association endorses the preservation and continued funding of programs that encourage physical and economic independence of disabled individuals, specifically programs in physical restoration, vocational rehabilitation and independent living (Council on Medical Education, p 90, A-92; reaffirmed CM-R Rep. 2-A-02; reaffirmed CME Rep. 1-A-12).


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, and
i. Coordinating with the educational system for mentally healthy schools, and

Quality Care for Mentally Ill: The Texas Medical Association supports efforts of the Texas Health and Human Services Commission and its appropriate agency councils to maintain physicians’ ability to provide good quality medical care to the mentally ill patient, including appropriate use of psychotropic medication, while under court-ordered mental treatment (Council on Socioeconomics, p 181, I-94; amended CSA Rep. 6-A-04; reaffirmed CSPH Rep. 2-A-14).

Child Psychiatrists in State Agency Policymaking Positions: The Texas Medical Association promotes the creation of staff positions for physicians with expertise in child and adolescent mental health in all state agencies involved in policymaking regarding children’s mental health services (CM-CAH Rep. 2-A-08).

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 (only relevant policy included):

B. 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 (AHCM-MAC Rep. 1-1-04; amended SC-MCU Rep. 1-A-15)
AMA Policies:

H-90.996 Education of Handicapped Children
Our AMA supports efforts to ensure an appropriate role for physicians in the development of special education programs for handicapped children.

H-90.969 Early Intervention for Individuals with Developmental Delay
(1) Our AMA will continue to work with appropriate medical specialty societies to educate and enable physicians to identify children with developmental delay, autism and other developmental disabilities, and to urge physicians to assist parents in obtaining access to appropriate individualized early intervention services. (2) Our AMA supports a simplified process across appropriate government agencies to designate individuals with intellectual disabilities as a medically underserved population.

H-90.967 Support for Persons with Intellectual Disabilities
Our AMA encourages appropriate government agencies, non-profit organizations, and specialty societies to develop and implement policy guidelines to provide adequate psychosocial resources for persons with intellectual disabilities, with the goal of independent function when possible.

H-90.977 Impairment and Disability Evaluations
It is the policy of the AMA: (1) that in settings where impairment and disability evaluations are required, physicians should determine medical impairment and their functional consequences, including those associated with HIV infection, using medically established and approved guidelines; and (2) to encourage physicians to contribute their medical expertise to disability determinations.

References
Whereas, Drug abuse and addiction are major physical, psychological, and economic burdens across all social, ethnic, and economic classes but more often for the poor and minorities; and

Whereas, The most recent efforts to control these afflictions have been focused on laws and their enforcement, the result being an extremely expensive campaign (war on drugs) with a larger burden on the poor and minorities who have been incarcerated for possessing and/or distributing these substances; and

Whereas, The number of those who have suffered and died as a result of a drug abuse and addiction continues to rise; and

Whereas, In the case of a minor, the parents/guardians legally can force the individual who suffers from drug addiction into treatment, but for those who have reached the age of majority, participation in treatment programs is voluntary; thus those who are addicted or abusing drugs can and often do refuse treatment, thereby limiting friends’ and family’s options to help them; and

Whereas, Emotional growth is stunted by drug abuse and addiction, possibly offering an option for those who reach an age of majority to receive enforced treatment; and

Whereas, A high percentage of those who are abusing and/or addicted to drugs suffer from the consequences of preexisting social experiences such as sexual abuse, abusive home environment, or parents who abuse drugs or alcohol, and/or psychological conditions like schizophrenia, anxiety, and depression, to name a few, which results in efforts by the affected individual in the preadolescent or adolescent years to self-medicate with drugs in an effort to relieve their pain and suffering; and

Whereas, These social and psychological issues should be diagnosed by properly trained individuals such as pediatricians; and

Whereas, Those who become addicted during their adolescent years compared with those who become so at an older age are much less likely (factor of three) to become abstinent from drugs, although the earlier in the disease process treatment begins, the greater the likelihood of remission and future abstinence; therefore be it

RESOLVED, That the Texas Medical Association convene a panel of experts in the field of child and adolescent addiction and the use of psychotropic medications, such as pediatricians, psychiatrists, neurologists, pain management physicians, and representatives of other medical professions that are stakeholders; and be it further
RESOLVED. That TMA develop resources for physicians on early detection and prevention of substance abuse in adolescents and on community-based patient and family support services for those who suffer from drug abuse and addiction.

Relevant TMA Policy

55.007 Adolescent Health and Substance Abuse: Role of the physician. TMA encourages physicians treating adolescents to provide substance use education and screening to adolescents during routine clinical care and offer counseling and/or referral where appropriate. All physicians who treat adolescents should be prepared to address issues related to substance use, including educating adolescent patients and their families on the unique dangers of youth using alcohol, tobacco, marijuana, and other controlled substances, and the importance of avoiding drugs and other intoxicating substances that pose serious health risks when consumed. Physicians should be informed on developmentally appropriate screening for substance use, brief intervention, and/or referrals to treatment. Physicians should be knowledgeable about the prevalence of substance use trends and co-occurring psychiatric diagnoses so that assessments can include screening for any coexisting disorders.

Role of the Texas Medical Association. (1) Sponsor and promote education for physicians concerning adolescent health and substance use; (2) Encourage medical schools and residency programs to provide education on prevention and treatment of alcoholism and substance use in youth; (3) Work with relevant medical and specialty societies to inform physicians on adolescent alcohol, tobacco, and other drug use trends, emerging issues related to adolescent substance use, evidence-based community prevention and treatment programming, and developmentally appropriate, evidence-based tools to help physicians address substance use issues with their patients and families; (4) Encourage physicians to become advocates and resources in their communities; (5) Advocate funding for statewide resources that will increase substance use prevention services for youth and families; (6) Promote easily accessible behavioral health risk awareness training in communities and schools; (7) Encourage uniform instruction and comprehensive health education for grades kindergarten through 12th grade on avoidance of tobacco, alcohol, marijuana, controlled substances, and illegal drugs, including performance-enhancing drugs. Education should be age appropriate and taught by teachers who have specialized training in drug use prevention and health education; (8) Support school-based health clinics in their efforts to facilitate access to care for adolescents; (9) Encourage enforcement of laws related to drugs, alcohol, and tobacco and support evidence-based policies that will prevent youth access to alcohol and harmful substances, including those substances not currently labeled as a drug or alcohol product; (10) Support state efforts to rehabilitate addicted youth; and (11) Support efforts to restrict alcohol and other harmful substance marketing and advertising (Council on Public Health, p 100, A-93; reaffirmed CM-CAH Rep. 2-A-03; amended CM-CAH Rep. 4-A-10; amended CSPH and CM-CAH Report 1-A-15; amended CM-CAH Rep. 1-A-16).
Whereas, More and more patients have become health conscious, and in an effort to better educate
themselves, particularly with the aid of the internet, may be exposed to health information for which often
they are not educated to understand fully, and this information may be inaccurate or confusing to the point
that it could lead to patient harm or even death; and

Whereas, Physicians frequently are criticized as lacking education on and failing to educate patients in the
areas of nutrition, supplements, and vitamins, and while these claims have merit, physicians have the best
scientific foundation to evaluate supplements and vitamins critically and to educate ourselves as well as
our patients; and

Whereas, Physicians for decades have advocated strongly for patients to minimize sun exposure or use
sunscreen ointments to protect themselves, particularly those with lighter skin, from skin damage and
cancer as a result of damaging UVA and UVB sunlight, and these warnings have resulted in more people
heeding this advice, particularly parents concerning their children, leading to unintended and unfortunate
side effects; and

Whereas, Since the major human source of vitamin D3 (cholecalciferol) is through sun exposure (UVB
light) to the skin, those who receive less sunlight produce less cholecalciferol and thus have lower blood
25-hydroxyvitamin D levels, the form of vitamin D3 measured in blood; and

Whereas, Cholecalciferol is a known and important vitamin such that in the United States cow’s milk is
supplemented with 100 IU cholecalciferol per eight ounces of milk; and

Whereas, Cholecalciferol has been shown to have effects on 5 percent of the human genome including
sleep, diet, and cancer; and

Whereas, Those who live on the equator are estimated to produce cholecalciferol at the rate of 30,000-
40,000 IU per day from sun exposure alone, yet U.S. National Institutes of Health and the Food and Drug
Administration (FDA) experts have recommended, depending on age, a daily dose for healthy individuals
of between 400 and 1,000 IU; and

Whereas, In humans, the greater the melanin content of one’s skin, the longer the exposure of equal
intensity sunlight that is required to produce an equivalent amount of cholecalciferol; and

Whereas, FDA considers blood levels 25-hydroxvitamin D at 30-100 ng/ml to be healthy and safe, and a
level above 100 ng/ml as possibly toxic, yet a recent study of a group of the Maasai, an African tribe with
a high skin melanin content living a traditional rural agrarian lifestyle and working outside while wearing
traditional native clothing and consuming no commercial vitamin D supplementation, had, when tested, an average blood level of 25-hydroxyvitamin D of 117 ng/ml; therefore be it

RESOLVED, That the Texas Medical Association recommend initial and then twice yearly cholecalciferol blood testing or more often as directed by the physician, such that it becomes a standard to determine the health of the individual patient despite age; and be it further

RESOLVED, That TMA encourage the Food and Drug Administration and the National Institutes of Health to recommend better defined and higher blood levels of 25-hydroxyvitamin D.
Subject: Promoting Safe and Effective Disposal of Unused Medications

Introduced by: Webb-Zapata-Jim Hogg County Medical Society

Referred to: Reference Committee on Science and Public Health

Whereas, Patients increasingly are forced to fill their medications at three-months intervals by the health insurance companies/pharmacy benefit managers/third-party payers; and

Whereas, Patients and/or family members are burdened with the disposal of unused/excessive medications and possibly disposing of the medications into the garbage, which can contaminate landfills; and

Whereas, Patients and/or family members are burdened with the disposal of unused/excessive medications and possibly flushing the medications into the household drains, which can contaminate water supplies; and

Whereas, Extra unused medications can lead to diversion of certain harmful drugs to family members and others; and

Whereas, Senate Bill 1757 (81st legislature) authorized the Texas Commission on Environmental Quality to conduct a study regarding methods for disposing of unused pharmaceutical products to prevent contamination of our state water systems, and it recommended a statewide education effort for consumers, physicians, and health care providers on proper disposal of unused pharmaceuticals; and

Whereas, Certain communities in Texas may have established drop-off sites, but they are not well known or targeted to the elderly or widely publicized to the public; and

Whereas, Strategies that encourage or require manufacturers to manage their products’ waste, or extended producer responsibility policies have been implemented throughout the country, focusing on products including computers and other electronic waste; and

Whereas, These extended producer responsibility policies have begun to be applied to pharmaceuticals, such as in a recent ordinance, passed in Contra Costa County, Calif., whereby “[d]rug makers will be required to establish drop-off centers and to pay the full cost of establishing and operating a network of centers to accept unwanted, unused, or expired medications”; and

Whereas, This is a national public health issue that pertains not only to Texas; therefore be it

RESOLVED, That the Texas Medical Association work to educate physicians, other health professionals, patients, family members, and the public about the safe and effective disposal of nonprescription/prescription medications; and be it further
RESOLVED, That TMA promote local county medical societies partnering with qualified and safe drop-off sites and encouraging local physicians to disseminate the information in their office to patients; and be it further

RESOLVED, That patients receive written disposal information at the point of purchase or in the boxes of medications sent via a third party to the patients; and be it further

RESOLVED, That TMA work to encourage pharmaceutical firms to take full responsibility in addressing this issue of taking back unused, expired, and unwanted nonprescription/prescription medications and paying for proper and safe disposal of the medications; and be it further

RESOLVED, That the Texas Delegation to the American Medical Association takes this resolution to the AMA House of Delegates for consideration.

Relevant TMA Policy:

95.040 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 (not complete policy; CSPH and TF-BH Joint Rep. 1-A-15)

Relevant AMA Policy:

H-135.936 Proper Disposal of Unused Prescription and Over-the-Counter (OTC) Drugs:

1. Our AMA supports initiatives designed to promote and facilitate the safe and appropriate disposal of unused medications.

2. Our AMA will work with other national organizations and associations to inform, encourage, support and guide hospitals, clinics, retail pharmacies, and narcotic treatment programs in modifying their US Drug Enforcement Administration registrations to become authorized medication collectors and operate collection receptacles at their registered locations.

3. Our AMA will work with other appropriate organizations to develop a voluntary mechanism to accept non-controlled medication for appropriate disposal or recycling.
AGENDA
REFERENCE COMMITTEE ON SOCIOECONOMICS
Friday, May 5, 2017
Marriott Marquis, Level 2, Houston Ballroom 3

2. Council on Socioeconomics Report 3 – Prescription Drug Price Negotiation
3. Council on Socioeconomics Report 4 – Prescription Drug Value Based Contracting
5. Council on Socioeconomics Report 6 – MACRA Update
7. Council on Socioeconomics and Select Committee on Medicaid, CHIP, and the Uninsured Joint Report 6 – Federal Medicaid Reform and Implications for Texas
8. Resolution 401 – Opposition to Capped Federal Medicaid Funding (Bexar County Medical Society)
9. Resolution 402 – Proposed Change in Medicaid Funding (Concho Valley County Medical Society)
10. Resolution 403 – Supporting Community-Based Health Care Delivery Models for Vulnerable Patients (Dallas County Medical Society)
11. Resolution 404 – Allowing Exceptions to the Centers for Medicare & Medicaid Services’ Locum Tenens 60-Day Limit (Harris County Medical Society)
12. Resolution 405 – Minimum Standards for Interstate Sale of Health Insurance Products (Harris County Medical Society)
13. Resolution 406 – Transparency and Payments for Prior Authorizations (Harris County Medical Society)
14. Resolution 407 – Medicaid Block Grants Per Capita Caps (Ben G. Raimer, MD, FAAP, Texas Pediatric Society; Kimberly M. Carter, MD, Texas Association of Obstetricians and Gynecologists; Troy T. Fiesinger, MD, Texas Academy of Family Physicians)
15. Resolution 408 – Compensation of Physicians for Authorizations and Preauthorizations (Ori Hampel, MD)
16. Resolution 409 – Medicaid Payments for Speech Therapy, Physical Therapy, and Occupational Therapy (Medical Student Section)
17. Resolution 410 – Public- and Private-Sector Funding of Interpretation Services for Limited English Speakers and American Sign Language (Medical Student Section)
18. Resolution 411 – Clearer Language Regarding the Physician’s Role in Providing Auxiliary Aid for Effective Communication Under Current Federal Laws (Medical Student Section)

19. Resolution 412 – Preference of Medicaid Funding Proposals (Harris County Medical Society)

20. Resolution 413 – Addressing Zika Through Increasing Medicaid Coverage of Insect Repellent (Medical Student Section)

21. Resolution 414 – Regulations Regarding Freestanding Emergency Care Facilities (Evans Smith, MD)

22. Resolution 415 - Replacing the Medical Malpractice Litigation System With a “No-Fault” Patients’ Compensation System (Ori Hampel, MD)
Subject: Increasing Use of Narrow Networks by Medicare Advantage Plans

Presented by: John Carlo, MD, Chair

Referred to: Reference Committee on Socioeconomics

In recent years, there has been an observable increase in health plans that employ a very narrow network of contracted providers while providing limited or no coverage to patients who seek care out of network. This use of narrow networks extends into the Medicare Advantage (MA) plan market. In this market, Medicare contracts with and pays private health plans to provide coverage for Medicare benefits.

Currently more than 10 million Medicare beneficiaries receive their Medicare coverage through an MA plan.

In 2013, physicians across the country started receiving notices from MA plans that they were being kicked out of the MA plan networks. TMA asked the Centers for Medicare & Medicaid Services (CMS) “to take immediate action” to make sure Medicare beneficiaries participating in MA plans “have accurate and reliable information to make health insurance elections during the 2014 Open Enrollment period.”

TMA urged CMS to extend the MA open enrollment period and require MA plan sponsors that had reduced their networks to immediately:

- Provide and document that patients received actual and accurate notice of whether their current physicians would be in the 2014 network;
- Ensure that patients knew they could retain their physician by choosing fee-for-service or by choosing a product with an out-of-network benefit if their plan provided one;
- Give physicians information needed to challenge network adequacy based on CMS regulations and extend the appeals deadline until physicians received such information;
- Tell the American Medical Association and the state medical societies how many patients were impacted and which physicians were terminated; and
- Direct plans to hold all terminations initiated just prior to or during Open Enrollment in abeyance for 2014.

Congress is now considering a policy option that would require Medicare Advantage plans to allow enrollees to change plans after the open enrollment period if they discover, after enrolling, that their physician is not in the provider network. Currently TMA has no directly relevant policy.

Recommendation: That TMA adopt the following as policy:

Extending Open Enrollment for Medicare Advantage Plans: The Texas Medical Association supports congressional policy changes that would require Medicare Advantage (MA) plans to allow enrollees to change plans after the open enrollment period if they discover, after enrolling, that their physician is not in the MA plan provider network.
The issue of drug pricing is an increasing source of concern for patients and physicians. A special report presented to the Special Committee on Aging in the U.S. Senate (2016) estimated 60 percent of Americans (90 percent of seniors) take prescription drugs and will spend more than $328 billion on them. The federal government will pick up $126 billion of the cost through programs including Medicare, Medicaid, and the U.S. Department of Veterans Affairs.

Federal law prevents Medicare from leveraging its purchasing power to lower drug prices but requires broad coverage, including all products in some therapeutic classes. Prescription drug coverage under Medicare Part D is one of few health care services for which the Centers for Medicare & Medicaid Services does not negotiate or set prices.

Between 2013 and 2015, net spending on prescription drugs increased approximately 20 percent. Price increases affect all Americans as taxpayers help shoulder the cost. Furthermore, higher drug costs lead to higher copays, which reduce the affordability of medications and have been shown to reduce patient adherence. A poll conducted by the Kaiser Family Foundation in 2015 showed the majority of Americans favored allowing Medicare to negotiate with drug companies for lower drug prices (83 percent).

**Recommendation:** Adopt the following as TMA policy on Prescription Drug Negotiation in the Medicare Program:

**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.

**References:**


Subject: Prescription Drug Value Based Contracting

Presented by: John Carlo, MD, Chair

Referred to: Reference Committee on Socioeconomics

The ongoing issue of drug pricing has caused health insurers and pharmaceutical companies to create new ways of making expensive drugs available to patients without it being a huge financial drain. Value-based contracting already exists between physicians and health insurers. This new way of applying value-based contracts between insurers and pharmacy benefit managers (PBMs) potentially may leave physicians out of the loop and create a number of issues for both the patient and the physician.

Novartis and both Aetna and Cigna agreed on a deal for a value-based contract earlier this year for a heart drug the Food and Drug Administration approved recently, Entresto. The average annual cost for the drug is $4,500. Cigna and Aetna have agreed to make the medication a preferred drug on their formularies, subject to prior authorization. Aetna and Cigna will pay Novartis a discounted amount if the medication fails to reduce hospitalizations for commercially insured patients with congestive heart failure. It has been reported that Express Scripts, the largest PBM in the nation, is conducting a similar program for certain cancer drugs.

The lack of physician involvement in the establishment of these value-based contracts is alarming. The Entresto program will require physicians to prescribe a more expensive drug to a narrow portion of their patient population, despite the long-standing demands of all health plans to use generic medications as often as possible. This will be a drastic shift in behavior for physicians who are accustomed to using low-cost and effective generics.

In addition, clinical metrics will have to be developed. They will have to be measurable and relevant. Physicians not being part of the value-based contract team means they have no involvement in the development process.

The final concern is how the data will be collected to determine if the drug has lived up to its claims. Most of that data will be contained within the patient’s medical record, which would create intrusion and administrative burdens on physicians.

Recommendation: Adopt the following as TMA policy on Prescription Drug Value Based Contracting:

Prescription Drug Value Based Contracting: While the Texas Medical Association applauds innovative ways to make prescription drugs more available and affordable for patients, TMA believes that doing so without physician input may be construed as the corporate practice of medicine. Therefore, TMA insists that physicians be included in the development of any new contracting programs to ensure that physician and, more importantly, patient interests are considered. 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.
Prior to the passage of the federal Affordable Care Act, the state of Texas ran a high-risk health insurance pool that was available to provide insurance coverage to individuals who otherwise would be uninsurable.

Starting in 2010, the Texas high-risk pool gradually became unnecessary and was replaced, first by a federal high-risk pool, and subsequently by federally qualified plans that were prohibited from applying risk rating or coverage exclusions.

With the recent change in federal leadership, it is likely that the relevant federal regulations will be removed or modified to permit exclusions or risk rating in at least some cases. Consequently, the discontinued Texas high-risk pool plan may need to be recreated in some form. While TMA has previously approved policy supporting the high-risk pool, its demise and the possible need to recreate it may call for some policy revisions, as follows:

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. The status of Texas’ high-risk pool should be monitored and any necessary reforms should be supported in response to federal reforms (CSE Rep. 6-I-01; amended CSE Rep. 8-A-11).

Recommendation: Retain as amended.
The Medicare Access and CHIP Reauthorization Act (MACRA) made some major revisions to Medicare payment policy but failed to fix multiple underlying methodology problems. Consequently, certain current TMA policies need only minor revision to make it clear they still are applicable. The proposed amendments are as follows:

**Medicare Value-Based Payment Modifier Payment Incentives and Penalties:** The Texas Medical Association advocates that any Medicare’s penalty or incentive program including the Value-Based Payment Modifier program and the Merit-Based Incentive Payment System purchasing program 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).

**Sustainable Growth Rate Medicare Fees:** The Medicare physician fee schedule update formula is based on incorrect assumptions. 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 non-physicians costly hospital-based settings. The Medicare SGR update formula causes the wrong incentives. Adequate fees and a revision of the 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, permanent fix to the update formula (CSE Rep. 3-A-07).

**Recommendation:** Retain as amended.
House of Delegates policies in the association’s Policy Compendium are reviewed periodically for relevance and appropriateness. The following policies are recommended for retention as they are current, valid, and relevant:

1. **Compensation for Emergency Department Care**: Physicians who are required by hospitals to cover hospital emergency services have the right to compensation from hospitals for such services or should share in the compensation (from federal, state, and local resources) for emergency services being provided in emergency departments and subsequent in-hospital care. (Res. 405-A-03; amended Res. 405-A-07).

2. **Medicare HMOs**: The Texas Medical Association voted to take appropriate steps with the Medicare carrier and Medicare HMOs doing business in Texas to establish policies, procedures and legislative proposals, if necessary, to bring about a verification system to allow physicians to conveniently and expeditiously identify Medicare HMO patients so that services may be provided or appropriate referrals and precertification requirements are arranged (Res. 28A, p 120, I-95; reaffirmed CSE Rep. 1-A-05).

3. **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).

4. **Healthcare Integrity and Protection Data Bank**: The Texas Medical Association will strive to assure that the Healthcare Integrity and Protection Data Bank enabling legislation and regulations and interpretive guidelines be amended to assure that due process is provided before any reporting to its data bank (CSE Rep. 4-A-07).

5. **Workers’ Compensation Prompt Pay**: Workers’ compensation health plans should have the same prompt pay rules as commercial health plans. (Res.410-A-07).

**Recommendation 1**: Retain.

The council reviewed the following policies for amendment, recognizing that while the Medicare Access and CHIP Reauthorization Act repealed the Sustainable Growth Rate formula, more than a decade of inadequate updates have drastically eroded fee adequacy, and scheduled future updates continue to be wholly inadequate.

6. **Product Liability Lawsuit Impact on Premiums**: Rules should be promulgated by the Texas State Board of Department of Insurance forbidding professional liability insurance carriers from considering product liability lawsuits in determining the treating physician’s future premium level (Res. 404-A-01).
Advocacy Efforts Regarding Health Care Payment Plans: The Texas Medical Association adopted the following recommendations of the Ad Hoc Committee on Managed Care and Insurance on association advocacy efforts with regard to health care payment plans:

Transparency/non-contracted physicians/"balance billing"/network adequacy: Support legislation or rulemaking that will establish the responsibility for necessary disclosure to patients as that of the entity that controls the information. Consult and coordinate with other healthcare stakeholders the most efficient manner in which to provide access to patients. Support legislation or rulemaking that will establish network adequacy standards to ensure healthcare access for patients.

Smart Cards: Build upon current law to encourage the completion of the financial transaction concurrently with the provision of medical services. Urge inclusion of real-time adjudication of claims and payment of deductibles at point-of-service in any modification to current statute.

Tiered Networks/Economic Credentialing: Pursue multiple avenues utilizing current law that may offer tools to prevent the use of tiered networks as an incentive to limit medically necessary care. Initiate discussions with the Department of Insurance and Attorney General to determine whether current law offers a solution.

Pay-for-performance: Ensure that any such programs offer only incentives to physicians who practice in accord with accepted standards of practice as set by physicians based upon evidence-based criteria and the AMA developed standards. Close scrutiny of any federal or state regulatory proposal is recommended.

Uniform Policy Provision Law (UPPL): Support legislation to repeal UPPL. Urge Council on Legislation to consider pursuing as part of TMA’s legislative agenda if such legislation is not filed by others.

Standardized Managed Care Physician Contracts: Support legislation for standardized contracts. The specific contract language should not be negotiated during the legislative session.

Rental PPO Networks and Third-Party Administrators (TPA): Support AMA model legislation or other similar provision language. Seek passage of state legislation that will ensure only authorized discounts on physician services are taken. Continue to encourage the Texas Department of Insurance to utilize current insurance code provisions that may alleviate the problem.

ERISA Reform: In collaboration with the AMA, other state medical associations, and other similarly affected stakeholders: propose and actively support federal legislation clarifying that ERISA preemption does not apply to physician/insurer contracting issues; develop, propose, and actively support federal legislation that requires all third party payers serving as administrators for ERISA plans to accept assignment of benefits by patients to physicians; and develop and support federal and state legislation prohibiting “all products” clauses or linking participation in one product to participation in other “tied” products administered or offered by third party payers or their affiliates (CL/CSE Rep. 1-A-07; Res. 407-A-07).
235.026  **Medical Care and Fair Compensation:** Medical care should not be an unfunded mandate from the government; however, if a governmental body provides access to health care, fair compensation to the physician must be provided (Amended Res. 104-A-07).

240.018  **Sustainable Growth Rate Medicare Fee Adequacy:** For many years, the Medicare physician fee schedule update formula was based on incorrect assumptions. Inadequate fee updates 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. Congressionally mandated updates continue to be far below cost inflation, causing further erosion in fee adequacy. Inadequate fees lead to a shift of care to non-physicians, poor access to care for Medicare beneficiaries. The Medicare SGR update formula causes the wrong incentives. Adequate fees and a revision of the update factors that are equal to cost increases are necessary to accomplish improvements in medical care quality. Congress should act now to set Medicare fees at an adequate rate and enact a permanent fix to the update formula equal to the Medicare Economic Index (MEI) cost inflation measure. (CSE Rep. 3-A-07).

**Recommendation 2:** Retain as amended.
Background

On March 6, 2017, House Speaker Paul Ryan introduced the American Health Care Act to repeal and replace the Affordable Care Act. By March 24, the bill was dead, pulled down without a House vote due to insufficient support. Despite its quick death, efforts to revive the legislation continue, with congressional leaders vowing to reconsider AHCA — or its successor — in May. Though the legislation will undergo some revision to accommodate dissenters’ concerns, it undoubtedly will have significant implications for Texas’ health care delivery system, particularly its safety net. Provisions in the bill would not only terminate enhanced Medicaid funding for states to use to expand health insurance coverage to low-income patients but also upend the programs’ entire financing and benefit structures, ending a 50-year commitment of guaranteed funding and minimum benefits for poor and low-income patients. (The AHCA also would have substantial implications for the commercial health insurance market, but this report focuses only on the Medicaid provisions).

While the AHCA contains numerous Medicaid provisions, of particular concern are two:

1) Eliminating the 90 percent federal matching rate for Medicaid expansion. As a result of the Affordable Care Act, states have the option to expand Medicaid coverage for parents and childless adults up to 138 percent of federal poverty using either the state’s current Medicaid delivery system or a state-designed model that enrolls patients in private health insurance or mimics key elements of the private sector. To date, 31 states have done so, including more than a half-dozen Republican led ones. Texas has not. The AHCA forecloses the option.

2) Eliminating Medicaid’s guaranteed, open-ended financing mechanism, replacing it with one of two capped federal funding options — a per-capita cap or block grant — in exchange for granting states greater flexibility to determine Medicaid benefits, services, and payments. However, through Medicaid waivers, states already have considerable latitude to reshape Medicaid. This provision is inarguably the most alarming since it would mean Texas receiving less money for doing what it already does.

Texas physicians strongly support prudent reforms to simplify Medicaid administrative requirements for physicians, patients, and the state as well as ongoing, thoughtful efforts to curtail costs. Like all payers, Medicaid costs are rising, and limited state tax dollars must be diligently managed. But Medicaid costs are driven primarily by caseload growth, not per-person expenditures. Texas is the fastest growing state in the country. Enactment of capped funding would tie the state’s hands, not only preventing it from
enacting broader coverage but also limiting its ability to address current health care disparities and inequities, including inadequate Medicaid physician payments.

Medicaid Basics: Current Texas Medicaid Financing, Eligibility and Coverage

➤ Financing
Under current federal law, Medicaid is financed jointly by the states and the federal government. Minimally, states receive a 50/50 match. The U.S. Department of Health and Human Services sets matching rates annually based, in part, on a state’s economic health relative to other states. For fiscal year 2018, Texas’ federal matching rate will be 56.88 percent, meaning for every dollar spent by Texas Medicaid nearly 57 percent of the costs will be paid by the federal government. In 2015, Texas received $21.4 billion in federal Medicaid matching funds for Texas’ $14.8 billion in state spending.

Historically, Texas’ matching rate has fluctuated between 58 percent and 60 percent, but if Medicaid spending increases due to a recession, natural disaster, public health emergency, or new medical or pharmaceutical innovations that intensify Medicaid spending, the federal government guarantees to match it so long as the state complies with federal minimum eligibility and benefit standards. According to the Kaiser Family Foundation, during the 2008-2011 recession, Texas’ unemployed rate soared to 8.4 percent, resulting in 475,900 more people enrolling in Medicaid. Federal matching funds grew to accommodate the new enrollees. Under a block grant formula, a state’s federal Medicaid allotment would not change, regardless of any pressures to serve more patients.

Texas receives supplemental Medicaid funding via hospital disproportionate share funds (DSH) and the 1115 Medicaid Transformation Waiver. Under the latter, local taxing authorities – mostly hospital districts but also rural and border counties – provide the state’s share of matching funds to draw down additional federal funds. Under Texas’ current Medicaid 1115 waiver, which began in 2011 and has been extended at least through the end of this year, Texas receives more than $3 billion per year in additional federal dollars to offset hospital uncompensated care and to fund innovative projects at the community-level to expand access to and quality of services for Medicaid and uninsured patients. While the waiver has drawbacks, including inadequate community physician input and participation, without it many safety-net providers would cease to operate or limit their services. Late last year, HHSC submitted a letter to the Centers for Medicare and Medicaid Services requesting a 21-month waiver extension, which would provide additional dollars through Sept. 30, 2019 if approved.

➤ Eligibility
Federal law establishes mandatory Medicaid populations — children, pregnant women, poor parents, patients with disabilities, and seniors — and the minimum eligibility levels for each. For each mandatory population, states have the option to expand coverage above the federal minimum. Texas Medicaid eligibility adheres strictly to the federal minimum standards for all populations except two: pregnant women/newborns and patients needing long-term care services.
More than 4 million Texans currently obtain health care coverage via Medicaid, 67 percent of whom are children. Indeed, Medicaid plays a vital role in children’s coverage. Some forty percent of all Texas children are insured via the program, including all children in foster care.

Medicaid provides children benefits tailored to their particular needs. Through a provision in federal law known as the Early Periodic Diagnosis Screening and Treatment (EPSDT) Act, states must provide children all medically necessary services, including preventive, primary, and specialty physician services, behavioral health, hospital care, and dental and vision services. EPSDT also ensures children with special health care needs receive necessary ancillary services, such as durable medical equipment, physical,
speech, and occupational therapy, and community-based long-term care, making Medicaid the single largest provider of services for children with disabilities.

Medicaid is the largest payer of maternity care. It pays for 52 percent of all Texas births, though that number is substantially higher in rural, urban, and border communities. Additionally, the program serves as a critical stakeholder in improving birth outcomes, pushing quality improvement measures to reduce rates of prematurity and low-birth weight babies, as well as promoting early entry prenatal care.

According to the Medicaid and CHIP Payment Advisory Commission, Medicaid is the single largest payer for behavioral health services in the U.S., covering everything from autism spectrum disorders to severe and persistent mental illness to dementia. Among adults enrolled in Medicaid (excluding dually eligible patients), almost half of those who enroll on the basis of a disability have a mental illness. For children in foster care, these services are particularly important since children with a history of physical or mental trauma often need more intensive behavioral health interventions.

For seniors, Medicaid is vitally important, covering not only long-term care services and supports but also Medicare cost-sharing for those poor enough to qualify for both Medicaid and Medicare. Seventy percent of nursing home care is paid by Medicaid. Medicaid also pays for less expensive community-based services to help keep seniors and people with disabilities in their homes instead of institutions.

From a population health perspective, Medicaid plays a critical role, funding vaccines for children, championing initiatives to promote better birth outcomes, and screening eligible patients for a wide range of infectious diseases, including Zika and tuberculosis, that could harm the general public if left undetected and untreated.

At the same time, contrary to popular opinion, being poor does not necessarily qualify a person for Medicaid. Patients must meet Medicaid income and categorical coverage requirements. Very few low-income parents actually qualify. For example, women qualify for Medicaid while pregnant and for two-months postpartum, but after that time, they no longer qualify for coverage unless their income is at or below 15 percent of poverty, the eligibility rate for Texas parents. Parents earning more than $3,200 annually are not eligible. (Only Alabama has lower income level eligibility rate for parents — 13 percent of poverty). In addition to income and categorical requirements, patients must be Texas residents and U.S. citizens, though for emergency services, including labor and delivery, undocumented immigrants are eligible so long as they meet all other Medicaid eligibility requirements.

**AHCA Medicaid Reform Provisions**

The AHCA contains two broad provisions designed to fundamentally restructure Medicaid:

1) **Eliminate the 90 percent federal matching funds for states to pursue Medicaid expansion.**

   As a result of the Affordable Care Act, states have the option to expand Medicaid coverage for parents and childless adults up to 138 percent of federal poverty ($16,587 for a single adult) using either a state’s current Medicaid delivery system or a state-designed model that enrolls patients in private health insurance or mimics key elements of the private sector. To date, 31 states have expanded coverage, including a dozen Republican led ones. Texas has not. The AHCA forecloses the option.

   An estimated 1 million uninsured, working-age Texans would potentially gain coverage via Medicaid expansion. **In 2013, the TMA House of Delegates adopted policy 190.032 Medicaid**
Coverage and Reform encouraging state legislative leaders to draw down all available federal funding to expand access to health care for poor Texans.

If enacted, the AHCA would eliminate the enhanced federal matching funds to expand Medicaid. Instead, it would create a $10 billion safety-net pool apportioned among the 19 non-expansion states over five years based on each state’s low-income population. Texas’ estimated portion would be $500 million annually to be shared among physicians and providers. Under current law, if Texas expanded Medicaid coverage in accordance with TMA policy, the federal government would pay 90 percent of the costs from 2020 on resulting in up to $10 billion annually for the state. That is a 20-fold differential. (The ACA provided states 100-percent federal funding for Medicaid expansion from 2014-2016, gradually tapering down to down to 90 percent by 2020 on).

2) Eliminate Medicaid’s guaranteed, open-ended financing mechanism, replacing it with one of two capped federal funding options: a per-capita cap or block grant.

As described above, capped federal funding would give states a fixed annual sum plus a nominal growth factor, such as general or medical inflation, but less than estimated cost growth over a 10-year period. For both a block grant and per-capita cap, a state’s allotment would be based on its historical level of spending. In the case of the AHCA, each state’s base allotment would be built on 2016 expenditures. This means Texas’ previous decisions to fund — or not fund — services or benefits would be locked into its base funding formula as would low physician payment rates. Texas physician payments stopped receiving annual inflation updates in 1993. Since then, rates have mostly stagnated or declined, with the exception of rate increases for children’s preventive care and a temporary Medicaid to Medicare parity adjustment for select primary care physician services in 2013 and 2014 funded by the Affordable Care Act.

Even though the per-capita grant would grow with population, neither a block grant nor per-capita cap would adjust if the state’s costs increased due to changes in medical costs from new technology or pharmaceutical innovations or due to a public health emergency or catastrophic event. Had capped funding been in place in 2015 when new Hepatitis C drugs were approved by the FDA, the cost of the new drugs would not be reflected in Texas’ federal matching funds just as a capped funding formula would not be adjusted to reflect higher-than-anticipated Zika-related expenditures for prenatal laboratory testing, neonatal intensive care services, or follow up services.

Summary of major AHCA Medicaid provisions:

- Reduce Medicaid federal funding by an estimated $880 billion over ten years, approximately 25 percent less than projected under current law (source: Congressional Budget Office; AHCA as filed); Conservatively, Texas’ share of the reduction would total $15 billion (source: Urban Institute)
- Beginning in 2020, for each of five patient categories — children, blind and disabled, elderly, other adults (including pregnant women and poor parents), and expansion adults — states would receive a fixed per capita cap (PCC) amount based on the state’s average per person spending amount in 2016 trended forward to 2019 by medical Consumer Price Index. Certain expenditures and populations would be outside the adjusted per-capita cap, including vaccines for children, women with breast or cervical cancer services, and dual eligible. The per-capita cap funding level would increase annually based on the medical Consumer Price Index but less than the Congressional Budget Office’s projected Medicaid growth projections, shifting the higher costs to the states.
• The per-capita cap formula accounts for caseload growth, but not for other unexpected Medicaid costs, including an infectious disease outbreak such as Zika or other public health emergency, such as the opioid addiction crisis, the advent of new, costly life changing medical interventions or medications, including those to treat Hepatitis C or muscular dystrophy, a surge in demand following a natural disaster, or new medical technology, such as telemedicine.

• The proposed bill bases Medicaid capped funding on 2016 expenditures trended forward to 2019 using medical CPI. Effectively, this will lock in perpetuity Texas’ low rates of physician payments, including the cuts enacted in 2012 for dual eligible cost sharing and in 2015 for children’s services because Texas will not be able gain matching dollars for new investments in payments or services.

• If a state’s Medicaid expenditures exceed its per-capita cap target amount within a fiscal year, then it will have its payments reduced in the following fiscal year by the amount of the excess payments.

• Eliminates scheduled cuts in hospital disproportionate share (DSH) funds to mitigate increases in the number of uninsured; however, it remained unclear whether the bill’s base-level funding formula fully accounted for supplemental Medicaid funds, including Texas’ 1115 Medicaid transformation waiver, and how such funding would trend forward.

• A last minute manager’s amendment provided states the option to establish a block grant for children, pregnant women, or both, with an annual growth factor pegged to the consumer price index +1. States selecting the option would be locked into that decision through 2020. As previously noted, Texas’ Medicaid costs are driven primarily by caseload, not per-person costs, so the purchasing power of a 10-year block grant without caseload growth would quickly erode, leaving Texas with unpalatable choices to make up the difference — either increasing state spending or making reductions in services, eligibility, and/or physician payments. To entice states to adopt the block grant, the bill would reduce state contributions to obtain the federal funds for this population, resulting in even a deeper funding cut for the block grant population. Other populations would be subject to per-capita caps.

• Under the block grant option, minimum federal eligibility and benefit standards would be eliminated, including EPSDT protections for children.

The following table summarizes the key differences among the current Medicaid funding system, block grants, and the per-capita cap.

<table>
<thead>
<tr>
<th>Current Medicaid Funding</th>
<th>Block Grants</th>
<th>Per-Capita Cap</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Funding</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Open ended    Aggregate cap  Per-enrollee cap (by eligibility group)
<table>
<thead>
<tr>
<th>Current Medicaid Funding</th>
<th>Block Grants</th>
<th>Per-Capita Cap</th>
</tr>
</thead>
<tbody>
<tr>
<td>Risk</td>
<td>States bear risk of both higher enrollment and health care costs</td>
<td>States bears spending risk of higher health care costs</td>
</tr>
<tr>
<td>Annual Trend</td>
<td>Determined by health care costs in the state and individual state spending decisions</td>
<td>National trend rate</td>
</tr>
<tr>
<td>Ability to Accommodate Increase Costs due to Medical Advances or Public Health Crises</td>
<td>Federal payments automatically increase as state costs rise</td>
<td>Federal payments fixed – no additional funding for public health emergencies or new medical technology</td>
</tr>
<tr>
<td>Spending Higher than Cap</td>
<td>N/A</td>
<td>States responsible for higher than anticipated costs, including caseload growth</td>
</tr>
<tr>
<td>State Flexibility</td>
<td>States must adhere to federal minimum standards, but Section 1115 waivers provide additional flexibility and innovation</td>
<td>Increased flexibility; unknown whether minimum federal standards will apply. Flexibility must be achieved within the funding level</td>
</tr>
<tr>
<td>Benefits</td>
<td>Federal minimum standards, including special protections for children via EPSDT</td>
<td>Likely no federal minimum standards; benefits and services determined by the state</td>
</tr>
<tr>
<td></td>
<td>Current Medicaid Funding</td>
<td>Block Grants</td>
</tr>
<tr>
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<td>------------------------------------------------------------------------------</td>
</tr>
<tr>
<td><strong>Physician Payments</strong></td>
<td>Federal standards regarding access, but rates determined by state; increased funding for payments will be matched by federal funds</td>
<td>Rates determined by state; if rates increased after state’s base allotment is determined, higher costs not included in block grant base</td>
</tr>
<tr>
<td><strong>Supplemental Funding</strong></td>
<td>Funded via Medicaid 1115 waivers</td>
<td>Appears to be funded in base funding</td>
</tr>
</tbody>
</table>

Source: Manatt Health, TMA

Without a doubt, capped Medicaid funding will have enormous implications for patients, physicians, providers — and the state. According to the Kaiser Family Foundation, if a Medicaid per-capita cap funding formula had been in place from 2000-2011 and per-enrollee growth had been limited to the Consumer Price Index-Medical — the same growth factor envisioned by the AHCA — federal funding would have been $128 billion (7 percent) less nationally, costing Texas $13 billion (11 percent) in federal funds. Of Texas’ losses, $9.9 billion (24 percent) would have come from the child-enrollee group.
Texas is grappling with formidable health issues. Cuts in federal funding will hamper our ability to respond. Beyond continuing to be the nation’s uninsured capital, 21 percent of Texas children live in poverty, a known risk factor for short- and long-term behavioral and physical health disorders; 34 percent of adults are considered obese, contributing to high rates of chronic health conditions, including diabetes and heart disease; and opioid addictions continue to escalate. Alarmingly, Texas also has one of the highest rates of maternal mortality and morbidity, doubling from 18 per 100,000 births to 36 per 100,000 births from 2010 to 2012. While the factors contributing to maternal death and illness are complex and varied, lack of access to care in the 12 months following delivery is one of them. Without coverage, women with chronic conditions, such as hypertension, diabetes, or perinatal depression, often go without care, with results to match. If Texas were to draw down the federal funds to enhance coverage, it could devise a benefit package to ensure women at risk of postpartum mortality or complications receive the services they need.

If history provides a guide, capped federal funding will not grow over the decade but decline. A 2016 analysis conducted by the national Center on Budget and Policy Priorities of 13 federal housing, health, and social policy block grants found that funding for 11 of the 13, including the Temporary Assistance to Needy Families (TANF), failed to keep pace with inflation and dropped significantly over time. According to the study, the median funding change was a decline of about 26 percent. For four of the block grants, funding plunged by significantly more than half.
Additionally, according to an Urban Institute analysis, a 2012 House Medicaid block grant proposal would have cut Texas Medicaid funding by 32 percent over 10 years. For Texas to avoid steep enrollment cuts, it would have needed to increase spending by 46 percent to 78 percent. Nationally, the same analysis found that over 10 years, 14 million Americans would have lost coverage and provider payments (primarily among hospitals and nursing homes) would have declined some 30 percent. While the AHCA provisions are not identical, the analysis of the 2012 legislation is instructive because as of this writing, the Congressional Budget Office had not published state-by-state analyses of the AHCA.

It also should be noted that without the Medicaid entitlement, federal funding would be appropriated annually, forcing states to lobby Congress every year to retain their federal commitment, much like physicians were forced to do each year for more than a decade to prevent SGR-triggered Medicare payment cuts.

While the capped funding discussion often gets discussed in the same context as repeal of Medicaid expansion, a per-capita cap or block grant, as envisioned by the AHCA, would apply to all Medicaid enrollees – the current federally mandated populations (low-income pregnant women, parents, children, patients with disabilities and seniors) as well as higher income enrollees eligible for ACA Medicaid expansion. A block grant would end guaranteed Medicaid coverage for the poorest Texans, with the likely impact being a large increase in Texans without coverage and a concomitant increase in uncompensated care for physicians and hospitals.

Undoubtedly, Medicaid has its limitations, beginning with too many paperwork headaches and too little payment. But Medicaid is the keystone to Texas’ safety net system. Funding cuts to the program
will harm not only patients enrolled in the program and physicians who treat them, but also the entire health care system. Nearly every hospital in Texas receives supplemental Medicaid funding to offset uncompensated care. Cuts in funding would jeopardize their ability to provide services, including maternity and trauma services, for all Texans and make it increasingly difficult for remaining participating physicians and providers to deliver even basic health care services. In some communities, the loss of funding would shutter hospital doors. Further, Texas counties are constitutionally required to provide indigent care. If the federal government shifts costs to the states, Texas will shift costs to counties, which in turn will increase property taxes and/or reduce services to compensate.

Policy Implications and Recommendations

In January, TMA’s Select Committee on Medicaid, CHIP and the Uninsured held two meetings to discuss implications of a Medicaid capped-funding formula and how to respond. From those discussions, it developed key policy questions to ask about any legislation.

Capped Funding Policy Questions

- How will the block grant and/or per-capita cap base year be calculated?
- Will the funding be periodically rebased over time?
- Would states be required to continue matching payments to receive federal funds?
- Will supplemental payments, including the state’s 1115 Medicaid waiver funding, be incorporated into a block grant, limited, or carved out?
- How will the proposal avoid financially penalizing Texas, which already has low per-person costs as a result of low provider payments and aggressive cost-containment initiatives?
- Will Texas receive additional dollars to account for its Medicaid expansion population?
- Will the block grant or per-capita cap discontinue EPSDT protections for children?
- Will existing federal minimum patient and provider protections remain in place, including minimum standards for eligibility, benefits, and services?
- Will the reforms establish minimum federal eligibility and coverage standards, including maintenance of effort for existing mandatory populations?
- Will a block grant or per-capita cap apply to all Medicaid populations and services or exclude some? (E.g. carve out nursing homes and long-term care)?
- Will CMS maintain federal minimum standards for Medicaid managed care regarding network adequacy, benefits, quality improvement, etc.?
- Will states lose funding for emergency Medicaid, which offsets costs of uncompensated care provided to immigrants ineligible for coverage?
- Will federal rebates for prescription drugs end?
- How will capped funding impact long-term care services, including community-based services? Would it preclude moving patients from waiting lists?
- Poverty is a key driver of health care costs. Will states with high poverty rates, particularly among children, receive additional dollars to address social determinants of health?
- Will the funding formula be adjusted to account for Texas’ low physician payment rates and other funding disparities?
Concurrently, in January, TMA and the Texas Hospital Association formed a joint, 14-person Block Grant Task Force, chaired by TMAs Board of Trustees Chair Doug Curran, MD, to develop joint principles to guide both organizations’ evaluation of federal block grant legislation and to communicate to Texas’ congressional and state legislative leadership reform priorities for physicians and hospitals. The task force convened twice, culminating in a letter to Texas’ congressional delegation outlining TMA’s and THA’s strong concerns about the AHCA’s per-capita cap scheme (see Appendix 1 for letter and task force roster).

Many state lawmakers argue in favor of capping federal Medicaid funding in exchange for greater programmatic flexibility. But lawmakers already have tremendous latitude in designing Medicaid, ranging from the amounts the state pays physicians and providers to services covered by the Medicaid delivery system. For other issues, such as experimenting with Medicaid cost-sharing or testing innovative models of care, states can seek federal waivers. Flexibility and capped funding are not inherently linked — states can pursue greater federal flexibility without upending Medicaid financing by reducing federal funds. Low-spending states like Texas might find their ability to implement additional services, such as enhancing opioid addiction treatment, or covering more people, diminished.

If federal strings go away, it is likely the Texas Legislature will push for additional cuts. In 2011, Texas reduced funding for preventive women’s health services. The result was an increase in Medicaid births and a significant cost increase to the program far above the savings achieved. In 2015, lawmakers cut $350 million in Medicaid therapy services, resulting in reduced access to these services for Texans with disabilities and low-income Medicaid beneficiaries.

**Beyond the potential to jeopardize patient care, capped funding likely also would increase physician uncompensated care substantially.** According to the Texas Comptroller and Texas Health and Human Services Commission, caseload is the primary driver of Medicaid costs, not per-person spending. Texas legislators have squeezed the program significantly over the past decade. Ninety-two percent of Medicaid patients are now enrolled in managed care, and physician Medicaid payments average roughly 73 percent of Medicare’s. Each session, lawmakers squeeze Medicaid even further, establishing more and more unrealistic cost-containment goals. There really are no additional realistic options for Texas to curtail costs under a capped-funding scheme except to reduce benefits, eligibility, and payments.

While the AHCA’s final form is unknown, it is clear that congressional efforts to fundamentally alter Medicaid will persist. Given the sweeping implications of capped funding for patients, physicians, and Texas’ health care safety net system, the council and committee recommend a path that would not irreparably harm the existing system. Instead the focus should be on maintaining uncapped federal Medicaid funding, preserving minimum Medicaid benefit and eligibility protections for the lowest income Texans, including EPSDT for children, and pursuing initiatives to expand health care coverage to low-income Texans using private-sector solutions. Furthermore, TMA also should collaborate with state legislative leadership to pursue federal reforms to streamline federal administrative processes that impose undue burdens on patients, physicians, and the state.

**Recommendations:**

**Recommendation 1:** That TMA vigorously advocate to preserve guaranteed, uncapped federal Medicaid funding for at least all Texas Medicaid populations covered by the program as of Jan. 1, 2017.
Recommendation 2: That TMA strongly advocate maintaining mandated minimum services, benefits and cost-sharing requirements for pregnant women and children, including protecting the Early Periodic Screening Diagnosis and Treatment (EPSDT) program to ensure Medicaid-enrolled children retain access to all medically necessary services, and maternal health services to promote healthy pregnancies and birth outcomes.

Recommendation 3: That TMA strongly reiterate its support for measures that promote continuity of care and the patient-centered medical home, including maintaining 12-month continuous coverage for children enrolled in the Children’s Health Insurance Program and advocating for the same policy for children’s Medicaid, and preserve measures to simplify and streamline Medicaid and CHIP enrollment processes so that children and other enrollees do not lose coverage due to red-tape and bureaucracy.

Recommendation 4: That TMA reiterate its commitment to implementing a comprehensive initiative to expand health care coverage to low-income Texans using federal funding and private sector solutions.

Recommendation 5: That TMA evaluate the feasibility of piloting a capped Medicaid funding scheme for Medicaid expansion population should Texas implement a coverage option for low-income Texans, so long as the initiative provides patients meaningful coverage as devised by an advisory panel of primary and specialty care physicians and does not increase uncompensated care for physicians.

Recommendation 6: That TMA advocate strongly to stand against any federal or state reform measure that will diminish patient access to services or increase physicians’ uncompensated care.

Recommendation 7: That TMA collaborate with state legislative leadership to seek relief from federal administrative requirements that impose undue costs and paperwork on patients, physicians, and the state without improving patient care or outcomes.
Subject: Opposition to Capped Federal Medicaid Funding

Introduced by: Bexar County Medical Society

Referred to: Reference Committee on Socioeconomics

Whereas, Current federal legislative proposals to repeal and/or replace the Affordable Care Act drastically alter the nature of the Medicaid program by eliminating guaranteed funding and services and replacing them with a fixed funding amount; and

Whereas, The mechanism by which current legislative proposals address Medicaid funding include capping the federal share of funding in the form of per-capita caps, which would cap federal spending per eligibility group; and

Whereas, Proposals capping the federal share of Medicaid funding do not fully account for medical inflation or surges in costs due to public health emergencies, and ultimately will shift additional costs to already strained state budgets; and

Whereas, Texas’ Medicaid cost increases are driven primarily by caseload growth; therefore be it

RESOLVED, That the Texas Medical Association apply all appropriate resources to oppose capped Medicaid funding to ensure that vulnerable Texas children, pregnant women, and other populations continue to receive necessary medical services and that Texas does not increase uncompensated care for physicians.

Relevant TMA Policy:

190.007 Medicaid Funding: The Texas Medical Association made as one of its highest priorities the provision of adequate funding for the Texas Medicaid program. In addition, TMA voted to seek, through legislative and regulatory means, to have the Medicaid fee schedule conversion factor made equal to at least the Medicare fee schedule conversion factor (Res. 28X, p 194A, I-92; reaffirmed Res. 406-A-03; amended CSE Rep. 1-A-13).

190.010 Medicaid Fiscal Integrity: The fiscal integrity of the present Medicaid program should be preserved in the interests of the beneficiaries of the program and the taxpayers who support it (Council on Socioeconomics, p 179, I-94; reaffirmed CSE Rep. 3-A-04; reaffirmed CSE Rep. 2-A-14).

190.022 Medicaid and CHIP Funding and Access to Care for Children: The Texas Medical Association will work toward improving access to care for Texas children by opposing legislative proposals for Medicaid and CHIP funding cuts and supporting increased reimbursement for Medicaid and CHIP; by educating communities and taxpayers about the
negative impact of shifting costs from the state budget to local economies; and by
emphasizing that physicians and providers of health care for children under Medicaid and
CHIP must receive reimbursement parity with Medicare (Amended Res. 406-A-03;

190.023 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.

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.

190.095 Floor for Medicaid Payments: The Texas Medical Association will work with all applicable
agencies to increase Medicaid payment equal to at least Medicare payments and will offer
model legislation in Article II of the state budget to ensure Medicaid payments are sufficient
to support medical practices of all specialties and include annual updates based on the
Medical Economic Index (Res. 404-A-14).

Relevant AMA Policy:

H-385.921 Health Care Access for Medicaid Patients: It is AMA policy that to increase and maintain
access to health care for all, payment for physician providers for Medicaid, TRICARE, and
any other publicly funded insurance plan must be at minimum 100% of the RBRVS Medicare
allowable (Res. 103-A-07; reaffirmed CMS Rep. 2, I-08; reaffirmation A-12; reaffirmed Res.
Whereas, Congress is seriously considering changing Medicaid financing to a block grant or “per-capita cap,” both of which would end the program’s guaranteed funding to states; and

Whereas, The goal of block grants and per-capita caps is to cut Medicaid funding by giving states a fixed annual allotment plus a nominal growth factor less than the expected rate of actual costs; and

Whereas, Proposals currently under consideration would not compensate Texas for higher-than-expected costs from new pharmaceuticals, public health emergencies, or natural disasters; and

Whereas, Block grants would end guaranteed Medicaid coverage for patients who currently are eligible — low-income children, pregnant women, poor parents, patients with disabilities, and seniors — and allow states to establish their own benefits and eligibility levels or even to establish waiting lists; and

Whereas, Medicaid is vital to low-income children and pregnant women: 72 percent of Texas Medicaid enrollees are under age 18, and 52 percent of all Texas births are paid by Medicaid; and

Whereas, Texas Medicaid covers poor parents with incomes at or below 20 percent of poverty (about $181 per month), tied with Alabama for lowest in the country; and

Whereas, Block grants/per-capita caps would end Medicaid’s protection for children, known as Early Periodic Screening Diagnosis and Treatment, which requires states to pay for all medically necessary services for children; and

Whereas, Medicaid is the major source of funding for public mental health and substance abuse treatment; and

Whereas, Pregnant women and children are a vulnerable population in which untreated medical problems affect their health and success for an entire generation; and

Whereas, The aged and disabled with complex medical problems are insured through Medicaid and require a multiplicity of medical and long-term care services; and

Whereas, A Kaiser Family Foundation and Urban Institute analysis of House Speaker Paul Ryan’s 2012 block grant proposal estimated it would reduce Texas’ Medicaid coverage by nearly 1 million; and

Whereas, The same study estimated (1) Texas would need to increase spending by 46 percent to 78 percent to maintain existing eligibility levels, and (2) Medicaid funding for Texas’ hospitals would decline 21 percent, harming hospitals that serve our poorest patients; and
Whereas, While a block grant might result in Texas paying physicians a fairer Medicaid payment rate, it also more likely would result in reductions in patients with coverage, thereby shifting more uncompensated care to physicians and hospitals; and

Whereas, The Medicaid expansion population (which Texas did not fund) consists mainly of healthy adults, and block grant proposals may eliminate funding to cover more Texans in that category; and

Whereas, The Texas Health and Human Service Commission says increases in Medicaid costs stem mostly from rising enrollment due to Texas’ population growth; therefore be it

RESOLVED, That the Texas Medical Association:

1. Support maintaining the present Medicaid coverage, including Early Periodic Screening Diagnosis and Treatment, for the following populations: children, pregnant women, parents, patients with disabilities, and seniors;
2. Support the concept of block or per-capita grants for the Medicaid expansion population;
3. Support the basis for any block grant or per-capita grant being national per-capita expenditure averages, rather than historical expenditures by state; and
4. Support block or per-capita grants being adjusted annually to account for the medical inflation rate and population growth.

Reference

Subject: Supporting Community-Based Health Care Delivery Models for Vulnerable Patients

Introduced by: Dallas County Medical Society

Referred to: Reference Committee on Socioeconomics

Whereas, Texas continues to have the highest uninsured population in the United States; and

Whereas, Thousands of Texas residents are insured through Medicare, individual exchange/marketplace plans, and Medicaid, yet remain vulnerable because of a lack of access to comprehensive, coordinated primary and specialty outpatient care; and

Whereas, Uninsured and underinsured patients often experience a fragmented, chaotic system of health care delivery, resulting in medical care at later stages of disease progression, often through hospital emergency departments, and ultimately at great financial cost to the citizens of Texas; and

Whereas, Physicians and county medical societies are playing a key role in the design of community-based health care delivery models, bringing together concepts that are transparent, transformative, accountable, and patient-centric; and

Whereas, The state of Texas is appealing a decision by the Centers for Medicare & Medicaid Services to deny an extension of the Medicaid 1115 Waiver, a waiver intended to redesign and reform the system of care for this vulnerable population; and

Whereas, The current Medicaid 1115 Waiver has not translated into meaningful access to the broader health care system by prohibiting funds from being used easily to cover the costs of expanding comprehensive, coordinated primary and specialty outpatient care, while health care systems and hospitals use much of these funds to reimburse themselves for uncompensated care delivered at the most expensive locus of the health care system; and

Whereas, The Dallas County, Travis County, and Harris County medical societies have come together to develop a framework for the design of community-based health care delivery models for use across Texas; therefore be it

RESOLVED, That the Texas Medical Association support the concept and implementation of community-based health care delivery models emphasizing meaningful access for vulnerable patients throughout Texas; and be it further

RESOLVED, That TMA 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.
Relevant TMA Policy


115.015 Accountable Care Organizations: Accountable Care Organizations will develop into complex organizations tailored to meet the health care needs of a local community. The Texas Medical Association supports accountable care organizations as a tool in the delivery of medical care if the following safeguards and elements are present:

Physician Outreach and Education. Texas physicians must receive guidance, tools, and education about accountable care organizations. Toolkits that provide the information necessary for physicians to make informed decisions about establishing, affiliating, or joining ACOs must be developed and disseminated. In addition, development and dissemination of information about ACO governance, payment models, as well as economic and quality measures (including strategies to meet them) should be undertaken. Various methods of outreach should be utilized including webinars, podcasts, seminars, and publications.

ACO Governance.

Physician Led. ACOs must be physician-led and encourage an environment of collaboration and professionalism among physicians and other health care team members. This ensures that health care delivered under the ACO model is patient-centric and that a physician’s medical decisions are not based on commercial interests but rather on professional medical judgment that puts patients’ interests first. Primary care and subspecialty physicians must be actively engaged in the organization’s design, implementation, monitoring and evaluation.

Physicians Retain Independent Medical Judgment Within an ACO. Medical decisions should be made by physicians. ACOs must be operationally structured and governed by an appropriate number of physicians (rather than lay entities) and place patients’ interests first. Physicians are the medical professionals best qualified by training, education, and experience to provide diagnosis and treatment of patients. Clinical decisions must be made by the physician or physician-controlled entity in an environment where they are free to exercise independent medical judgment free from commercial influence.

(1) Policies and Procedures. ACOs may not have any policies and procedures that serve to impede a physician’s primary ethical obligation to the well-being and safety of his patients. Any time period for an appeal of an alleged breach of conduct must be heard in a clinically appropriate time frame.

(2) Whistleblowing Protections. Physicians should be afforded the right to whistleblowing to ACO leadership and/or to the appropriate regulatory authority if the ACO acts in any way contrary to the patient’s best interests. No retaliation should be permitted by the ACO or associated hospital/parent entity for such whistleblowing. For an ACO to truly be patient-centric, physicians must be free to advocate for their patients. The physician’s ethical obligations to the patient must supersede the physician’s employment or contractual obligations to the ACO or an associated hospital.
(3) Medical record ownership. To aid in continuity of care and to ensure the highest
quality of treatment, there should be joint ownership of the medical records by the ACO
and the participating physician. In the alternative, ACOs should provide participating
physicians (including upon their departure from the ACO) with a right of access to the
medical record in the same form in which the medical record is typically maintained.

Physician Board of Directors. The ACO should be governed by a physician board of
directors that is elected by the ACO professionals. The governing board is ultimately
responsible for the care and well-being of patients. The ACO must adopt a conflicts of
interest policy and conflicts of interest disclosure policy to ensure that the board of
directors appropriately represents the interests of the ACO. Any physician-entity (e.g.,
independent physician association (IPA), medical group, and so on) that contracts with,
or is otherwise part of, the ACO should be physician-controlled and governed by an
elected board of directors.

Hospital-participating ACOs. Where a hospital is part of an ACO:

(1) The governing board of the ACO, which is comprised of physicians, should be
separate and independent from the hospital governing board; and

(2) The physician’s privileges at the hospital should not be conditioned on the physician’s
participation in the ACO, nor should the physician’s privileges at the hospital
automatically cease upon the termination of the physician’s agreement with the ACO.

Physician Leadership Licensure/Practice. The ACO’s physician leaders, including the
medical directors, should be licensed in the state in which the ACO operates and in the
active practice of medicine. To ensure local accountability and oversight, any medical
director(s) must report to the physician governing board who will be actively engaged in
the development and oversight of the ACO’s medical policy, utilization review, quality
improvement, and performance measurement.

ACO State Regulation. Existing state laws offer appropriate means for organization of
ACOs without the need for ACO-specific legislation in Texas. Depending upon an
ACO’s structure and scope of activities, various state agencies should have oversight
authority over an ACO organized and/or operating in Texas. For example, the Texas
Medical Board should appropriately regulate the practice of medicine (i.e., clinical
aspects) associated with an ACO. If an ACO takes on insurance risk (e.g., capitation), the
Texas Department of Insurance (TDI) should appropriately regulate that function. TDI
has the background and expertise to deal with the financial and risk-bearing aspects of
ACO operations. ACOs should maintain appropriate and adequate reserves and risk-
based capital requirements in the same manner as licensed health insurance carriers.

Physician Participation. Physician participation in an ACO generally should be voluntary
unless they are a member of a preexisting physician group that elects to participate.
Physicians should not be required to join an ACO as a condition of contracting with
Medicare, Medicaid, or a private payer or being admitted to a hospital medical staff.

Patient Participation. Patient participation in an ACO must be voluntary. Patients must be
free to choose whether to enroll in an ACO.
Marketplace Limiting Agreements. As the purpose of an ACO is to promote community-based care, an ACO must not impose marketplace limiting agreements (e.g., covenants not to compete and exclusivity provisions) upon physicians or physician practices. Further, the ACO must not interfere with the internal management of physician practices regarding covenants not to compete.

Due Process. Physician participants in an ACO should have due process (consisting of, at a minimum, the right to notice, a hearing, and an appeal to the physician board of directors) to challenge:

- The physician’s (or his group’s) involuntary termination from participation in an ACO;
- The physician’s satisfaction of performance standards (with an opportunity to explain and/or cure any alleged departures from performance standards);
- The physician’s eligibility to receive savings or distributions from the ACO;
- The amount of the distribution received by the physician from the ACO (i.e., the appropriate distribution of savings and revenue of an ACO);
- The patients assigned to the physician’s care under the ACO;
- The measurements used to determine the quality of care/efficiency of care provided to patients under the ACO; and
- The ACO’s assessment of the quality of care provided to patients by the physician under the ACO.

Economic and Quality Measures. Physicians currently in clinical practice must be actively involved in the development of economic and quality measures used by ACOs for performance measurement. Such measures and methodologies must be transparent, valid, and approved by the physician governing board. The economic and quality performance standards must meet the TMA principles for reporting, including the use of nationally accepted, physician specialty-validated clinical measures; the inclusion of a sufficient number of patients to produce statistically valid quality information; appropriate attribution methodology; risk adjustment; reflection of geographic costs; and the right for physicians to appeal inaccurate quality/efficiency reports and have them corrected. There also must be timely notification and feedback provided to physicians regarding the economic and quality measures and results. Physicians must be provided all economic and quality measures prior to the evaluation period. ACOs should periodically conduct assessments of patients’ satisfaction with the timeliness and availability of care.

Flexibility in Patient Referral and Antitrust Laws. The federal and state antikickback and self-referral laws and the federal Civil Monetary Penalties (CMP) statute (which prohibits payments by hospitals to physicians to reduce or limit care) should be sufficiently flexible (with bright-line exemptions) to allow physicians to collaborate with hospitals in forming ACOs without being employed by the hospitals or ACOs or in legal jeopardy. This is particularly important for physicians in small- and medium-size practices who may want to remain independent but otherwise integrate and collaborate with other physicians (i.e., so-called virtual integration) for purposes of participating in the ACO. The Patient Protection and Affordable Care Act explicitly authorizes the secretary to
waive requirements under the Civil Monetary Penalties statute, the Antikickback statute, and the Ethics in Patient Referrals (Stark) law for Medicare ACOs. The secretary should establish a full range of waivers and safe harbors that will enable independent physicians to use existing or new organizational structures to participate as Medicare ACOs. In addition, the secretary should work with the Federal Trade Commission to provide explicit exceptions to the antitrust laws for ACO participants in Medicare, Medicaid, other state-based programs, and commercial markets. Physicians cannot completely transform their practices only for the Medicare patients, and antitrust enforcement could prevent them from creating clinical integration structures involving their privately insured patients. These waivers and safe harbors should be allowed where appropriate to exist beyond the end of the initial agreement between the ACO and CMS so that any new organizational structures that are created to participate in the program do not suddenly become illegal simply because the shared savings program does not continue.

Medicare ACOs.

CMS Provision of ACO Resources. Additional resources should be provided up front to encourage ACO development. CMS’s Center for Medicare and Medicaid Innovation (CMI) should provide grants to physicians in order to finance up-front costs of creating an ACO. ACO incentives must be aligned with the physician or physician group’s risks (e.g., start-up costs, systems investments, culture changes, and financial uncertainty). Developing this capacity for physicians practicing in rural communities and solo-small group practices requires time and resources and the outcome is unknown. Providing additional resources for the up-front costs will encourage the development of ACOs since the “shared savings” model only provides for potential savings at the back-end, which may discourage the creation of ACOs (particularly among independent physicians and in rural communities).

ACO Spending Benchmark in Shared Savings Program. The ACO spending benchmark should be adjusted for differences in geographic practice costs and risk adjusted for individual patient risk factors.

(1) The ACO spending benchmark, which will be based on historical spending patterns in the ACO’s service area and negotiated between Medicare and the ACO, must be risk adjusted to incentivize physicians with sicker patients to participate in ACOs and incentivize ACOs to accept and treat sicker patients, such as the chronically ill. The use of standardized mechanisms across different types of ACOs will minimize the administrative complexity and costs of physicians participating in an ACO and make it easier to analyze ACO performance across multiple populations.

(2) The ACO benchmark should be risk adjusted for the socioeconomic and health status of the patients that are assigned to each ACO, such as income/poverty level, insurance status prior to Medicare enrollment, race, and ethnicity, and health status. Studies show that patients with these factors have experienced barriers to care and are more costly and difficult to treat once they reach Medicare eligibility.

(3) The ACO benchmark must be adjusted for differences in geographic practice costs, such as physician office expenses related to rent, wages paid to office staff and nurses, hospital operating factors (i.e., hospital wage index) and physician HIT costs.
(4) The ACO benchmark should include a reasonable spending growth rate based on the
growth in physician and hospital practice expenses as well as the patient socioeconomic
and health status factors.

(5) There shall be a determination that access to care is not compromised in fragile
medical environments (e.g., inner city and rural settings).

Medicare Shared Savings Procedural Due Process. An ACO must be afforded procedural
due process with respect to the secretary’s discretion to terminate an agreement with an
ACO for failure to meet the quality performance standard.

Medicaid ACO Spending Benchmark. Any ACO spending benchmarks established under
the Medicaid program should be adjusted for differences in geographic practice costs and
risk adjusted for individual patient risk factors.

The ACO spending benchmarks must be risk adjusted to incentivize physicians with
sicker patients to participate in ACOs and incentivize ACOs to accept and treat sicker
patients, such as the chronically ill. The use of standardized mechanisms across different
types of ACOs will minimize the administrative complexity and costs of physicians
participating in an ACO and make it easier to analyze ACO performance across multiple
populations.

The ACO benchmark should be risk adjusted for the socioeconomic and health status of
the patients that are assigned to each ACO, such as income/poverty level, insurance status
prior to Medicaid enrollment, race, and ethnicity, and health status. Studies show that
patients with these factors have experienced barriers to care and are more costly and
difficult to treat once they reach Medicaid eligibility.

The ACO benchmark must be adjusted for differences in geographic practice costs, such
as physician office expenses related to rent, wages paid to office staff and nurses, hospital
operating factors (i.e., hospital wage index) and physician HIT costs.

The ACO benchmark should include a reasonable spending growth rate based on the
growth in physician and hospital practice expenses as well as the patient socioeconomic
and health status factors.

If Medicaid tests the ACO concept, the state should seek input from practicing physicians
and providers on the pilot’s design, including the pilot’s quality and financial
benchmarks, the mechanisms for collecting and reporting data, and how data will be
shared with ACO physician participants, patients, and the public. Any ACO pilot tested
in the Medicaid system must be of sufficient length to ensure valid and reliable
evaluation of the pilot’s impact on health outcomes and spending.

There shall be a determination that access to care is not compromised in fragile medical
environments (e.g., inner city, rural settings).

State ACO Pilot Initiatives [e.g., Employee Retirement System (ERS)/Teachers
Retirement System (TRS)] Spending Benchmarks. Any ACO spending benchmarks
established under a state ACO pilot initiative should be adjusted for differences in
geographic practice costs and risk adjusted for individual patient risk factors.
The ACO spending benchmarks must be risk adjusted to incentivize physicians with sicker patients to participate in ACOs and incentivize ACOs to accept and treat sicker patients, such as the chronically ill. The use of standardized mechanisms across different types of ACOs will minimize the administrative complexity and costs of physicians participating in an ACO and make it easier to analyze ACO performance across multiple populations.

The ACO benchmark should be risk adjusted for the socioeconomic and health status of the patients that are covered by the ERS/TRS ACO, such as income/poverty level, insurance status prior to ERS/TRS enrollment or ACO assignment, race and ethnicity, and health status. Studies show that patients without health coverage have experienced barriers to care and are more costly and difficult to treat once they do have coverage due to pent up demand.

The ACO benchmark must be adjusted for differences in geographic practice costs, such as physician office expenses related to rent, wages paid to office staff and nurses, hospital operating factors (i.e., hospital wage index) and physician HIT costs.

The ACO benchmark should include a reasonable spending growth rate based on the growth in physician and hospital practice expenses as well as the patient socioeconomic and health status factors.

If ERS tests the ACO concept, the state should seek input from practicing physicians and providers on the pilot’s design, including the pilot’s quality and financial benchmarks, the mechanisms for collecting and reporting data, and how data will be shared with ACO physician participants, patients, and the public. Any ACO pilot tested in the ERS system must be of sufficient length to ensure valid and reliable evaluation of the pilot’s impact on health outcomes and spending.

There shall be a determination that access to care is not compromised in fragile medical environments (e.g., inner city, rural settings).

Financial Incentives.

Public and private payers who partner with ACOs must invest sufficient resources to monitor and evaluate the ACO’s compliance with financial and quality benchmarks, including mechanisms to ensure the entity is not withholding medically necessary care to achieve financial gain.

ACOs should have the flexibility to use a variety of payment methods alone or simultaneously, including fee-for-service, care management fees, shared savings, partial capitation, or global capitation.

ACOs must have the flexibility to develop a mix of financial and other incentives designed to foster safe, high quality and cost-effective patient care. However, to ensure that incentives are fair and reasonable, and not intended to promote the inappropriate denial of medically necessary care or unfair restraint of trade, the ACO’s local physician governing board shall develop and oversee the incentive structure. Further, the ACO shall publicly disclose the types of incentives to avoid appearance of impropriety.
As ACOs gain expertise in patient care management and become more cost-effective, there will be a diminishing rate of achievable savings over time. Financial incentives must be designed to recognize that successful ACOs will eventually achieve efficiencies that will not offer ever increasing savings. To impose penalties where there is little or no opportunity to increase savings may create an improper incentive that may adversely affect patient care. To that end, and to ensure an ACO maintains a patient-centered focus, ACOs that perform at or below a national or state spending benchmark should continue to be rewarded for maintaining cost-effective, high quality care.

There shall be a determination that access to care is not compromised in fragile medical environments (e.g., inner city, rural settings).

Transparency. ACOs should be required to annually disclose administrative expenditures as well as the organization’s aggregate payments to physicians and providers (to permit comparison of payments to physicians versus facilities).

HIT. Health information technology, including use of interoperable electronic medical records, is a desirable feature of an ACO but should not be a required element. (CSE Rep. 6-A-11).
Subject: Allowing Exceptions to the Centers for Medicare & Medicaid Services’ Locum Tenens 60-Day Limit

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Socioeconomics

Whereas, A longstanding and widespread practice exists for a physician to retain a substitute physician (locum tenens) to take over his or her professional practice when the regular physician is absent for reasons such as illness, pregnancy, vacation, or continuing medical education, and for the regular physician to bill and receive payment for the locum tenens’ services as though the regular physician performed them; and

Whereas, The regular physician generally pays the locum tenens a fixed amount per diem, as allowed by the Social Security Act Amendments of 1994; and

Whereas, The Centers for Medicare & Medicaid Services (CMS) allows regular physicians to bill for locum tenens services for up to 60 days during the absence of the regular physician; and

Whereas, CMS developed an exception to the locum tenens 60-day billing limitation that allowed physicians who were called to active military duty to bill for locum tenens services beyond the 60-day limit; and

Whereas, Circumstances can occur, such as serious illness, physical impairment, or family emergency, that could require regular physicians to be out of the office for more than 60 consecutive days; and

Whereas, Those regular physicians should be able to apply for an exception to allow them to continue billing for locum tenens services beyond the 60-day limit; therefore be it

RESOLVED, That the Texas Medical Association support enhancing the Centers for Medicare & Medicaid Services’ (CMS’) locum tenens 60-day exemption policy to allow physicians the right to apply for an exception to the 60-day limit for billing for locum tenens services for circumstances beyond active military service such as serious illness and family emergency, and be it further

RESOLVED, That the Texas Delegation to the American Medical Association take to the AMA House of Delegates a resolution requesting that AMA work with CMS to modify CMS policy, allowing physicians the right to apply for an exception to the current 60-day limit for billing for locum tenens services due to unforeseen circumstances such as serious illness, physical impairment, or family emergency.

Relevant TMA Policy

275.001 Physician Relief Program: A registry, administered by the state rural health authority, of physicians willing to provide temporary relief to rural physicians who are without call coverage and time off or the ability to pay for locum tenens assistance, maintained by a central clearing house, would assist physicians in finding a cost-effective solution to the “burn out” problem and provide options for graduating physicians in their search for suitable practice environments. The Texas Medical Association supports a physician relief registry and identifying sources of funding (MSS, p 156, A-93; amended CME Rep. 6-A-03; amended CM-PDHCA Rep. 1-A-13).
Subject: Minimum Standards for Interstate Sale of Health Insurance Products

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Socioeconomics

Whereas, During the recent national elections, many Republican candidates spoke favorably about the concept of selling health insurance across state lines; and

Whereas, President Trump’s new secretary of the U.S. Department of Health and Human Services, Tom Price, MD, has expressed support for allowing the sale of health insurance products across state lines; and

Whereas, The Texas Medical Association has not endorsed the sale of health insurance products across state lines; and

Whereas, Texas has some robust laws governing the regulation of health plans in Texas that a new federal law could supersede; therefore be it

RESOLVED, That the Texas Medical Association adopt the following minimum standards to apply to the interstate sale of health insurance products sold in Texas, should such a policy be approved at the federal level:

1. Products with in-network/out-of-network distinctions must meet Texas network adequacy standards;
2. Products must adhere to Texas prompt pay requirements;
3. Each company or HMO must meet minimum financial solvency standards required in Texas; and
4. The jurisdiction for all legal challenges is determined by the location where the care is given;

and be it further

RESOLVED, That the Texas Delegation to the American Medical Association carry a similar resolution to AMA establishing minimum federal standards not lower than the Texas threshold.

Relevant TMA Policy:

120.001 Health Care Reform: The Texas Medical Association weighs heavily in its evaluation of health care reform proposals the following concepts (only relevant policy included):

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;

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 (only relevant policy included).
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.

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).


145.014 Texas Department of Insurance: The Texas Medical Association supports continued efforts to fund the Texas Department of Insurance (TDI) adequately and require that TDI resolve complaints and ensure insurance companies pay claims within the state-mandated statutory time frame (Amended Res. 406-I-00; amended CSE Rep. 1-A-10).

145.020 Insurer Liability for Unpaid Claims: The Texas Medical Association advocates for Texas Department of Insurance regulatory authority mandating that insurance companies be held liable for payment when a physician’s office documents verification of coverage, eligibility, and authorization by the insurance company (Res. 403-A-03; reaffirmed CSE Rep. 1-A-13).

145.032 Improving Network Adequacy in Health Insurance Plans: Following is Texas Medical Association policy on improving network adequacy in health insurance plans:

Allow Consumers to Purchase the Product They Demand. TMA supports legislation that will require all state-regulated insurers offering preferred provider benefit plans to offer, for purchase, additional coverage to settle claims for labor and delivery, emergency care, and any subsequent admission to the hospital at the preferred level of coverage. This should apply to individual, small group, and large group coverage.

Protect and Keep Old and New Consumer Protections. TMA should advocate to ensure Texas consumers continue to receive the advantage of Texas Department of Insurance HMO emergency care/inadequate network protections and the new PPO/PPBP rules that credit all payments for out-of-network care in emergencies (or where the network is inadequate) to a consumer’s in-network deductible and out-of-pocket maximum. Also, the PPO/PPBP regulations, which provide guidance to insurers that usual and customary charges must be used to settle claims where the network is inadequate, should also remain unchanged.

Authorize the Office of Public Insurance Counsel to Monitor Networks. TMA should support legislation that seeks to augment the Office of Public Insurance Counsel’s (OPIC’s) authority to monitor network adequacy in the HMO and PPO/PPBP lines of insurance business. OPIC should be granted statutory authority to file complaints with the Texas Department of Insurance (TDI) upon OPIC’s discovery of an inadequate network or other violation of network adequacy laws or regulations. OPIC currently issues HMO report cards for use by consumers. These report cards should be required to contain an evaluation of HMO network
adequacy, and OPIC should be charged with the duty to develop and issue report cards for
PPO/PPBP plans that include an evaluation of those networks.

Authorize the Office of Public Insurance Counsel to Intervene in Access Plan Filings and
Network Adequacy Waiver Filings. TMA should support legislation that will require HMOs
and insurers to provide a copy of any such filings to the Office of Public Insurance Counsel
(OPIC) and permit OPIC to oppose Texas Department of Insurance approval of any filed
access plan requests if OPIC finds the access plans or waiver applications unacceptable.

Stabilize Networks. The network directories that consumers depend on are notoriously
inaccurate. TMA should support legislation that will stabilize the networks the insurers
market by restricting without cause terminations of physicians and providers. The legislation
should prohibit insurers from exercising without cause termination clauses within the first six
calendar months and last three calendar months of each year. TMA should support legislation
that will authorize the Office of Public Insurance Counsel to file complaints with the Texas
Department of Insurance on inaccurate HMO and PPO/PPBP directories (CSE Rep. 2-A-15;

145.034 National Association of Insurance Commissioners and Insurance Regulators: The Texas
Medical Association strongly objects to the National Association of Insurance
Commissioners and state insurance regulators adopting regulations that fall outside of
regulation of insurance companies. The regulation of physicians and other providers by
insurance regulators is not acceptable and should remain with the appropriate state authority
such as the Texas Medical Board (CSE Report 1-A-16).

180.007 Managed Care Business Principles: Managed care organizations should be required by law
to consider the impact on patient care and welfare of any changes in their network rosters

180.010 Health Maintenance Organizations: The Texas Medical Association supports multiple
approaches to health care delivery, offering the broadest freedom of choice, and innovations
which improve health care for the people of Texas. TMA endorses health maintenance
organizations as one system of prepaid health care delivery if operated (1) in compliance with
all provisions of the Texas Medical Practice Act, including the acts’ current prohibition of the
corporate practice of medicine; and (2) in accordance with the Principles of Medical Ethics.
In addition, TMA believes that health maintenance organizations should not receive
governmental grant and loan subsidies (Council on Socioeconomics, p 179, I-94; reaffirmed

180.027 Prompt Payment of Claims: The Texas Medical Association reaffirms ongoing efforts
through the TMA Hassle Factor Log initiative, carrier meetings, and regulatory advocacy to
address the growing problems medical offices are encountering in obtaining prompt and
appropriate payment and continues to support legislative initiatives directed towards
streamlining and simplifying health plans’ claims processing and administrative requirements

180.030 Managed Care Disclosure: The Texas Medical Association supports appropriate legislative
and regulatory efforts to require proper disclosure by health plans of plan design, limitations
on provider referrals, and accurate delineation of the scope of their networks to provide
medically necessary care to their enrollees (Amended Res. 404-A-05; reaffirmed CSE Rep. 1-
A-15).
Advocacy Efforts Regarding Health Care Payment Plans: The Texas Medical Association adopted the following recommendations of the Ad Hoc Committee on Managed Care and Insurance on association advocacy efforts with regard to health care payment plans (only relevant policy included):

- Transparency/non-contracted physicians/"balance billing"/network adequacy: Support legislation or rulemaking that will establish the responsibility for necessary disclosure to patients as that of the entity that controls the information. Consult and coordinate with other healthcare stakeholders the most efficient manner in which to provide access to patients. Support legislation or rulemaking that will establish network adequacy standards to ensure healthcare access for patients.

Relevant AMA Policy:

Health Insurance Exchange Authority and Operation H-165.839
1. Our American Medical Association adopts the following principles for the operation of health insurance exchanges (only relevant policy included):
   A) Health insurance exchanges should maximize health plan choice for individuals and families purchasing coverage. Health plans participating in the exchange should provide an array of choices, in terms of benefits covered, cost-sharing levels, and other features.
   F) Any necessary federal authority or oversight of health insurance exchanges must respect the role of state insurance commissioners with regard to ensuring consumer protections such as grievance procedures, external review, and oversight of agent practices, training and conduct, as well as physician protections including state prompt pay laws, protections against health plan insolvency, and fair marketing practices.


Comprehensive Health System Reform H-165.841
Our AMA supports the overall goal of ensuring that every American has access to affordable high quality health care coverage and will work with interested members of Congress to seek legislation consistent with AMA policy.

Policy Timeline: Sub. Res. 924, I-07 Reaffirmed: Res. 239, A-12

Educating the American People About Health System Reform H-165.844
Our AMA reaffirms support of pluralism, freedom of enterprise and strong opposition to a single payer system.

Policy Timeline: Res. 717, I-07 Reaffirmation A-09

Adequacy of Health Insurance Coverage Options H-165.846
1. Our AMA supports the following principles to guide in the evaluation of the adequacy of health insurance coverage options (only relevant policy included):
   A. Any insurance pool or similar structure designed to enable access to age-appropriate health insurance coverage must include a wide variety of coverage options from which to choose.
   B. Existing federal guidelines regarding types of health insurance coverage (e.g., Title 26 of the US Tax Code and Federal Employees Health Benefits Program [FEHBP] regulations) should be used as a reference when considering if a given plan would provide meaningful coverage.
   D. Mechanisms must be in place to educate patients and assist them in making informed choices, including ensuring transparency among all health plans regarding covered services, cost-sharing obligations, out-of-pocket limits and lifetime benefit caps, and excluded services.


Comprehensive Health System Reform H-165.847
1. Comprehensive health system reform, which achieves access to quality health care for all Americans while improving the physician practice environment, is of the highest priority for our AMA.
2. Our AMA recognizes that as our health care delivery system evolves, direct and meaningful physician input is essential and must be present at every level of debate.
Policy Timeline: Res. 613, A-06 Reaffirmation I-07 Reaffirmed: CMS Rep. 6, I-08

Health Insurance Market Regulation H-165.856
Our AMA supports the following principles for health insurance market regulation:
1. There should be greater national uniformity of market regulation across health insurance markets, regardless of type of sub-market (e.g., large group, small group, individual), geographic location, or type of health plan;
2. State variation in market regulation is permissible so long as states demonstrate that departures from national regulations would not drive up the number of uninsured, and so long as variations do not unduly hamper the development of multi-state group purchasing alliances, or create adverse selection;
3. Risk-related subsidies such as subsidies for high-risk pools, reinsurance, and risk adjustment should be financed through general tax revenues rather than through strict community rating or premium surcharges;
4. Strict community rating should be replaced with modified community rating, risk bands, or risk corridors. Although some degree of age rating is acceptable, an individual’s genetic information should not be used to determine his or her premium;
5. Insured individuals should be protected by guaranteed renewability;
6. Guaranteed renewability regulations and multi-year contracts may include provisions allowing insurers to single out individuals for rate changes or other incentives related to changes in controllable lifestyle choices;
7. Guaranteed issue regulations should be rescinded;
8. Health insurance coverage of pre-existing conditions with guaranteed issue within the context of an individual mandate, in addition to guaranteed renewability.
9. Insured individuals wishing to switch plans should be subject to a lesser degree of risk rating and preexisting conditions limitations than individuals who are newly seeking coverage; and
10. The regulatory environment should enable rather than impede private market innovation in product development and purchasing arrangements. Specifically:
   (a) Legislative and regulatory barriers to the formation and operation of group purchasing alliances should, in general, be removed; (b) Benefit mandates should be minimized to allow markets to determine benefit packages and permit a wide choice of coverage options; and (c) Any legislative and regulatory barriers to the development of multi-year insurance contracts should be identified and removed.

Expanding Choice in the Private Sector H-165.881
Our AMA will continue to actively pursue strategies for expanding patient choice in the private sector by advocating for greater choice of health plans by consumers, equal-dollar contributions by employers irrespective of an employee’s health plan choice, and expanded individual selection and ownership of health insurance where plans are truly accountable to patients.
Achieving Health Care Coverage for All D-165.974

Achieving Health Care Coverage for All — Our American Medical Association joins with interested medical specialty societies and state medical societies to advocate for enactment of a bipartisan resolution in the US Congress establishing the goal of achieving health care coverage through a pluralistic system for all persons in the United States consistent with relevant AMA policy.

Policy Timeline: Res. 733, I-02 Modified: CCB/CLRDPD Rep. 4, A-12

Expanding Patient Choice in the Private Sector D-165.996

Our AMA will continue to place a high priority on the development and implementation of advocacy communications, coalition-building initiatives, and targeted outreach activities as a means of expanding patient choice in the private sector.


AMA Establishment of a Nationwide Federation of Physician Networks H-285.938

Our AMA will: (1) disseminate general information to national medical specialty societies, state medical associations, county medical societies, and interested physician members regarding opportunities for physicians to form networks to directly contract with self-funded employers; (2) act as a clearinghouse for information and expertise directed at providing assistance in the development of local and regional physician networks; and (3) serve as a facilitator and convener of meetings among existing physician networks interested in pursuing interstate and/or national contracts with self-funded employers.

Whereas, Prior authorizations have increased drastically over the past year; and
Whereas, Prior authorizations have interrupted patient care by delaying care; and
Whereas, Physicians are pushed to use electronic health records, yet a recent American Medical
Association prior authorization study found that payer prior authorizations are still a very manual process.
The survey found the most common ways physicians complete prior authorizations are via phone calls
and faxes; and
Whereas, Most medication prior authorizations are due to cost and not care; and
Whereas, Medication prior authorizations are required for medications on which patients have been stable
for long periods; and
Whereas, Prior authorizations are denied, appealed, and undergo peer-to-peer reviews outside the
“medical necessity” mandate; and
Whereas, Physicians are not paid for this service through relative value units because Medicare Part B
does not require prior authorizations; and
Whereas, The physician is the one who bears the brunt of increased costs to hire more staff to cover all
the unnecessary prior authorizations; therefore be it
RESOLVED, That current Texas Medical Association policy be revised as follows:

235.034  **Authorizations Initiated by Third-Party Payers:** The Texas Medical Association supports
policy and legislation that third-party payers 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 (Res. 401-A-11);

and be it further

RESOLVED, That, if payers and third parties do not compensate physicians for the prior authorization
burdens listed above, physicians may charge subscribers, since these burdens are not a covered service;
and be it further
RESOLVED, That prior authorizations may be allowed for only new medications and not for medications that patients have been receiving previously and continuously; and be it further

RESOLVED, That TMA pursue new Texas laws that incorporate the AMA Ensuring Transparency in Prior Authorization 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; and be it further

RESOLVED, That TMA support legislation to mandate that payers accept and respond to standard electronic prior authorization (ePA) transactions, such as the NCPDP SCRIPT Standard ePA transactions; and be it further

RESOLVED, That the Texas Delegation to the American Medical Association take this resolution to AMA for a national unified movement.

Relevant TMA Policy:

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).

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).

Relevant AMA Policy:

Prior Authorization Simplification and Standardization D-120.938
Our AMA will address the negative impact of medication step therapy programs on patient access to needed treatment by supporting state legislation that places limitations and restrictions around the use of such programs and their interference with a physician’s best clinical judgement.
Policy Timeline: CMS Rep. 07, A-16

Opposition to Prescription Prior Approval D-125.992
Our AMA will urge public and private payers who use prior authorization programs for prescription drugs to minimize administrative burdens on prescribing physicians.

Administrative Simplification in the Physician Practice D-190.974
1. Our AMA strongly encourages vendors to increase the functionality of their practice management systems to allow physicians to send and receive electronic standard transactions directly to payers and completely automate their claims management revenue cycle and will continue to strongly encourage payers and their vendors to work with the AMA and the Federation to streamline the prior authorization process.
2. Our AMA will continue its strong leadership role in automating, standardizing and simplifying all administrative actions required for transactions between payers and providers.
3. Our AMA will continue its strong leadership role in automating, standardizing, and simplifying the claims revenue cycle for physicians in all specialties and modes of practice with all their trading partners, including, but not limited to, public and private payers, vendors, and clearinghouses.
4. Our AMA will prioritize efforts to automate, standardize and simplify the process for physicians to estimate patient and payer financial responsibility before the service is provided, and determine patient and payer financial responsibility at the point of care.

5. Our AMA will continue to use its strong leadership role to support state and specialty society initiatives to simplify administrative functions.

6. Our AMA will expand its Heal the Claims process (TM) campaign as necessary to ensure that physicians are aware of the value of automating their claims cycle.

Policy Timeline: CMS Rep. 8, I-11 Appended: Res. 811, I-12 Reaffirmation A-14

**Prior Authorization Simplification and Standardization D-320.986**

Our AMA will explore and report on potential funding sources and mechanisms to pay for time and expertise expended pursuing prior authorization procedures.

Policy Timeline: CMS Rep. 07, A-16

**Prior Authorization Simplification and Standardization D-320.987**

Our AMA will, in collaboration with state medical associations and national medical specialty societies and relevant patient groups, create a set of best practices for PA and possible alternative approaches to utilization control; advocate that accreditation organizations include these concepts in their program criteria; and urge health plans to abide by these best practices in their PA programs and to pilot PA alternative programs.

Policy Timeline: CMS Rep. 07, A-16

**Preauthorization D-320.988**

1. Our AMA will conduct a study to quantify the amount of time physicians and their staff spend on nonclinical administrative tasks, to include (a) authorizations and preauthorizations and (b) denial of authorization appeals.

2. There will be a report back to the House of Delegates at the 2015 Annual Meeting

3. Our AMA will utilize its advocacy resources to combat insurance company policies that interfere with appropriate laboratory testing by requiring advance notification or prior authorization of outpatient laboratory services.


**Prescription Drug Plans and Patient Access D-330.910**

Our AMA will explore problems with prescription drug plans, including issues related to continuity of care, prior authorization, and formularies, and work with the Centers for Medicare and Medicaid Services and other appropriate organizations to resolve them.

Policy Timeline: Res. 135, A-14

**Web-Based Prior Authorization Process H-285.912**

Our AMA supports legislation requiring all health insurers to include web-based prior authorization services among options for granting prior authorization.

Policy Timeline: Res. 725, A-09

**Managed Care Cost Containment Involving Prescription Drugs H-285.965**

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.


Approaches to Increase Payer Accountability H-320.968

Our AMA supports the development of legislative initiatives to assure that payers provide their insureds with information enabling them to make informed decisions about choice of plan, and to assure that payers take responsibility when patients are harmed due to the administrative requirements of the plan. Such initiatives should provide for disclosure requirements, the conduct of review, and payer accountability.

(1) Disclosure Requirements. Our AMA supports the development of model draft state and federal legislation to require disclosure in a clear and concise standard format by health benefit plans to prospective enrollees of information on (a) coverage provisions, benefits, and exclusions; (b) prior authorization or other review requirements, including claims review, which may affect the provision or coverage of services; (c) plan financial arrangements or contractual provisions that would limit the services offered, restrict referral or treatment options, or negatively affect the physician’s fiduciary responsibility to his or her patient; (d) medical expense ratios; and (e) cost of health insurance policy premiums. (Ref. Cmt. G, Rec. 2, A-96; Reaffirmation A-97)

(2) Conduct of Review. Our AMA supports the development of additional draft state and federal legislation to: (a) require private review entities and payers to disclose to physicians on request the screening criteria, weighting elements and computer algorithms utilized in the review process, and how they were developed; (b) require that any physician who recommends a denial as to the medical necessity of services on behalf of a review entity be of the same specialty as the practitioner who provided the services under review; (c) Require every organization that reviews or contracts for review of the medical necessity of services to establish a procedure whereby a physician claimant has an opportunity to appeal a claim denied for lack of medical necessity to a medical consultant or peer review group which is independent of the organization conducting or contracting for the initial review; (d) require that any physician who makes judgments or recommendations regarding the necessity or appropriateness of services or site of service be licensed to practice medicine in the same jurisdiction as the practitioner who is proposing the service or whose services are being reviewed; (e) require that review entities respond within 48 hours to patient or physician requests for prior authorization, and that they have personnel available by telephone the same business day who are qualified to respond to other concerns or questions regarding medical necessity of services, including determinations about the certification of continued length of stay; (f) require that any payer instituting prior authorization requirements as a condition for plan coverage provide enrollees subject to such requirements with consent forms for release of medical information for utilization review purposes, to be executed by the enrollee at the time services requiring such prior authorization are recommended or proposed by the physician; and (g) require that payers compensate physicians for those efforts involved in complying with utilization review requirements that are more costly, complex and time consuming than the completion of standard health
insurance claim forms. Compensation should be provided in situations such as obtaining preadmission
certification, second opinions on elective surgery, and certification for extended length of stay.

(3) Accountability. Our AMA believes that draft federal and state legislation should also be developed to
impose similar liability on health benefit plans for any harm to enrollees resulting from failure to disclose
prior to enrollment the information on plan provisions and operation specified under Section 1 (a)-(d)
above.

Reaffirmation I-98 Reaffirmation A-99; Reaffirmation I-99 Reaffirmation A-00 Reaffirmed in lieu of
Rep. 07, A-16

Remuneration for Physician Services H-385.951
1. Our AMA actively supports payment to physicians by contractors and third party payers for physician
time and efforts in providing case management and supervisory services, including but not limited to
coordination of care and office staff time spent to comply with third party payer protocols.
2. It is AMA policy that insurers pay physicians fair compensation for work associated with prior
authorizations, including pre-certifications and prior notifications, that reflects the actual time expended
by physicians to comply with insurer requirements and that compensates physicians fully for the legal
risks inherent in such work.
3. Our AMA urges insurers to adhere to the AMA’s Health Insurer Code of Conduct Principles including
specifically that requirements imposed on physicians to obtain prior authorizations, including
pre-certifications and prior notifications, must be minimized and streamlined and health insurers must
maintain sufficient staff to respond promptly.

Policy Timeline: Sub. Res. 814, A-96 Reaffirmation A-02 Reaffirmation I-08 Reaffirmation I-09
Appended: Sub. Res. 126, A-10; Reaffirmed in lieu of Res. 719, A-11 Reaffirmed in lieu of Res. 721,
A-11 Reaffirmation A-11 Reaffirmed in lieu of Res. 822, I-11 Reaffirmed in lieu of Res. 711, A-14

Reference
AMA Ensuring Transparency in Prior Authorization Act model bill, located at
www.ama-assn.org/sites/default/files/media-browser/specialty%20group/arc/ensuring-transparency-
in-prior-authorization_1.pdf
Whereas, Major legislative changes being proposed in the U.S. Congress would fundamentally alter the funding mechanism for Medicaid; and

Whereas, Those proposed changes include a block grant and/or per-capita cap on funding given to the states that would severely limit the ability of Texas to maintain the current guarantee of coverage and benefits for Texas children and pregnant women; and

Whereas, The 85th Texas Legislature also is considering funding cuts on the Medicaid program; and

Whereas, The Early and Periodic Screening, Diagnosis, and Treatment service (also known as Texas Health Steps) is Medicaid’s best-practice, comprehensive preventive child health service (medical, dental, and case management); and

Whereas, Texas’ rate of maternal mortality more than doubled over the past two years, and early and ongoing prenatal care is vital not only to ensure pregnant women receive preventive care but also to detect and manage behaviors and illnesses that may affect the health of the mother and baby; and

Whereas, Nearly 40 percent of Texas children have Medicaid as their only medical insurance, and approximately 50 percent of births are covered by Texas Medicaid; therefore be it

RESOLVED, That the Texas Medical Association apply all appropriate resources and efforts to ensure that children and pregnant women who are currently eligible for or enrolled in Medicaid remain eligible and fully covered by Texas Medicaid programs or programs that provide the same coverage; and be it further

RESOLVED, That the Texas Medical Association apply all appropriate resources and efforts to ensure that children enrolled in the Medicaid program continue to receive the level of Early and Periodic Screening, Diagnosis, and Treatment benefits they currently have.
Subject: Compensation of Physicians for Authorizations and Preauthorizations

Introduced by: Ori Z. Hampel, MD

Referred to: Reference Committee on Socioeconomics

Whereas, Insurance and managed care companies ("payers") demand authorization and preauthorization for coverage and payment for prescriptions, laboratory tests, radiology tests, procedures, surgeries, hospitalizations, and physician visits; and

Whereas, The purpose of such authorization and preauthorization is to delay and deny care, thus allowing payers to save, keep, and invest money that otherwise would provide patient care; and

Whereas, Such authorization and preauthorization procedures cause unnecessary testing and delay of care, which may harm patients; and

Whereas, The overwhelming majority of such authorization and preauthorization requests eventually are authorized by payers; and

Whereas, Physicians and their staff spend onerous amounts of time and money on authorization and preauthorization procedures, thus increasing physician overhead while decreasing availability for patient care by physicians and their staff; and

Whereas, Authorization and preauthorization procedures and their direct and indirect costs endanger the viability of the private practice of medicine; and

Whereas, Time spent by physicians and their staff on such authorization and preauthorization activity is "management" of patient care, and the Current Procedural Terminology (CPT) coding system establishes codes for evaluation and management (E&M), correlating time spent with specific CPT E&M codes for established patients as demonstrated in the following table; and

<table>
<thead>
<tr>
<th>Time typically spent</th>
<th>CPT Code</th>
</tr>
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<tbody>
<tr>
<td>Up to 5 minutes</td>
<td>99211</td>
</tr>
<tr>
<td>Up to 10 minutes</td>
<td>99212</td>
</tr>
<tr>
<td>Up to 15 minutes</td>
<td>99213</td>
</tr>
<tr>
<td>Up to 25 minutes</td>
<td>99214</td>
</tr>
<tr>
<td>Up to 40 minutes</td>
<td>99215</td>
</tr>
</tbody>
</table>

Whereas, Physicians are not compensated for such authorization and preauthorization procedures that benefit only payers to the detriment of patients and physicians; therefore it be

RESOLVED, 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 relevant information 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.

Relevant TMA Policy:

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).

235.034 Authorizations Initiated by Third-Party Payers: The Texas Medical Association supports policy that third-party payers 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 (Res. 401-A-11).
Resolution 409
A-17

Subject: Medicaid Payments for Speech Therapy, Physical Therapy, and Occupational Therapy

Introduced by: Medical Student Section

Referred to: Reference Committee on Socioeconomics

Whereas, Texas Medical Association policy expresses the necessity for comprehensive medical care for children receiving Medicaid benefits; and

Whereas, Texas state Medicaid payments for speech therapists, physical therapists, and occupational therapists were recently reduced as a result of 2015 legislation, potentially causing 60,000 children to lose access to such services; and

Whereas, TMA opposes Medicaid funding cuts that would diminish care of our most vulnerable Texans; and

Whereas, TMA already possesses policy related to ensuring federal funding of rehabilitation services; and

Whereas, The coming 2017-19 budget in Texas will be smaller than expected, and cuts are likely in the two largest items — health services and education; and

Whereas, No organization is “recession-proof,” and reduced budgets can be expected to occur from time to time; and

Whereas, TMA recognizes the need for appropriate Medicaid payments, as a method of ensuring care of those receiving Medicaid benefits; and

Whereas, TMA “endorses the preservation and continued funding of programs that encourage physical and economic independence of disabled individuals”; and

Whereas, Early childhood intervention (ECI) programs result in long-term favorable outcomes in areas such as “academic achievement, behavior, educational progression and attainment, delinquency and crime, and labor market success”; and

Whereas, ECI programs generate socioeconomic returns in the long term, “ranging from $1.80 to $17.07 for each dollar spent on the program”; and

Whereas, Two-thirds of children enrolled in ECI programs also are enrolled in Medicaid; and

Whereas, Sixty-nine percent of ECI program directors state they expect to reduce the number of services as a result of Medicaid cuts; and
Whereas, Many state officials who believed such cuts would have little effect on Medicaid beneficiaries changed their mind when the use of such services was explained to them; therefore be it

RESOLVED, That the Texas Medical Association recognize the importance of funding for allied health care professionals, such as speech therapists, physical therapists, and occupational therapists, to treat economically disadvantaged minors, and be it further RESOLVED, That TMA collaborate with specialty societies to bring forth educational materials for legislators and the general public explaining the purpose of non-physician health services, such as speech therapy, physical therapy, and occupational therapy, in promoting healthy children.

Related TMA policy:

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).

190.022 Medicaid and CHIP Funding and Access to Care for Children: The Texas Medical Association will work toward improving access to care for Texas children by opposing legislative proposals for Medicaid and CHIP funding cuts and supporting increased reimbursement for Medicaid and CHIP; by educating communities and taxpayers about the negative impact of shifting costs from the state budget to local economies; and by emphasizing that physicians and providers of health care for children under Medicaid and CHIP must receive reimbursement parity with Medicare (Amended Res. 406-A-03; reaffirmed CSE Rep. 1-A-13).

270.001 Rehabilitation Services Access and Funding: The Texas Medical Association supports efforts to abolish inappropriate reimbursement practices related to rehabilitation services by the Medicare carrier using administrative, legislative, and legal channels to mandate the Centers for Medicare and Medicaid to remove dollar-value caps on therapy services and replace them with appropriate-utilization guidelines (Amended Res. 28U, p 156, I-91; amended CSE Rep. 3-A-04; amended CSE Rep. 2-A-14).

190.023 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 (only relevant policy included):

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.

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.

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 (AHCM-MAC Rep. 1-1-04; amended SC-MCU Rep. 1-A-15).

190.035 Floor for Medicaid Payments: The Texas Medical Association will work with all applicable agencies to increase Medicaid payment equal to at least Medicare payments and will offer model legislation in Article II of the state budget to ensure Medicaid payments are sufficient to support medical practices of all specialties and include annual updates based on the Medical Economic Index (Res. 404-A-14).

90.001 Funding of Services for Disabled Persons: The Texas Medical Association endorses the preservation and continued funding of programs that encourage physical and economic independence of disabled individuals, specifically programs in physical restoration, vocational rehabilitation and independent living (Council on Medical Education, p 90, A-92; reaffirmed CM-R Rep. 2-A-02; reaffirmed CME Rep. 1-A-12).

References
4. Texans Care for Children and Methodist Healthcare Ministries of South Texas, Inc. Left Out: The Impact of State Cuts to Early Childhood Intervention (ECI) for Young Texas Kids with
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 410
A-17

Subject: Public-and Private-Sector Funding of Interpretation Services for Limited English Speakers and American Sign Language

Introduced by: Medical Student Section

Referred to: Reference Committee on Socioeconomics

Whereas, Title III of the Americans with Disabilities Act (ADA) prohibits discrimination against those with disabilities by any business open to the public, including any health care facility regardless of size or number of employees, and requires appropriate auxiliary aids and services to ensure “effective communication”; and

Whereas, “Effective communication” includes, but is not limited to, qualified interpreters, notes, and the use of electronic media (i.e., computers, tablets); and

Whereas, Title VI of the Civil Rights Act of 1964 requires policies and practices that allow persons with limited English proficiency to equally access federally funded programs; and

Whereas, Equal access in some cases will necessitate the use of interpretive services; and

Whereas, Although states are given an option for reimbursement of interpretative services, reimbursement is highly limited to specific circumstances; and

Whereas, the Texas Administrative Code in section 354.1069 helps physicians enrolled in the Texas Medicaid Program with reimbursement of interpretive services but also is limited in scope — e.g., it applies only to practices with 14 or fewer employees and only to interpretive services for deaf and hard-of-hearing patients; and

Whereas, Physicians who are not covered by these reimbursement rules are obligated to bear the costs of these interpretive services in full as they are not considered mandatory Medicaid 1905 services; and

Whereas, Research indicates diminished quality of care arising from miscommunication due to language barriers; and

Whereas, Lack of reimbursement and subsequent financial burdens deter physicians and health care providers from paying for interpreters, which contributes to increased health care costs; and

Whereas, Reimbursement for these services would reduce overhead for physicians, decrease emergency department cost of care, and increase access to preventive health services, and

Whereas, Reimbursement would reduce the hundreds of thousands of dollars paid out of pocket by physicians to families in damages incurred from lawsuits brought forth from noncompliance due to medical liability insurance not covering these types of cases; and
Whereas, Templates exist in other states for mandatory coverage of interpretive services by insurers and for accessing $270 million under the Affordable Care Act to fund the training and services of interpreters; therefore be it

RESOLVED, That the Texas Medical Association advocate with interested parties to support expanded reimbursement from Medicaid, the Children’s Health Insurance Program, and other public sector insurers, as well as private-sector coverage for interpretive services; and be it further

RESOLVED, That TMA support expanded legislation that might arise concerning reimbursement of interpretive services for both American Sign Language and limited English speakers; and be it further

RESOLVED, That TMA advocate for increased access to qualified medical interpretive services for physicians.

Relevant TMA Policy:

90.001 Funding of Services for Disabled Persons: The Texas Medical Association endorses the preservation and continued funding of programs that encourage physical and economic independence of disabled individuals, specifically programs in physical restoration, vocational rehabilitation and independent living (Council on Medical Education, p 90, A-92; reaffirmed CM-R Rep. 2-A-02; reaffirmed CME Rep. 1-A-12).


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).

265.022 Improving Patient Care Quality by Decreasing Communication Errors From Language Barriers: The Texas Medical Association recognizes that residents should be informed about laws and regulations on the use in clinical practice of medical translators, interpreters, and other communication services for patients who are deaf, hearing impaired, or with limited English proficiency. Because policies differ among institutions, each training site should educate residents on site-specific policies including orientation on the availability of such services and how and when such services should be utilized. Further, residents should be provided the broader education needed, including information on the potential liability risk, to ensure compliance with laws and regulations on the use of translator, interpreter, and other communication methods when the resident completes training and enters medical practice. (CME Rep. 2-A-13).
Relevant AMA Policy:

**H-160.924 Use of Language Interpreters in the Context of the Patient-Physician Relationship**

AMA policy is that: (1) further research is necessary on how the use of interpreters — both those who are trained and those who are not — impacts patient care;

(2) treating physicians shall respect and assist the patients’ choices whether to involve capable family members or friends to provide language assistance that is culturally sensitive and competent, with or without an interpreter who is competent and culturally sensitive;

(3) physicians continue to be resourceful in their use of other appropriate means that can help facilitate communication — including print materials, digital and other electronic or telecommunication services with the understanding, however, of these tools’ limitations — to aid LEP patients’ involvement in meaningful decisions about their care; and

(4) physicians cannot be expected to provide and fund these translation services for their patients, as the Department of Health and Human Services’ policy guidance currently requires; when trained medical interpreters are needed, the costs of their services shall be paid directly to the interpreters by patients and/or third party payers and physicians shall not be required to participate in payment arrangements.

**D-90.999 Interpreters For Physician Visits**

Our AMA continues to monitor enforcement of those provisions of the ADA to assure that physician offices are not subjected to undue burdens in their efforts to assure effective communication with hearing disabled patients.

**H-285.985 Discrimination Against Physicians by Health Care Plans**

Our AMA: (1) will develop draft federal and model state legislation requiring managed care plans and third party payers to disclose to physicians and the public, the selection criteria used to select, retain, or exclude a physician from a managed care or other provider plans;

(2) will request an advisory opinion from the Department of Justice on the application of the Americans with Disabilities Act of 1990 to selective contracting decisions made by managed care plans or other provider plans;

(3) will support passage of federal legislation to clarify the Americans With Disabilities Act to assure that coverage for interpreters for the hearing impaired be provided for by all health benefit plans. Such legislation should also clarify that physicians practicing in an office setting should not incur the costs for qualified interpreters or auxiliary aids for patients with hearing loss unless the medical judgment of the treating physician reasonably supports such a need;

(4) encourages state medical associations and national medical specialty societies to provide appropriate assistance to physicians at the local level who believe they may be treated unfairly by managed care plans, particularly with respect to selective contracting and credentialing decisions that may be due, in part, to a physician's history of substance abuse; and

(5) urges managed care plans and third party payers to refer questions of physician substance abuse to state medical associations and/or county medical societies for review and recommendation as appropriate.

**D-160.992 Appropriate Reimbursement for Language Interpretive Services**

1. Our AMA will seek legislation to eliminate the financial burden to physicians, hospitals and health care providers for the cost of interpretive services for patients who are hearing impaired or do not speak
2. Our AMA will seek legislation and/or regulation to require health insurers to fully reimburse physicians and other health care providers for the cost of providing sign language interpreters for hearing impaired patients in their care.

**H-385.928 Patient Interpreters**
Our AMA supports sufficient federal appropriations for patient interpreter services and will take other necessary steps to assure physicians are not directly or indirectly required to pay for interpreter services mandated by the federal government.

**D-385.978 Language Interpreters**
Our AMA will: (1) continue to work to obtain federal funding for medical interpretive services; (2) redouble its efforts to remove the financial burden of medical interpretive services from physicians; (3) urge the Administration to reconsider its interpretation of Title VI of the Civil Rights Act of 1964 as requiring medical interpretive services without reimbursement; (4) consider the feasibility of a legal solution to the problem of funding medical interpretive services; and (5) work with governmental officials and other organizations to make language interpretive services a covered benefit for all health plans inasmuch as health plans are in a superior position to pass on the cost of these federally mandated services as a business expense.

**References**


Subject: Clearer Language Regarding the Physician’s Role in Providing Auxiliary Aid for Effective Communication Under Current Federal Laws

Introduced by: Medical Student Section

Referred to: Reference Committee on Socioeconomics

 Whereas, Title III of the Americans with Disabilities Act (ADA) prohibits discrimination against those with disabilities by any business open to the public, including any health care facility regardless of size or number of employees, and necessitates a duty to provide appropriate auxiliary aids and services to ensure “effective communication”; and

 Whereas, “Effective communication” includes, but is not limited to, qualified interpreters, notes, and the use of electronic media (i.e., computers, tablets); and

 Whereas, A physician or health care provider has flexibility under the ADA to choose a method deemed reasonable to provide “effective communication” with input from the patient; and

 Whereas, The physician is the ultimate decisionmaker as to the type of aid provided; and

 Whereas, Under the “undue burden” clause of the ADA, physicians can review (1) the nature and cost of the aid, (2) their financial ability to provide the aid, (3) the health care facility’s proximity to its parent company (e.g., as with satellite care centers), (4) overall financial resources, and (5) the type of operations undertaken by any parent company; and

 Whereas, Costs of these services exceeding the fee received for a visit is not considered an undue burden; and

 Whereas, By law, the choice made by the physician must not fundamentally alter the nature of goods or services provided; and

 Whereas, Section 504 of the Rehabilitation Act of 1973 states that any institution receiving federal monies must ensure effective communication with people who are deaf or hard of hearing; and

 Whereas, A physician may be liable for out-of-pocket punitive damages even when mutually agreeing on a form of communication with the patient and providing proper care; therefore be it

 RESOLVED, That the Texas Medical Association advocate with interested parties to support clarification of current federal laws in regards to what constitutes effective communication towards patients with interpretive needs; and be it further

 RESOLVED, That TMA support the creation of clearer guidelines in the Americans with Disabilities Act for what is considered undue burden and recognize that negative resolution flow be a consideration; and be it further
RESOLVED, That TMA support measures to provide smaller practices that have limited resources and availability of interpretive services with better legal protections and accessibility to qualified medical interpreters; and be it further

RESOLVED, That the Texas Delegation to the American Medical Association bring this resolution to the AMA House of Delegates.

Relevant TMA Policy:

90.002  **Americans With Disabilities:** The Texas Medical Association supports seeking a change in the Americans with Disabilities Act to permit public sector funding of interpretation services for the deaf (Res. 28R, p 195, I-93; reaffirmed CM-R Rep. 3-A-03; reaffirmed CSE Rep. 2-A-14).

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).

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).

265.022  **Improving Patient Care Quality by Decreasing Communication Errors From Language Barriers:** The Texas Medical Association recognizes that residents should be informed about laws and regulations on the use in clinical practice of medical translators, interpreters, and other communication services for patients who are deaf, hearing impaired, or with limited English proficiency. Because policies differ among institutions, each training site should educate residents on site-specific policies including orientation on the availability of such services and how and when such services should be utilized. Further, residents should be provided the broader education needed, including information on the potential liability risk, to ensure compliance with laws and regulations on the use of translator, interpreter, and other communication methods when the resident completes training and enters medical practice. (CME Rep. 2-A-13).

Relevant AMA Policy:

H-385.929 **Availability and Payment for Medical Interpreters Services in Medical Practices**

It is the policy of our AMA to: (1) the fullest extent appropriate, to actively oppose the inappropriate extension of the OCR LEP guidelines to physicians in private practice; and (2) continue our proactive, ongoing efforts to correct the problems imposed on physicians in private practice by the OCR language interpretation requirements.
H-90.971 Enhancing Accommodations for People with Disabilities

Our AMA encourages physicians to make their offices accessible to patients with disabilities, consistent with the Americans with Disabilities Act (ADA) guidelines.

H-160.924 Use of Language Interpreters in the Context of the Patient-Physician Relationship

AMA policy is that: (1) further research is necessary on how the use of interpreters—both those who are trained and those who are not—impacts patient care;

(2) treating physicians shall respect and assist the patients' choices whether to involve capable family members or friends to provide language assistance that is culturally sensitive and competent, with or without an interpreter who is competent and culturally sensitive;

(3) physicians continue to be resourceful in their use of other appropriate means that can help facilitate communication—including print materials, digital and other electronic or telecommunication services with the understanding, however, of these tools' limitations—to aid LEP patients’ involvement in meaningful decisions about their care; and

(4) physicians cannot be expected to provide and fund these translation services for their patients, as the Department of Health and Human Services’ policy guidance currently requires; when trained medical interpreters are needed, the costs of their services shall be paid directly to the interpreters by patients and/or third party payers and physicians shall not be required to participate in payment arrangements.

D-90.999 Interpreters For Physician Visits

Our AMA continues to monitor enforcement of those provisions of the ADA to assure that physician offices are not subjected to undue burdens in their efforts to assure effective communication with hearing disabled patients.

H-285.985 Discrimination Against Physicians by Health Care Plans

Our AMA: (1) will develop draft federal and model state legislation requiring managed care plans and third party payers to disclose to physicians and the public, the selection criteria used to select, retain, or exclude a physician from a managed care or other provider plans;

(2) will request an advisory opinion from the Department of Justice on the application of the Americans with Disabilities Act of 1990 to selective contracting decisions made by managed care plans or other provider plans;

(3) will support passage of federal legislation to clarify the Americans With Disabilities Act to assure that coverage for interpreters for the hearing impaired be provided for by all health benefit plans. Such legislation should also clarify that physicians practicing in an office setting should not incur the costs for qualified interpreters or auxiliary aids for patients with hearing loss unless the medical judgment of the treating physician reasonably supports such a need;

(4) encourages state medical associations and national medical specialty societies to provide appropriate assistance to physicians at the local level who believe they may be treated unfairly by managed care plans, particularly with respect to selective contracting and credentialing decisions that may be due, in part, to a physician's history of substance abuse; and

(5) urges managed care plans and third party payers to refer questions of physician substance abuse to state medical associations and/or county medical societies for review and recommendation as appropriate.
D-160.992 Appropriate Reimbursement for Language Interpretive Services

1. Our AMA will seek legislation to eliminate the financial burden to physicians, hospitals and health care providers for the cost of interpretive services for patients who are hearing impaired or do not speak English.

2. Our AMA will seek legislation and/or regulation to require health insurers to fully reimburse physicians and other health care providers for the cost of providing sign language interpreters for hearing impaired patients in their care.

D-385.978 Language Interpreters

Our AMA will: (1) continue to work to obtain federal funding for medical interpretive services; (2) redouble its efforts to remove the financial burden of medical interpretive services from physicians; (3) urge the Administration to reconsider its interpretation of Title VI of the Civil Rights Act of 1964 as requiring medical interpretive services without reimbursement; (4) consider the feasibility of a legal solution to the problem of funding medical interpretive services; and (5) work with governmental officials and other organizations to make language interpretive services a covered benefit for all health plans inasmuch as health plans are in a superior position to pass on the cost of these federally mandated services as a business expense.

D-90.994 Threats Against Physicians Based on Americans With Disabilities Act

Our AMA encourages AMA members who are threatened with non-meritorious lawsuits, supposedly founded on the Americans with Disabilities Act, to contact the AMA's Private Sector Advocacy Group for assistance. The AMA will post a notice on its web site, informing physicians how to report such incidents.

References:


Whereas, The Trump Administration has given many signals that it is considering changing the means by which the federal government funds state Medicaid programs by allowing more flexibility through some form of set dollar amount payments; and

Whereas, The two most commonly discussed means of financing such a federal program to the states are block grants or per-capita caps; and

Whereas, Block grants actually offer less flexibility to states and are more financially restrictive because they control both spending and enrollment growth; and

Whereas, Some analysts believe that states like Texas with rapidly growing populations would have a better chance to increase the amount of federal money they receive for Medicaid through a per-capita cap program; and

Whereas, Under an analysis by Avalere Health, only one state, North Dakota, would experience an increase in federal funding (11 percent) under a block grant system, while Texas would experience a reduction of greater than 30 percent; and

Whereas, In the same analysis, Texas was one of 24 states that would see an increase in federal funds under a per-capita cap model; therefore be it

RESOLVED, That, while not an endorsement of set dollar amount funding, if the federal government mandates a set dollar amount to the states for Medicaid, the Texas Medical Association recommend to our congressional leaders the use of a per-capita cap mechanism over block grants; and be it further

RESOLVED, That TMA work with our congressional leaders to ensure that states that did not expand Medicaid will not be penalized and should receive the same federal funding as expansion states.

Relevant TMA Policy:

190.007 Medicaid Funding: The Texas Medical Association made as one of its highest priorities the provision of adequate funding for the Texas Medicaid program. In addition, TMA voted to seek, through legislative and regulatory means, to have the Medicaid fee schedule conversion factor made equal to at least the Medicare fee schedule conversion factor (Res. 28X, p 194A, I-92; reaffirmed Res. 406-A-03; amended CSE Rep. 1-A-13).

190.010 Medicaid Fiscal Integrity: The fiscal integrity of the present Medicaid program should be preserved in the interests of the beneficiaries of the program and the taxpayers who support it (Council on Socioeconomics, p 179, I-94; reaffirmed CSE Rep. 3-A-04; reaffirmed CSE Rep. 2-A-14).
190.022 **Medicaid and CHIP Funding and Access to Care for Children:** The Texas Medical Association will work toward improving access to care for Texas children by opposing legislative proposals for Medicaid and CHIP funding cuts and supporting increased reimbursement for Medicaid and CHIP; by educating communities and taxpayers about the negative impact of shifting costs from the state budget to local economies; and by emphasizing that physicians and providers of health care for children under Medicaid and CHIP must receive reimbursement parity with Medicare (Amended Res. 406-A-03; reaffirmed CSE Rep. 1-A-13).

190.023 **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 (*only relevant policy included*):

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:

[4] Advocate enactment of federal waivers that allow Texas to draw down additional federal matching funds.

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.

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:

1. Draws down all available federal dollars to expand access to health care for poor Texans;
2. Gives Texas the flexibility to change the plan as our needs and circumstances change;
3. Clears away Medicaid’s financial, administrative, and regulatory hurdles that are driving up costs and driving Texas physicians away from the program;
4. 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;
5. Provides Medicaid payments directly to physicians for patient care equal to at least those of Medicare payments; and
6. 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).

Reference
Whereas, *Aedes albopictus* and *Aedes aegypti* are two species of mosquitoes that have been implicated as vectors for Zika virus and are endemic to the North American continent; and

Whereas, The spread of Zika virus has been reported across the US, Texas ranks second in number of locally acquired infections. The number of illnesses due to Zika virus infections in Texas is rising with 308 cases reported in 2015-2016; and

Whereas, Zika virus has been associated with microcephaly, serious brain anomalies, vision impairment, and fetal death; and

Whereas, There is no vaccine against Zika Virus. The CDC recommends usage of insect repellents that are Environmental Protection Agency (EPA)-registered as a first line defense against mosquitoes, which may harbor Zika virus. Active ingredients in EPA-registered insect repellents have been shown to be safe in children and pregnant women; and

Whereas, Beginning August 9, 2016 through December 2016, Texas Medicaid issued a standing order for coverage of two cans of mosquito repellent per month for women who are between the ages of 10 and 45 or pregnant. Most women who were eligible for insect repellent coverage received these benefits through pregnancy-related Medicaid, CHIP Perinatal, or Healthy Texas Women; and

Whereas, Males have fewer pathways to receive coverage and are currently not eligible for prescription insect repellent benefits under Medicaid. Yet, there is supporting evidence for transmission of Zika through sexual contact. It was reported sexual transmission rates was male-female (92.5 percent), female-male (3.7 percent) and male-male (3.7 percent), and Zika virus RNA was found in semen as late as 188 days after onset of symptoms; therefore be it

RESOLVED, That TMA advocate for continued Medicaid coverage of insect repellent; and be it further

RESOLVED, That TMA advocate for men insured through Medicaid receive similar insect repellent prescription coverage as their female counterpart.

**Relevant TMA policy**

190.002 **Medicaid Medications:** The Texas Medical Association encourages Texas Medicaid to revise its medications policy so that beneficiaries of the program may receive all necessary medications (YPS, p 156, I-90; reaffirmed CSE Rep. 5-I-01; reaffirmed CSE Rep. 8-A-11).
190.022 Medicaid and CHIP Funding and Access to Care for Children: The Texas Medical Association will work toward improving access to care for Texas children by opposing legislative proposals for Medicaid and CHIP funding cuts and supporting increased reimbursement for Medicaid and CHIP; by educating communities and taxpayers about the negative impact of shifting costs from the state budget to local economies; and by emphasizing that physicians and providers of health care for children under Medicaid and CHIP must receive reimbursement parity with Medicare (Amended Res. 406-A-03; reaffirmed CSE Rep. 1-A-13).

190.023 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:

B. 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.

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. (AHCM-MAC Rep. 1-1-04; amended SC-MCU Rep. 1-A-15)

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).

Relevant AMA policy

D-440.930 Enhanced Zika Virus Public Health Action:

1. Our AMA urges Congress to enact legislation, without further delay, to provide increased and sufficient funding for research, prevention, control, and treatment of illnesses associated with the Zika virus, commensurate with the public health emergency that the virus poses, without diverting resources from other essential health initiatives.
2. Our AMA will work with experts in all relevant disciplines, and convene expert workgroups when appropriate, to help develop needed United States and global strategies and limit the spread and impact of this virus.
3. Our AMA will consider collaboration with other educational and promotional entities (e.g., the AMA Alliance) to promote family-directed and community-directed strategies that minimize the transmission of Zika virus to potentially pregnant women.

References:

(2) Zika In Texas. (2017) “Summary of Zika Cases.” Available at http://www.texaszika.org/prevention.htm
(6) Margaret A. Honein, PhD1; April L. Dawson, MPH1; Emily E. Petersen, MD1; et al. (2017) Birth Defects Among Fetuses and Infants of IS Women With Evidence of Possible Zika Virus Infection During Pregnancy.” JAMA. 2017;317(1):59-68. doi:10.1001/jama.2016.19006. Available at http://jamanetwork.com/journals/jama/fullarticle/2593702?resultClick=1
Subject: Regulations Regarding Freestanding Emergency Care Facilities

Introduced by: Evans Smith, MD, FAAEM, FACEP

Referred to: Reference Committee on Socioeconomics

Whereas, No certificate of need is required to build an emergency department, and therefore more than 300 freestanding emergency medical care facilities have been built in locations of convenience for the most affluent, leaving hospital emergency departments responsible for the near entirety of the poor and underserved; and

Whereas, Because most freestanding emergency medical care facilities do not participate in Medicare or Medicaid, they are free of the regulations associated with caring for those patients, placing the burden of emergency care for the underinsured and charitable care on community hospital-based emergency departments; and

Whereas, Most freestanding emergency medical care facilities do not accept emergency medical service ambulance traffic, causing patients to be unable to access emergency care, especially during high-volume times when local hospitals are on a divert status; and

Whereas, There is no certification process for freestanding emergency medical care centers through The Joint Commission, whose purpose is to set minimum standards in all emergency departments; therefore be it

Resolved, That the Texas Medical Association encourage and support legislation to level the playing field between hospital-based emergency departments, which serve as the safety net for our communities, and freestanding emergency medical centers, which serve primarily the financial interests of their owners; and be it further

Resolved, That TMA urge legislation to require any facility presenting itself as an emergency department to participate in Medicare and Medicaid with all of their regulatory requirements; and be it further

Resolved, That TMA urge legislation to require that freestanding emergency care facilities not be allowed to deny emergency medical service (ambulance)- patients access to emergency care during times of critical need such as when local hospitals are on a divert status; and be it further

Resolved, That TMA urge the Texas Department of State Health Services to investigate freestanding emergency medical care facilities’ compliance with Title 25, Part 1, Chapter 131, Subchapter C, Rule 131.46 (a) of the Texas Administrative Code regarding the treatment and stabilization of patients without regard to their ability to pay.
Relevant TMA policy:

**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).

**100.021 Free-standing Emergency Departments:** The Texas Medical Association advocates legislation establishing minimum operating criteria and regulatory framework for free-standing emergency departments (FSEDs). At a minimum, the legislation should specify that FSEDs must:

- Have and maintain equipment and supplies suitable for provision of emergency care services, including 1) equipment needed for the evaluation or resuscitation of critically injured patients, 2) appropriate diagnostic laboratory and radiological equipment, and 3) other essential equipment as determined by the state via rules.

- Be open to receive patients 24 hours a day, seven days a week.

- Have a referral, transmission, or admission agreement with a licensed hospital with an emergency room before the facility accepts any patient for treatment or diagnosis. The legislation should direct the state to establish via rulemaking the appropriate maximum mileage allowed to transport the patient from the FSED to the admitting hospital.

- Maintain full time coverage by a physician(s) either board certified in emergency medicine or otherwise qualified to provide emergency medical care.

- Be staffed with physicians, nurses, and other necessary staff with specialty training or experience in managing catastrophic illnesses or life-threatening injuries, including training in advanced cardiac life support, advanced trauma life support, and pediatric advanced life support.

- Adhere to the minimum architectural, sanitary, hygiene, privacy, and medical record standards as defined by the state via rules.

- Maintain an internal pharmacy capable of dispensing medications and controlled substances that are necessary for the prompt and medically appropriate treatment of those conditions that regularly present at a traditional hospital-based emergency room.

- Be capable of accepting ambulance traffic.

- Be accredited by the Joint Commission or other independent accrediting body.

- Provide medical screening and stabilization services for all patients seeking emergency services (CM-EMS Rep. 1-A-08).

**100.024 Regulation of Free-Standing Emergency Departments:** The Texas Medical Association supports legislation regulating free-standing emergency departments that would include (1)a requirement to be open 24 hours a day, seven days a
week, every day of the year, and (2) a minimum requirement for life support
equipment and training for both adults and pediatric patients, set forth minimum
standards for licensed personnel staffing the emergency departments, and require
certification by the Joint Commission or other such independent accreditation
body. TMA will collaborate with the Texas College of Emergency Physicians
regarding proposed regulations and will oppose any proposed regulations that are
onerous or go against TMA policy (Amended Res. 204-A-08).
Whereas, The current tort system fails at accomplishing the mission of the medical professional liability legal system because (1) access to justice is denied with less than 20 percent of injured patients ever receiving compensation and less than 1 percent receiving a jury award, (2) prevention of similar injury to future patients is impeded by gag orders and a “blame and shame” system, and (3) defensive medicine wastes up to $650 billion of health care resources annually; and

Whereas, Only 11 percent of premium payments for medical malpractice insurance are used to compensate patients; and

Whereas, The medical professional liability legal system denies access to Medicaid recipients, Medicare participants, the unemployed, the elderly, the poor, and young people; and

Whereas, Physicians and other health care personnel must view every patient as a potential plaintiff; and

Whereas, Although Texas medical tort system reforms have dramatically decreased medical professional liability premiums and increased patients’ access to primary care physicians and specialists, they have failed to decrease the practice of defensive medicine, which deprives the populace of billions of dollars that could be redirected to provide patient care; therefore be it

RESOLVED, That the Texas Medical Association support a “no-fault” patients’ compensation system, modeled after the workers’ compensation system, that replaces our broken professional liability litigation system, eliminates the practice of defensive medicine, and ensures real access to real justice for all injured patients, with goals of (1) reducing the incidence of “defensive medicine,” thus lowering health care costs by avoiding unnecessary tests and procedures performed because of fear of litigation; (2) eliminating the practice of “defensive medicine” by eliminating physicians’ fear of personal financial liability and the fear of the litigation process; (3) improving quality of patient care by realigning incentives towards patient safety and a reduction in medical errors; and (4) ensuring that iatrogenic adverse events are evaluated openly, resolved quickly, and compensated fairly.

Reference:
www.patientsforfaircompensation.org
Relevant TMA Policy:

170.005 **Professional Liability (Statute of Limitation):** The Texas Medical Association supports limiting the statute of limitations on medical professional liability cases to two years (Res. 28N, p 208C, I-94; reaffirmed CSE Rep. 3-A-04; reaffirmed CSE Rep. 2-A-14).

170.006 **Physician Liability for Acts of Assistants:** The Texas Medical Association, through its Council on Legislation, will review the legal risks physicians assume when directing nurses, including advanced nurse practitioners, physician assistants, and other health care workers not in their employ and determine if legislative reform is indicated to limit the liability risks assumed by these delegating physicians (Committee on Liaison with State Bar of Texas, p 86, A-96; reaffirmed CL Rep. 1-A-06; reaffirmed COL Rep. 1-A-16).

170.007 **Professional Liability:** To ensure access to medical care for Texans, the Texas Medical Association will continue efforts to (1) reduce or limit frivolous professional liability claims; (2) continue to examine the causes of claims frequency; (3) monitor claims data collected by the Texas Department of Insurance and the Texas Medical Board and make the aggregate data available to the membership; (4) advocate for judicial enforcement of current expert witness and cost bond provisions; and (5) allow the right to countersue (Substitute Res. 102, 103, 108-I-00; amended CSE Rep. 1-A-10).

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).

170.009 **Product Liability Lawsuit Impact on Premiums:** Rules should be promulgated by the Texas State Board of Insurance forbidding professional liability insurance carriers from considering product liability lawsuits in determining the treating physician’s future premium level (Res. 404-A-01).

170.010 **Professional Liability Coverage for Physicians Providing Long-Term Care:** To assure access to care for vulnerable elderly Texans, affordable professional liability coverage should be available for physicians who see nursing home patients (CHSO Rep 1-A-02; reaffirmed CHSO Rep. 2-A-12).

170.011 **Liability for Acts or Omissions:** Texas law should be changed to provide that (1) managed care organizations and insurance plans shall not be vicariously liable for any act or omission of a physician; (2) physicians shall not be vicariously liable for acts or omissions of managed care organizations or insurance plans; and (3) all agreements by which a physician or medical group practice indemnifies a managed care organization or insurance plan are void, including agreements entered into prior to the effective date of the amended statute (Res. 109-A-02; reaffirmed CSE Rep. 1-A-13).

170.013 **Health Plan Liability Requirements:** Health plans should be prohibited from requiring physicians to secure higher policy limits of professional liability insurance coverage than is required by the hospitals, health care facilities, and institutions in which they practice (Res. 403-A-05; reaffirmed CHSO Rep. 1-A-15; reaffirmed CSE Rep. 1-A-15).
TexMed 2017
TMA’s Annual Meeting, Premier Educational Showcase, and Expo
May 5-6 ★ Houston
RENEW YOUR PASSION
www.texmed.org/TexMed

Supplement to Handbook

Download the NEW TexMed 2017 meeting app Apple App Store or Google Play Store
Connect with #texmed2017  facebook.com/texmed  @texmed  @wearetma
CONTENTS OF SUPPLEMENT
TO THE HANDBOOK FOR DELEGATES
2017 Annual Session

At General Information Tab:
Replace What to Do When page with Revised What to Do When page;
Replace Reference Committees page with Revised Reference Committees page;
Replace Caucus Meetings Map with Revised Caucus Meetings Map;
Insert House of Delegates Seating Chart after Caucus Meetings Map.

At Composition Tab:
Insert House of Delegates Composition page at the front of the Composition Tab.

At Elections Tab:
Replace 4 page Election Charts with Revised Election Charts;
Insert 16 Candidate Profiles after Disclosure of Affiliations.

At Agendas Tab:
Replace Opening Session Agenda page with Revised Opening Session Agenda;
Replace 6 page Order of Business with Revised Order of Business.

At Informational Reports Tab:
Replace first page list of “Informational Reports” with Revised list;
Replace BOT Report 4-A-17 with Revised BOT Report 4-A-17;

At Financial and Organizational Affairs Tab:
Replace 2 page agenda with 2 page Revised agenda;
Insert PRES Report 1-A-17 before SPKR Report 1-A-17;

At Science and Public Health Tab:
Replace 2 page agenda with 2 page Revised agenda;
Insert Resolution 315-A-17 after Resolution 314-A-17;
WHAT TO DO WHEN

FRIDAY, May 5

6:30-7:30 am
TexMed Orientation: M, Level 2, Montgomery
New members of the house meet for breakfast to review procedures.

7 am-6 pm
Registration: CC, Level 3, Expo Hall

8 am
House of Delegates convenes: CC, Level 3, Expo Hall

Immediately Following Opening Session
Reference committees meet in rooms at M, Level 2:
Financial & Organizational Affairs: Houston Ballroom 1
Medical Education: Liberty
Science & Public Health: Houston Ballroom 2
Socioeconomics: Houston Ballroom 3

Noon-1 pm
Free Networking Lunch: CC, Level 3, Expo Hall

12:30-1:45 pm
Candidate Forum: CC, Level 3, Expo Hall
Learn about the candidates running for TMA offices.
Candidates will answer questions from the audience.

3:00-5 pm Sponsored by TMLT
Opening General Session: CC, Level 3, Expo Hall
Physicians in the Age of Terrorism —
Stories of the Battlefield by Chancellor William H. McRaven

Connect and Be Heard: Make a Difference in Health Care with Social Media by Kevin Pho, MD

5-6 pm Sponsored by TMLT
Welcome Reception and Book Signing: CC, Level 3, Expo Hall

6-7 pm Sponsored by TMAIT
2017-18 TMA/TMAA Presidents’ Reception: M, Level 2, Harris

7-10:30 pm
TMA Foundation Annual Gala, “Blast Off!”: M, Level 4, Texas 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 6

6 am-1:30 pm
Registration: CC, Level 3, Expo Hall

8:30 am
House of Delegates meets: CC, Level 3, Expo Hall

12:30-1:30 pm
Free EXPO Lunch: CC, Level 3, Expo Hall

1:30-2:30 pm
Closing General Session: CC, Level 3, Expo Hall
Civilian Response to an Active Shooter Situation by Pete Blair, PhD

Caucus Meetings
Bexar County Medical Society
Saturday, 6:30 am, CC, Level 3, Room 361A

Collin-Fannin County Medical Society
Friday 6 pm - 6:30 pm, M, Lobby Level, Cueva

Dallas County Medical Society
Saturday, 6:30 am, CC, Level 3, Room 350D

Harris County Medical Society
Saturday, 6:30 am, CC, Level 3, Room 360B

Lone Star Caucus
Friday, 6:30 am, M, Level 2, Houston Ballroom 4
Saturday, 6:30 am, CC, Level 3, Room 351E

Tarrant County Medical Society
Saturday, 6:30 am, CC, Level 3, Room 351D

Travis County Medical Society
Saturday, 6:30 am, CC, Level 3, Room 360A

Medical Student Section
Saturday, 6:30 am, M, Level 2, Brazoria

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 Reports Room, Room 2801.

• 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 only.

• Wi-Fi: The free wireless network is TexMed2017 and the password is texmed. Please note you will need to reconnect to the network when moving between the hotel and the convention center.

Key
M = Marriott Marquis Hotel
CC = George R. Brown Convention Center
REFERENCE COMMITTEES
May 2017

CHIEF TELLER
Charles E. Cowles Jr., MD, chair, Harris County Medical Society

CREDENTIALS
Sandra Dee Dickerson, MD, chair, Lubbock-Crosby-Garza County Medical Society
Faraz A. Khan, MD, Harris County Medical Society
Leah Hanselka Jacobson, MD, Bexar County Medical Society
Yvonne Kew, MD, PhD, Harris County Medical Society

FINANCIAL AND ORGANIZATIONAL AFFAIRS
George W. Williams II, MD, chair, Harris County Medical Society
Anees A. Siddiqui, MD, Travis County Medical Society
Ann C. Hughes Bass, MD (resident), Lubbock-Crosby-Garza County Medical Society
Bernard M. Gerber, MD, Harris County Medical Society
Jonathan Wayne Williams, MD, Wichita-Archer-Baylor-Clay-Knox CMS
Kathleen A. Cubine, DO, Concho Valley County Medical Society
Lubna Naeem, MD, Bexar County Medical Society

MEDICAL EDUCATION
Stephen E. Whitney, MD, chair, Harris County Medical Society
Alice Kim Gong, MD, Bexar County Medical Society
Kevin Wayne Klein, MD, Dallas County Medical Society
Lindsay K. Botsford, MD, Harris County Medical Society
Mateo Ziu, MD, Travis County Medical Society
Mr. William Alexander Estes (student), Lubbock-Crosby-Garza Medical Society
Priscilla J. Metcalf, MD, Wharton-Matagorda County Medical Society

SCIENCE AND PUBLIC HEALTH
Udaya Bhaskar Padakandla, MD, chair, Denton County Medical Society
Ben G. Raimer, MD, Galveston County Medical Society
Carla F. Ortique, MD, Harris County Medical Society
Celia B. Neavel, MD, Travis County Medical Society
John J. Nava, MD, Bexar County Medical Society
Sarah Lynn Helfand, MD, Dallas County Medical Society
Tilden L. Childs, III, MD, Tarrant County Medical Society

SOCIOECONOMICS
G. Sealy Massingill, MD, chair, Tarrant County Medical Society
Brenda Vozza-Zeid, MD, Rusk County Medical Society
Brian M. Bruel, MD, Harris County Medical Society
Habeeb Munir Salameh, MD, (resident), Galveston County Medical Society
Katharina Hathaway, MD, Travis County Medical Society
Michael Ian Vengrow, MD, Dallas County Medical Society
Nefertiti C. duPont, MD, Montgomery 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 2017 Texas Caucus Meetings

**Caucus Meetings**

- **Bexar County Medical Society**
  - Jayesh B. Shah, MD, Chair
  - Michael A. Battista, MD, Co-Chair
  - Saturday, 6:30 am, CC, Level 3, Room 361A

- **Collin-Fannin County Medical Society**
  - Carrie E. de Moor, MD, President
  - Friday, 6-6:30 pm, M, Lobby Level, Cueva

- **Dallas County Medical Society**
  - Steven R. Hays, MD, Co-Chair
  - Robert T. Gunby Jr., MD, Co-Chair
  - Saturday, 6:30 am, CC, Level 3, Room 350D

- **Harris County Medical Society**
  - Charlotte M. Stelly-Seitz, MD, Chair
  - Sherif Zaafran, MD, Vice Chair
  - Saturday, 6:30 am, CC, Level 3, Room 360B

- **Lone Star**
  - Brad Holland MD, Co-Chair
  - Jed Grisel, MD, Co-Chair
  - Gregory R. Johnson, MD, Co-Vice Chair
  - Lenore DePapeger, DO, Co-Vice Chair
  - Friday, 6:30 am, M, Level 2, Houston Ballroom 4
  - Saturday, 6:30 am, CC, Level 3, Room 351E

- **Tarrant County Medical Society**
  - Robert J. Rogers, MD, Co-Chair
  - Gary Floyd, MD, Co-Chair
  - Saturday, 6:30 am, CC, Level 3, Room 351D

- **Travis County Medical Society**
  - Tony R. Aventa, MD, Chair
  - Michelle Berger, MD, Vice Chair
  - Saturday, 6:30 am, CC, Level 3, Room 360A
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HOUSE OF DELEGATES COMPOSITION
May 2017

County society delegates .................................................................391

Ex officio-voting positions.........................................................*147
President .................................................................................. 1
President-Elect ......................................................................... 1
Immediate Past President ....................................................... 1
Secretary/Treasurer ................................................................... 1
Speaker ...................................................................................... 1
Vice Speaker ........................................................................... 1
At-large members of the Board of Trustees ......................... 12
Councilors ............................................................................... 15
Texas Delegation to the AMA ............................................... 29
Members of the Council on Legislation ......................... 15
Chairs of all other councils .................................................. 8
International Medical Graduate Section delegate ........ 1
Young Physician Section delegates ........................................ 6
Resident and Fellow Section delegates ............................... 4
Medical Student Section delegates .................................... 6
Specialty society delegates .................................................... 24
Past Presidents ........................................................................ 21

Ex officio nonvoting positions:
TEXPAC Chair ........................................................................... 1
Delegates emeritus of the Texas Delegation to the AMA .... 8

County society alternate delegates .......................................... 236

Delegates .................................................................................... 391
Ex officio .................................................................................. 147
Less those holding multiple positions ................................. 19

Total voting membership ..........................................................519

*Past presidents who are active or emeritus members have a vote, but they are not included in the quorum count.
**ELECTIONS**  
**May 2017**

General officers listed serve one-year terms except secretary/treasurer and 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 Ada Drozd, executive coordinator, Office of the EVP, at ada.drozd@texmed.org or (800) 880-1300, ext. 1540.

### 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 21</th>
</tr>
</thead>
<tbody>
<tr>
<td>President-Elect</td>
<td>Carlos J. Cárdenas</td>
<td>No</td>
<td>2017-18</td>
<td>Douglas W. Curran Henderson</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>Clifford K. Moy Dallas</td>
</tr>
<tr>
<td>Secretary/Treasurer</td>
<td>Michelle A. Berger</td>
<td>Yes</td>
<td>2017-20</td>
<td>Michelle A. Berger Travis</td>
</tr>
<tr>
<td>Speaker, House of Delegates</td>
<td>Susan M. Strate</td>
<td>Yes</td>
<td>2017-18</td>
<td>Susan M. Strate Wichita</td>
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<tr>
<td>Vice Speaker, House of Delegates</td>
<td>Arlo F. Weltge</td>
<td>Yes</td>
<td>2017-18</td>
<td>Arlo F. Weltge Harris</td>
</tr>
<tr>
<td>Three Trustees*</td>
<td>Gary W. Floyd</td>
<td>Yes</td>
<td>2017-20</td>
<td>Sue S. Bornstein Dallas</td>
</tr>
<tr>
<td></td>
<td>E. Linda Villarreal</td>
<td></td>
<td></td>
<td>G. Ray Callas Jefferson</td>
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<td></td>
<td>Dan K. McCoy**</td>
<td>Yes</td>
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<td>Gary W. Floyd Tarrant</td>
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<td></td>
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<td>Yes</td>
<td></td>
<td>John R. Holcomb Bexar</td>
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<td>Yes</td>
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<td>E. Linda Villarreal Hidalgo-Starr</td>
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*Trustee positions are “at large,” not slotted. TMA Bylaws provide that all nominees for trustee will be listed on a single ballot. Should Dr. Curran be elected president-elect, there will be a vacancy for trustee.

**Dr. McCoy will not be seeking re-election to the Board of Trustees**
## COUNCILORS

<table>
<thead>
<tr>
<th>District</th>
<th>Incumbent</th>
<th>Eligible For Election</th>
<th>Term of Position</th>
<th>Candidates Announced as of April 21</th>
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<tbody>
<tr>
<td>District 7</td>
<td>James R. Eskew</td>
<td>Yes</td>
<td>2017-20</td>
<td>James R. Eskew</td>
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<tr>
<td>District 8</td>
<td>Kevin H. McKinney</td>
<td>Yes</td>
<td>2017-20</td>
<td>Kevin H. McKinney</td>
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<tr>
<td>District 9</td>
<td>Michael A. Altman</td>
<td>Yes</td>
<td>2017-20</td>
<td>Michael A. Altman</td>
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<tr>
<td>District 10</td>
<td>David J. Bailey</td>
<td>No</td>
<td>2017-20</td>
<td>Kyle G. Krohn</td>
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<tr>
<td>District 13</td>
<td>Jed J. Grisel</td>
<td>Yes</td>
<td>2017-20</td>
<td>Jed J. Grisel</td>
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<tr>
<td>District 14</td>
<td>Edward W. Tuthill</td>
<td>Yes</td>
<td>2017-18</td>
<td>Edward W. Tuthill</td>
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## VICE COUNCILORS*

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<th>District</th>
<th>Incumbent</th>
<th>Eligible For Election</th>
<th>Term of Position</th>
<th>Candidates Announced as of April 21</th>
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<tbody>
<tr>
<td>District 7</td>
<td>Susan M. Pike</td>
<td>Yes</td>
<td>2017-20</td>
<td>Susan M. Pike</td>
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<tr>
<td>District 8</td>
<td>Alisa Marie D. Berger</td>
<td>Yes</td>
<td>2017-20</td>
<td>Steven M. Petak</td>
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<tr>
<td>District 9</td>
<td>Steven M. Petak</td>
<td>Yes</td>
<td>2017-20</td>
<td>David Vineyard</td>
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<tr>
<td>District 10</td>
<td>Vacant</td>
<td>—</td>
<td>2017-20</td>
<td>Chad White</td>
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<tr>
<td>District 13</td>
<td>Vacant</td>
<td>—</td>
<td>2017-18</td>
<td>Victor L. Vines</td>
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</table>

District elections are held for vice councilors and names are forwarded to the House of Delegates for confirmation. Terms are three years. 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 (800) 880-1300, ext. 1340, immediately.
## AMA DELEGATION ELECTIONS
### May 2017

### 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 April 21</th>
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<tbody>
<tr>
<td>1</td>
<td>Clifford K. Moy</td>
<td>No</td>
<td>2018-19</td>
<td>Jayesh B. Shah</td>
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<td>3</td>
<td>David N. Henkes</td>
<td>Yes</td>
<td>2018-19</td>
<td>David N. Henkes</td>
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<tr>
<td>4</td>
<td>Gary W. Floyd</td>
<td>Yes</td>
<td>2018-19</td>
<td>Gary W. Floyd</td>
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<td>5</td>
<td>Lyle S. Thorstenson</td>
<td>Yes</td>
<td>2018-19</td>
<td>Lyle S. Thorstenson</td>
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<tr>
<td>6</td>
<td>Diana L. Fite</td>
<td>Yes</td>
<td>2018-19</td>
<td>Diana L. Fite</td>
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<td>7</td>
<td>John T. Gill</td>
<td>Yes</td>
<td>2018-19</td>
<td>John T. Gill</td>
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### ALTERNATE DELEGATES

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<th>Alternate Delegates</th>
<th>Incumbent</th>
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<th>Candidates Announced as of April 21</th>
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<tbody>
<tr>
<td>1</td>
<td>Vacancy</td>
<td>Yes</td>
<td>2018-19</td>
<td>Robert H. Emmick</td>
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<td>2</td>
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<td>Yes</td>
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<td>John G. Flores</td>
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<td>3</td>
<td>Vacancy</td>
<td>Yes</td>
<td>2018-19</td>
<td>John T. Carlo</td>
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<td>4</td>
<td>Vacancy</td>
<td>Yes</td>
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<td>John G. Flores</td>
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<td>6</td>
<td>John T. Carlo</td>
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<td>7</td>
<td>Clausyl Plummer II*</td>
<td>No</td>
<td>May 6, 2017-May 19, 2018</td>
<td>Habeeb Salameh</td>
</tr>
<tr>
<td>8</td>
<td>Jennifer Nordhauser*</td>
<td>No</td>
<td>May 6, 2017-May 19, 2018</td>
<td>Jessie Ho</td>
</tr>
</tbody>
</table>

Delegates and alternate delegates serve two-year terms, Jan. 1, 2017-Dec. 31, 2018; except that the terms for alternate delegate slots designated for a resident and a medical student are May 6, 2017-May 19, 2018.

*Nominations are made by the Resident and Fellow Section and Medical Student Section.*
President-Elect
(Vote for one)

Douglas W. Curran, MD

The Lone Star Caucus and the Henderson County Medical Society are pleased to nominate Douglas W. Curran, MD, for president-elect of the Texas Medical Association. Dr. Curran is a practicing family physician with East Texas Medical Center and Lakeland Medical Associates in Athens, Texas. During his 37 years in medicine, he has become a recognized advocate for the patients and physicians of Texas. His commitment to medicine is evidenced most recently by the Texas Rural Health Association’s selection of Dr. Curran as the recipient of the 2016 Rural Health Champion Award.

He played a leading role in the passage of Texas’ groundbreaking medical liability reforms, fought for sweeping patients’ rights reforms, including holding managed-care companies accountable for their actions, championed legislation to improve the Children’s Health Insurance Program and Medicaid, and fought attempts by non-physician practitioners to expand their scope of practice.

Throughout his career, Dr. Curran has been active in the Texas Medical Association, Texas Academy of Family Physicians (TAFP), and American Academy of Family Physicians (AAFP), serving on numerous committees and in various leadership roles. He currently serves as chair of the TMA Board of Trustees. He is a member of TMA’s Select Committee on Medicaid, CHIP, and the Uninsured; and he chaired TMA’s Select Committee on National Health System Reform. Dr. Curran has served as a delegate from Henderson County Medical Society to the TMA House of Delegates for more than 19 years.

Dr. Curran currently serves on the board of directors of TAFP. He is a past president of TAFP; has served as chair of the TAFP Commission on Membership and Member Services and of the TAFP Commission on Legislative and Public Affairs; and is an active member of TAFPPAC. For AAFP, Dr. Curran served on the prestigious Commission for Governmental Advocacy.

As a caring physician and community leader, Dr. Curran is committed to improving access to quality health care for all Texans. He was instrumental in the creation of a rural health clinic and an obstetrical care clinic for patients with no means of payment, and through his participation in the Statewide Preceptorship Program, he has helped foster the interest of the next generation of Texas physicians. Dr. Curran is joined in his endeavors by his wife of 46 years, Sandy Curran; their daughter, Cortney; and their son, Chris, and his wife, Britne. Dr. Curran enjoys serving his church, tending his cattle, sharing in hospitality with friends and neighbors, and shaking a leg every now and then to a good Texas swing band.
Personal Statement: “For 37 years, I’ve been blessed to be doing exactly what I’m convinced I was meant for: I’ve cared for the people of my community. I’ve stood beside my colleagues in support of medicine with the conviction that if we fight for our patients’ best interests, we will succeed in crafting good policy for Texas. Today, we face crises of cost and access at the local, state, and national levels that threaten to shake the very foundation of our association. We must unite as never before, and with wisdom and courage, stand strong for the protection of our patients and the sanctity of our profession. I am prepared to be that voice that advocates, that leader for TMA.”

PROFILE
Specialty: Family Medicine
Medical School (with year graduated): University of Arkansas for Medical Sciences, 1976
Residency Program: Southwestern Medical School Family Medicine Residency Program at John Peter Smith Hospital
Board Certification(s): American Board of Family Medicine
Primary Residence: Athens, Texas
Practice Type/Employment Status: Direct patient care – solo, small group, or shared overhead
Primary Practice/Employment Location: East Texas Medical Center, Athens, Texas
Do you expect to maintain your current employment status and location through your term in office? Yes
Does your current employment situation require you to work outside of Texas? No
Including the past five years, list all other organizations from which you have received payment, reimbursement, or financial consideration for consulting, advisory, or leadership responsibilities exceeding $1,000 per year in excess of actual expenses: Physician Advisory Board for Blue Cross and Blue Shield of Texas
Have you been convicted of a felony or is your medical license restricted? Please explain. No
What TMA positions have you held?
  Current
  • Chair, TMA Board of Trustees
  • Member, TMA Board of Trustees
  Past
  • Member, Council on Legislation
  • Member, TEXPAC Executive Committee
  • Member, Primary Care Coalition
  • Member, Select Committee on Medicaid, CHIP, and the Uninsured
  • Chair, Select Committee on Health System Reform
  • Member, Task Force on Health System Reform
  • Member, Council on Member Services
  • Member, Committee on Professional Liability

DISCLOSURE OF AFFILIATIONS
  • American Academy of Family Physicians
  • Texas Academy of Family Physicians
  • Blue Cross/Blue Shield
  • Lakeland Medical Associates
  • Texas Medical Association PracticeEdge, LLC
  • VaxCARE
The Dallas delegation to the Texas Medical Association is pleased to nominate Clifford K. Moy, MD, for the office of president-elect of the Texas Medical Association.

Dr. Moy is a dedicated and proven leader. He has a long and distinguished history of service to the physicians of Texas and to the Texas Medical Association. Dr. Moy has been a leader in organized medicine since he attended medical school in the 1980s. After serving on Harris County Medical Society’s Medical Student Committee, he chaired TMA’s Medical Student Section and its Resident and Fellow Section. He served in numerous appointed and elected roles in Harris and Travis counties, having lived in both areas of the state during his career, later returning to the Dallas area.

Dr. Moy has served on TMA and American Medical Association councils and committees, and as a member of both organizations’ House of Delegates. He has served on the TMA Delegation to the AMA since 1998, the TMA Committee on Physician Distribution and Health Care Access, the TMA Council on Medical Education, and as chair of a TMA reference committee. He’s worked on numerous county society committees across the state, including current service on the DCMS Communications Committee. Dr. Moy has served as teller in the AMA House and as a member of the AMA Rules and Credentials Committee. He has completed the Glazer Advanced Workshop for Presiding Officers.

Dr. Moy is a trusted leader. This trust has earned him the respect of his peers. He was elected and served as vice speaker and speaker of House of Delegates for seven years. With great effectiveness, humor, and integrity, he guided the House, all while serving on the TMA Board of Trustees. In response to the TMA policy that allows a maximum of 10 years of service on the TMA board, he voluntarily stepped down from the role of speaker to preserve the required three years of service as president-elect to past-president.

**Personal Statement:** “As president-elect, I will enthusiastically communicate our powerful message of 'Improving the Health of All Texans,' and advocate our policies to promote the effective and satisfying practice of medicine for our 50,000 members. From my earliest days as a medical student to the present, I have dedicated myself to being a positive voice for medicine to Texas patients, physicians, and medical students. During my term as speaker/vice speaker for seven years, I gave voice to the House of Delegates within the TMA. My breadth and length of experience in our professional organizations, heightened by listening to and engaging physicians, have prepared me for the pressing challenges in medical practice.”
PROFILE
Specialty: Psychiatry
Medical School (with year graduated): John P. and Kathrine G. McGovern Medical School, 1985
Residency Program: UT Southwestern Parkland Memorial Hospital
Board Certifications: General Psychiatry
Primary Residence: Frisco, Texas
Practice Type/Employment Status: Administrative: government, health plan, or health-related, but no
direct patient care
Primary Employer/Employment Location: TMF Health Quality Institute, Austin, Texas
Do you expect to maintain your current employment status and location through your term in office? Yes
Does your current employment situation(s) require you to work outside of Texas? No
Including the past five years, list all other organizations from which you have received payment,
reimbursement or financial consideration for consulting, advisory or leadership responsibilities
exceeding $1,000 per year in excess of actual expenses: Texas A&M Rural Community Health
Institute (consulting)
Have you been convicted of a felony or is your medical license restricted? No
What TMA positions have you held?
• Speaker House of Delegates, 2012–2015
• Vice-Speaker House of Delegates, 2008–2012
• Texas Delegation to the American Medical Association, Delegate, 2004–present
• Texas Delegation to the American Medical Association, Alternate Delegate, 1998–2003
• Committee on Physician Distribution and Health Careers, 1994–2003
• Medical Student Section, chair, 1984–1985

DISCLOSURE OF AFFILIATIONS
• Member and past chair, AMA Council on Long-Range Planning and Development
• Immediate past president, McGovern Medical School Alumni Association
• Member, Communications Committee, Dallas County Medical Society
On behalf of the Travis County Medical Society, we are proud and honored to nominate Michelle Berger, MD, for re-election to the office of secretary/treasurer of the Texas Medical Association.

Prior to her election to the TMA office, she served the Travis County Medical Society (TCMS) in numerous leadership roles, most notably as its president in 2013 and secretary/treasurer from 2010-2011. With 15 years’ past service on the TCMS Executive Board and as a current trustee of We Are Blood, a TCMS affiliate, Dr. Berger has been actively involved in the financial oversight of annual operating budgets of over $33 million. She was chair of the TCMS Delegation to the TMA from 2009-2013 and is currently vice chair of the delegation.

Dr. Berger was president of the Texas Ophthalmological Association (TOA) in 2009. She was a TOA councilor and delegate to the Interspecialty Society Committee (ISC) of TMA and chaired the ISC from 2006 to 2008. She was also a member of the Council on Socioeconomics from 2012-2014. Currently, Dr. Berger is a TMA delegate to the American Medical Association. She is also on the Executive Board of the Phi Beta Kappa Alumni Association of Greater Austin.

Please join us in supporting Dr. Michelle Berger for re-election to the office of Secretary/Treasurer of the Texas Medical Association.

**Personal Statement:** “I have been working with the excellent financial staff of our TMA to formalize procedures of the Compensation Committee and to create financial orientation materials for the Board of Trustees. I ask for your vote to be able to complete these tasks and to help keep TMA in the strong fiscal position we have built over the past years.”
PROFILE
Specialty: Ophthalmology
Medical School (with year graduated): Medical College of Wisconsin, 1977-1981
Residency Program: Scott and White Hospital, 1981-85
Board Certification(s): American Board of Ophthalmology, 1985
Primary Residence: Austin, Texas
Practice Type/Employment Status: Direct patient care – solo, small group, or shared overhead
Primary Practice/Employment Location: Self-solo practice, Austin, Texas
Do you expect to maintain your current employment status and location through your term in office? Yes
Does your current employment situation(s) require you to work outside of Texas? 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?
• Board of Trustees, Secretary/Treasurer, 2014-present
• Texas Delegation to the AMA, alternate delegate, 2009-16
• Texas Delegation to the AMA, delegate, 2017-present
• Council on Socioeconomics, 2012-14
• House of Delegates member, Travis County Medical Society, 1998-present
• Interspecialty Society delegate from Ophthalmology, 1988-present
• Interspecialty Society Committee member, 1992-present, chair, 2006-08
• Ad Hoc Committee on Health Care Reform, 2009-10
• Ad Hoc Committee on ACOs, 2010-11

DISCLOSURE OF AFFILIATIONS
• Austin ENT
• Office of Michelle Berger, MD
Speaker, House of Delegates
(Vote for one)

Susan M. Strate, MD

The Lone Star Caucus and the Wichita County Medical Society (WCMS) are proud to endorse the candidacy of Susan M. Strate, MD, for re-election as speaker of the Texas Medical Association House of Delegates. As current speaker of the TMA House of Delegates, Dr. Strate has worked to maximize House efficiency and effectiveness, clarify the election process, enhance electronic communication, and update the parliamentary authority.

Dr. Strate has an exemplary record of TMA leadership, serving as chair of the Council on Socioeconomics, the Patient-Physician Advocacy Committee, and TEXPAC. She is a past president of the TMA Foundation and a current member of the TMA Foundation Endowment for Innovation campaign cabinet. She has served as a strong advocate for Texas physicians, providing testimony before Texas legislative committees on some of medicine’s most complex and contentious issues.

A practicing physician for over 30 years in Wichita Falls, Dr. Strate holds staff privileges and provides pathology and laboratory director services at multiple community and rural hospitals, as well as the local public health department.

Since 1996, Dr. Strate has served as president of Texoma Independent Physicians, a 200-plus physician independent practice association, where she has successfully worked to defend the rights of patients and physicians. From 1994 to 1995, she served as chief of staff at Wichita General Hospital and in 1996, as president of WCMS. From 2001 to 2008, Dr. Strate served the Wichita Falls Family Practice Residency Program as its board chair and chief executive officer, fortifying the primary care workforce in the region. Dr. Strate was recognized for her leadership as the 2010 recipient of WCMS’s Distinguished Service Award and the 2011 recipient of the College of American Pathologists Lifetime Achievement award.

From 2012 to 2015, she served on the Texas Institute of Health Care Quality and Efficiency Board of Directors, where she was a strong advocate for Texas patients and physicians.

She currently serves as vice chair of the Texoma Health Information Exchange Board and is a member of the Health Coalition of Wichita County.
With her broad knowledge of the issues, her strong advocacy for physicians and their patients, and her high level of energy, Dr. Strate will continue to ensure the voice of Texas physicians is heard as we seek solutions to the challenges of today’s medical practice.

**Personal Statement:** “As your Speaker, I will continue work to conduct the business of the house efficiently and effectively. I pledge to reach out to physicians across the state, listen to their needs, and work to represent physicians in primary and specialty care in a wide variety of practice settings. We must speak loudly with one united voice and advocate for our patients, as we forcefully work to cut over-regulation, advocate to protect physician freedom of choice in practice model and protect the patient-physician relationship, tort reform, and physician autonomy. I will work to ensure the collective strength of the house in policy making translates into a positive difference in our practices and in the health of our patients.”

**PROFILE**
Specialty: Pathology
Medical School (with year graduated): University of Nebraska College of Medicine, 1979
Residency Program: The University of Texas Southwestern Medical School (The University of Texas Southwestern Medical Center), 1979-83
Board Certification: American Board of Pathology (Anatomic and Clinical Pathology), 1983
Primary Residence: Wichita Falls, Texas
Practice Type/Employment Status: Direct patient care – solo, small group, or shared overhead practice
Primary Practice/Employment Location: North Texas Medical Laboratory, Wichita Falls, Texas

Do you expect to maintain your current employment status and location through your term in office? Yes
Does your current employment situation require you to work outside of Texas? No

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

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

What TMA positions have you held?
- **Current**
  - Delegate, Wichita-Archer-Baylor-Clay-Knox County Medical Society
  - Member, TMA Foundation Endowment for Innovation Campaign Cabinet
  - Member, TMA Foundation Leadership Society
  - Speaker, TMA House of Delegates
- **Past**
  - Vice Speaker, TMA House of Delegates
  - Chair, Council on Socioeconomics
  - Chair, Patient-Physician Advocacy Committee
  - Chair, TEXPAC Candidate Evaluation Committee
  - Chair, TEXPAC Executive Committee
  - Consultant, Council on Legislation
  - Delegate, Interspecialty Society Committee, Texas Society of Pathologists
  - Member, Council on Health Care Quality
  - Member, Ad Hoc Committee on Sunset Review of Texas State Medical Board
  - Member, Ad Hoc Committee on Patient Safety
  - Member, Ad Hoc Committee on Medical Errors
  - Member, TMA Foundation Grants Committee
  - President, TMA Foundation
  - Vice Chair, Select Committee on Patient Safety
DISCLOSURE OF AFFILIATIONS

- Texoma Independent Physicians, President and CEO
- Texoma Health Information Exchange, Board of Directors
- North Texas Medical Laboratory (performs clinical and anatomic pathology services)
- Texas Society of Pathologists, Council on Legislation
- Health Coalition of Wichita County
The Harris County Medical Society (HCMS) is proud to nominate Arlo F. Weltge, MD, for re-election as Vice Speaker of the Texas Medical Association House of Delegates.

During his past year as Vice Speaker, Dr. Weltge has worked with Speaker, Dr. Susan Strate, on a number of projects designed to make the House of Delegates operate more efficiently. Together they have worked with the Speaker’s Advisory Council and involved Leadership College representatives to improve House operations which include the design of the new House of Delegates web site and improved web access to TMA policies.

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 over 35 years. He has been an active member of TMA and the American Medical Association for over 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 over 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. Throughout his years of full-time clinical practice, he has practiced in Nacogdoches, Wharton, and Houston, gaining 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 fundamental strength and essential pillar of the organization is keeping our members engaged in the policy setting body - the House of Delegates - and therefore, connected to our common issues and committed to collaboratively setting policy that drives the efforts of our organization. I would welcome the opportunity to continue to serve as the Vice Speaker of our House of Delegates for the purpose of maintaining and fostering member engagement within our TMA.”

**PROFILE**

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; Emergency Medicine Foundation, American College of Emergency Physicians, Teaching Fellowship, 1989-90; 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% (60% 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: The 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
American College of Emergency Physicians
Occasional review for medical defense law firms for the Texas Medical Board and medical legal cases; no listing of specific firms

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 Texas Medical Association 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
- Chair and member, TEXPAC 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)
The Dallas delegation to the Texas Medical Association is proud to nominate Sue S. Bornstein, MD, for the position of trustee to 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 honor 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 to be elected president-elect of the hospital’s medical staff.

Since 2008, Dr. Bornstein has been executive director of the Texas Medical Home Initiative, a nonprofit physician-led organization dedicated to implementing the patient-centered medical home model of care in Texas.

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

At TMA, Dr. Bornstein is the inaugural chair of the TMA 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 was 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.

At DCMS, Dr. Bornstein was instrumental in forming the Women in Medicine Committee in 2016. She served on the DCMS Board of Directors from 2005-2007, including a term as secretary/treasurer. Dr. Bornstein also is a critical component in 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 front line who work hard to provide their patients with timely, patient-centered, accessible, affordable, and appropriate care. I will add my voice to that of the other primary care physicians on the Board.
I believe strongly that physicians should have the opportunity to practice in whatever setting suits them best. If elected, I will continue to seek the development of tools to enable physicians to remain in their practice setting of choice.

The 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 ensuring that our public health system remains viable.

The TMA has been tireless in its advocacy for increasing funding for Graduate Medical Education. 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
Specialty: Internal Medicine
Medical School (with year graduated): Texas Tech University Health Science 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: Administrative: government, health plan, or health-related, but no direct patient care
Primary Employer and 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
Including the past five years, list all other organizations from which you have received payment, reimbursement or financial consideration for consulting, advisory or leadership responsibilities exceeding $1,000 per year in excess of actual expenses. None
Have you been convicted of a felony or is your medical license restricted? No
What TMA positions have you held?
• Select Committee on Medicaid, CHIP and the Uninsured 2010–2017, Member
• Primary Care Coalition 2012–2013, Chair
• Committee on Primary Care and the Medical Home 2014–2016, Chair
• Committee on Physician Distribution 2013–2014, Member
• Texas Medical Association Interspecialty Society (Texas ACP delegate) 2007–2014; 2016–2017, Member
• TMA Leadership College 2012–2014, Mentor
• TMA House of Delegates (Texas ACP delegate) 2013–2017, Delegate
• Physician Services Organization Selection Committee 2013, Member
• TMA delegation to the American Medical Association 2014–2016, Alternate Delegate
• Physician Services Organization Steering Committee 2014–2015, Member

DISCLOSURE OF AFFILIATIONS
• PathAdvantage Associated: pathology practice
• American College of Physicians Regent 2017-19
G. Ray Callas, MD

G. Ray Callas, MD, served his country in the United States Navy as a submariner during Operation Desert Storm. He then graduated from Texas A&M University, earned his medical degree from the University of Texas Medical Branch at Galveston School of Medicine, and completed his anesthesiology residency at UTMB.

Dr. Callas is chair of the TMA Council on Legislation, has been a member of the TMA House of Delegates since 2004, and serves on the TEXPAC Board of Directors and TEXPAC Candidate Evaluation Committee. He first joined TMA in 1996, while attending medical school, and is a graduate of the inaugural class of the TMA Leadership College. Dr. Callas also serves as vice-chair of the Texas Medical Liability Trust Board of Directors, chair of the governor-appointed Jefferson and Orange County Board of Pilot Commissioners, and as advisory director of the Beaumont Chamber of Commerce.

He is a board-certified diplomat of the American Board of Anesthesiology. He has practiced medicine with Anesthesia Associates — one of the oldest incorporated and independent anesthesia groups in Texas — since 2004 and has served as secretary of its Board of Directors for 12 years. He serves multiple hospitals and surgical center facilitates in Jefferson County and Beaumont, Texas.

Dr. Callas is relentless in his efforts to protect physicians and their patients through his work with Jefferson County Medical Society (JCMS), Texas Society of Anesthesiologists (TSA), American Society of Anesthesiologists (ASA), Texas Medical Association, American Medical Association, and the Beaumont community.

Dr. Callas has been involved in JCMS since 2005, serving as president in 2010 and is a current member of its Board of Directors. He serves on the TSA Board of Directors, where he is speaker of the House of Delegates and editor of the *TSA Bulletin*. At TSA, he is actively involved in the Professional Development Committee, Long-Range Planning Committee, and Governmental Affairs Committee; as well as chairing the Anesthesiologists Serving in the Military Committee.

**Personal Statement:** “I passionately believe that physicians must advocate actively for their patients, something I’ve done as chair of the Council on Legislation as I walked the halls of the Texas Capitol and the U.S. Capitol this past year. I want to promote professionalism in medicine and continue the work we started to boost TMA’s public image to our patients, elected officials, and legislators. I want to work for you to oversee and guide the Association as an at-large-member of the Board of Trustees. Whether representing TMA, AMA, my county society, my specialty society, my practice, or my hospital — I speak out on behalf of the medical profession and for our patients. At a time when outside forces are trying to tear us apart, we Texas physicians need a strong and united TMA more than ever.”
PROFILE
Specialty: Anesthesiology
Medical School (with year graduated): The University of Texas Medical Branch at Galveston School of Medicine (UTMB), 2000
Residency Program: Anesthesiology UTMB
Board Certification(s): American Board of Anesthesiology
Primary Residence: Galveston, Texas
Practice Type/Employment Status: Private practice full-time anesthesiologist/board member
Primary Practice/Employment Location: Anesthesia Associates, Beaumont, Texas
Do you expect to maintain your current employment status and location through your term in office? Yes
Does your current employment situation(s) require you to work outside of Texas? No
Including the past five years, list all other organizations from which you have received payment, reimbursement, or financial consideration for consulting, advisory, or leadership responsibilities exceeding $1,000 per year in excess of actual expenses: Texas Medical Liability Trust, Baxter Healthcare, Cadance Pharmaceuticals, Blue Cross and Blue Shield of Texas Physicians’ Advisory Committee
Have you been convicted of a felony or is your medical license restricted? Please explain. No
What TMA positions have you held?

Current
- Chair, Council on Legislation
- Patron member, TEXPAC
- Member, TEXPAC Candidate Evaluation Committee and TEXPAC Board of Directors
- Delegate, House of Delegates
- Alternate Delegate, Texas Delegation to the AMA

Past
- Member, Interspecialty Society Committee
- Member, Balance Billing Task Force
- District chair, TEXPAC
- Member, TMA Foundation Board
- Member, Task Force on Physician Services Organization
- Mentor, TMA Leadership College (Graduate 2011)
- Member and chair, Council on Constitution and Bylaws
- Member, TMA of the Future
- Chair, Small Districts Caucus
- Alternate Delegate, TMA House of Delegates

DISCLOSURE OF AFFILIATIONS
- Anesthesia Associates
- Texas Medical Liability Trust
- Mallinckrodt Pharmaceuticals
- Blue Cross Blue Shield of Texas
Tarrant County Medical Society (TCMS) is proud to nominate one of their proven leaders, Gary W. Floyd, MD, to continue as a member of the TMA Board of Trustees. Dr. Floyd received his medical degree from The University of Texas Medical Branch at Galveston in 1976. He completed his pediatric residency at Oklahoma Children’s Memorial Hospital. He has practiced pediatrics for over 35 years in various capacities, including private general pediatric practice, academic pediatrics, pediatric emergency and urgent care medicine, and administrative medicine chief medical officer. He is board certified by the American Board of Pediatrics and is a fellow of the American Academy of Pediatrics.

Dr. Floyd is a recognized leader at the local, state, and national levels of government, as well as his specialty society and medical association. He frequently testifies before Texas House and Senate committees on health care issues dealing with safe management and treatment of patients, protection of physicians’ clinical autonomy, and independent medical judgment. He has been a strong voice for TMA policies before the legislature for many years.

Dr. Floyd is currently serving as an at-large member of the TMA Board of Trustees. He also serves as vice-chair and delegate of the Texas Delegation to the AMA. He is a member of the TEXPAC Patron Club. He previously served on the TMA Council on Constitution and Bylaws, Council on Legislation, and Select Committee on Medicaid, CHIP, and the Uninsured.

Dr. Floyd is a past president of the Tarrant Council Medical Society, Texas Pediatric Society, and Texas Chapter of the American Academy of Pediatrics. He currently serves as vice-chair of AAP District VII, an elected position covering five states (Arkansas, Louisiana, Mississippi, Oklahoma and Texas) as well as chair of the MedStar Ambulance System’s Emergency Physicians’ Advisory Board. Dr. Floyd was most recently appointed to serve as a member of the AMA Council on Legislation. His commitment to serve his colleagues in numerous leadership positions at TCMS, TMA, AMA, TPS, and AAP is a testament to his dedication to patients, colleagues and to the medical profession.

**Personal Statement:** “I have always been a passionate advocate for patients and physicians as evidenced by work in my various practice situations, my roles in organized medicine, and numerous testimonies before Texas House and Senate Committees in each legislative session since 1991 concerning health care issues dealing with the safe management and treatment of patients, and the protection of physicians’ clinical autonomy and independent medical judgment. I believe the House of Delegates is the heartbeat of the TMA, and the members of the Board of Trustees serve to carry out the will of the House and preserve the financial integrity of the organization. I would be honored to continue to represent you on the Board of Trustees, and I look forward to continuing to serve with each of you in our TMA House.”
PROFILE
Specialty: Pediatrics
Medical School (with year graduated): The University of Texas Medical Branch at Galveston, 1972-76;
Residency Program: Pediatrics at Children’s Hospital of Oklahoma, The University of Oklahoma Health
Science Center, 1976-79
Board Certifications: American Board of Pediatrics — Lifetime Certificate, 1983
Primary Residence: Keller, Texas
Practice Type/Employment Status: Academic — Self-employed independent physician & consultant
Primary Practice/Employment Location: Self, Keller, Texas
Do you expect to maintain your current employment status and location through your term in office? Yes
Does your current employment situation require you to work outside of Texas? No
Including the past five years, list all other organizations from which you have received payment,
reimbursement, or financial consideration for consulting, advisory, or leadership responsibilities
exceeding $1,000 per year in excess of actual expenses: None
Have you been convicted of a felony or is your medical license restricted? No
What TMA positions have you held?
• Tarrant County Medical Society Alternate Delegate, 1996-97; Delegate, 1998-present
• Member, Council on Constitution and Bylaws, 2002-06
• TEXPAC, District 9 Chair, 2006-2014; Vice Chair 2005-06, Patron Club Member
• Member, Council on Legislation, 2006-12; Chair, 2011-12; Consultant, 2012-2016
  Chair, Ad Hoc Committee on Retail Health Clinics, 2008-09
• Texas Delegation to the AMA, Alternate Delegate, 2006-2016; Delegate, 2016-present;
  Vice-Chair, Texas Delegation to the AMA, 2016-present;
  AMA Reference Committee B (Legislation), 2011, 2014;
  AMA Reference Committee F, 2015-present
• Select Committee on Medicaid, CHIP, and the Uninsured, 2007-present
• TMA Reference Committee on Socioeconomics in 1999, 2000, and 2003; chair in 2000
• Member, TMA Board of Trustees, 2014-present;
  At-large member, Executive Committee, 2016-present;
  Chair, Investment Committee, 2016-present
• Member, TMA PracticeEdge Board of Trustees, 2016-present

DISCLOSURE OF AFFILIATIONS
• Chair, Emergency Physicians’ Advisory Board for Metropolitan Area EMS Authority, 2017-present
• EPAB Member to Metropolitan Area EMS Board of Directors, 2017-present
• Vice Chair, AAP District VII (AR, LA, MS, OK, TX), 2014-present
• Texas Pediatric Society, Texas Chapter of AAP, Board of Trustees and Executive Board— ex officio
  member as an AAP district officer, 2014-present
• Member, Texas Medical Foundation Health Quality Institute Board of Trustees, 2015-present;
• Member, TMF HQI Executive Committee, 2016-present;
• Member, TMA Practice Edge Board of Trustees, 2016-present;
• Tarrant County Medical Society Board of Directors, 1996-present;
• Tarrant County Academy of Medicine Board of Directors, 2013-present;
• Testify before House and Senate committees concerning issues pertinent to patients, children, and
  physicians as needed by TMA, TPS, AMA, and AAP
The Bexar County Medical Society is pleased to nominate John R. Holcomb, MD, for a seat on the TMA Board of Trustees.

Dr. Holcomb has been a member of BCMS and TMA since 1982, and has held many leadership positions at BCMS, including as president in 1993. He currently serves on the BCMS Board, and as a TMA Delegate. At TMA, he served nine years on the Council on Socioeconomics, and as chair, Select Committee on Medicaid, CHIP, and Access to Care for 15 years. He has served on many TMA ad hoc committees, and has made himself available on numerous occasions to provide testimony to the Legislature on matters affecting Texas patients and their physicians. He has also been appointed as a physician resource for a number of Health and Human Services work groups, and the HHSC Executive Waiver Committee, in its deliberations regarding the recent Medicaid 1115 waiver.

Dr. Holcomb is a graduate of Texas A&M University and Southwestern Medical School, and trained in San Francisco and in San Antonio. He is board-certified in internal medicine, pulmonary medicine, and critical care medicine. His practice includes all patients requiring his services, regardless of insurance status or ability to pay. He is affiliated with Methodist Healthcare System in San Antonio, and has served as chief of staff, and on the governing board of that organization. He is a Certified Principal Investigator, and supervises ongoing clinical research studies for new drug applications.

He has served on other boards in the past, including the Texas Society of Internal Medicine, the Patient Safety Alliance, the Texas Hospital Association, and the Methodist Physician-Hospital Alliance. He currently serves on the board of Texas Medical Liability Trust, and is chair of BexarPAC, a political action committee in Bexar County dedicated to election of fair-minded District Court candidates.

Dr. Holcomb is a retired U.S. Army colonel, having served with 1st Special Forces Group, U.S. Army Academy of Health Sciences, Brooke Army Medical Center, 114th Evacuation Hospital, U.S. Army Hospital, Camp Bondsteel, Kosovo and with the 90th ARCOM as Command Surgeon.

Dr. Holcomb has a broad background in leadership and service, and would serve TMA well on the Board of Trustees.
PROFILE
Specialty: Pulmonary/Critical Care
Medical School (with year graduated): Southwestern 1967-1971
Residency Program: University of California Hospitals, 1971-1972 (Internship); University of Texas Health Science Center San Antonio 1975-1979 (Residency and Fellowship)
Board Certifications: Internal Medicine, Pulmonary Critical Care
Primary Residence: San Antonio, TX
Practice Type/Employment Status: Direct Patient Care: solo, small group, or shared overhead
Primary Practice/Employment Location: Self, San Antonio, TX
Do you expect to maintain your current employment status and location through your term in office? Yes
Does your current employment situation require you to work outside of Texas? No
Including the past five years, list all other organizations from which you have received payment, reimbursement, or financial consideration for consulting, advisory, or leadership responsibilities exceeding $1,000 per year in excess of actual expenses: TMLT (Board) Multiple Expert Opinions
Have you been convicted of a felony or is your medical license restricted? No
What TMA positions have you held?
• Council on Socioeconomics, 1998-2002
• Chair of the Select Committee on Medicaid, CHIP, and the Uninsured, 15 years

DISCLOSURE OF AFFILIATIONS
• J.R. Holcomb, MD, PA: Medical Practice
• TMLT Board Member
E. Linda Villarreal, MD

E. Linda Villarreal, MD, has been in a solo internal medicine, preventive medicine, and wellness practice in Edinburg for 27 years. Prior to solo practice, she spent 10 years as a pharmacist. She is active in TMA, serving on the Patient and Physician Advocacy Committee, Council on Legislation, and as a delegate on the Texas Delegation to the AMA. She is vice director for TEXPAC from Hidalgo County District and a TMA Foundation board member.

Dr. Villarreal has attended TMA's First Tuesdays at the Capitol since its inception, many times the only physician from Hidalgo County. She has been involved with local, state, and national grassroots lobbying efforts advocating for patient care, medical homes, and physician payment reform. Since the early 2000s, Dr. Villarreal has traveled throughout Texas advocating for tort reform. She especially notes an unforgettable "crop duster jump" trip in 2003 with Carlos Cardenas, MD, while out on the advocacy trail.

Dr. Villarreal contributes time to various community organizations. Previously serving as chief of staff at Edinburg Regional Medical Center, she is a past president of Hidalgo-Starr CMS, RGV Health Services District chair, and a past member of the Rio Grande Valley Partnership. Dr. Villarreal has served as board chair for Easter Seals, receiving the Easter Seals' Humanitarian of the Year award. Dr. Villarreal also served on the American Heart Association board, and was honored as a Heart of Gold recipient. The Zonta Club of West Hidalgo County has recognized her as a Shining Star.

**Personal Statement:** "Texas is changing. Medicine is changing. We must adapt to it. We owe this to those who have come before us and for those who will be coming after. But I believe that at no other time has organized medicine been so strong in advocating for our patients, for the profession of medicine and for our 50,000-strong membership. My experience as a member of the Board of Trustees has allowed me to see firsthand the diligence on the part of our physician board and our TMA team. I have been fortunate to witness the amazing grassroots effort on the part of all our physicians to protect our profession and promote the continuation of our number one goal which is to encourage and enhance the healthcare of all Texans. My experience, my passion, my geographical location, and background continue to assist me in caring for my own patients in my private practice that has existed since 1989. They have also given me many lessons in the importance of continuing to be involved within the framework of organized medicine to accomplish more not only for South Texas but for the entire state in every way I can.

I was humbled with my first election to the Board of Trustees and will never forget that experience, but even more humbled that “OUR HOUSE” has continued to give me the opportunity, by re-electing me. I am hoping for another term to continue to represent physicians as a Board of Trustee member.”
PROFILE
Specialty: Internal Medicine
Medical School (with year graduated): Universidad de Noreste, Tampico, Mexico, 1980-83,
License of Internado, 1983-84
Postgraduate: San Antonio State Hospital/University of Texas at Houston Medical School; Jan 1984 –
          Dec 1984
Internship: Huron Road Hospital, Cleveland, OH, Jan 1985-June 1986
Residency: Texas Tech University Health Sciences Center, RAHSC at El Paso 1986-1988
Board Certifications(s): BE
Primary Residence: Edinburg, Texas
Practice Type/Employment Status: Direct patient care - solo, small group, or shared overhead, 100%;
          Public Health: volunteer
Primary Practice/Employment Location: Self, Edinburg, 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?
  • Board of Trustees
  • Council on Legislation
  • Patient Physician Advocacy Committee
  • Texas Delegation to the AMA alternate delegate and delegate
  • TEXPAC

DISCLOSURE OF AFFILIATIONS
Cornerstone Hospital, Edinburg
AMA Alternate Delegate
(Vote for four)

Robert H. Emmick, MD

On behalf of the Travis County Medical Society, we are pleased and honored to nominate Robert H. Emmick Jr, MD, as a candidate for alternate delegate to the American Medical Association.

Dr. Emmick’s commitment to organized medicine began 30 years ago when he was elected to leadership positions first in the Medical Student Section, Resident Physician Section, and then in the Young Physician Section. As a practicing doctor, he has served in the TMA House of Delegates from the Brazos-Robertson, El Paso and now Travis County Medical Societies. He also served on the Texas Delegation to the AMA as an alternate delegate for more than 10 years, before resigning in 2011 to move to Alaska. Upon his return to Texas in 2013, he joined the Travis County Medical Society, immediately becoming active in both TCMS and TMA including participation in First Tuesdays at the Capitol.

In addition to his experience in both the TMA and AMA Houses of Delegates, Dr. Emmick has served on the board of directors of the Texas College of Emergency Physicians and on numerous TMA councils and committees, and was chair of the Council on Public Health and chair of the Patient-Physician Advocacy Committee.

Dr. Emmick is board certified in Emergency Medicine and his experience includes a broad range of practice settings as an academic physician, independent contractor and large-group employee. He has been the medical director for three different emergency departments and has served on two medical executive committees, one as chief of staff. He currently works at the Baylor Scott & White Emergency Medical Center in Cedar Park, Texas.

Please join us in supporting Dr. Robert Emmick as a candidate for alternate delegate to the American Medical Association with your vote.

**Personal Statement:** “Thirty years ago, as an eager young medical student, it was my desire to be part of an impactful profession and not just hold down a job with a paycheck. I wanted the ability to influence my profession and the larger society as a whole. A search for organizations that shared these goals led me to the Texas Medical Association and American Medical Association, and I have been active in organized medicine ever since.

Over the years, disparate forces have tried to separate us from our patients and reduce our profession to just that job with a paycheck. Our TMA has always responded with thoughtful policies that both protect...
our patients and upheld our honored profession. I promise to work diligently to help carry those policies forward if elected as an alternate delegate from Texas to the AMA House of Delegates.

I humbly ask for your vote.”

PROFILE
Specialty: Emergency Medicine
Medical School (with year graduated): Texas Tech University School of Medicine (1987 – 1991)
Board Certification(s): American Board of Emergency Medicine
Primary Residence: Austin, Texas
Practice Type/Employment Status: Direct Patient Care: large group practice (over 20 members)
Primary Practice/Employment Location: Baylor Scott & White, Cedar Park, 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?
Texas Delegation to the AMA House of Delegates
  Alternate Delegate (Resident) 1993 – 1994
  Alternate Delegate 2000 – 2002
  Alternate Delegate 2004 – 2011
Texas Delegation to the AMA Young Physician Section
  Alternate Delegate 1995 – 1999
  Delegate 1999 – 2000
  Alternate Delegate 2000 – 2001
Texas Delegation to the AMA Resident Physician Section
  Delegation Chair 1993 – 1994
  Delegate 1992 – 1995
Texas Delegation to the AMA Medical Student Section
  Delegate 1989 – 1990
  Alternate Delegate 1988 – 1989
Texas Medical Association House of Delegates
  Member 1987 – 2002
  2004 – 2011
  2014 – Present
TMA Council on Health Services Organizations
  Member 2010 – 2011
TMA Patient-Physician Advocacy Committee
  Member 2004 – 2010
  2001 – 2002
  Chair 2006 – 2009
Council on Public Health
  Member 1995 – 2001
  Chair 2000 – 2001
  Vice-Chair 1997 – 2000
Council on Socioeconomics  
    Resident Representative 1991 – 1995  
    Student Representative 1988 – 1991  
Council on Legislation  
    Resident Representative 1992 – 1995  
Committee on EMS and Trauma  
    Resident Representative 1993 – 1994  
TMA Young Physician Section  
    Executive Council 1995 – 2001  
TMA Resident Physicians Section  
    Chair 1993 – 1994  
TMA Medical Student Section  
TEXPAC  
    Board of Directors 1996 – 2002  
    Candidate Evaluation Committee 1999 - 2002  
Texas Medical Association Foundation  
    Board of Directors 1999 – 2002  
    Vice-President 2001 – 2002  

(Disclosure of affiliations is not required of AMA delegates and alternate delegates.)
AMA Alternate Delegate
(Vote for four)

Laura Faye Gephart, MD, MBA

Dr. Laura Faye Gephart, MD, MBA, from Baylor Scott & White Health Memorial Hospital in Temple, Texas, is seeking election as an Alternate Delegate to the Texas Delegation to the American Medical Association. Dr. Gephart has been active in organized medicine for the last 12 years and first served in the AMA House of Delegates in 2008 as a medical student.

Dr. Gephart’s passion for the policy, politics, and business of medicine inspired her to pursue a Master’s in Business Administration with a focus on health care administration. This appreciation and expertise allowed her to be twice elected to the AMA’s Council on Medical Service as the Resident and Fellow representative. Before dedicating herself to the AMA’s Council on Medical Service, Dr. Gephart was elected twice to the governing council of the AMA’s Medical Student Section. Through her training as a medical student in California and an obstetrics and gynecology resident in Florida, Dr. Gephart has established relationships with many members of the AMA House of Delegates.

Since moving to Texas for fellowship in Female Pelvic Medicine and Reconstructive Surgery, Dr. Gephart has been an active participant in the TMA; serving first on the TEXPAC Executive Board and now on the TMA Board of Trustees as the Resident and Fellow representative. She also served as an AMA delegate through the Residents and Fellows section, allocating her membership so that the state of Texas received another TMA voting seat in the AMA House of Delegates.

Dr. Gephart’s connections with other young doctors around the country within the AMA will make her an invaluable resource to the Texas Delegation to the AMA. Her time on the AMA’s Council on Medical Service has solidified her relationship with future leaders of the AMA. She understands the politics of the AMA House of Delegates, and she will work tirelessly to ensure that Texas’ priorities are efficiently and effectively turned into AMA policies and actions.

As a provider of obstetric and gynecologic care, Dr. Gephart has experience as a primary care provider as well as a surgical subspecialist. She is able to appreciate the multiple approaches and facets to the provision of medical care in Texas and beyond. Dr. Gephart’s addition to the Texas Delegation to the AMA as an Alternate Delegate would be an asset to the delegation.

Personal Statement: “I would be honored to continue to serve the Texas Medical Association as part of our delegation to the AMA. Our job on the delegation is to help the AMA be more like the TMA. Through my knowledge of, and experience in, the AMA HOD, I can help get Texans elected to leadership positions and adjust policy to help Texas doctors and our patients. I humbly ask for your vote.”
PROFILE
Specialty: Female Pelvic Medicine and Reconstructive Surgery
Medical School: Loma Linda University, MD, MBA, 2010
Residency Program: Intern, Howard University Hospital; Residency, University of South Florida;
Fellowship, Scott & White Healthcare
Board Certifications: American Board of Obstetrics and Gynecology
Primary Residence: Temple, Texas
Practice Type/Employment Status: Academic
Primary Employer and Employment Location: Baylor Scott & White Health, Temple, Texas
Do you expect to maintain your current employment status and location through your term in office? No.
   Starting September 1, 2017, I will be full-time FPMRS faculty at the University of Texas, Rio Grande
   Valley.
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, beyond my employer, Baylor Scott &
White Health
Have you been convicted of a felony or is your medical license restricted? No
What TMA positions have you held?
   • TEXPAC Board of Directors, Resident and Fellow member
   • TMA Board of Trustees, Resident and Fellow member

(Disclosures of affiliations is not required of AMA delegates and alternate delegates)
AMA Alternate Delegate
(Vote for four)

Steven R. Hays, MD

The Dallas delegation to the Texas Medical Association is proud to nominate Steven R. Hays, MD, for alternate delegate to the American Medical Association House of Delegates representing the Texas Delegation.

Dr. Hays is a nephrologist in private practice. An Alpha Omega Alpha member, he attended medical school at the University of Illinois College of Medicine, and completed his internship, residency, and fellowship at UT Southwestern, where he served as an honorary Burroughs Wellcome and Hoffman LaRoche fellow. While on faculty at UT Southwestern Medical Center from 1986-1993, he served as a basic scientist and an instructor of medical students, residents, and fellows. He is board certified in internal medicine and in nephrology.

Dr. Hays transitioned to Baylor University Medical Center in Dallas in 1993, serving as a staff physician and continuing as a clinical teaching faculty member at UT Southwestern. In 1993, he joined Dallas Nephrology Associates, a 75-member nephrology group in Dallas-Fort Worth, and served as financial chairman.

Dr. Hays has been a respected leader among his peers for many years. He served as chief of the medical staff at Baylor University Medical Center in Dallas and chairman of the BUMC Medical Board. He serves as medical director of the renal replacement therapy and living kidney donor programs. He is president of the Texas ACP Services, a fellow in the American College of Physicians, and a member in the American Society of Nephrology.

An involved and effective leader in DCMS and TMA since he became a member in 1986, Dr. Hays has advocated on behalf of physicians during First Tuesdays at the Capitol program since 2005. He served on the DCMS Board of Directors and was secretary/treasurer in 2011. He chairs the DCMS Legislative Affairs Committee and has co-chaired the Dallas Delegation to the TMA for more than six years. When appointed to serve on TMA councils and committees, he serves tirelessly. He has served on the TEXPAC Board of Directors and Executive Committee for years, and he chairs the TMA Council on Medical Education.
Nationally, Dr. Hays is Region IV representative to the Living Donor Board of United Network Organ Sharing (UNOS). He donates to local civic organizations and endows funds in memory of his late wife, Suzanne Ahn, MD, with the Dallas Women's Foundation and the Asian American Journalists Association.

Dr. Hays will be a strong addition to the AMA Delegation from Texas. He is the type of physician leader Texas is known for across the United States.

**Personal Statement:** “I have served locally and nationally as a representative to help preserve our voice in the government of medicine. I have the capacity to listen to all viewpoints and represent Texas’ interest in the process of shaping our national healthcare policies.”

**PROFILE**

*Specialty:* Nephrology  
*Medical School:* University of Illinois College of Medicine, 1979  
*Residency Program:* University of Texas Health Science Center at Dallas  
*Board Certifications:* American Board of Internal Medicine, 1982  
  - American Board of Internal Medicine, Subspecialty–Nephrology, 1988  
*Primary Residence:* Dallas, Texas  
*Practice Type/Employment Status:* Direct Patient Care; large group practice (over 75 members) (80%); Direct Patient Care; non-profit corporation (20%)  
*Primary Employer and Employment Location:* Dallas Nephrology Associates, Dallas, TX  
*Do you expect to maintain your current employment status and location through your term in office? Yes*  
*Does your current employment situation(s) require you to work outside of Texas? 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:* Baylor University Medical Center, Baylor Quality Alliance (Baylor ACO), Dallas Nephrology Associates  
*Have you been convicted of a felony or is your medical license restricted? No*  
*What TMA positions have you held?*  
  - TMA Delegate, 2007–present  
  - TEXPAC Board of Directors, Chair, Senate District 23; 2009–present  

(Disclosures of affiliations is not required of AMA delegates and alternate delegates)
AMA Alternate Delegate
(Vote for four)

Richard W. McCallum, MD

Richard W. McCallum, MD, FACP, FRACP (AUST), FACP, AGAF is professor and founding chair of the Department of Internal Medicine at Texas Tech University Health Sciences Center and is also director of the Center for Neurogastroenterology and GI Motility, Paul L. Foster School of Medicine in El Paso.

He is recognized nationally and internationally for his pioneering work in gastric electrical stimulation to treat the nausea and vomiting of gastroparesis, as well as his research into the pathophysiology and treatments for gastroparesis. His scientific publications in peer-reviewed journals exceed 450, he has edited 13 textbooks and holds five patents. His research on the pathophysiology and treatments for Gastroparesis is NIH funded, and he recently received another five-year renewal of this grant for $2 million.

Dr. McCallum has been a member of the TMA and the El Paso County Medical Society since his arrival in El Paso in 2009. He has served on the Education Committee of the TMA for the past five years and received the TMA Award for Excellence in Academic Medicine at the Gold level in 2016. He currently is a TMA delegate as well as the assistant treasurer for the El Paso County Medical Society and serves on the Editorial Board of the El Paso Physician. He was the first Medical Director of the RotoCare Texas Tech Free Clinic founded by the Rotary Club in El Paso and continues to supervise the education of the 1st and 2nd year medical students, volunteering his time on Saturday mornings. He is also very active in the El Paso Community with a call-in radio talk show entitled “The Tummy Doctor,” a member of the El Paso Symphony Board, and Rotary. Dr. McCallum also participates in TMA’s First Tuesdays at the Capitol.

McCallum is a native of Brisbane, Australia, and earned his bachelor’s and medical degrees from the University of Queensland. After interning at the New Orleans Charity Hospital (LSU), he completed his residency at Barnes-Jewish Hospital Washington University and fellowship training in gastroenterology at UCLA. He then served on the faculty of Yale School of Medicine before his appointment as gastroenterology division chief and fellowship program director at the University of Virginia. In 1996 he became the chief of Gastroenterology and Hepatology at the University of Kansas as well as director of the Center for GI Nerve and Muscle Function and GI Motility.
McCallum has held several important leadership roles in the American College of Gastroenterology, the American Gastroenterological Association, the American Neurogastroenterology and Motility Society, and the Southern Society for Clinical Investigation. He has been honored by Texas Tech University, the American Gastroenterological Association, American Diabetes Association, the Texas Medical Association, and the Southern Society for Clinical Research.

**Personal Statement:** “I am a very active clinician, educator, researcher and mentor, and feel that with my extensive academic background I have the credentials to effectively represent and be a voice for Texas Physicians at the AMA National level.”

**PROFILE**
- Specialty: Gastroenterology
- Medical School: University Of Queensland Medical School, Brisbane, Australia – MD, 1968
- Residency Program: Charity Hospital, LSU Service, New Orleans & Barnes Hospital, Washington University, St. Louis
- Board Certifications: Internal Medicine and Gastroenterology
- Primary Residence: El Paso, Texas
- Practice Type/Employment Status: Direct Patient Care; solo, small group, or shared overhead (50%); Academic (30%); Research (non-clinical) (20%)
- Primary Employer and Employment Location (city, state): Texas Tech University Medical Center, El Paso, 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: Salix Pharma, Allergan Pharma, Synergy Pharma, Medronic Corporation, Forest Pharma, Transzyme Pharma, Prostraken Pharma, Evoke Pharma
- Have you been convicted of a felony or is your medical license restricted? No
- What TMA positions have you held?
  - Member of the Education Committee since 2013
  - TMA Award for Excellence in Academic Medicine at the Gold Medal Level, 2016
  - Delegate for TMA from El Paso County Medical Society since 2015

(Disclosures of affiliations is not required of AMA delegates and alternate delegates)
AMA Alternate Delegate
(Vote for four)

Jennifer R. Rushton, MD

The Bexar County Medical Society (BCMS) is pleased to nominate Jennifer R. Rushton, MD, for American Medical Association alternate delegate.

Dr. Rushton has been a member of the Texas Medical Association since 2000, first with the Harris County Medical Society and with BCMS after moving to San Antonio in 2010. In 2008, she received her medical license and began practicing pathology in 2010. A 2004 graduate of Baylor College of Medicine, Dr. Rushton completed her residency program at Baylor in anatomic and clinical pathology, followed by fellowships in molecular genetic pathology and hematopathology. She is board certified in each.

Active in organized medicine, Dr. Rushton is a member of the TMA Young Physician Section and formerly served as delegate to the AMA Young Physician Section. She is currently an alternate delegate to the Interspecialty Society Committee. In addition, Dr. Rushton currently serves on the board of directors of the Texas Society of Pathologists and formerly served as chair of the Young Pathologists’ Section. Dr. Rushton also serves as a TMA delegate and is a member of the BCMS Legislative and Socioeconomics Committee. She is a strong supporter of legislative advocacy and has participated in First Tuesdays at the Capitol.

Locally, Dr. Rushton is a practicing community pathologist and physician leader, serving as the medical director of pathology and laboratory medicine for the Baptist Health System, an integrated group of five hospitals in San Antonio. She is also a member of the Baptist Health System Medical Staff Quality Committee.
PROFILE
Specialty: Pathology
Medical School (with year graduated): Baylor College of Medicine, 2000-2004
Residency Program: Anatomic and Clinical Pathology, Baylor College of Medicine, 2004-2008
Fellowship: molecular genetic pathology, 2008-2009
Fellowship: Hematopathology, Baylor College of Medicine, 2009-2010
Board Certification(s): Anatomic and clinical pathology, molecular genetic pathology, hematopathology
Primary Residence: San Antonio
Practice Type/Employment Status: Direct patient care: large group practice (more than 20 members)
Primary Practice/Employment Location: Clinical Pathology Associates, San Antonio
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?
• Delegate to the AMA Young Physician Section
• Alternate delegate to the Interspecialty Society Committee
• Delegate for BCMS
• Alternate delegate for the Young Physician Section
AMA Alternate Delegate
(Vote for four)

Sherif Zaafran, MD

The Harris County Medical Society (HCMS) is honored to nominate Sherif Zaafran, MD, as a candidate for alternate delegate to the American Medical Association.

Dr. Zaafran is a board-certified anesthesiologist who completed both medical school and his residency at the University of Texas Medical School at Houston. In practice since 1999, Dr. Zaafran currently works at the Memorial Hermann hospital in The Woodlands. He serves on the Physician Council for the MH System, chairs the System Joint Operating Council on the Perioperative Surgical Home, and chairs the MH System Anesthesia Committee.

Dr. Zaafran has been a member of TMA since medical school. Throughout his membership, he has been actively involved in the public policy process. He has served on the Committee on Membership, chaired the Council on Health Promotion, and continues to serve as a TMA delegate.

That passion for public policy turned into several leadership positions throughout the years. Dr. Zaafran has chaired the HCMS Board of Medical Legislation and currently serves as vice-chair of the HCMS Delegation to TMA. A Patron level member of TEXPAC, he sits on the Membership and Candidate Evaluation committees, and has been a long-time and very active District Chair. Dr. Zaafran also chairs the Government Affairs Committee of the Texas Society of Anesthesiologists (TSA), the American Society of Anesthesiologists Ad hoc Committee on Out-of-Network Payment, and is a recent gubernatorial appointment to the Texas Medical Board.

Keenly aware of the myriad national issues affecting physicians of all specialties and practice types, Dr. Zaafran’s experience chairing the government affairs committees of HCMS and his state specialty society has prepared him to represent Texas in the AMA House of Delegates. For nearly two decades, Dr. Zaafran has been one of several Texas physicians actively engaged with Congress to limit the federal regulatory burden placed on physicians. He also has promoted the Texas way of doing things in areas such as insurance and tort reform.

If elected, Texas physicians will be well represented by someone who both understands federal issues and can effectively guide the House of Delegates process to make sure Texas views are clearly heard by
AMA. Dr. Zaafran has been working for Texas physicians for years, and he is ready to do it as an alternate delegate to the AMA.

**Personal Statement:** “In the past several years, the politicians and bureaucrats in Washington have made drastic changes to our health care system, many of which have contributed nothing to patient care. Texas has been a strong, pro-physician state for some time now, and our perspective can only improve the AMA’s effectiveness in Washington. I feel that my experiences with TEXPAC, advocating in Austin and Washington for TMA and TSA, my work with the Texas Medical Board, and my experience in hospital leadership positions will allow me to take the unique perspective of Texas medicine, and the issues with which we struggle, to the AMA and use that experience to improve federal healthcare policy. I greatly appreciate your support.”

**PROFILE**

Specialty: Anesthesiology  
Medical School: University of Texas Medical School Houston, 1990-1995  
Residency Program: Baylor College of Medicine Transitional Program, 1995-1996; University of Texas Medical School Anesthesiology, 1996-1999  
Board Certifications: American Board of Anesthesiology  
Primary Residence: Houston, Texas  
Practice Type/Employment Status: Direct Patient Care; large group practice (over 20 members) (95%); Administrative: government, health plan, or health-related, but no direct patient care (5%)  
Primary Employer and Employment Location: US Anesthesia Partners, Houston, Texas  
Do you expect to maintain your current employment status and location through your term in office? Yes  
Does your current employment situation(s) require you to work outside of Texas? No  
Including the past five years, list all other organizations from which you have received payment, reimbursement or financial consideration for consulting, advisory or leadership responsibilities exceeding $1,000 per year in excess of actual expenses: Memorial Hermann Chair of Perioperative Clinical Pathway Committee. Memorial Hermann Chair of Joint Operating Council on Perioperative Surgical Home  
Have you been convicted of a felony or is your medical license restricted? No  
What TMA positions have you held?  
- TMA Delegate  
- Member and Chair of Council on Health Promotions  
- Member of Membership Committee

(Disclosures of affiliations is not required of AMA delegates and alternate delegates)
TEXAS MEDICAL ASSOCIATION
2017 HOUSE OF DELEGATES ANNUAL SESSION

OPENING SESSION
Friday, May 5, 8 am, Expo Hall, Level 3, George R. Brown Convention Center
(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
   Reverend David Garcia, Mission Concepcion, San Antonio

3. Report of Reference Committee on Credentials
   Sandra Dee Dickerson, MD, Chair

4. Approval of April 29-30, 2016 Minutes
   Michelle A. Berger, MD, Secretary/Treasurer

5. Address of Texas Medical Association Alliance President
   Debbie Pitts

6. Address of Texas Medical Association President
   Don R. Read, MD

7. Board of Trustees Annual Association Finances Report
   Douglas W. Curran, MD, Chair

8. Section Awards
   Young Physician Section, Sandra Williams, DO, Chair
   Young at Heart
   Medical Student Section, Romero Santiago, Chair
   C. Frank Webber, MD
   Student of the Year

9. Presentation of TMA-Established Organizations (video-taped)
   Texas Medical Liability Trust
   Robert Donohoe, President and CEO
   TMA PracticeEdge
   David N. Henkes, MD, Secretary/Treasurer
   TEXPAC
   Bradford Holland, MD, Chair, Board of Directors
   Texas Medical Association Foundation
   Deborah Fuller, MD, President

10. Nominating Speeches
    President-Elect
    Trustees
    AMA Alternate Delegates

11. Recognition of TMA Past Presidents
12. Recognition of Outgoing Council and Committee Chairs
13. Acceptance of Handbook Items as Business of the House (see Order of Business)
14. Consideration of Late Reports and Resolutions
15. Moment of Silence for Deceased Physicians
16. Announcements
17. Recess for Reference Committee Hearings
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES
ORDER OF BUSINESS
2017 ANNUAL SESSION
May 5-6, 2017

Reference Committee Key:
Financial and Organizational Affairs = F&OA
Medical Education = ME
Science and Public Health = SPH
Socioeconomics = SOCIO

REPORTS:

1. Report of President
   1. Nominations for Board of Governors, Texas Medical Liability Trust

2. Report of Speakers
   1. TMA Election Process

3. Reports of Board of Trustees
   1. 2016-17 Board Officers and Committees
   2. Disclosure of Affiliations
   3. TMA Collaboration
   4. TMAIT, TMFHQL, and TMLT
   5. TMA Leadership College
   6. Medical Student and Resident Physician Loan Funds
   7. Minority Scholarship Program
   8. Audit of 2015 Financial Statements and 2016-17 Operating Budgets
   9. Investments
   10. Pending Lawsuits Involving TMA
   11. Texas Two Step
   12. Continuation of International Medical Graduate Section
   13. Policy Review

4. Report of Executive Vice President
   1. 2016-17 Update

5. Report of Interspecialty Society Committee (no report)

6. Report of Committee on Membership
   1. Membership Development
   2. Policy Review

7. Reports of Board of Councilors
   1. Distinguished Service Award — Robert T. Gunby Jr., MD
   2. Bell CMS Bylaws
   3. Resolution 307
   4. Emeritus Nominations
   5. Honorary Nominations
   6. Policy Review

8. Reports of Committee on Physician Health and Wellness
   1. 2017 Goals; PHR Assistance Fund; Drug Screen Program
   2. Continuing Medical Education Programs
   3. Treatment Facilities; Medical Student and Resident Activities
   4. Policy Review

REferred to:

F&OA
Informational
F&OA
9. Reports of Texas Delegation to the AMA
   1. AMA House of Delegates Meetings in 2016  
   2. AMA Membership, Representation, and Delegation Leadership  

10. Reports of International Medical Graduate Section  
    (no report)  

11. Report of Medical Student, Resident and Fellow, and Young Physician Sections  
    (no report)  

12. Reports of Council on Constitution and Bylaws
   1. Improving TMA Committee Sunset Review Process  
   2. Board of Councilors Quorum and Voting Members  
   3. Authority to Take Action Without a Meeting  
   4. Membership in a Contiguous Society  
   5. Proposed Change to the TMA Election Process  

   1. Quality Update  
   2. Policy Review  

    (no report)  

15. Reports of Council on Health Service Organizations  
    (no report)  

   1. Policy Review  

17. Reports of Council on Medical Education
   1. Referral of PHW Report 2, Mental Illness  
   2. Referral of CME Report 3, Curriculum Mandates  
   3. Exceptions to Medicare GME Cap-Setting Deadlines  
   4. Rural Training Tracks  
   5. Need for Continued Expansion of GME Capacity  
   6. Referral of Res. 201 and Res. 207  
   7. Policy Review  

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

19. Reports of Committee on Physician Distribution and Health Care Access
   1. Long-Range State Health Care Workforce Study  
   2. Enhancements to State Physician Education Loan Repayment Program  
   3. Policy Review  

    (no report)  

21. Reports of Council on Science and Public Health
   1. All Hazards Disaster Planning  
   2. Parental Leave  
   3. Policy Review  

22. Report of Committee on Cancer  
    (no report)  

23. Report of Committee on Child and Adolescent Health
   1. Policy Review
24. Report of Committee on Emergency Medical Services and Trauma (no report)

25. Report of Committee on Infectious Diseases
   1. Policy Review

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

27. Reports of Council on Socioeconomics
   1. Delay the Implementation of Downside Risk in Alternative Payment Models
   2. Increasing Use of Narrow Networks by Medicare Advantage Plans
   3. Prescription Drug Price Negotiation
   4. Prescription Drug Value Based Contracting
   5. High-Risk Pool Policy
   6. MACRA Update
   7. Policy Review

28. Medical Home and Primary Care Committee (no report)

29. Report of Patient-Physician Advocacy Committee
   1. Patient-Physician Advocacy Update
   2. Policy Review

30. Report of Committee on Rural Health (no report)

31. Report of Select Committee on Medicaid, CHIP, and the Uninsured
   1. Report on Resolution 107

32. Joint Reports
   1. Parliamentary Authority Transition for TMA
   2. TMA Bylaws Concerning Retired Member Classification
   3. Resolution 310 Prevention of In-Hospital Newborn Falls
   4. Resolution 311 Sexual Orientation Change Efforts in Minors
   5. Preexposure Prophylaxis as HIV Prevention

33. Report of TEXPAC
   1. 2017-18 TEXPAC Board of Directors

34. Report of Texas Medical Association Insurance Trust
   1. TMAIT 2016 Annual Report

35. Report of TMF Health Quality Institute
   1. TMFHQI 2016 Annual Report

36. Report of Texas Medical Association Foundation
   1. TMA Foundation 2016 Annual Report

37. Report of Texas Medical Association Alliance
   1. Alliance Activities and Accomplishments
RESOLUTIONS:

101. Election of TMA Board of Trustees Members
   Lone Star Caucus
   FOA
102. Replacing the Medical Malpractice Litigation System With a “No-Fault” Patients
   Compensation System
   Ori Hampel, MD
   FOA
103. Texas Medical Board License Renewal Notifications and Payment
   Harris County Medical Society
   FOA
104. Tort Reform Celebration Day
   El Paso County Medical Society
   FOA
105. TMA Outreach to Displaced and Refugee Physicians
   Harris County Medical Society
   FOA
106. Reduced and Alternative Documentation and Administrative Requirements for
   Medical Documentation for Prescribers in Times of Declared Disasters
   Harris County Medical Society
   FOA
107. Support of Evidence-Based Medicine
   Young Physician Section, Resident and Fellow Section, and
   Medical Student Section
   FOA
108. Recognition of John R. Holcomb, MD
   Bexar County Medical Society
   FOA
109. Election Results
   Angelina County Medical Society
   FOA
110. Integrating Advance Directives Conversation to Maintain Autonomy
    Medical Student Section
    FOA
111. Addressing Physician Mental Health Status Disclosures
    Medical Student Section
    FOA
112. Commendation of 2017 Texas Two-Step CPR: Save a Life Campaign
    Arlo F. Weltge, MD, Harris County Medical Society
    Carlos J. Cardenas, MD, Hidalgo-Starr County Medical Society
    Douglas W. Curran, MD, Henderson County Medical Society
    Diana L. Fite, MD, Harris County Medical Society
    A. Tomas Garcia III, MD, Harris County Medical Society
    Keith A. Bourgeois, MD, Harris County Medical Society
    Kayla A. Riggs, Medical Student Section
    Carrie E. de Moor, MD, Collin-Fannin County Medical Society
    Laura Faye Gephart, MD, Bell County Medical Society
    Don R. Read, MD, Dallas County Medical Society
    Richard W. Snyder II, MD, Dallas County Medical Society
    E. Linda Villarreal, MD, Hidalgo-Starr County Medical Society
    David C. Fleeeger, MD, Travis County Medical Society
    Michelle A. Berger, MD, Travis County Medical Society
    Dan K. McCoy, MD, Dallas County Medical Society
    Gary F. Floyd, MD, Tarrant County Medical Society
    David N. Henkes, MD, Bexar County Medical Society
    Susan M. Strate, MD, Wichita-Archer-Baylor-Clay-Knox County Medical Society
    FOA
113. HIPAA and Physician Rating Websites
    Harris County Medical Society
    FOA
201. Inclusion of Advocacy Education in Medical School Curricula
    Harris County Medical Society
    ME
202. Medical School Clinical Skills Exams
    Medical Student Section
    ME
203. Resolving the Impact of Travel and Immigration Bans on Health Care Provision
    Medical Student Section
    ME
RESOLUTIONS: REFERRED TO:

301. Creating a Statewide Crisis Standards-of-Care Framework     SPH
   Dallas County Medical Society

302. Palliative Care     SPH
   Larry Driver, MD

303. Sudden Increase in Liability Claims for Wernicke’s Encephalopathy in Bariatric Patients     SPH
   Harris County Medical Society

304. Rejection of Discrimination     SPH
   Young Physician Section, Resident and Fellow Section, and
   Medical Student Section

305. Addressing the Diaper Gap     SPH
   Medical Student Section

306. Addressing the Need for Improved Water Supply Quality in Texas     SPH
   Medical Student Section

307. Reducing errors in pharmacy     SPH
   Lubbock-Crosby-Garza County Medical Society

308. Expansion of Next Generation 911     SPH
   Medical Student Section

309. Addressing the Medical Inaccuracies of the Mandated “A Woman’s Right to Know” Booklet     SPH
   Medical Student Section

310. Healthy Food in Hospitals     SPH
   Medical Student Section

311. Addressing Access to Maternal Personal Protective Equipment from Radiation     SPH
   Medical Student Section

312. Implementing a Sugar Sweetened Beverage Tax in Texas     SPH
   Medical Student Section

313. Improved Concussion Protocol to Reduce Psychological Morbidity in High School Athletes     SPH
   Medical Student Section

314. Promoting Increased Awareness and Research for Grade School Soccer Related Head Injury     SPH
   Medical Student Section

315. Addressing the Expanding Habitats of Vectors of Infectious Disease     SPH
   Medical Student Section

316. Addressing Transgender Public Facility Use     SPH
   Medical Student Section

317. Precision Medicine in Refractory Cancer Treatment and Transparency in Compendia     SPH
   Medical Student Section

318. Access to Special Education Services     SPH
   Medical Student Section

319. Identification and Prevention of Adolescent Substance     SPH
   Webb-Zapata-Jim Hogg County Medical Society

320. Vitamin D3 Supplementation     SPH
   Webb-Zapata-Jim Hogg County Medical Society

321. Promoting Safe and Effective Disposal of Unused Medications     SPH
   Webb-Zapata-Jim Hogg County Medical Society

401. Opposition to Capped Federal Medicaid Funding     SOCIO
   Bexar County Medical Society

402. Proposed Change in Medicaid Funding     SOCIO
   Concho Valley County Medical Society

403. Supporting Community-Based Healthcare Delivery Models     SOCIO
   Dallas County Medical Society

404. Allowing Exceptions to the Centers for Medicare & Medicaid Services’ Locum Tenens 60-Day Limit     SOCIO
   Harris County Medical Society
RESOLUTIONS:

405. Minimum Standards for Interstate Sale of Health Insurance Products
     Harris County Medical Society

406. Transparency and Payments for Prior Authorizations
     Harris County Medical Society

407. Medicaid Block Grants Per Capita Caps
     Ben G. Raimer, MD, FAAP, Texas Pediatric Society
     Kimberly M. Carter, MD, Texas Association of Obstetricians and Gynecologists
     Troy T. Fiesinger, MD, Texas Academy of Family Physicians

408. Compensation of Physicians for Authorizations and Preauthorizations
     Ori Hampel, MD

409. Medicaid Payments for Speech Therapy, Physical Therapy, and Occupational Therapy
     Medical Student Section

410. Public- and Private-Sector Funding of Interpretation Services for Limited English Speakers
     and American Sign Language
     Medical Student Section

411. Clearer Language Regarding the Physician’s Role in Providing Auxiliary Aid for Effective
     Communication Under Current Federal Laws
     Medical Student Section

412. Preference of Medicaid Funding Proposals
     Harris County Medical Society

413. Addressing Zika Through Increasing Medicaid Coverage of Insect Repellent
     Medical Student Section
Reports of Board of Trustees
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1. Quality Update

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Report of Patient-Physician Advocacy Committee
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Report of TEXPAC
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Report of Texas Medical Association Alliance
1. TMA Alliance Activities and Accomplishments
REPORT OF BOARD OF TRUSTEES

BOT Report 4-A-17

Subject: TMAIT, TMFHQI, and TMLT

Presented by: Douglas W. Curran, MD, Chair

Texas Medical Association Insurance Trust Board of Trustees
The TMA Board of Trustees has responsibility to appoint four members of the TMA Insurance Trust 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 September 2015, the Board of Trustees recommended Richard L. Noel, MD, Houston, to serve a three-year term to fill the seat being vacated by Robert A. Light, MD; Jack L. Cortese, MD, Corpus Christi, to serve a second three-year term; Roberto San Martin, MD, San Antonio, to serve a final three-year term; and Bernard M. Gerber, MD, Bellaire, to serve a final three-year term. Dr. Noel and Dr. San Martin were appointed by the TMA Board of Trustees; Dr. Cortese and Dr. Gerber were elected at the TMAIT annual meeting in September.

TMF Health Quality Institute 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 2017, no physician terms are expiring.

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

Texas Medical Liability Trust 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 2016, no terms were expiring.
Subject: Report on Resolution 107: Requiring Doctors to Swear to Be Honest

Presented by: Ryan Van Ramshorst, MD, Chair

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**Background**
At the 2016 annual meeting, the House of Delegates referred Resolution 107, Requiring Doctors to Swear to Be Honest (Bexar County Medical Society). The resolution calls for the following:

“That physicians in Texas not be required by any governmental agency or function to swear that they will not be dishonest in dealings with state agencies or functions, and that they not be required to swear that they will seek out colleagues that they suspect are guilty of misbehavior without specific guidance as to what is considered ‘misbehavior.”

**Discussion**
In early 2016, the new Inspector General (IG) of the Texas Health and Human Services Commission Office of the Inspector General (OIG), Stuart Bowen, announced a new IG Integrity Initiative to reduce waste, fraud, and abuse. Styled a “community policing initiative,” it called for Medicaid providers to pledge to report all suspected fraud, abuse, and waste to the IG. Many Texas Medical Association members were naturally concerned about a coercive program requiring or strong-arming them to sign what they viewed as an unnecessary pledge to act as tattle-tales on their colleagues.

With this in mind, last April, the Select Committee on Medicaid, CHIP, and the Uninsured joined by members of the Board of Trustees met with the IG to discuss their concerns regarding the Integrity Initiative. Mr. Bowen clarified that the initiative is completely voluntary and that no physician would be forced to seek out and report on other physicians suspected of misbehavior. Additionally, he acknowledged actual fraud is low among physicians and that unintended errors are not tantamount to fraud. He outlined his desire to establish a constructive rapport with TMA and ongoing discussions about fair strategies to reduce actual fraud, waste and abuse.

After the IG clarified that the program is voluntary, TMA received no further complaints. Rather, committee leaders and county medical societies have indicated their support for the IG’s transparent, collaborative, approach. Since there have been no additional complaints since the IG clarified the initiative is voluntary, the Select Committee believes no further action is needed at this time. However, since a future IG could implement a compulsory pledge, the committee will continue to closely monitor the initiative.

**Conclusion**
Given the clarification received from Mr. Bowen and the collaborative relationship that the committee has developed with the OIG, the Select Committee on Medicaid, CHIP, and the Uninsured does not recommend specific action, but will continue to constructively work with the OIG to ensure physicians accused of waste, fraud, or abuse be accorded appropriate and timely due process.
REPORT OF TEXPAC

Subject: 2017-18 TEXPAC Board of Directors

Presented by: Bradford W. Holland, MD, Chair

Appointment of TEXPAC Board of Directors
TMA Bylaws provide that the TMA Board of Trustees shall provide general policy and operational supervision of TEXPAC, that the TEXPAC Board of Directors shall report to the Board of Trustees, and that members of the TEXPAC Board of Directors shall be appointed by the Board of Trustees.

In April 2017, the TMA Board of Trustees appointed the following TEXPAC officers for 2017-18:
• Robert Rogers, MD, Chair, TEXPAC Board of Directors
• Alexander Kenton, MD, Chair, Candidate Evaluation Committee
• Brad Patt, MD, Chair, Membership Committee

The Board of Trustees also appointed the TEXPAC district chairs, executive committee and Candidate Evaluation Committee, attached to this report.
# 2017-18 TEXPAC Board of Directors District Chairs

<table>
<thead>
<tr>
<th>District</th>
<th>District Chair</th>
<th>Specialty</th>
<th>CMS</th>
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<tr>
<td>1</td>
<td>Asa Lockhard, MD</td>
<td>Anesthesiology</td>
<td>Smith</td>
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<td>Yasser Zeid, MD</td>
<td>OB-GYN</td>
<td>Gregg-Upshur</td>
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<td>Lisa Swanson, MD</td>
<td>Pediatrics</td>
<td>Dallas</td>
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<td>2</td>
<td>John Scott, DO</td>
<td>Anesthesiology</td>
<td>Dallas</td>
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<td>3</td>
<td>J. Patrick Walker, MD</td>
<td>General Surgery</td>
<td>Houston</td>
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<td>William Strinden, MD</td>
<td>Plastic Surgery</td>
<td>Angelina</td>
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<td>4</td>
<td>David Teuscher, MD</td>
<td>Orthopedics</td>
<td>Jefferson</td>
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<td>Stacy Norrell, MD</td>
<td>Anesthesiology</td>
<td>Harris</td>
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<td>5</td>
<td>Susan Pike, MD</td>
<td>Plastic Surgery</td>
<td>Williamson</td>
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<td>Jimmy Widmer, MD</td>
<td>Internal Medicine</td>
<td>Bell</td>
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<td>Kenneth Mattox, MD</td>
<td>Thoracic Surgery</td>
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<td>Patrick Carter, MD</td>
<td>Family Medicine</td>
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<td>7</td>
<td>Debra Osterman, MD</td>
<td>Psychiatry</td>
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<td>Richard Bradley, MD</td>
<td>Emergency Medicine</td>
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<td>8</td>
<td>Lee Ann Pearse, MD</td>
<td>Pediatric Cardiology</td>
<td>Dallas</td>
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<td>Seth Kaplan, MD</td>
<td>Pediatrics</td>
<td>Collin-Fannin</td>
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<td>Jason Terk, MD</td>
<td>Pediatrics</td>
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<td>Gregory Fuller, MD</td>
<td>Family Medicine</td>
<td>Tarrant</td>
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<td>G. Sealy Massingill, MD</td>
<td>OB-GYN</td>
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<td>Tilden Childs, III, MD</td>
<td>Radiology</td>
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<td>11</td>
<td>Mina Sinacori, MD</td>
<td>OB-GYN</td>
<td>Harris</td>
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<td>Carlos Vital, MD</td>
<td>Allergy &amp; Immunology</td>
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<td>John Flores, MD</td>
<td>Internal Medicine</td>
<td>Denton</td>
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<td>Joseph Valenti, MD</td>
<td>OB-GYN</td>
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<td>Faraz Khan, MD</td>
<td>Diagnostic Radiology</td>
<td>Harris</td>
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<td>William Gilmer, MD</td>
<td>Neurology</td>
<td>Harris</td>
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### 2017-18 TEXPAC Board of Directors Alliance Members

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### TEXPAC Executive Committee

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### Candidate Evaluation Committee

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AGENDA
REFERENCE COMMITTEE ON FINANCIAL AND ORGANIZATIONAL AFFAIRS
Friday, May 5, 2017
Marriott Marquis, Level 2, Houston Ballroom 1

1. Presidents Report 1 – Nominations for Board of Governors, Texas Medical Liability Trust
2. Speakers Report 1 – TMA Election Process
3. Board of Trustees Report 11 – Texas Two Step
4. Board of Trustees Report 12 – Continuation of International Medical Graduate Section
5. Board of Trustees Report 13 – Policy Review
7. Board of Councilors Report 3 – Resolution 307
8. Board of Councilors Report 4 – Emeritus Nominations
9. Board of Councilors Report 5 – Honorary Nominations
12. Council on Constitution and Bylaws Report 2 – Board of Councilors Quorum and Voting Members
13. Council on Constitution and Bylaws Report 3 – Authority to Take Action Without a Meeting
15. Council on Constitution and Bylaws Report 5 – Proposed Change to the TMA Election Process
17. Physician-Patient Advocacy Committee Report 1 – Policy Review
18. Speaker and Council on Constitution and Bylaws Joint Report 1 – Parliamentary Authority Transition for TMA
19. Committee on Membership and Council on Constitution and Bylaws Joint Report 2 – TMA Bylaws Concerning Retired Member Classification
20. Resolution 101 – Election of TMA Board of Trustees Members (Lone Star Caucus)
21. Resolution 102 – Replacing the Medical Malpractice Litigation System With a “No-Fault” Patients Compensation System (Ori Hampel, MD)
22. Resolution 103 – Texas Medical Board License Renewal Notifications and Payment (Harris County Medical Society)

23. Resolution 104 – Tort Reform Celebration Day (El Paso County Medical Society)

24. Resolution 105 – TMA Outreach to Displaced and Refugee Physicians (Harris County Medical Society)

25. Resolution 106 – Reduced and Alternative Documentation and Administrative Requirements for Medical Documentation for Prescribers in Times of Declared Disasters (Harris County Medical Society)

26. Resolution 107 – Support of Evidence-Based Medicine (Young Physician Section, Resident and Fellow Section, and Medical Student Section)

27. Resolution 108 – Recognition of John R. Holcomb, MD (Bexar County Medical Society)

28. Resolution 109 – Election Results (Angelina County Medical Society)

29. Resolution 110 – Integrating Advance Directives Conversation to Maintain Autonomy (Medical Student Section)

30. Resolution 111 – Addressing Physician Mental Health Status Disclosures (Medical Student Section)

31. Resolution 112 – Commendation of 2017 Texas Two-Step CPR: Save a Life Campaign (Arlo F. Weltge, MD; Michelle A. Berger, MD; Keith A. Bourgeois, MD; Carlos J. Cardenas, MD; Douglas W. Curran, MD; Carrie E. de Moor, MD; Diana L. Fite, MD; David C. Fleeger, MD; Gary F. Floyd, MD; A. Tomas Garcia III, MD; David N. Henkes, MD; Laura Faye Gephart, MD; Dan K. McCoy, MD; Don R. Read, MD; Kayla A. Riggs; Richard W. Snyder II, MD; Susan M. Strate, MD; E. Linda Villarreal, MD)

32. Resolution 113 – HIPAA and Physician Rating Websites (Harris County Medical Society)
The trust instrument that controls the operations of the Texas Medical Liability Trust (TMLT) requires that nominations for its 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.

The following nominations are made by the TMLT Board of Governors to fill two three-year terms beginning in 2016:

- **Mark S. Gonzalez, MD**, McAllen, cardiovascular disease, for reelection to Place 1;
- **Russell B. Krienke, MD**, Austin, family medicine for reelection to Place 2; and
- **Pamela D. Holder, MD**, Houston, pathology, for reelection to Place 3.

**Recommendation:** Approval of Drs. Mark S. Gonzalez, Russell B. Krienke, and Pamela D. Holder, nominees of the TMLT Board of Governors, to be placed before TMLT policyholders for election.
REPORT OF BOARD OF TRUSTEES

BOT Report 11-A-17

Subject: Texas Two Step: Save a Life Campaign 2017

Presented by: Douglas W. Curran, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

In 2016, the TMA Board of Trustees approved TMA’s involvement in the Texas College of Emergency Physicians’ (TCEP) unique community service project to train Texans on how to save lives with hands-on, hands only CPR. The TMA Foundation approved a financial grant for TMA to present to TCEP. Nine Texas medical schools and more than 650 students provided this free CPR training to over 4,200 Texans on Feb. 2 in 10 Texas cities.

Again this year, TMA was a sponsor and the TMA Foundation approved a financial grant for the program which was held on Feb. 11-12 at 42 sites across 14 Texas cities making the “Texas Two Step” what organizers believe to be the largest event of its kind in the U.S.

Seven hundred and fifty medical students representing all 11 Texas medical schools trained over 6,500 Texans in the technique in 2017.

Recommendation: That the Texas Medical Association recognize and congratulate the Texas Two Step CPR Board of Directors and leadership and the Texas medical students for their collaboration and superb success of the annual “Texas Two Step” community service project.
AGENDA
REFERENCE COMMITTEE ON SCIENCE AND PUBLIC HEALTH
Friday, May 5, 2017
Marriott Marquis, Level 2, Houston Ballroom 2

2. Council on Science and Public Health Report 1 – All Hazards Disaster Planning
5. Committee on Child and Adolescent Health Report 1 – Policy Review
6. Committee on Infectious Diseases Report 1 – Policy Review
7. Committee on Reproductive, Women’s, and Perinatal Health Report 1 – Policy Review
8. Committee on Child and Adolescent Health and Committee on Reproductive, Women’s, and Perinatal Health Joint Report 3 – Resolution 310, Prevention of In-Hospital Newborn Falls
10. Committee on Infectious Diseases and Committee on Child and Adolescent Health Joint Report 5 – Preexposure Prophylaxis as HIV Prevention
11. Resolution 301 – Creating a Statewide Crisis Standards-of-Care Framework (Dallas County Medical Society)
12. Resolution 302 – Palliative Care (Larry Driver, MD)
13. Resolution 303 – Sudden Increase in Liability Claims for Wernicke’s Encephalopathy in Bariatric Surgery Patients (Harris County Medical Society)
14. Resolution 304 – Rejection of Discrimination (Young Physician Section, Resident and Fellow Section, and Medical Student Section)
15. Resolution 305 – Addressing the Diaper Gap (Medical Student Section)
16. Resolution 306 – Addressing the Need for Improved Water Supply Quality in Texas (Medical Student Section)
17. Resolution 307 – Reducing Errors in Pharmacy (Lubbock-Crosby-Garza County Medical Society)
18. Resolution 308 – Expansion of Next Generation 911 (Medical Student Section)
19. Resolution 309 – Addressing the Medical Inaccuracies of the Mandated “A Woman’s Right to Know” Booklet and Related Patient Information (Medical Student Section)
20. Resolution 310 – Healthy Food in Hospitals (Medical Student Section)
21. Resolution 311 – Addressing Access to Maternal Personal Protective Equipment from Radiation (Medical Student Section)

22. Resolution 312 – Implementing a Sugar-Sweetened Beverage Tax in Texas (Medical Student Section)

23. Resolution 313 – Improved Concussion Protocol to Reduce Psychological Morbidity in High School Athletes (Medical Student Section)

24. Resolution 314 – Promoting Increased Awareness and Research for Grade School Soccer-Related Head Injury (Medical Student Section)

25. Resolution 315 – Addressing the Expanding Habitats of Vectors of Infectious Disease (Medical Student Section)

26. Resolution 316 – Addressing Transgender Public Facility Use (Medical Student Section)

27. Resolution 317 – Precision Medicine in Refractory Cancer Treatment and Transparency in Compendia Used for Providing Coverage for Off-Label Cancer Drug Usage (Medical Student Section)

28. Resolution 318 – Access to Special Education Services (Medical Student Section)

29. Resolution 319 – Identification and Prevention of Adolescent Substance Abuse (Webb-Zapata-Jim Hogg County Medical Society)

30. Resolution 320 – Vitamin D3 Supplementation (Webb-Zapata-Jim Hogg County Medical Society)

31. Resolution 321 – Promoting Safe and Effective Disposal of Unused Medications (Webb-Zapata-Jim Hogg County Medical Society)
Subject: Addressing the Expanding Habitats of Vectors of Infectious Disease

Introduced by: Medical Student Section

Referred to: Reference Committee on Science and Public Health

RESOLVED, That the Texas Medical Association promote awareness for physicians and patients on infectious disease vectors, including the factors that affect the presence of vectors and disease; and be it further

RESOLVED, That TMA work with like-minded organizations and individuals to support legislation regarding both the study of the expanding habitats of the Aedes aegypti and Culex mosquitoes, as well as the preparation for and prevention of the spread of the Zika and West Nile Viruses.
Relevant 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).

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 (CPH, p 125A, I-96; amended CPH Rep. 2-A-09; amended CSPH Rep. 3-A-13).

Relevant AMA Policy:

H-135.938 Global Climate Change and Human Health
Our AMA:
1. Supports the findings of the Intergovernmental Panel on Climate Change's fourth assessment report and concurs with the scientific consensus that the Earth is undergoing adverse global climate change and that anthropogenic contributions are significant. These climate changes will create conditions that affect public health, with disproportionate impacts on vulnerable populations, including children, the elderly, and the poor.
2. Supports educating the medical community on the potential adverse public health effects of global climate change and incorporating the health implications of climate change into the spectrum of medical education, including topics such as population displacement, heat waves and drought, flooding, infectious and vector-borne diseases, and potable water supplies.
3. (a) Recognizes the importance of physician involvement in policymaking at the state, national, and global level and supports efforts to search for novel, comprehensive, and economically sensitive approaches to mitigating climate change to protect the health of the public; and (b) recognizes that whatever the etiology of global climate change, policymakers should work to reduce human contributions to such changes.
4. Encourages physicians to assist in educating patients and the public on environmentally sustainable practices, and to serve as role models for promoting environmental sustainability.
5. Encourages physicians to work with local and state health departments to strengthen the public health infrastructure to ensure that the global health effects of climate change can be anticipated and responded to more efficiently, and that the AMA's Center for Public Health Preparedness and Disaster Response assist in this effort.

Enhanced Zika Virus Public Health Action - Now D-440.930
1. Our AMA urges Congress to enact legislation, without further delay, to provide increased and sufficient funding for research, prevention, control, and treatment of illnesses associated with the Zika
virus, commensurate with the public health emergency that the virus poses, without diverting resources from other essential health initiatives.

2. Our AMA will work with experts in all relevant disciplines, and convene expert workgroups when appropriate, to help develop needed United States and global strategies and limit the spread and impact of this virus.

3. Our AMA will consider collaboration with other educational and promotional entities (e.g., the AMA Alliance) to promote family-directed and community-directed strategies that minimize the transmission of Zika virus to potentially pregnant women.

Next Generation Infectious Disease Diagnostics H 440.834

1. Our AMA supports strong federal efforts to stimulate early research and development of emerging rapid ID (infectious disease) diagnostic technologies through increased funding for appropriate agencies.

2. Our AMA supports the reduction of regulatory barriers to allow for safe and effective emerging rapid diagnostic tests, particularly those that address unmet medical needs, to more rapidly reach laboratories for use in patient care.

3. Our AMA supports improving the clinical integration of new diagnostic technologies into patient care through outcomes research that demonstrates the impact of diagnostics on patient care and outcomes, educational programs and clinical practice guidelines for health care providers on the appropriate use of diagnostics, and integration of diagnostic tests results into electronic medical records.

4. Our AMA supports efforts to overcome reimbursement barriers to ensure coverage of the cost of emerging diagnostics.

References:


5. Center for Disease Control and Prevention. (2017). Zika Virus Case Counts in the US. Atlanta, GA.

6. Texas Department of State Health Services Infectious Disease Control Unit Zoonosis Control Branch. (2017) Zika in Texas. Austin, TX.


Subject: Promoting Safe and Effective Disposal of Unused Medications

Introduced by: Webb-Zapata-Jim Hogg County Medical Society

Referred to: Reference Committee on Science and Public Health

Whereas, Patients increasingly are forced to fill their medications at three-months intervals by the health insurance companies/pharmacy benefit managers/third-party payers; and

Whereas, Patients and/or family members are burdened with the disposal of unused/excessive medications and possibly disposing of the medications into the garbage, which can contaminate landfills; and

Whereas, Patients and/or family members are burdened with the disposal of unused/excessive medications and possibly flushing the medications into the household drains, which can contaminate water supplies; and

Whereas, Extra unused medications can lead to diversion of certain harmful drugs to family members and others; and

Whereas, Senate Bill 1757 (81st legislature) authorized the Texas Commission on Environmental Quality to conduct a study regarding methods for disposing of unused pharmaceutical products to prevent contamination of our state water systems, and it recommended a statewide education effort for consumers, physicians, and health care providers on proper disposal of unused pharmaceuticals; and

Whereas, Certain communities in Texas may have established drop-off sites, but they are not well known or targeted to the elderly or widely publicized to the public; and

Whereas, Strategies that encourage or require manufacturers to manage their products’ waste, or extended producer responsibility policies have been implemented throughout the country, focusing on products including computers and other electronic waste; and

Whereas, These extended producer responsibility policies have begun to be applied to pharmaceuticals, such as in a recent ordinance, passed in Contra Costa County, Calif., whereby “[d]rug makers will be required to establish drop-off centers and to pay the full cost of establishing and operating a network of centers to accept unwanted, unused, or expired medications”; and

Whereas, This is a national public health issue that pertains not only to Texas; therefore be it

RESOLVED, That the Texas Medical Association work to educate physicians, other health professionals, patients, family members, and the public about the safe and effective disposal of nonprescription/prescription medications; and be it further

RESOLVED
RESOLVED, That TMA promote local county medical societies partnering with qualified and safe drop-off sites and encouraging local physicians to disseminate the information in their office to patients; and be it further

RESOLVED, That patients receive written disposal information at the point of purchase or in the boxes of medications sent via a third party to the patients; and be it further

RESOLVED, That TMA work to encourage pharmaceutical firms to take full responsibility in addressing this issue of taking back unused, expired, and unwanted nonprescription/prescription medications and paying for proper and safe disposal of the medications; and be it further

RESOLVED, That the Texas Delegation to the American Medical Association takes this resolution to the AMA House of Delegates for consideration.

Relevant TMA Policy:

95.040 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 (not complete policy; CSPH and TF-BH Joint Rep. 1-A-15)

Relevant AMA Policy:

H-135.936 Proper Disposal of Unused Prescription and Over-the-Counter (OTC) Drugs:

1. Our AMA supports initiatives designed to promote and facilitate the safe and appropriate disposal of unused medications.

2. Our AMA will work with other national organizations and associations to inform, encourage, support and guide hospitals, clinics, retail pharmacies, and narcotic treatment programs in modifying their US Drug Enforcement Administration registrations to become authorized medication collectors and operate collection receptacles at their registered locations.

3. Our AMA will work with other appropriate organizations to develop a voluntary mechanism to accept non-controlled medication for appropriate disposal or recycling.
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Late Items

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At General Information Tab:
Add Memorial List to the end of the tab.

At Agendas Tab:
Replace Order of Business with “Revised, Distributed at Meeting” Order of Business.

At Informational Reports Tab:
Replace first page list of “Informational Reports” with “Revised, Distributed at Meeting” list; and

At Financial and Organizational Affairs Tab:
Replace “Revised” agenda with “Revised, Distributed at Meeting” agenda; and
Remove BOC Report 3-A-17 (this report is now referred to the Reference Committee on Science and Public Health); and
Replace BOC Report 4-A-17 with “Revised, Distributed at Meeting” Report 4-A-17; and
Remove Resolution 102-A-17 (this resolution is now Resolution 415-A-17); and
Replace Resolution 105-A-17 with, “Revised, Distributed at Meeting” Resolution 105-A-17.

At Medical Education Tab:
Replace “Revised” agenda with “Revised, Distributed at Meeting” agenda; and

At Science and Public Health Tab:
Replace “Revised” agenda with “Revised, Distributed at Meeting” agenda; and

At Socioeconomics Tab:
Replace “Revised” agenda with “Revised, Distributed at Meeting” agenda; and
Add CSE and SC-MCU Joint Report 6-A-17 after CSE Report 7; and
Add Resolution 414-A-17 after Resolution 413-A-17; and
Add Resolution 415-A-17 to the end of the tab.
MEMORIAL LIST
March 16, 2016 – May 1, 2017

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Jacobo Lastrache, MD, Corpus Christi
Charles A. LeMaistre, MD, San Antonio
Robert L. Leon, MD, Austin
Raymond Eugene Liverman, DO, Arlington
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TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES
ORDER OF BUSINESS
2017 ANNUAL SESSION
May 5-6, 2017

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

REPORTS:

1. Report of President
   1. Nominations for Board of Governors, Texas Medical Liability Trust

2. Report of Speakers
   1. TMA Election Process

3. Reports of Board of Trustees
   1. 2016-17 Board Officers and Committees
   2. Disclosure of Affiliations
   3. TMA Collaboration
   4. TMAIT, TMFHQI, and TMLT
   5. TMA Leadership College
   6. Medical Student and Resident Physician Loan Funds
   7. Minority Scholarship Program
   8. Audit of 2015 Financial Statements and 2016-17 Operating Budgets
   9. Investments
   10. Pending Lawsuits Involving TMA
   11. Texas Two Step
   12. Continuation of International Medical Graduate Section
   13. Policy Review

4. Report of Executive Vice President
   1. 2016-17 Update

5. Report of Interspecialty Society Committee (no report)

6. Reports of Committee on Membership
   1. Membership Development
   2. Policy Review

7. Reports of Board of Councilors
   1. Distinguished Service Award — Robert T. Gunby Jr., MD
   2. Bell CMS Bylaws
   3. Resolution 307-A-16
   4. Emeritus Nominations
   5. Honorary Nominations
   6. Policy Review

8. Reports of Committee on Physician Health and Wellness
   1. 2017 Goals; PHR Assistance Fund; Drug Screen Program
   2. Continuing Medical Education Programs

REFERRED TO:

FOA
Informational
SPH
3. Treatment Facilities; Medical Student and Resident Activities
4. Policy Review

9. **Reports of Texas Delegation to the AMA**
   1. AMA House of Delegates Meetings in 2016
   2. AMA Membership, Representation, and Delegation Leadership

10. **Report of International Medical Graduate Section** (no report)

11. **Reports of Medical Student, Resident and Fellow, and Young Physician Sections** (no report)

12. **Reports of Council on Constitution and Bylaws**
    1. Improving TMA Committee Sunset Review Process
    2. Board of Councilors Quorum and Voting Members
    3. Authority to Take Action Without a Meeting
    4. Membership in a Contiguous Society
    5. Proposed Change to the TMA Election Process

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


15. **Report of Council on Health Service Organizations** (no report)

    1. Policy Review

17. **Reports of Council on Medical Education**
    1. Referral of PHW Report 2, Mental Illness
    2. Referral of CME Report 3-A-16, Curriculum Mandates
    3. Support for Exceptions to Medicare GME Cap-Setting Deadlines
    4. Rural Training Tracks
    5. Need for Continued Expansion of GME Capacity
    7. Policy Review

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

19. **Reports of Committee on Physician Distribution and Health Care Access**
    1. Long-Range State Health Care Workforce Study
    2. Enhancements to State Physician Education Loan Repayment Program
    3. Policy Review


    1. All Hazards Disaster Planning
    2. Parental Leave
    3. Policy Review

22. **Report of Committee on Cancer** (no report)
23. Report of Committee on Child and Adolescent Health
   1. Policy Review

24. Report of Committee on Emergency Medical Services and Trauma (no report)

25. Report of Committee on Infectious Diseases
   1. Policy Review

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

27. Reports of Council on Socioeconomics
   1. Delay the Implementation of Downside Risk in Alternative Payment Models
   2. Increasing Use of Narrow Networks by Medicare Advantage Plans
   3. Prescription Drug Price Negotiation
   4. Prescription Drug Value Based Contracting
   5. High-Risk Pool Policy
   6. MACRA Update
   7. Policy Review

28. Report of Medical Home and Primary Care Committee (no report)

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

30. Report of Committee on Rural Health (no report)

31. Report of Select Committee on Medicaid, CHIP, and the Uninsured
   1. Report on Resolution 107-A-16

32. Joint Reports
   1. Parliamentary Authority Transition for TMA
   2. TMA Bylaws Concerning Retired Member Classification
   3. Resolution 310-A-16 Prevention of In-Hospital Newborn Falls
   4. Resolution 311-A-16 Sexual Orientation Change Efforts in Minors
   5. Preexposure Prophylaxis as HIV Prevention
   6. Federal Medicaid Reform and Implications for Texas

33. Report of TEXPAC
   1. 2017-18 TEXPAC Board of Directors

34. Report of Texas Medical Association Insurance Trust
   1. TMAIT 2016 Annual Report

35. Report of TMF Health Quality Institute
   1. TMFHQI 2016 Annual Report

36. Report of Texas Medical Association Foundation
   1. TMA Foundation 2016 Annual Report

37. Report of Texas Medical Association Alliance
   1. Alliance Activities and Accomplishments
RESOLUTIONS:

101. Election of TMA Board of Trustees Members
    Lone Star Caucus
    FOA

103. Texas Medical Board License Renewal Notifications and Payment
    Harris County Medical Society
    FOA

104. Tort Reform Celebration Day
    El Paso County Medical Society
    FOA

105. TMA Outreach to Displaced and Refugee Physicians
    Harris County Medical Society
    FOA

106. Reduced and Alternative Documentation and Administrative Requirements for
    Medical Documentation for Prescribers in Times of Declared Disasters
    Harris County Medical Society
    FOA

107. Support of Evidence-Based Medicine
    Young Physician Section, Resident and Fellow Section, and
    Medical Student Section
    FOA

108. Recognition of John R. Holcomb, MD
    Bexar County Medical Society
    FOA

109. Election Results
    Angelina County Medical Society
    FOA

110. Integrating Advance Directives Conversation to Maintain Autonomy
    Medical Student Section
    FOA

111. Addressing Physician Mental Health Status Disclosures
    Medical Student Section
    FOA

112. Commendation of 2017 Texas Two-Step CPR: Save a Life Campaign
    Arlo F. Welte, MD, Harris County Medical Society
    Carlos J. Cardenas, MD, Hidalgo-Starr County Medical Society
    Douglas W. Curran, MD, Henderson County Medical Society
    Diana L. Fite, MD, Harris County Medical Society
    A. Tomas Garcia III, MD, Harris County Medical Society
    Keith A. Bourgeois, MD, Harris County Medical Society
    Kayla A. Riggs, Medical Student Section
    Carrie E. de Moor, MD, Collin-Fannin County Medical Society
    Laura Faye Gephart, MD, Bell County Medical Society
    Don R. Read, MD, Dallas County Medical Society
    Richard W. Snyder II, MD, Dallas County Medical Society
    E. Linda Villarreal, MD, Hidalgo-Starr County Medical Society
    David C. Fleeger, MD, Travis County Medical Society
    Michelle A. Berger, MD, Travis County Medical Society
    Dan K. McCoy, MD, Bexar County Medical Society
    Gary F. Floyd, MD, Tarrant County Medical Society
    David N. Henkes, MD, Bexar County Medical Society
    Susan M. Strate, MD, Wichita-Archer-Baylor-Clay-Knox County Medical Society
    FOA

113. HIPAA and Physician Rating Websites
    Harris County Medical Society
    FOA

201. Inclusion of Advocacy Education in Medical School Curricula
    Harris County Medical Society
    ME

202. Medical School Clinical Skills Exams
    Medical Student Section
    ME

203. Resolving the Impact of Travel and Immigration Bans on Health Care Provision
    Medical Student Section
    ME

301. Creating a Statewide Crisis Standards-of-Care Framework
    Dallas County Medical Society
    SPH
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406. Transparency and Payments for Prior Authorizations  
      Harris County Medical Society  
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407. Medicaid Block Grants Per Capita Caps  
      Ben G. Raimer, MD, FAAP, Texas Pediatric Society  
      Kimberly M. Carter, MD, Texas Association of Obstetricians and Gynecologists  
      Troy T. Fiesinger, MD, Texas Academy of Family Physicians  
      SOCIO

408. Compensation of Physicians for Authorizations and Preauthorizations  
      Ori Hampel, MD  
      SOCIO

409. Medicaid Payments for Speech Therapy, Physical Therapy, and Occupational Therapy  
      Medical Student Section  
      SOCIO

410. Public- and Private-Sector Funding of Interpretation Services for Limited English Speakers and American Sign Language  
      Medical Student Section  
      SOCIO

411. Clearer Language Regarding the Physician’s Role in Providing Auxiliary Aid for Effective Communication Under Current Federal Laws  
      Medical Student Section  
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412. Preference of Medicaid Funding Proposals  
      Harris County Medical Society  
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413. Addressing Zika Through Increasing Medicaid Coverage of Insect Repellent  
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414. Regulations Regarding Freestanding Emergency Care Facilities  
      Evans Smith, MD  
      SOCIO

415. Replacing the Medical Malpractice Litigation System With a “No-Fault” Patients’ Compensation System  
      Ori Hampel, MD (formerly Resolution 102)  
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TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES
2017 Annual Session
INFORMATIONAL REPORTS

Reports of Board of Trustees
1. 2016-17 Board Officers and Committees
2. Disclosure of Affiliations
3. TMA Collaboration
4. TMAIT, TMFHQI, and TMLT
5. TMA Leadership College
6. Medical Student and Resident Physician Loan Funds
7. Minority Scholarship Program
8. Audit of 2015 Financial Statements and 2016-17 Operating Budgets
9. Investments
10. Pending Lawsuits Involving TMA

Report of Executive Vice President
1. 2016-17 Update

Report of Committee on Membership
1. Membership Development

Reports of Board of Councilors
1. Distinguished Service Award — Robert T. Gunby Jr., MD
2. Bell CMS Bylaws

Reports of Committee on Physician Health and Wellness
1. 2017 Goals; PHR Assistance Fund; Drug Screen Program
2. Continuing Medical Education Programs
3. Treatment Facilities; Medical Student and Resident Activities

Reports of Texas Delegation to the AMA
1. AMA House of Delegates Meetings in 2016
2. AMA Membership, Representation, and Delegation Leadership

Report of Council on Constitution and Bylaws
1. Improving TMA Committee Sunset Review Process

Report of Council on Health Care Quality
1. Quality Update

Report of Council on Medical Education
1. Referral of PHW Report 2-A-16, Mental Illness

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

Report of Council on Socioeconomics
1. Delay the Implementation of Downside Risk in Alternative Payment Models

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

Report of Select Committee on Medicaid, CHIP, and the Uninsured
1. Report on Resolution 107-A-16

Report of TEXPAC
1. 2017-18 TEXPAC Board of Directors

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1. TMAIT 2016 Annual Report

Report of TMF Health Quality Institute
1. TMFHQI 2016 Annual Report

Report of Texas Medical Association Foundation
1. TMA Foundation 2016 Annual Report

Report of Texas Medical Association Alliance
1. TMA Alliance Activities and Accomplishments
REPORT OF COUNCIL ON CONSITUTION AND BYLAWS

CCB Report 1-A-17

Subject: Improving TMA Committee Sunset Review Process

Presented by: Mark A. Casanova, MD, Chair

Background

At the 2016 Winter Conference, the Board of Trustees approved a report detailing the findings and recommendations of the Board of Trustees (BOT) Task Force on TMA Committee Sunset Review Process. The task force’s report was in response to Resolution 106-A-15, TMA Sunset Review of Councils, Committees, and Sections, which was referred to the board for study.

Upon review and deliberation of the issues raised in Resolution 106-A-15, the board discerned the need for greater collaboration of all parties involved in and affected by sunset recommendations. The board further recognized the importance of transparency of criteria and inclusive communication of process prior to sunset recommendations coming before the House of Delegates. These observations largely comprise the five recommendations issued in the BOT Task Force Report, which are as follows:

1. That, as part of their appointment, council and committee members be provided with annual objectives and goals and how they align with TMA’s overall strategic efforts;
2. That criteria for sunset review align with TMA strategic goals and objectives and that the criteria be communicated to councils and committees in a transparent and efficient manner at the beginning of each year with ongoing collaboration with the Board of Trustees as the year progresses;
3. That sunset review be accomplished as reasonably and efficiently as possible and that for any major change (discharge, reorganization), the Board of Trustees actively participate and collaborate with all affected councils or committees and, if necessary, seek external member input prior to forwarding recommendations to the House of Delegates;
4. That TMA provide (1) an orientation of council and committee chairs as to their roles and the association’s organizational structure; and (2) a mechanism for better communication between council chairs and the Board of Trustees and between council chairs with each other; and
5. That the Council on Constitution and Bylaws be asked to consider issues identified in this report in light of options for alternatives to standing committees such as use of subcommittees to allow organizational effectiveness and efficiency.

Implementation Plan

While these recommendations contain some novel concepts, they are in general alignment with efforts the board and other TMA components already have initiated or are in the process of undertaking. TMA’s Council on Constitution and Bylaws has found that, as a supplement to TMA Bylaws, parliamentary procedure provides a good deal of direction concerning the functions of committees, subcommittees, and special groups. The council has recommended adoption of the new American Institute of Parliamentarians Standard Code of Parliamentary Procedure (AIP) to ensure TMA is following the most up-to-date parliamentary procedures.

The council recommends the following action plan in conjunction with the adoption of AIP and its principles concerning committee operations. Together, these activities will serve to further promote and enhance the clarity and effectiveness of the committee sunset review process.
1. Production of two council and committee orientation online videos — one for chairs and one for members — that new council or committee appointees can view any time. These orientation videos would clearly describe the functions and work products expected of TMA councils and committees, as well as other general requirements including attendance. Further, the orientation videos could discuss the TMA governance process and the process of committee sunset review.

2. Creation of a simple, one-page overview of TMA’s committee sunset process, to be included in committee meeting packets on an annual basis. This process would lay out ongoing goals for all committees, as well as describe the Board of Trustees’ role in assisting with sunset review.

3. Implementation of a standard sunset review form that allows the committee to indicate which TMA 2020 goal(s) it supports, how it has fulfilled its purpose over the review period, and whether the committee has met its attendance requirements as provided for in the bylaws. The parent council will review these forms and produce recommendations for committee continuance or sunset.

4. Special review by the BOT of council recommendations involving sunset of a committee. The board will consult with others as needed, including council and committee chairs, when considering a recommendation for sunset.
AGENDA
REFERENCE COMMITTEE ON FINANCIAL AND ORGANIZATIONAL AFFAIRS
Friday, May 5, 2017
Marriott Marquis, Level 2, Houston Ballroom 1

1. *Presidents Report 1 – Nominations for Board of Governors, Texas Medical Liability Trust*
2. Speakers Report 1 – TMA Election Process
3. *Board of Trustees Report 11 – Texas Two Step*
4. Board of Trustees Report 12 – Continuation of International Medical Graduate Section
5. Board of Trustees Report 13 – Policy Review
7. *Board of Councilors Report 4 – Emeritus Nominations*
8. Board of Councilors Report 5 – Honorary Nominations
11. Council on Constitution and Bylaws Report 2 – Board of Councilors Quorum and Voting Members
12. Council on Constitution and Bylaws Report 3 – Authority to Take Action Without a Meeting
17. Speaker and Council on Constitution and Bylaws Joint Report 1 – Parliamentary Authority Transition for TMA
18. Committee on Membership and Council on Constitution and Bylaws Joint Report 2 – TMA Bylaws Concerning Retired Member Classification
19. Resolution 101 – Election of TMA Board of Trustees Members (Lone Star Caucus)
20. Resolution 103 – Texas Medical Board License Renewal Notifications and Payment (Harris County Medical Society)
21. Resolution 104 – Tort Reform Celebration Day (El Paso County Medical Society)

22. Resolution 105 – TMA Outreach to Displaced and Refugee Physicians (Harris County Medical Society)

23. Resolution 106 – Reduced and Alternative Documentation and Administrative Requirements for Medical Documentation for Prescribers in Times of Declared Disasters (Harris County Medical Society)

24. Resolution 107 – Support of Evidence-Based Medicine (Young Physician Section, Resident and Fellow Section, and Medical Student Section)

25. Resolution 108 – Recognition of John R. Holcomb, MD (Bexar County Medical Society)

26. Resolution 109 – Election Results (Angelina County Medical Society)

27. Resolution 110 – Integrating Advance Directives Conversation to Maintain Autonomy (Medical Student Section)

28. Resolution 111 – Addressing Physician Mental Health Status Disclosures (Medical Student Section)

29. Resolution 112 – Commendation of 2017 Texas Two-Step CPR: Save a Life Campaign (Arlo F. Weltge, MD; Michelle A. Berger, MD; Keith A. Bourgeois, MD; Carlos J. Cardenas, MD; Douglas W. Curran, MD; Carrie E. de Moor, MD; Diana L. Fite, MD; David C. Fleeger, MD; Gary F. Floyd, MD; A. Tomas Garcia III, MD; David N. Henkes, MD; Laura Faye Gephart, MD; Dan K. McCoy, MD; Don R. Read, MD; Kayla A. Riggs; Richard W. Snyder II, MD; Susan M. Strate, MD; E. Linda Villarreal, MD)

30. Resolution 113 – HIPAA and Physician Rating Websites (Harris County Medical Society)

Note:
Resolution 102 was referred to the Reference Committee on Socioeconomics and is now Resolution 415.
REPORT OF BOARD OF COUNCILORS

Subject: Emeritus Nominations

Presented by: Dan L. Locker, MD, Chair

Referred to: Reference Committee on Financial and Organizational Affairs

The House of Delegates, upon nomination by the county medical society (CMS) 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 nominations of Alan C. Baum, MD, Donald R. Butts, MD, and Thomas Coopwood, MD, for emeritus membership and recommends their election by the House of Delegates. A brief sketch follows for Dr. Baum, Dr. Butts, and Dr. Coopwood.

Alan C. Baum, MD (Harris CMS)
Dr. Baum received his medical degree from the University of Texas Medical Branch in Galveston where he was awarded the Ashbel Smith Distinguished Alumnus Award in 1999. He has been a member of Harris County Medical Society and TMA for 45 years.

Dr. Baum has served as Chairman of the Board of Trustees and as President of TMA. He is a former President of the Texas Ophthalmology Association. He has served as Chief of Staff at Memorial Southeast Hospital and has been the Ophthalmology Section Chairman at both the Memorial Southeast and Southwest Hospitals.

Donald R. Butts, MD (Harris CMS)
Dr. Butts received his medical degree from The University of Texas Medical School at Galveston. He has been a member of Harris County Medical Society, TMA, and the American Medical Association for 47 years.

Dr. Butts received his board certification from the American Board of Colon and Rectal Surgery in 1972. He has served as President of Harris CMS and its delegate to TMA, and as chief medical staff of Houston Northwest Medical Center. At TMA, he served on the Cancer, Patient-Physician Advocacy, and Membership committees and is a member of TMA’s 50 Year Club. He served on the Harris CMS Board of Medical Legislation and Council of Specialty Societies, and on the board of the Houston Academy of Medicine and Texas Medical Liability Trust. Also, he lobbied in Washington, DC for Tort Reform.

Thomas Coopwood, MD (Travis CMS)
Dr. Coopwood received his medical degree from Balor College of Medicine. He has been a member of TMA for 37 years. He has been a member of the Travis County Medical Society for 33 years. Previously he was a member of Harris County Medical Society.

Dr. Coopwood has served as President of the Travis CMS and on its Mediation, Nominating, and ED/EMS Advisory committees, and on its ad hoc committee for Wrong Site Wrong Procedure and Trauma Coverage, serving as chair of the latter. He also represented Travis CMS on the boards of the Central Texas Medical Foundation and the Blood and Tissue Center of Central Texas.

Recommendation: That the House of Delegates elect Alan C. Baum, MD, Donald R. Butts, MD, and Thomas Coopwood, MD, to emeritus membership in the Texas Medical Association.
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 105
A-17

Subject: TMA Outreach to Displaced and Refugee Physicians

Introduced by: Harris County Medical Society

Referred to: Reference Committee on Financial and Organizational Affairs

Whereas, The practice of medicine is both a science and an art, requiring advanced learning, years of practice, and high ethical principles; and

Whereas, Civil instability, wars, disruption in the economy, and a variety of other causes can force physicians in other countries voluntarily or involuntarily to leave their homes, their practices, their patients, and their families; and

Whereas, Displaced and refugee physicians from other countries are multilingual, highly productive, dedicated to helping society, and often trained in diseases not frequently seen in the United States; and

Whereas, Displaced and refugee physicians from other countries have lost a part of their identity, are cut off from professional connections and relationships, and have few resources to access the path to reestablishing their medical profession; and

Whereas, The British Medical Association recognizes the value displaced and refugee physicians can make to the delivery of health care services and has established a program to connect with, and provide support for, these physicians through professional medical associations; and

Whereas, The Texas Medical Association is the largest state medical association, in one of the most ethnically diverse and dynamic states in the United States; and

Whereas, Our association can benefit by offering displaced and refugee physicians the opportunity to connect with fellow physicians, supporting their efforts to reestablish their professional roles, and encouraging them in their journey to become Texas physicians and, ultimately, TMA members; and

Whereas, TMA currently has the International Medical Graduate Section, but this is open only to foreign medical graduates currently licensed to practice in Texas; therefore be it

RESOLVED, That the Texas Medical Association study the number of current displaced and refugee physicians in Texas; the role and impact TMA might offer to support and connect them with Texas colleagues; and the potential impact these individuals, as future TMA members, might have on the organization; and report back to the House of Delegates; and be it further

RESOLVED, That, if this study appears to be of benefit to TMA for residents of Texas who are displaced and refugee physicians, TMA consider moving this matter forward to the American Medical Association.

Fiscal Note: >$20,000
Relevant 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).

**245.010 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 original or geographic location of medical school (Amended Res. 301-I-99; amended BOC Rep. 6-A-09).

Relevant AMA Policy:

**Retraining Refugee Physicians H-200.950**

Our AMA supports federal programs, and funding for such programs, that assist refugee physicians who wish to enter the US physician workforce, especially in specialties experiencing shortages and in underserved geographical areas in the US and its territories. Policy Timeline: BOT Rep. 20, A-10

**AMA Principles on International Medical Graduates H-255.988**

Our AMA supports (only relevant policy included):

10. That special consideration be given to the limited number of IMGs who are refugees from foreign governments that refuse to provide pertinent information usually required to establish eligibility for residency training or licensure.

15. The participation of all physicians, including graduates of foreign as well as U.S. and Canadian medical schools, in organized medicine. The AMA offers encouragement and assistance to state, county, and specialty medical societies in fostering greater membership among IMGs and their participation in leadership positions at all levels of organized medicine, including AMA committees and councils and state boards of medicine, by providing guidelines and non-financial incentives, such as recognition for outstanding achievements by either individuals or organizations in promoting leadership among IMGs.

16. Support studying the feasibility of conducting peer-to-peer membership recruitment efforts aimed at IMGs who are not AMA members.

17. AMA membership outreach to IMGs, to include a) using its existing publications to highlight policies and activities of interest to IMGs, stressing the common concerns of all physicians; b) publicizing its many relevant resources to all physicians, especially to nonmember IMGs; c) identifying and publicizing AMA resources to respond to inquiries from IMGs; and d) expansion of its efforts to prepare and disseminate information about requirements for admission to accredited residency programs, the availability of positions, and the problems of becoming licensed and entering full and unrestricted medical practice in the U.S. that face IMGs. This information should be addressed to college students, high school and college advisors, and students in foreign medical schools.

18. Recognition of the common aims and goals of all physicians, particularly those practicing in the U.S., and support for including all physicians who are permanent residents of the U.S. in the mainstream of American medicine.

19. Its leadership role to promote the international exchange of medical knowledge as well as cultural understanding between the U.S. and other nations.

21. Informing foreign national IMGs that the availability of training and practice opportunities in the U.S. is limited by the availability of fiscal and human resources to maintain the quality of medical education and patient care in the U.S., and that those IMGs who plan to return to their country of origin have the opportunity to obtain GME in the United States.

24. The Federation of State Medical Boards, its member boards, and the ECFMG in their willingness to adjust their administrative procedures in processing IMG applications so that original documents do not have to be recertified in home countries when physicians apply for licenses in a second state.

References
- The British Medical Association has a program for health professionals:
- The Refugee Council (United Kingdom) has a link for health professionals:
  www.refugeecouncil.org.uk/what_we_do/refugee_services/refugees_into_jobs/refugee_health_professionals/services_and_links_for_refugee_professionals
AGENDA
REFERENCE COMMITTEE ON MEDICAL EDUCATION
Friday, May 5, 2017
Marriott Marquis, Level 2, Liberty


2. Council on Medical Education Report 3 – Support for Exceptions to Medicare GME Cap-Setting Deadlines in Underserved Areas


4. Council on Medical Education Report 5 – Need for Continued Expansion of Graduate Medical Education Capacity


7. Committee on Physician Distribution and Health Care Access Report 1 – Long-Range State Health Care Workforce Study

8. Committee on Physician Distribution and Health Care Access Report 2 – Enhancements to State Physician Education Loan Repayment Program


10. Resolution 201 – Inclusion of Advocacy Education in Medical School Curricula (Harris County Medical Society)

11. Resolution 202 – Medical School Clinical Skills Exams (Medical Student Section)

12. Resolution 203 – Resolving the Impact of Travel and Immigration Bans on Health Care Provision (Medical Student Section)
This proposal is in recognition of the critically important role of general surgeons in meeting health care needs. Surgeons augment the highly important role of primary care physicians. In rural areas, surgeons largely serve the needs of elderly Texans which prevents the need for elderly Texans to travel to urban centers for these services. Non-residents of rural areas can also potentially benefit from reasonable access to surgeons when urgent and emergency care is needed as a result of events such as car accidents for those traveling through rural areas.

3. Restoring Loan Repayment for Non-Primary Care Physicians Serving Medicaid/CHIP, and the Healthy Texas Women’s Program

The Coordinating Board predicts repayment monies will not be available in FY 2018-19 for physicians who are not located in HPSAs who provide services to Texans eligible for Medicaid or the Healthy Texas Women’s Program. The Texas Medicaid program faces serious challenges in recruiting and retaining physicians and loan repayment is a valuable incentive for addressing the challenge. TMA has policy in support of increases in Medicaid physician fees, however, achieving this goal in the next biennium will be unlikely given the state’s predicted budget challenges. It is important to be able to offer loan repayment to attract and retain physicians in the Medicaid program.

Under a provision adopted as part of the FREW lawsuit settlement, loan repayment was available to physicians in non-primary care specialties and subspecialties who participated in Medicaid. This ended in 2011. Specialist participation in Medicaid is an ongoing challenge in many areas of the state. For example, at this time there are reports of shortages of psychiatry, neurology, and gastroenterology. The ability to offer loan repayment can be a valuable tool in recruiting specialists to the Medicaid and CHIP programs. The committee believes it is important to restore these expanded loan repayment provisions.

To better manage the competition for available loan repayment monies that may result from this proposed expansion in eligibility, the expansion could focus on specialties with the highest level of shortages in the Medicaid program. It would be critically important for the Coordinating Board to continue collaborating with the Texas Health and Human Services Commission in identifying these specialties, possibly on an annual basis or as loan repayment funds become available.

TMA recommends physicians receiving loan repayment under this provision be required to contract with one or more Medicaid managed care plans in their community (90 percent of Medicaid enrollees are enrolled in managed care so to reach the population, physicians would need to join at least one HMO network), as appropriate, and also meet the threshold for serving a defined number of Medicaid and CHIP enrollees, or clients of the Healthy Texas Women’s Program, as applicable to the physician’s specialty.

The Texas Higher Education Coordinating Board should work with the Texas Health and Human Services Commission, TMA, and appropriate state medical specialty societies in defining the Medicaid-related loan repayment requirements. This is to include annual updates to the defined targets for the number of clients served by physicians receiving loan repayment and for setting eligibility priorities for physician specialties with the greatest shortages in the Medicaid program.

**Recommendation 1:** Adopt the following as TMA policy on Enhancing the State’s Physician Education Loan Repayment Program:

TMA urges expansion of the State Physician Education Loan Repayment Program to increase the number of physicians receiving repayment from 100 to 150 per year, beginning in State Fiscal Year 2018.

TMA supports expanding the first priority for eligible applicants for the State Physician Education Loan Repayment Program to include general surgeons practicing in primary care Health Professional Shortage
Areas (HPSAs). In addition to primary care physicians, general surgeons provide core medical services that are critical to the viability of hospitals.

TMA supports an expansion of the Medicaid-related eligibility provision in the State Physician Education Loan Repayment Program to include primary care physicians and physicians practicing in critically needed non-primary care specialties and subspecialties. This is for the purposes of improving access to physician services for Texans eligible for Medicaid, CHIP, and the Healthy Texas Women’s Program.

Amendment of TMA policy 205.021 is recommended because the number of repayments was reduced from five to four. This would bring the policy in line with current program operations:

205.021 **State Loan Repayment Program:** Recognizing the effectiveness of the State Physician Education Loan Repayment Program in recruiting and retaining physicians in underserved areas of the state, TMA supports increased state funding for this program to allow the state to maximize federal matching dollars, to maintain the five four-year escalating repayment levels as a retention aid for underserved areas, and to allow for annual growth in the number of physicians receiving loan repayment (CME Rep. 5-I-00).

Proposed changes to the title of 205.002 would better reflect the policy statement:

205.002 **Support for Federal Match for State Loan Repayment Program Student Loan Funds Repayment:** TMA recognizes the value of federal matching funds to the Texas Physician Education Loan Repayment Program in recruiting and retaining physicians for underserved areas of the state and supports the continued availability of federal matching funds (Supplemental Council on Medical Education, p 123, A-90; amended CME Rep. 5-I-00; reaffirmed CME Rep. 2-A-10).

Policy 185.017 remains relevant but is in need of updating in (1) and (2) to reflect the loan repayment program’s current procedures:

185.017 **Addressing the Threat to Primary Care in Texas:** TMA advocates the following to help alleviate the shortage of primary care physicians in Texas:

1. TMA should continue to **monitor** the impact of physician education loan repayment in the state, including repayment amounts that better correspond to current debt levels, which now average $131,000. Input from graduating medical students, residents, and practicing physicians should be considered in developing the new defining repayment levels.

2. Annual loan repayment amounts should be increased for each year a physician practices in an underserved community, within a defined cap, such as **five four years**.

3. Strong consideration should be given to expanding the state loan repayment program to include medical specialties experiencing shortages in addition to primary care.

4. Consideration should be given to offering higher repayment amounts for physicians who practice in areas of greatest need, including areas with longstanding physician shortages.

5. Reaffirmation of TMA Policy 185.013 that “encourages Texas medical schools with rural missions to periodically evaluate their student admission criteria to ensure that the most appropriate criteria are utilized for identifying students most likely to select careers in rural
AGENDA
REFERENCE COMMITTEE ON SCIENCE AND PUBLIC HEALTH
Friday, May 5, 2017
Marriott Marquis, Level 2, Houston Ballroom 2

2. Council on Science and Public Health Report 1 – All Hazards Disaster Planning
5. Committee on Child and Adolescent Health Report 1 – Policy Review
6. Committee on Infectious Diseases Report 1 – Policy Review
7. Committee on Reproductive, Women’s, and Perinatal Health Report 1 – Policy Review
8. Committee on Child and Adolescent Health and Committee on Reproductive, Women’s, and Perinatal Health Joint Report 3 – Resolution 310, Prevention of In-Hospital Newborn Falls
10. Committee on Infectious Diseases and Committee on Child and Adolescent Health Joint Report 5 – Preexposure Prophylaxis as HIV Prevention
11. Board of Councilors Report 3 – Resolution 307-A-16, Gender and Sex Options on Medical Paperwork (referral change from Reference Committee on Financial and Organizational Affairs)
12. Resolution 301 – Creating a Statewide Crisis Standards-of-Care Framework (Dallas County Medical Society)
13. Resolution 302 – Palliative Care (Larry Driver, MD)
14. Resolution 303 – Sudden Increase in Liability Claims for Wernicke’s Encephalopathy in Bariatric Surgery Patients (Harris County Medical Society)
15. Resolution 304 – Rejection of Discrimination (Young Physician Section, Resident and Fellow Section, and Medical Student Section)
16. Resolution 305 – Addressing the Diaper Gap (Medical Student Section)
17. Resolution 306 – Addressing the Need for Improved Water Supply Quality in Texas (Medical Student Section)
18. Resolution 307 – Reducing Errors in Pharmacy (Lubbock-Crosby-Garza County Medical Society)
19. Resolution 308 – Expansion of Next Generation 911 (Medical Student Section)
20. Resolution 309 – Addressing the Medical Inaccuracies of the Mandated “A Woman’s Right to Know” Booklet and Related Patient Information (Medical Student Section)

21. Resolution 310 – Healthy Food in Hospitals (Medical Student Section)

22. Resolution 311 – Addressing Access to Maternal Personal Protective Equipment from Radiation (Medical Student Section)

23. Resolution 312 – Implementing a Sugar-Sweetened Beverage Tax in Texas (Medical Student Section)

24. Resolution 313 – Improved Concussion Protocol to Reduce Psychological Morbidity in High School Athletes (Medical Student Section)

25. Resolution 314 – Promoting Increased Awareness and Research for Grade School Soccer-Related Head Injury (Medical Student Section)

26. Resolution 315 – Addressing the Expanding Habitats of Vectors of Infectious Disease (Medical Student Section)

27. Resolution 316 – Addressing Transgender Public Facility Use (Medical Student Section)

28. Resolution 317 – Precision Medicine in Refractory Cancer Treatment and Transparency in Compendia Used for Providing Coverage for Off-Label Cancer Drug Usage (Medical Student Section)

29. Resolution 318 – Access to Special Education Services (Medical Student Section)

30. Resolution 319 – Identification and Prevention of Adolescent Substance Abuse (Webb-Zapata-Jim Hogg County Medical Society)

31. Resolution 320 – Vitamin D3 Supplementation (Webb-Zapata-Jim Hogg County Medical Society)

32. Resolution 321 – Promoting Safe and Effective Disposal of Unused Medications (Webb-Zapata-Jim Hogg County Medical Society)
Subject: Resolution 307-A-16, Gender and Sex Options on Medical Paperwork

Presented by: Dan L. Locker, MD, Chair

Referred to: Reference Committee on Science and Public Health

Background
At TexMed 2016, the Medical Student Section filed Resolution 307 relating to gender and sex options on medical paperwork. The resolution states that (1) adding more gender and sex options to patient paperwork will prevent medical errors by encouraging more complete patient disclosure, (2) accurate gender information will help physicians screen for gender and lifestyle-specific disease, and (3) the lack of data on nonbinary gender identities in health care limits the performance of quality health care research on these criteria.

The resolution asks that the Texas Medical Association (1) recognize the importance of delineating gender identities in patients to promote the delivery of thorough medical care and support the addition of gender and sex options on patients’ medical records, and (2) support patient data collection inclusive of nonbinary gender identities, as it will allow for relevant medical research.

The House of Delegates referred the resolution to the Reference Committee on Science and Public Health. The reference committee heard largely supportive testimony; however, members raised concerns regarding the scope of the policy and whether the recommendations should be expanded to address related issues, including how physician offices can ensure an inclusive and welcoming environment for patients. The resolution ultimately was referred and later assigned to the TMA Board of Councilors.

Discussion
TMA currently does not have any policy in this area. The American Medical Association has no direct policy but maintains several policies concerning gender identity, sexual orientation, and human rights. The Board of Councilors reviewed and discussed the resolution and accompanying documents. Members were supportive of the recommendations in the resolution. The board moved that TMA should adopt policy on gender and sex identity to improve quality of care and increase medical research in this area.

Conclusion
The Board of Councilors discussed the importance of gender and sex identity information being part of medical records and recommends the following:

**Recommendation:** That the Council on Science and Public Health develop policy on the topic of patient gender and sex identity for consideration by the House of Delegates at the 2018 annual session.

**Related TMA Policy:** None

**Related AMA Policy:**
AMA Policy H-65.976 Nondiscriminatory Policy for the Health Care Needs of LGBT Populations
Our AMA encourages physician practices, medical schools, hospitals, and clinics to broaden any nondiscriminatory statement made to patients, health care workers, or employees to include “sexual orientation, sex, or gender identity” in any nondiscrimination statement. (Res. 414, A-04; Modified: BOT Rep. 11, A-07; Modified: Res. 08, A-16).

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. (CSA Rep. C, I-81; Reaffirmed: CLRPD Rep. F, I-9; 1 CSA Rep. 8 - I-94; Appended: Res. 506, A-00; Modified and Reaffirmed: Res. 501, A-07; Modified: CSAPH Rep. 9, A-08; Reaffirmation A-12; Modified: Res. 08, A-16).

AMA Policy H-65.965 Support of Human Rights and Freedom

Our AMA: (1) continues to support the dignity of the individual, human rights and the sanctity of human life, (2) reaffirms its longstanding policy that there is no basis for the denial to any human being of equal rights, privileges, and responsibilities commensurate with his or her individual capabilities and ethical character because of an individual’s sex, sexual orientation, gender, gender identity, or transgender status, race, religion, disability, ethnic origin, national origin, or age; (3) opposes any discrimination based on an individual’s sex, sexual orientation, gender identity, race, religion, disability, ethnic origin, national origin or age and any other such reprehensible policies; (4) recognizes that hate crimes pose a significant threat to the public health and social welfare of the citizens of the United States, urges expedient passage of appropriate hate
crimes prevention legislation in accordance with our AMA’s policy through letters to members of Congress; and registers support for hate crimes prevention legislation, via letter, to the President of the United States. (CCB/CLRDP Rep. 3, A-14).

AMA Policy H-65.967 Conforming Birth Certificate Policies to Current Medical Standards for Transgender Patients

1. Our AMA supports policies that allow for a change of sex designation on birth certificates for transgender individuals based upon verification by a physician (MD or DO) that the individual has undergone gender transition according to applicable medical standards of care.

2. Our AMA: (a) supports elimination of any requirement that individuals undergo gender affirmation surgery in order to change their sex designation on birth certificates and supports modernizing state vital statistics statutes to ensure accurate gender markers on birth certificates; and (b) supports that any change of sex designation on an individual’s birth certificate not hinder access to medically appropriate preventive care. (Res. 4, A-13; Appended: BOT Rep. 26, A-14).

AMA Policy H-185.950 Removing Financial Barriers to Care for Transgender Patients

Our AMA supports public and private health insurance coverage for treatment of gender dysphoria as recommended by the patient’s physician. (Res. 122 A-08; Modified: Res. 05, A-16).

AMA Policy H-525.988 Sex and Gender Differences in Medical Research

Our AMA: (1) reaffirms that gender exclusion in broad medical studies questions the validity of the studies’ impact on the health care of society at large;

(2) affirms the need to include both genders in studies that involve the health of society at large and publicize its policies;

(3) supports increased funding into areas of women’s health research;

(4) supports increased research on women’s health and participation of women in clinical trials, the results of which will permit development of evidence-based prevention and treatment strategies for all women from diverse cultural and ethnic groups, geographic locations, and socioeconomic status; and

(5) recommends that all medical/scientific journal editors require, where appropriate, a sex-based analysis of data, even if such comparisons are negative. (Res. 80, A-91; Appended: CSA Rep. 4, I-00; Modified: CSAPH Rep. 1, A-10; Reaffirmed: CSAPH Rep. 05, A-16).

AMA Policy H-185.927 Clarification of Medical Necessity for Treatment of Gender Dysphoria

Our AMA: (1) recognizes that medical and surgical treatments for gender dysphoria, as determined by shared decision making between the patient and physician, are medically necessary as outlined by generally-accepted standards of medical and surgical practice; and (2) will advocate for federal, state, and local policies to provide medically necessary care for gender dysphoria. (Res. 05, A-16).

AMA Policy H-295.878 Eliminating Health Disparities - Promoting Awareness and Education of Lesbian, Gay, Bisexual, and Transgender (LGBT) 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, and Transgender 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 LGBT 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 LGBT patients. (Res. 323, A-05; Modified in lieu of Res. 906, I-10;  
Reaffirmation A-11; Reaffirmation A-12; Reaffirmation A-16).

AMA Policy D-65.996 Nondiscriminatory Policy for the Health Care Needs of LGBT  
Populations
Our AMA will encourage and work with state medical societies to provide a sample printed  
nondiscrimination policy suitable for framing, and encourage individual physicians to display for  
patient and staff awareness-as one example: “This office appreciates the diversity of human  
beings and does not discriminate based on race, age, religion, ability, marital status, sexual  
orientation, sex, or gender identity.” (Res. 414, A-04; Modified: BOT Rep. 11, A-07; Modified:  
Res. 08, A-16).

AMA Policy H-180.980 Sexual Orientation and/or Gender Identity as Health Insurance  
Criteria
The AMA opposes the denial of health insurance on the basis of sexual orientation or gender  
AGENDA
REFERENCE COMMITTEE ON SOCIOECONOMICS
Friday, May 5, 2017
Marriott Marquis, Level 2, Houston Ballroom 3

2. Council on Socioeconomics Report 3 – Prescription Drug Price Negotiation
3. Council on Socioeconomics Report 4 – Prescription Drug Value Based Contracting
5. Council on Socioeconomics Report 6 – MACRA Update
7. Council on Socioeconomics and Select Committee on Medicaid, CHIP, and the Uninsured Joint Report 6 – Federal Medicaid Reform and Implications for Texas
8. Resolution 401 – Opposition to Capped Federal Medicaid Funding (Bexar County Medical Society)
9. Resolution 402 – Proposed Change in Medicaid Funding (Concho Valley County Medical Society)
10. Resolution 403 – Supporting Community-Based Health Care Delivery Models for Vulnerable Patients (Dallas County Medical Society)
11. Resolution 404 – Allowing Exceptions to the Centers for Medicare & Medicaid Services’ Locum Tenens 60-Day Limit (Harris County Medical Society)
12. Resolution 405 – Minimum Standards for Interstate Sale of Health Insurance Products (Harris County Medical Society)
13. Resolution 406 – Transparency and Payments for Prior Authorizations (Harris County Medical Society)
14. Resolution 407 – Medicaid Block Grants Per Capita Caps (Ben G. Rainer, MD, FAAP, Texas Pediatric Society; Kimberly M. Carter, MD, Texas Association of Obstetricians and Gynecologists; Troy T. Fiesinger, MD, Texas Academy of Family Physicians)
15. Resolution 408 – Compensation of Physicians for Authorizations and Preauthorizations (Ori Hampel, MD)
16. Resolution 409 – Medicaid Payments for Speech Therapy, Physical Therapy, and Occupational Therapy (Medical Student Section)
17. Resolution 410 – Public- and Private-Sector Funding of Interpretation Services for Limited English Speakers and American Sign Language (Medical Student Section)
18. Resolution 411 – Clearer Language Regarding the Physician’s Role in Providing Auxiliary Aid for Effective Communication Under Current Federal Laws (Medical Student Section)

19. Resolution 412 – Preference of Medicaid Funding Proposals (Harris County Medical Society)

20. Resolution 413 – Addressing Zika Through Increasing Medicaid Coverage of Insect Repellent (Medical Student Section)

21. Resolution 414 – Regulations Regarding Freestanding Emergency Care Facilities (Evans Smith, MD)

22. Resolution 415 - Replacing the Medical Malpractice Litigation System With a “No-Fault” Patients’ Compensation System (Ori Hampel, MD)
Background

On March 6, 2017, House Speaker Paul Ryan introduced the American Health Care Act to repeal and replace the Affordable Care Act. By March 24, the bill was dead, pulled down without a House vote due to insufficient support. Despite its quick death, efforts to revive the legislation continue, with congressional leaders vowing to reconsider AHCA — or its successor — in May. Though the legislation will undergo some revision to accommodate dissenters’ concerns, it undoubtedly will have significant implications for Texas’ health care delivery system, particularly its safety net. Provisions in the bill would not only terminate enhanced Medicaid funding for states to use to expand health insurance coverage to low-income patients but also upend the programs’ entire financing and benefit structures, ending a 50-year commitment of guaranteed funding and minimum benefits for poor and low-income patients. (The AHCA also would have substantial implications for the commercial health insurance market, but this report focuses only on the Medicaid provisions).

While the AHCA contains numerous Medicaid provisions, of particular concern are two:

1) Eliminating the 90 percent federal matching rate for Medicaid expansion. As a result of the Affordable Care Act, states have the option to expand Medicaid coverage for parents and childless adults up to 138 percent of federal poverty using either the state’s current Medicaid delivery system or a state-designed model that enrolls patients in private health insurance or mimics key elements of the private sector. To date, 31 states have done so, including more than a half-dozen Republican led ones. Texas has not. The AHCA forecloses the option.

2) Eliminating Medicaid’s guaranteed, open-ended financing mechanism, replacing it with one of two capped federal funding options — a per-capita cap or block grant — in exchange for granting states greater flexibility to determine Medicaid benefits, services, and payments. However, through Medicaid waivers, states already have considerable latitude to reshape Medicaid. This provision is inarguably the most alarming since it would mean Texas receiving less money for doing what it already does.

Texas physicians strongly support prudent reforms to simplify Medicaid administrative requirements for physicians, patients, and the state as well as ongoing, thoughtful efforts to curtail costs. Like all payers, Medicaid costs are rising, and limited state tax dollars must be diligently managed. But Medicaid costs are driven primarily by caseload growth, not per-person expenditures. Texas is the fastest growing state in the country. Enactment of capped funding would tie the state’s hands, not only preventing it from
enacting broader coverage but also limiting its ability to address current health care disparities and inequities, including inadequate Medicaid physician payments.

**Medicaid Basics: Current Texas Medicaid Financing, Eligibility and Coverage**

- **Financing**
  
  Under current federal law, Medicaid is financed jointly by the states and the federal government. Minimally, states receive a 50/50 match. The U.S. Department of Health and Human Services sets matching rates annually based, in part, on a state’s economic health relative to other states. For fiscal year 2018, Texas’ federal matching rate will be 56.88 percent, meaning for every dollar spent by Texas Medicaid nearly 57 percent of the costs will be paid by the federal government. In 2015, Texas received $21.4 billion in federal Medicaid matching funds for Texas’ $14.8 billion in state spending.

  Historically, Texas’ matching rate has fluctuated between 58 percent and 60 percent, but if Medicaid spending increases due to a recession, natural disaster, public health emergency, or new medical or pharmaceutical innovations that intensify Medicaid spending, the federal government guarantees to match it so long as the state complies with federal minimum eligibility and benefit standards. According to the Kaiser Family Foundation, during the 2008-2011 recession, Texas’ unemployed rate soared to 8.4 percent, resulting in 475,900 more people enrolling in Medicaid. Federal matching funds grew to accommodate the new enrollees. Under a block grant formula, a state’s federal Medicaid allotment would not change, regardless of any pressures to serve more patients.

  Texas receives supplemental Medicaid funding via hospital disproportionate share funds (DSH) and the 1115 Medicaid Transformation Waiver. Under the latter, local taxing authorities – mostly hospital districts but also rural and border counties – provide the state’s share of matching funds to draw down additional federal funds. Under Texas’ current Medicaid 1115 waiver, which began in 2011 and has been extended at least through the end of this year, Texas receives more than $3 billion per year in additional federal dollars to offset hospital uncompensated care and to fund innovative projects at the community-level to expand access to and quality of services for Medicaid and uninsured patients. While the waiver has drawbacks, including inadequate community physician input and participation, without it many safety-net providers would cease to operate or limit their services. Late last year, HHSC submitted a letter to the Centers for Medicare and Medicaid Services requesting a 21-month waiver extension, which would provide additional dollars through Sept. 30, 2019 if approved.

- **Eligibility**
  
  Federal law establishes mandatory Medicaid populations — children, pregnant women, poor parents, patients with disabilities, and seniors — and the minimum eligibility levels for each. For each mandatory population, states have the option to expand coverage above the federal minimum. Texas Medicaid eligibility adheres strictly to the federal minimum standards for all populations except two: pregnant women/newborns and patients needing long-term care services.
More than 4 million Texans currently obtain health care coverage via Medicaid, 67 percent of whom are children. Indeed, Medicaid plays a vital role in children’s coverage. Some forty percent of all Texas children are insured via the program, including all children in foster care.

Medicaid provides children benefits tailored to their particular needs. Through a provision in federal law known as the Early Periodic Diagnosis Screening and Treatment (EPSDT) Act, states must provide children all medically necessary services, including preventive, primary, and specialty physician services, behavioral health, hospital care, and dental and vision services. EPSDT also ensures children with special health care needs receive necessary ancillary services, such as durable medical equipment, physical,
speech, and occupational therapy, and community-based long-term care, making Medicaid the single largest provider of services for children with disabilities.

Medicaid is the largest payer of maternity care. It pays for 52 percent of all Texas births, though that number is substantially higher in rural, urban, and border communities. Additionally, the program serves as a critical stakeholder in improving birth outcomes, pushing quality improvement measures to reduce rates of prematurity and low-birth weight babies, as well as promoting early entry prenatal care.

According to the Medicaid and CHIP Payment Advisory Commission, Medicaid is the single largest payer for behavioral health services in the U.S., covering everything from autism spectrum disorders to severe and persistent mental illness to dementia. Among adults enrolled in Medicaid (excluding dually eligible patients), almost half of those who enroll on the basis of a disability have a mental illness. For children in foster care, these services are particularly important since children with a history of physical or mental trauma often need more intensive behavioral health interventions.

For seniors, Medicaid is vitally important, covering not only long-term care services and supports but also Medicare cost-sharing for those poor enough to qualify for both Medicaid and Medicare. Seventy percent of nursing home care is paid by Medicaid. Medicaid also pays for less expensive community-based services to help keep seniors and people with disabilities in their homes instead of institutions.

From a population health perspective, Medicaid plays a critical role, funding vaccines for children, championing initiatives to promote better birth outcomes, and screening eligible patients for a wide range of infectious diseases, including Zika and tuberculosis, that could harm the general public if left undetected and untreated.

At the same time, contrary to popular opinion, being poor does not necessarily qualify a person for Medicaid. Patients must meet Medicaid income and categorical coverage requirements. Very few low-income parents actually qualify. For example, women qualify for Medicaid while pregnant and for two-months postpartum, but after that time, they no longer qualify for coverage unless their income is at or below 15 percent of poverty, the eligibility rate for Texas parents. Parents earning more than $3,200 annually are not eligible. (Only Alabama has lower income level eligibility rate for parents — 13 percent of poverty). In addition to income and categorical requirements, patients must be Texas residents and U.S. citizens, though for emergency services, including labor and delivery, undocumented immigrants are eligible so long as they meet all other Medicaid eligibility requirements.

**AHCA Medicaid Reform Provisions**

The AHCA contains two broad provisions designed to fundamentally restructure Medicaid:

1) **Eliminate the 90 percent federal matching funds for states to pursue Medicaid expansion.**

As a result of the Affordable Care Act, states have the option to expand Medicaid coverage for parents and childless adults up to 138 percent of federal poverty ($16,587 for a single adult) using either a state’s current Medicaid delivery system or a state-designed model that enrolls patients in private health insurance or mimics key elements of the private sector. To date, 31 states have expanded coverage, including a dozen Republican led ones. Texas has not. The AHCA forecloses the option.

An estimated 1 million uninsured, working-age Texans would potentially gain coverage via Medicaid expansion. **In 2013, the TMA House of Delegates adopted policy 190.032 Medicaid**
Coverage and Reform encouraging state legislative leaders to draw down all available federal funding to expand access to health care for poor Texans.

If enacted, the AHCA would eliminate the enhanced federal matching funds to expand Medicaid. Instead, it would create a $10 billion safety-net pool apportioned among the 19 non-expansion states over five years based on each state’s low-income population. Texas’ estimated portion would be $500 million annually to be shared among physicians and providers. Under current law, if Texas expanded Medicaid coverage in accordance with TMA policy, the federal government would pay 90 percent of the costs from 2020 on resulting in up to $10 billion annually for the state. That is a 20-fold differential. (The ACA provided states 100-percent federal funding for Medicaid expansion from 2014-2016, gradually tapering down to down to 90 percent by 2020 on).

2) Eliminate Medicaid’s guaranteed, open-ended financing mechanism, replacing it with one of two capped federal funding options: a per-capita cap or block grant.

As described above, capped federal funding would give states a fixed annual sum plus a nominal growth factor, such as general or medical inflation, but less than estimated cost growth over a 10-year period. For both a block grant and per-capita cap, a state’s allotment would be based on its historical level of spending. In the case of the AHCA, each state’s base allotment would be built on 2016 expenditures. This means Texas’ previous decisions to fund — or not fund — services or benefits would be locked into its base funding formula as would low physician payment rates. Texas physician payments stopped receiving annual inflation updates in 1993. Since then, rates have mostly stagnated or declined, with the exception of rate increases for children’s preventive care and a temporary Medicaid to Medicare parity adjustment for select primary care physician services in 2013 and 2014 funded by the Affordable Care Act.

Even though the per-capita grant would grow with population, neither a block grant nor per-capita cap would adjust if the state’s costs increased due to changes in medical costs from new technology or pharmaceutical innovations or due to a public health emergency or catastrophic event. Had capped funding been in place in 2015 when new Hepatitis C drugs were approved by the FDA, the cost of the new drugs would not be reflected in Texas’ federal matching funds just as a capped funding formula would not be adjusted to reflect higher-than-anticipated Zika-related expenditures for prenatal laboratory testing, neonatal intensive care services, or follow up services.

Summary of major AHCA Medicaid provisions:

- Reduce Medicaid federal funding by an estimated $880 billion over ten years, approximately 25 percent less than projected under current law (source: Congressional Budget Office; AHCA as filed); Conservatively, Texas’ share of the reduction would total $15 billion (source: Urban Institute)
- Beginning in 2020, for each of five patient categories — children, blind and disabled, elderly, other adults (including pregnant women and poor parents), and expansion adults — states would receive a fixed per capita cap (PCC) amount based on the state’s average per person spending amount in 2016 trended forward to 2019 by medical Consumer Price Index. Certain expenditures and populations would be outside the adjusted per-capita cap, including vaccines for children, women with breast or cervical cancer services, and dual eligible. The per-capita cap funding level would increase annually based on the medical Consumer Price Index but less than the Congressional Budget Office’s projected Medicaid growth projections, shifting the higher costs to the states.
• The per-capita cap formula accounts for caseload growth, but not for other unexpected Medicaid costs, including an infectious disease outbreak such as Zika or other public health emergency, such as the opioid addiction crisis, the advent of new, costly life changing medical interventions or medications, including those to treat Hepatitis C or muscular dystrophy, a surge in demand following a natural disaster, or new medical technology, such as telemedicine.

• The proposed bill bases Medicaid capped funding on 2016 expenditures trended forward to 2019 using medical CPI. Effectively, this will lock in perpetuity Texas’ low rates of physician payments, including the cuts enacted in 2012 for dual eligible cost sharing and in 2015 for children’s services because Texas will not be able gain matching dollars for new investments in payments or services.

• If a state’s Medicaid expenditures exceed its per-capita cap target amount within a fiscal year, then it will have its payments reduced in the following fiscal year by the amount of the excess payments.

• Eliminates scheduled cuts in hospital disproportionate share (DSH) funds to mitigate increases in the number of uninsured; however, it remained unclear whether the bill’s base-level funding formula fully accounted for supplemental Medicaid funds, including Texas’ 1115 Medicaid transformation waiver, and how such funding would trend forward.

• A last minute manager’s amendment provided states the option to establish a block grant for children, pregnant women, or both, with an annual growth factor pegged to the consumer price index +1. States selecting the option would be locked into that decision through 2020. As previously noted, Texas’ Medicaid costs are driven primarily by caseload, not per-person costs, so the purchasing power of a 10-year block grant without caseload growth would quickly erode, leaving Texas with unpalatable choices to make up the difference — either increasing state spending or making reductions in services, eligibility, and/or physician payments. To entice states to adopt the block grant, the bill would reduce state contributions to obtain the federal funds for this population, resulting in even a deeper funding cut for the block grant population. Other populations would be subject to per-capita caps.

• Under the block grant option, minimum federal eligibility and benefit standards would be eliminated, including EPSDT protections for children.

The following table summarizes the key differences among the current Medicaid funding system, block grants, and the per-capita cap.

<table>
<thead>
<tr>
<th>Current Medicaid Funding</th>
<th>Block Grants</th>
<th>Per-Capita Cap</th>
</tr>
</thead>
<tbody>
<tr>
<td>Federal Funding</td>
<td>Open ended</td>
<td>Aggregate cap</td>
</tr>
</tbody>
</table>
### Current Medicaid Funding vs Block Grants vs Per-Capita Cap

<table>
<thead>
<tr>
<th></th>
<th>Current Medicaid Funding</th>
<th>Block Grants</th>
<th>Per-Capita Cap</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Risk</strong></td>
<td>Federal government and state share enrollment and spending risk</td>
<td>States bear risk of both higher enrollment and health care costs</td>
<td>States bears spending risk of higher health care costs</td>
</tr>
<tr>
<td><strong>Annual Trend</strong></td>
<td>Determined by health care costs in the state and individual state spending decisions</td>
<td>National trend rate</td>
<td>National trend rate</td>
</tr>
<tr>
<td><strong>Ability to Accommodate Increase Costs due to Medical Advances or Public Health Crises</strong></td>
<td>Federal payments automatically increase as state costs rise</td>
<td>Federal payments fixed – no additional funding for public health emergencies or new medical technology</td>
<td>Federal payments fixed – no additional funding for public health emergencies or new medical technology</td>
</tr>
<tr>
<td><strong>Spending Higher than Cap</strong></td>
<td>N/A</td>
<td>States responsible for higher than anticipated costs, including caseload growth</td>
<td>Provides additional funding for caseload but spending higher than cap responsibility of state; if state outspends annual spending limit, federal funds reduced following year</td>
</tr>
<tr>
<td><strong>State Flexibility</strong></td>
<td>States must adhere to federal minimum standards, but Section 1115 waivers provide additional flexibility and innovation</td>
<td>Increased flexibility; unknown whether minimum federal standards will apply. Flexibility must be achieved within the funding level</td>
<td>Increased flexibility, but could set some minimal standards and accountability</td>
</tr>
<tr>
<td><strong>Benefits</strong></td>
<td>Federal minimum standards, including special protections for children via EPSDT</td>
<td>Likely no federal minimum standards; benefits and services determined by the state</td>
<td>Unclear whether states will continue to be required to adhere to federal minimum benefits</td>
</tr>
<tr>
<td>Current Medicaid Funding</td>
<td>Block Grants</td>
<td>Per-Capita Cap</td>
<td></td>
</tr>
<tr>
<td>--------------------------</td>
<td>--------------</td>
<td>----------------</td>
<td></td>
</tr>
<tr>
<td>Physician Payments</td>
<td>Federal standards regarding access, but rates determined by state; increased funding for payments will be matched by federal funds</td>
<td>Rates determined by state; if rates increased after state’s base allotment is determined, higher costs not included in block grant base</td>
<td>Rates determined by state; if rates increased after state’s base allotment is determined, higher costs not included in block grant base</td>
</tr>
<tr>
<td>Supplemental Funding</td>
<td>Funded via Medicaid 1115 waivers</td>
<td>Appears to be funded in base funding</td>
<td>Appears to be funded in base funding</td>
</tr>
</tbody>
</table>

Source: Manatt Health, TMA

Without a doubt, capped Medicaid funding will have enormous implications for patients, physicians, providers — and the state. According to the Kaiser Family Foundation, if a Medicaid per-capita cap funding formula had been in place from 2000-2011 and per-enrollee growth had been limited to the Consumer Price Index-Medical — the same growth factor envisioned by the AHCA — federal funding would have been $128 billion (7 percent) less nationally, costing Texas $13 billion (11 percent) in federal funds. Of Texas’ losses, $9.9 billion (24 percent) would have come from the child-enrollee group.
Texas is grappling with formidable health issues. Cuts in federal funding will hamper our ability to respond. Beyond continuing to be the nation’s uninsured capital, 21 percent of Texas children live in poverty, a known risk factor for short- and long-term behavioral and physical health disorders; 34 percent of adults are considered obese, contributing to high rates of chronic health conditions, including diabetes and heart disease; and opioid addictions continue to escalate. Alarmingly, Texas also has one of the highest rates of maternal mortality and morbidity, doubling from 18 per 100,000 births to 36 per 100,000 births from 2010 to 2012. While the factors contributing to maternal death and illness are complex and varied, lack of access to care in the 12 months following delivery is one of them. Without coverage, women with chronic conditions, such as hypertension, diabetes, or perinatal depression, often go without care, with results to match. If Texas were to draw down the federal funds to enhance coverage, it could devise a benefit package to ensure women at risk of postpartum mortality or complications receive the services they need.

If history provides a guide, capped federal funding will not grow over the decade but decline. A 2016 analysis conducted by the national Center on Budget and Policy Priorities of 13 federal housing, health, and social policy block grants found that funding for 11 of the 13, including the Temporary Assistance to Needy Families (TANF), failed to keep pace with inflation and dropped significantly over time. According to the study, the median funding change was a decline of about 26 percent. For four of the block grants, funding plunged by significantly more than half.
Additionally, according to an Urban Institute analysis, a 2012 House Medicaid block grant proposal would have cut Texas Medicaid funding by 32 percent over 10 years. For Texas to avoid steep enrollment cuts, it would have needed to increase spending by 46 percent to 78 percent. Nationally, the same analysis found that over 10 years, 14 million Americans would have lost coverage and provider payments (primarily among hospitals and nursing homes) would have declined some 30 percent. While the AHCA provisions are not identical, the analysis of the 2012 legislation is instructive because as of this writing, the Congressional Budget Office had not published state-by-state analyses of the AHCA.

It also should be noted that without the Medicaid entitlement, federal funding would be appropriated annually, forcing states to lobby Congress every year to retain their federal commitment, much like physicians were forced to do each year for more than a decade to prevent SGR-triggered Medicare payment cuts.

While the capped funding discussion often gets discussed in the same context as repeal of Medicaid expansion, a per-capita cap or block grant, as envisioned by the AHCA, would apply to all Medicaid enrollees – the current federally mandated populations (low-income pregnant women, parents, children, patients with disabilities and seniors) as well as higher income enrollees eligible for ACA Medicaid expansion. A block grant would end guaranteed Medicaid coverage for the poorest Texans, with the likely impact being a large increase in Texans without coverage and a concomitant increase in uncompensated care for physicians and hospitals.

Undoubtedly, Medicaid has its limitations, beginning with too many paperwork headaches and too little payment. But Medicaid is the keystone to Texas’ safety net system. Funding cuts to the program

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**Changes in Overall Funding for Housing, Health, and Human Services Block Grants**

<table>
<thead>
<tr>
<th>Year</th>
<th>Adjusted for inflation</th>
<th>Adjusted for inflation and population growth</th>
<th>Adjusted for growth in gross domestic product</th>
</tr>
</thead>
<tbody>
<tr>
<td>2000</td>
<td>-5%</td>
<td>-10%</td>
<td>-15%</td>
</tr>
<tr>
<td>2005</td>
<td>-10%</td>
<td>-20%</td>
<td>-25%</td>
</tr>
<tr>
<td>2010</td>
<td>0%</td>
<td>5%</td>
<td>10%</td>
</tr>
<tr>
<td>2015</td>
<td>5%</td>
<td>10%</td>
<td>15%</td>
</tr>
<tr>
<td>2020</td>
<td>10%</td>
<td>20%</td>
<td>25%</td>
</tr>
</tbody>
</table>

Source: CBPP based on Office of Management and Budget data. Figures generally reflect obligations, which are the amounts distributed as grants during the year. Inflation adjustments use CPI-U.
will harm not only patients enrolled in the program and physicians who treat them, but also the entire
health care system. Nearly every hospital in Texas receives supplemental Medicaid funding to offset
uncompensated care. Cuts in funding would jeopardize their ability to provide services, including
maternity and trauma services, for all Texans and make it increasingly difficult for remaining
participating physicians and providers to deliver even basic health care services. In some communities,
the loss of funding would shutter hospital doors. **Further, Texas counties are constitutionally required
to provide indigent care. If the federal government shifts costs to the states, Texas will shift costs to
counties, which in turn will increase property taxes and/or reduce services to compensate.**

**Policy Implications and Recommendations**

In January, TMA’s Select Committee on Medicaid, CHIP and the Uninsured held two meetings to discuss
implications of a Medicaid capped-funding formula and how to respond. From those discussions, it
developed key policy questions to ask about any legislation.

**Capped Funding Policy Questions**

- How will the block grant and/or per-capita cap base year be calculated?
- Will new financing include growth for medical inflation as well account for innovations in
- Will the funding be periodically rebased over time?
- Would states be required to continue matching payments to receive federal funds?
- Will supplemental payments, including the state’s 1115 Medicaid waiver funding, be
incorporated into a block grant, limited, or carved out?
- How will the proposal avoid financially penalizing Texas, which already has low per-person costs
as a result of low provider payments and aggressive cost-containment initiatives?
- Will Texas receive additional dollars to account for its Medicaid expansion population?
- Will the block grant or per-capita cap discontinue EPSDT protections for children?
- Will existing federal minimum patient and provider protections remain in place, including
minimum standards for eligibility, benefits, and services?
- Could Texas achieve “flexibility” without a wholesale change in Medicaid financing? What key
issues require additional flexibility? Cost-sharing? Work requirements? Administrative
processes? Other?
- Will the reforms establish minimum federal eligibility and coverage standards, including
maintenance of effort for existing mandatory populations?
- Will a block grant or per-capita cap apply to all Medicaid populations and services or exclude
some? (E.g. carve out nursing homes and long-term care)?
- Will CMS maintain federal minimum standards for Medicaid managed care regarding network
adequacy, benefits, quality improvement, etc.?
- Will states lose funding for emergency Medicaid, which offsets costs of uncompensated care
provided to immigrants ineligible for coverage?
- Will federal rebates for prescription drugs end?
- How will capped funding impact long-term care services, including community-based services?
Would it preclude moving patients from waiting lists?
- Poverty is a key driver of health care costs. Will states with high poverty rates, particularly
among children, receive additional dollars to address social determinants of health?
- Will the funding formula be adjusted to account for Texas’ low physician payment rates and other
funding disparities?
Concurrently, in January, TMA and the Texas Hospital Association formed a joint, 14-person Block
Grant Task Force, chaired by TMA’s Board of Trustees Chair Doug Curran, MD, to develop joint
principles to guide both organizations’ evaluation of federal block grant legislation and to communicate to
Texas’ congressional and state legislative leadership reform priorities for physicians and hospitals. The
task force convened twice, culminating in a letter to Texas’ congressional delegation outlining TMA’s
and THA’s strong concerns about the AHCA’s per-capita cap scheme (see Appendix 1 for letter and task
force roster).

Many state lawmakers argue in favor of capping federal Medicaid funding in exchange for greater
programmatic flexibility. But lawmakers already have tremendous latitude in designing Medicaid,
ranging from the amounts the state pays physicians and providers to services covered by the Medicaid
delivery system. For other issues, such as experimenting with Medicaid cost-sharing or testing innovative
models of care, states can seek federal waivers. Flexibility and capped funding are not inherently linked
— states can pursue greater federal flexibility without upending Medicaid financing by reducing federal
funds. Low-spending states like Texas might find their ability to implement additional services, such as
enhancing opioid addiction treatment, or covering more people, diminished.

If federal strings go away, it is likely the Texas Legislature will push for additional cuts. In 2011, Texas
reduced funding for preventive women’s health services. The result was an increase in Medicaid births
and a significant cost increase to the program far above the savings achieved. In 2015, lawmakers cut
$350 million in Medicaid therapy services, resulting in reduced access to these services for Texans with
disabilities and low-income Medicaid beneficiaries.

Beyond the potential to jeopardize patient care, capped funding likely also would increase
physician uncompensated care substantially. According to the Texas Comptroller and Texas Health
and Human Services Commission, caseload is the primary driver of Medicaid costs, not per-person
spending. Texas legislators have squeezed the program significantly over the past decade. Ninety-two
percent of Medicaid patients are now enrolled in managed care, and physician Medicaid payments
average roughly 73 percent of Medicare’s. Each session, lawmakers squeeze Medicaid even further,
establishing more and more unrealistic cost-containment goals. There really are no additional realistic
options for Texas to curtail costs under a capped-funding scheme except to reduce benefits, eligibility,
and payments.

While the AHCA’s final form is unknown, it is clear that congressional efforts to fundamentally alter
Medicaid will persist. Given the sweeping implications of capped funding for patients, physicians, and
Texas’ health care safety net system, the council and committee recommend a path that would not
irreparably harm the existing system. Instead the focus should be on maintaining uncapped federal
Medicaid funding, preserving minimum Medicaid benefit and eligibility protections for the lowest income
Texans, including EPSDT for children, and pursuing initiatives to expand health care coverage to low-
income Texans using private-sector solutions. Furthermore, TMA also should collaborate with state
legislative leadership to pursue federal reforms to streamline federal administrative processes that impose
undue burdens on patients, physicians, and the state.

Recommendations:

**Recommendation 1:** That TMA vigorously advocate to preserve guaranteed, uncapped federal Medicaid
funding for at least all Texas Medicaid populations covered by the program as of Jan. 1, 2017.
Recommendation 2: That TMA strongly advocate maintaining mandated minimum services, benefits and cost-sharing requirements for pregnant women and children, including protecting the Early Periodic Screening Diagnosis and Treatment (EPSDT) program to ensure Medicaid-enrolled children retain access to all medically necessary services, and maternal health services to promote healthy pregnancies and birth outcomes.

Recommendation 3: That TMA strongly reiterate its support for measures that promote continuity of care and the patient-centered medical home, including maintaining 12-month continuous coverage for children enrolled in the Children’s Health Insurance Program and advocating for the same policy for children’s Medicaid, and preserve measures to simplify and streamline Medicaid and CHIP enrollment processes so that children and other enrollees do not lose coverage due to red-tape and bureaucracy.

Recommendation 4: That TMA reiterate its commitment to implementing a comprehensive initiative to expand health care coverage to low-income Texans using federal funding and private sector solutions.

Recommendation 5: That TMA evaluate the feasibility of piloting a capped Medicaid funding scheme for Medicaid expansion population should Texas implement a coverage option for low-income Texans, so long as the initiative provides patients meaningful coverage as devised by an advisory panel of primary and specialty care physicians and does not increase uncompensated care for physicians.

Recommendation 6: That TMA advocate strongly to stand against any federal or state reform measure that will diminish patient access to services or increase physicians’ uncompensated care.

Recommendation 7: That TMA collaborate with state legislative leadership to seek relief from federal administrative requirements that impose undue costs and paperwork on patients, physicians, and the state without improving patient care or outcomes.
Resolution 414
A-17

Subject: Regulations Regarding Freestanding Emergency Care Facilities

Introduced by: Evans Smith, MD, FAAEM, FACEP

Referred to: Reference Committee on Socioeconomics

Whereas, No certificate of need is required to build an emergency department, and therefore more than 300 freestanding emergency medical care facilities have been built in locations of convenience for the most affluent, leaving hospital emergency departments responsible for the near entirety of the poor and underserved; and

Whereas, Because most freestanding emergency medical care facilities do not participate in Medicare or Medicaid, they are free of the regulations associated with caring for those patients, placing the burden of emergency care for the underinsured and charitable care on community hospital-based emergency departments; and

Whereas, Most freestanding emergency medical care facilities do not accept emergency medical service ambulance traffic, causing patients to be unable to access emergency care, especially during high-volume times when local hospitals are on a divert status; and

Whereas, There is no certification process for freestanding emergency medical care centers through The Joint Commission, whose purpose is to set minimum standards in all emergency departments; therefore be it

Resolved, That the Texas Medical Association encourage and support legislation to level the playing field between hospital-based emergency departments, which serve as the safety net for our communities, and freestanding emergency medical centers, which serve primarily the financial interests of their owners; and be it further

Resolved, That TMA urge legislation to require any facility presenting itself as an emergency department to participate in Medicare and Medicaid with all of their regulatory requirements; and be it further

Resolved, That TMA urge legislation to require that freestanding emergency care facilities not be allowed to deny emergency medical service (ambulance)- patients access to emergency care during times of critical need such as when local hospitals are on a divert status; and be it further

Resolved, That TMA urge the Texas Department of State Health Services to investigate freestanding emergency medical care facilities’ compliance with Title 25, Part 1, Chapter 131, Subchapter C, Rule 131.46 (a) of the Texas Administrative Code regarding the treatment and stabilization of patients without regard to their ability to pay.
Relevant TMA policy:

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).

100.021 Free-standing Emergency Departments: The Texas Medical Association advocates legislation establishing minimum operating criteria and regulatory framework for free-standing emergency departments (FSEDs). At a minimum, the legislation should specify that FSEDs must:

- Have and maintain equipment and supplies suitable for provision of emergency care services, including 1) equipment needed for the evaluation or resuscitation of critically injured patients, 2) appropriate diagnostic laboratory and radiological equipment, and 3) other essential equipment as determined by the state via rules.

- Be open to receive patients 24 hours a day, seven days a week.

- Have a referral, transmission, or admission agreement with a licensed hospital with an emergency room before the facility accepts any patient for treatment or diagnosis. The legislation should direct the state to establish via rulemaking the appropriate maximum mileage allowed to transport the patient from the FSED to the admitting hospital.

- Maintain full time coverage by a physician(s) either board certified in emergency medicine or otherwise qualified to provide emergency medical care.

- Be staffed with physicians, nurses, and other necessary staff with specialty training or experience in managing catastrophic illnesses or life-threatening injuries, including training in advanced cardiac life support, advanced trauma life support, and pediatric advanced life support.

- Adhere to the minimum architectural, sanitary, hygiene, privacy, and medical record standards as defined by the state via rules.

- Maintain an internal pharmacy capable of dispensing medications and controlled substances that are necessary for the prompt and medically appropriate treatment of those conditions that regularly present at a traditional hospital-based emergency room.

- Be capable of accepting ambulance traffic.

- Be accredited by the Joint Commission or other independent accrediting body.

- Provide medical screening and stabilization services for all patients seeking emergency services (CM-EMS Rep. 1-A-08).

100.024 Regulation of Free-Standing Emergency Departments: The Texas Medical Association supports legislation regulating free-standing emergency departments that would include (1) a requirement to be open 24 hours a day, seven days a
week, every day of the year, and (2) a minimum requirement for life support
equipment and training for both adults and pediatric patients, set forth minimum
standards for licensed personnel staffing the emergency departments, and require
certification by the Joint Commission or other such independent accreditation
body. TMA will collaborate with the Texas College of Emergency Physicians
regarding proposed regulations and will oppose any proposed regulations that are
onerous or go against TMA policy (Amended Res. 204-A-08).
TEXAS MEDICAL ASSOCIATION HOUSE OF DELEGATES

Resolution 415
A-17

Subject: Replacing the Medical Malpractice Litigation System With a “No-Fault” Patients’ Compensation System

Introduced by: Ori Z. Hampel, MD

Referred to: Reference Committee on Socioeconomics

Whereas, The current tort system fails at accomplishing the mission of the medical professional liability legal system because (1) access to justice is denied with less than 20 percent of injured patients ever receiving compensation and less than 1 percent receiving a jury award, (2) prevention of similar injury to future patients is impeded by gag orders and a “blame and shame” system, and (3) defensive medicine wastes up to $650 billion of health care resources annually; and

Whereas, Only 11 percent of premium payments for medical malpractice insurance are used to compensate patients; and

Whereas, The medical professional liability legal system denies access to Medicaid recipients, Medicare participants, the unemployed, the elderly, the poor, and young people; and

Whereas, Physicians and other health care personnel must view every patient as a potential plaintiff; and

Whereas, Although Texas medical tort system reforms have dramatically decreased medical professional liability premiums and increased patients’ access to primary care physicians and specialists, they have failed to decrease the practice of defensive medicine, which deprives the populace of billions of dollars that could be redirected to provide patient care; therefore be it

RESOLVED, That the Texas Medical Association support a “no-fault” patients’ compensation system, modeled after the workers’ compensation system, that replaces our broken professional liability litigation system, eliminates the practice of defensive medicine, and ensures real access to real justice for all injured patients, with goals of (1) reducing the incidence of “defensive medicine,” thus lowering health care costs by avoiding unnecessary tests and procedures performed because of fear of litigation; (2) eliminating the practice of “defensive medicine” by eliminating physicians’ fear of personal financial liability and the fear of the litigation process; (3) improving quality of patient care by realigning incentives towards patient safety and a reduction in medical errors; and (4) ensuring that iatrogenic adverse events are evaluated openly, resolved quickly, and compensated fairly.

Reference:
www.patientsforfaircompensation.org
Relevant TMA Policy:

170.005 Professional Liability (Statute of Limitation): The Texas Medical Association supports limiting the statute of limitations on medical professional liability cases to two years (Res. 28N, p 208C, I-94; reaffirmed CSE Rep. 3-A-04; reaffirmed CSE Rep. 2-A-14).

170.006 Physician Liability for Acts of Assistants: The Texas Medical Association, through its Council on Legislation, will review the legal risks physicians assume when directing nurses, including advanced nurse practitioners, physician assistants, and other health care workers not in their employ and determine if legislative reform is indicated to limit the liability risks assumed by these delegating physicians (Committee on Liaison with State Bar of Texas, p 86, A-96; reaffirmed CL Rep. 1-A-06; reaffirmed COL Rep. 1-A-16).

170.007 Professional Liability: To ensure access to medical care for Texans, the Texas Medical Association will continue efforts to (1) reduce or limit frivolous professional liability claims; (2) continue to examine the causes of claims frequency; (3) monitor claims data collected by the Texas Department of Insurance and the Texas Medical Board and make the aggregate data available to the membership; (4) advocate for judicial enforcement of current expert witness and cost bond provisions; and (5) allow the right to countersue (Substitute Res. 102, 103, 108-I-00; amended CSE Rep. 1-A-10).

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).

170.009 Product Liability Lawsuit Impact on Premiums: Rules should be promulgated by the Texas State Board of Insurance forbidding professional liability insurance carriers from considering product liability lawsuits in determining the treating physician’s future premium level (Res. 404-A-01).

170.010 Professional Liability Coverage for Physicians Providing Long-Term Care: To assure access to care for vulnerable elderly Texans, affordable professional liability coverage should be available for physicians who see nursing home patients (CHSO Rep 1-A-02; reaffirmed CHSO Rep. 2-A-12).

170.011 Liability for Acts or Omissions: Texas law should be changed to provide that (1) managed care organizations and insurance plans shall not be vicariously liable for any act or omission of a physician; (2) physicians shall not be vicariously liable for acts or omissions of managed care organizations or insurance plans; and (3) all agreements by which a physician or medical group practice indemnifies a managed care organization or insurance plan are void, including agreements entered into prior to the effective date of the amended statute (Res. 109-A-02; reaffirmed CSE Rep. 1-A-13).

170.013 Health Plan Liability Requirements: Health plans should be prohibited from requiring physicians to secure higher policy limits of professional liability insurance coverage than is required by the hospitals, health care facilities, and institutions in which they practice (Res. 403-A-05; reaffirmed CHSO Rep. 1-A-15; reaffirmed CSE Rep. 1-A-15).